mentalwelfare
commission for scotland

VISIT AND MONITORING REPORT

Adults with Incapacity part 5

Unannounced visits to people receiving treatment under part 5 of the Adults with Incapacity (Scotland) Act 2000

Contents

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Why we carried out these visits

The Adults with Incapacity (Scotland) Act 2000 (The Act) sets out the framework for regulating medical treatment or research for people who may lack capacity to consent.

On our previous visits to care homes and hospitals we found that legal safeguards under the Act for medication and other interventions were not always properly observed, meaning that people who lacked capacity to consent were not receiving treatment in line with the law.

Consent to treatment is the principle that a person’s express permission is given before any medical treatment can be carried out (except in an emergency when treatment may be carried out in order to save a life or to prevent serious deterioration in a person’s condition).

A person’s consent to treatment is only considered valid if the person has the capacity to understand the information given about the treatment, the benefits and risks of that treatment and what could happen if the treatment did not go ahead.

Some people are unable to understand and appreciate these issues for a variety of reasons and this may be either on a permanent or temporary basis.

It is important that people who lack capacity should not be denied treatment that will benefit them because they are unable to consent to it.

Prior to the introduction of the Act, medical treatment for people who lacked capacity was often carried out if it was considered to be in their best interests. However, this did not provide adequate legal and ethical safeguards for the person receiving treatment and also for practitioners involved in the treatment.

Since the introduction of this legislation we have found that part 5 of the Act (which relates to medical treatment and research) is often misunderstood or disregarded. We have also come across services where we have found good practice that could be replicated elsewhere.

We believe people should receive medical treatment that is in line with the law and if people are not able to consent to their own treatment then the law must be used properly to safeguard them.

How we carried out our visits

From July 2011 to November 2012 we conducted a series of unannounced visits to hospitals and care homes. We have previously published an interim report based on our visits up to March 2012.

We identified hospital wards (in psychiatric and general hospitals) and care homes where there was a likelihood of finding people who were not able to consent to their treatment. We did not inform these wards and care homes in advance that we were visiting. Our visitors were our medical, nursing and social work practitioners. We asked the senior member of staff on duty to identify people who may lack the capacity to consent to their current treatment. We then spoke further with the nursing staff, examined the care file and met with the resident or patient where appropriate. We also asked the nursing staff to spend time with us to complete a questionnaire about procedures for assessing capacity and complying with the law.

We looked at the care files to see if there had been consideration of capacity to consent to treatment and if the appropriate documentation had been completed.

We also checked that the care and treatment the individual was receiving was consistent with the documentation and examined if there had been any discussion about whether to carry out cardiopulmonary resuscitation (CPR) in the event of a cardiac arrest.

Where we had concerns about treatment that appeared to us to be unlawful we raised this immediately with staff on the day of our visit and wrote to the person’s doctor. We also gave advice to the nursing/care staff and doctor if we considered that the treatment documentation was not completed in line with best practice guidance. We then entered all of the information into our database and conducted a thorough analysis.

General findings

We visited around 130 care homes and hospitals and examined in detail 879 individual care files, an average of about seven per visit. 60 percent of our visits were to care homes and 40 percent to hospitals.

The smallest services we visited were an NHS learning disability unit and a care home for residents with a learning disability, both with four beds. The largest service was a care home with ninety beds. We assessed several types of wards on our hospital visits. In psychiatric hospitals we visited wards for older people, learning disability units, rehabilitation wards and an acquired brain injury ward. In general hospitals we visited assessment wards for older people, continuing care wards and general medical wards. Our care home visits included general care homes and homes specialising in the care of people with learning disabilities, dementia and alcohol related brain damage.

We spoke with staff to ask them to identify how many people they thought lacked capacity to consent and then looked at how many of those residents had Section 47 certificates in place. Staff identified 1759 people as lacking capacity to consent. Of these 1759 people, 1393 (79%) had a Section 47 certificate in place. We subsequently examined 879 case files in detail. Of the 879 files we analysed, we found 777 people (88%) had a completed Section 47 certificate.

The majority of the individuals whose files we examined, around 70 percent, were identified as having dementia.

Around 13 percent had a learning disability, eight percent had a mental illness, and around five percent had an acquired brain injury. A further four percent had alcohol related brain damage.

We came across 87 people who had more than one diagnosis, for example learning disability and mental illness. A full breakdown of diagnoses is given in Appendix 1.

Section 47 certificates of incapacity

Section 47 of the Act authorises medical treatment (with some exceptions) for people who are unable to give or refuse consent. Under Section 47 a doctor or other authorised healthcare professional examines the person and issues a certificate of incapacity. The certificate is required by law and it provides evidence that the treatment complies with the principles of the Adults with Incapacity Act.

(A copy of the Section 47 certificate of incapacity is attached at Appendix 2.)

The Section 47 certificate certifies the incapacity in relation to decisions about particular medical treatments. The certificate can be issued for very short periods of time or for up to 36 months in cases of severe or profound learning disability, dementia or neurological disorders that are unlikely to improve.

We found that people in NHS care were most likely to have these certificates completed. In the majority of NHS services we visited all of the people identified by staff as lacking capacity to consent had a Section 47 certificate in place. Within NHS services, certificates were more likely to have been completed in psychiatric settings than in general hospitals.

We came across some cases where staff were clear that the person lacked capacity but no Section 47 certificate was in place as it was thought that it was not required if there was a welfare attorney or guardian with powers to consent to treatment (a proxy decision maker). The Code of Practice is clear that a Section 47 certificate is still required even when a proxy with welfare powers has been appointed.

We found about half of all care homes had Section 47 certificates in place for all residents identified as lacking capacity but that five percent of care homes had no residents with Section 47 certificates even where staff had identified that some individuals clearly lacked capacity. In one care home, staff identified 22 residents who lacked capacity but no certificates had been completed.

A quote from one of our visitors:

> *"I discussed the issue of the lack of Section 47 certificates with the care home manager. She says she has been raising the issue with local GPs for over a year. She has e-mailed them, written to them about individual residents and also given them a photocopy of the relevant section of the Code of Practice.*
>
> *Following my visit I was informed that the GP visited and has now completed certificates for six residents."*

Another visitor reported:

> *"I spoke with the manager and a staff nurse, neither knew very much about the AWI Act or Section 47 certificates. I could find no Section 47 certificates for any of the residents. Staff thought that 21 out of 24 residents lacked capacity to consent."*

Responsibility for completion of Section 47 certificates lies with the practitioner responsible for the provision of the proposed treatment or in a position to delegate appropriately the responsibility for the provision of treatment. In a care home this would usually be the General Practitioner. Completion of Section 47 certificates of this type is considered to be part of a General Practitioner’s usual duties with no fee payable (NHS Circular PCA(M)(2012)13).

Of the certificates we looked at, we considered about 15 percent to be invalid for the following reasons:

- on obsolete version of the form (therefore wording of certificate incorrect) (55)

- certificate had expired (23)

- certificate did not cover the treatments being given (19)

- service had drawn up own version of form not meeting statutory requirements (9)

- incomplete certificate e.g. nature of incapacity not given, no grounds given why three year certificate appropriate (6)

- not signed or dated (4)

We also came across a further 11 percent of certificates that we considered as valid but over-generalised. An example would be a certificate authorising “all medical treatments”. We think that these certificates went beyond what is recommended in the Code of Practice.

The Code of Practice defines “fundamental healthcare procedures” as including all measures to promote or safeguard the following: nutrition, hydration, hygiene, skincare and integrity, elimination, relief of pain and discomfort, mobility, communication, eyesight, hearing and simple oral hygiene.

We found wide variation from the term “fundamental healthcare procedures” as used in the Code of Practice. Some of the terms we found used instead were:

“All primary medical services”; “all general medical services”; “all primary medical treatment”; “basic healthcare provision”; “all medical and nursing treatment”; “all medical and dental and nursing interventions”.

We think that these terms go beyond what was intended in the definition and should be avoided.

We found one Section 47 certificate in a general hospital setting which stated that the patient was incapable in relation to “the decision to leave the hospital against medical advice”. The Section 47 certificate does not give authority to detain someone on this basis. Section 47 of the Act does not permit the use of force or detention “except where immediately necessary and only for as long as is necessary”. This means that in an immediate situation it is reasonable to prevent a person from leaving hospital for his/her own safety. If the person continually expresses a desire to leave or attempts to leave and has to be prevented from doing so then we do not think that the certificate gives authority for that level of intervention. In that situation we would recommend detention under mental health legislation if the necessary criteria are met. In this particular case we wrote to the hospital consultant to inform him of our views on this matter.

Assessment of capacity

As part of our monitoring we checked if there was an assessment of capacity other than the Section 47 certificate within the relevant notes.

In some cases there were difficulties finding this information in the notes. We found some settings where there was specific capacity assessment paperwork completed as part of the notes. In other settings assessment of capacity was considered as part of the admission process. Some areas use a pro forma for multidisciplinary team review which includes a section to record capacity. We occasionally found an assessment of capacity performed for a different statutory purpose, such as a certificate of incapacity under Part 4 of the Adults with Incapacity Act (Management of Residents' Finances).

In some cases an assessment of capacity was recorded within the medical notes. There were many occasions where an assessment of capacity could not be found. The assessment may have been in a previous volume of notes, or in the GP records, to which we did not have access.

We became aware of units demonstrating good practice in the assessment of capacity. An example of this is described in Appendix 3.

Treatment plans to accompany the certificates

The Code of Practice to Part 5 of the Adults with Incapacity Act recommends the use of treatment plans attached to the Section 47 certificate where there are "multiple or complex healthcare interventions".

Of the 777 Section 47 certificates we looked at, we found that 428 (55%) had a treatment plan completed. On further inspection we found that most (87%) of the treatment plans were consistent with the treatment being given.

Where there was a Section 47 certificate without a treatment plan, we thought that a treatment plan was required in a majority of cases (64%). We came across many examples where a large amount of information was crammed into the small box on the front of the Section 47 certificate and a separate treatment plan would have been helpful.

We found examples where the attached treatment plan was over-generalised. An example of this was a treatment plan stating “Administration of medicines”. We think that this is too broad to comply with the recommendations in the Code of Practice.

We also found treatment plans that did not state all of the treatments being given. There were examples where some of the current medication was included but others were omitted.

There were some treatment plans where the signature was illegible and there was no printed name to identify who had completed the plan. The treatment plan was undated in several cases. We think that it is important that the person completing the treatment plan can be identified and that the date of completion of the plan should be recorded.

We were told in two care homes that the local General Practitioners were reluctant to complete treatment plans to accompany Section 47 certificates. We advised both care home managers to write to the General Practitioners involved to highlight the relevant sections of the Code of Practice.

Covert medication

We came across seven cases where people were being given medication covertly without a completed Section 47 certificate. We would expect that treatment with covert medication would only be administered under a Section 47 certificate of incapacity or appropriate Mental Health Act documentation.

Our good practice guide on covert medication suggests a care pathway to be followed if considering administration of medication in this way.[1]

Do not attempt cardiopulmonary resuscitation (DNACPR)

NHS Scotland introduced the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Integrated Adult Policy in 2010 with the intention of preventing inappropriate, futile and/or unwanted attempts at CPR. The policy is intended as a

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[1] http://www.mwcscot.org.uk/media/51790/Covert%20Medication.pdf

positive step to help a person’s wishes to be followed at the end of life irrespective of whether care is being provided in a hospital, care home, hospice or at home.

CPR measures include external chest compression, artificial respiration and defibrillation. They do not include analgesia, antibiotics, medication for control of symptoms, feeding or hydration, investigation and treatment of a reversible condition, seizure control, suction or treatment for choking.

A diagnosis of dementia, learning disability or other condition that might lead to someone being unable to consent to medical treatment does not mean that decisions about CPR should be based on an individual professional’s opinion on quality of life. The policy recognises that opinions on quality of life are very subjective and often at variance with the views of the patient and relevant others.

Where a patient lacks capacity for involvement in advance decisions and has no welfare proxy then the responsibility for deciding if resuscitation is in the patient’s best interests lies with the lead clinician with clinical responsibility for the patient. Family/carers and next of kin do not have decision-making rights or responsibilities and discussion with them is to give them the opportunity to express their views and to clarify the patient’s views prior to the incapacity.

Where a patient lacks capacity but has a legally appointed proxy decision maker with welfare powers including consent or refusal to treatment then that proxy decision maker can make an advance refusal of CPR for the patient and consent to CPR if offered. The proxy decision maker cannot demand CPR if it is clear that CPR will not be successful in achieving sustainable life for the patient.

We decided to check if consideration was being given to DNACPR decisions, who was involved in that decision and if the National DNACPR form was being used and properly completed.

In around 38% of all the files we reviewed we found a DNACPR decision had been made (331 cases). It was documented on 75% of the DNACPR forms that relatives had been consulted. We found a small number of DNACPR forms that we thought were invalid or incomplete because:

- the rationale for the DNACPR decision was unclear

- there was no signature on the form

- the DNACPR decision had been taken based on an acute illness that had since resolved

- the DNACPR form had been completed stating that the next of kin was not to be resuscitated, rather than the intended individual.

A quote from one of our visitors:

"The DNACPR form was completed in 2009 and stated that CPR was unlikely to be successful because of an acute medical condition being treated at the time and now resolved. I advised that this DNACPR certificate was not appropriate and should be removed and the patient reassessed."

We noted good practice on some of the forms, such as stating the interval for review of the decision. We also found cases where the doctor completing the certificate had made a comprehensive record in the medical notes of discussing this decision with family members.

We found some DNACPR forms where there was no record of discussion with the welfare guardian. Doctors completing the form should attempt to ascertain if there is a welfare proxy with relevant powers in place.

Action taken by the Commission

We took action based on the findings from our visits. This was often done during the visit. In other instances we wrote to the relevant service with our recommendations.

The most frequent action was to recommend the use of treatment plans for people who already had a Section 47 certificate. This was often accompanied by the Code of Practice (Third Edition) or a link to the relevant website being provided.

There were many occasions where we recommended that a Section 47 certificate should be completed. We also found examples of out of date and ‘home-made’ certificates being used. The exact wording of the current form specified by the regulations (and included as an annex in the Code of Practice) must be used for the certificate to be valid.

We found examples of treatment plans where we thought that the wording was over-generalised. In these cases we recommended that the treatment plans should be rewritten to be more specific. We also found Section 47 certificates and treatment plans which did not list all of the treatments that were being provided and in these instances we advised that this should be rectified.

We identified three cases where we thought that people with a Section 47 certificate might not actually require one. We asked for a review of the need for the certificate for these individuals.

We found some Section 47 certificates which had expired, or did not have the expiry date completed. We identified two certificates where an incorrect diagnosis had been stated.

We identified one Section 47 certificate where we thought that the doctor who had completed the form was unaware of the existence of a welfare guardian. We notified staff at the care home and wrote to the guardian to confirm that the doctor should be discussing proposed medical treatment with her.

We also discovered several problems with other issues related to treatment. There are some treatments regulated under Section 48 of the Act which require additional safeguards. We found two cases where we advised that action was necessary to comply with Section 48 of the Act. Both individuals were receiving medication to reduce sex drive.

We found examples of covert use of medication. In the majority of cases a covert medication pathway was in use but we had to recommend the use of such a pathway on three occasions.

There were also some recommendations that we made regarding the use of DNACPR forms. We found two unsigned forms and two forms with incorrect information and brought this to the attention of the services involved. We also identified forms where discussion with a welfare guardian or family members had not been recorded and advised that these cases should be reviewed.

Conclusions

1. Treatment was being given under the authority of a Section 47 certificate to 79% of people who lacked capacity to consent to treatment.

2. There was better compliance with the legislation for individuals in hospital compared with residents in care homes. Compliance was higher in psychiatric hospitals than general hospitals. We found some care homes where compliance was very poor. This was due to a mixture of poor awareness of the law and an apparent reluctance by some general medical practitioners to complete Section 47 certificates.

3. Where certificates were granted, we had concerns in around one quarter of cases. In some cases the certificate appeared to be invalid or did not cover the treatment prescribed. In others, the wording of the certificate was very broad and did not seem to us to comply with the Code of Practice and the intention of the legislation.

4. While decisions not to attempt cardiopulmonary resuscitation were generally well made, we found a few cases where the decision and the reasons for it were not properly documented. Discussion with relatives or welfare proxies was not always recorded.

Recommendations

1. The provisions of Part 5 of the Act should be included in induction programmes and Continuing Professional Development for staff working in settings where people may lack capacity to consent to treatment..
2. The current Code of Practice should be available in all settings where Section 47 certificates are completed.
3. Services should ensure that they are using the most recent form of the Section 47 certificate (or the exact wording of that form if they have drawn up their own version of the document).
4. Treatment plans should be attached to the Section 47 certificate where there are multiple or complex healthcare interventions.
5. The NHS Scotland DNACPR policy should be followed when completing DNACPR forms, particularly with regard to discussion with welfare proxies and family members.

Definitions

Most = more than 80%

Majority = 56-80%

About half = 45-55%

A minority = 20-44%

A few = less than 20%

Very few = less than 10%

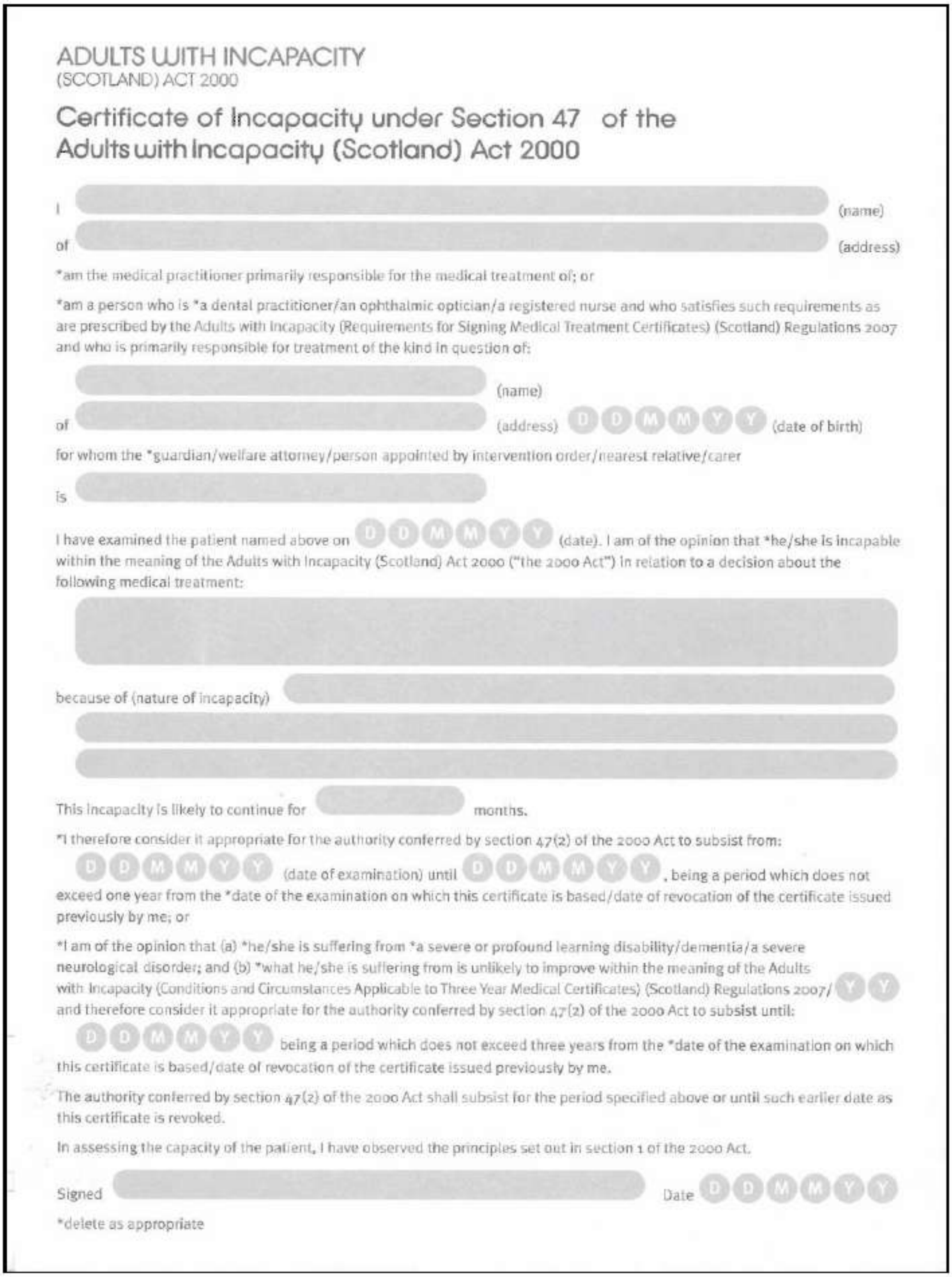
Appendix 1

Diagnosis	Number of people
Dementia	633
Learning Disability	119
Mental Illness	71
Acquired Brain Injury	48
Alcohol Related Brain Damage	35
Autistic Spectrum Disorder	20
Personality Disorder	3
Other	14

NB: total is more than number of files examined (879) as some individuals had more than one diagnosis.

Appendix 2

The current Section 47 certificate:



ADULTS WITH INCAPACITY
(SCOTLAND) ACT 2000

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I (name)

of (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

(name)

of (address) D D M M Y Y (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is

I have examined the patient named above on D D M M Y Y (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

because of (nature of incapacity)

This incapacity is likely to continue for months.

*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

D D M M Y Y (date of examination) until D D M M Y Y, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ Y Y and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

D D M M Y Y being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed Date D D M M Y Y

*delete as appropriate

Appendix 3

An example of good practice

The green box system

This system was introduced in NHS Lanarkshire to identify quickly and easily individuals who may require assessment of capacity and if necessary completion of a Section 47 certificate of incapacity. The progress in the assessment is indicated on the patient name board at the nurses' station by the use of green box symbols.

The green box system has been used successfully in some of the general hospital admission wards and may be rolled out further across NHS Lanarkshire admission wards.

For further information contact Ruth Thompson, Associate Director of Nursing at NHS Lanarkshire.

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Mental Welfare Commission (May 13)