NHS
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Quality Matters

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Issue 1

together we will

WELCOME

Welcome to the Trust's new clinical governance newsletter. It is intended that this will be circulated to all staff every couple of months, with each issue drawing together a key theme that has featured in recent clinical incidents, complaints or legal claims – to disseminate wider learning across the Trust. The newsletter will also capture any current Trust issues or developments about which staff should also be aware, and would welcome contributions from the divisions to share learning and good practice to a wider audience.

THIS ISSUE : CONSENT AND MENTAL CAPACITY

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CONSENT AND MENTAL CAPACITY

Consent must be voluntary and informed, and the patient must have capacity to make the decision. Compliance does not automatically mean the patient has capacity.

The Mental Capacity Act (MCA) 2005 applies to persons 16 years' and over. MCA assessments are DECISION and TIME SPECIFIC and MUST be completed if there is reason to doubt the patient's capacity to make the decision. You cannot assess for a blanket decisions.

Patients must be given all practicable support to make the decision; until this is done, they cannot be deemed to lack capacity. For example, if hard of hearing, write information down and the questions you ask the patient. If the patient does not speak English, you MUST use a translator. Refer to SALT if there are difficulties with verbal communication, such as expressive dysphasia. This must be documented within the capacity assessment.

In some cases, a person may have fluctuating cognition, where they are lucid at times and confused at other times, which may give you reason to doubt their capacity. They also may have capacity related to one decision and not to others. In these cases, it would be beneficial to have discussions with the patient regarding a decision (such as hospital admission or falls interventions) when they have capacity , so that their wishes can be respected when the person loses capacity. It will also mean that staff may need to consider different care plans to be put in place for when the patient is confused (such as an increased level of supervision), but when the patient is not confused, they have capacity to consent to this.

If a patient lacks capacity, a Best Interest decision MUST be completed by law, including for falls intervention, and it is a statutory duty to speak with family/friends (unless an emergency, but then as soon as possible – this can be completed via telephone). If there are no family/friends, or they are not appropriate, an IMCA referral must be completed for any serious medical treatment, including DNACPR.

The best interest decision must include the rationale for how the decision has been made, what the least restrictive option is (and, if not chosen, why not), and a plan of how to carry the best interest decision out, for example any restrictive practices required such as level of supervision or restraint.

Both MCA and Best Interest MUST be documented on the trust templates found via the safeguarding file within 'ad hoc', even if Consent Form 4 is being used.

DoLS applies to 18 years' and over and only allows staff to keep the patient in hospital; a separate MCA would be required for treatment, procedures, and interventions. This must be completed when the decision about hospital admission is being made and the patient meets the criteria for a DoLS: 18 years', lacks capacity for hospital admission, not free to leave (the patient does not need to be asking or trying), and is under continuous control and supervision.

Examples of Best Practice

- A patient lacks capacity for refusing medications and so a best interest decision needs to be completed with a plan. The doctor must look at each medication and decide if it is required. If required, it should be considered how can this be given ensuring least restrictive option (e.g. asking family / known carers to try to give, giving covertly, or changing to IV if able to give via that route). Consult Pharmacy.

- A patient is trying to leave but lacks capacity to self-discharge. A best interest decision must be

completed with a plan. The team should decide whether the patient is free to leave or not, what level of supervision the patient requires per Patient Observation Policy, whether family / known carer can come to support, and whether any level of restraint (physical or chemical) is required.

Examples of Incidents

- A patient refused chlordiazepoxide for alcohol withdrawal. The MCA assessment deemed the patient to lack capacity for this decision, but a best interest decision was not completed on how the medication would be provided. The patient became more aggressive and assaulted staff and patients.

- A patient was deemed to lack capacity for hospital admission and staff granted a DoLS, even though the patient was profoundly deaf, and staff did not evidence that they had written any information down for the patient. The patient was deprived of their liberty unlawfully.

- A patient lacked capacity for falls intervention. No best interest decision was made, which would include level of supervision. However, staff had the patient on level 3 supervision but then let the patient go to the toilet unsupervised and they fell.

Examples of Complaints

- Case 1: A non-verbal inpatient was given a vaccination. His wife had LPA for Health and Wellbeing. Throughout the patient's six-month admission there was no record of an MCA undertaken. Although staff stated that they believed the patient to have had capacity and that he had given non-verbal consent to the vaccination, given the patient's brain injury and complex communication issues, upon investigation this was unclear and it could not be evidenced whether he was consistent with his facial expressions or gestures; therefore, there was a reason to doubt his capacity.

- Case 2: A surgical patient whose sister had LPA for Health and Wellbeing raised concerns that the patient's consent to a procedure was invalid because he was unable to retain information. There had also been a previously documented ward discussion with a diabetes nurse in which the patient had stated that he had trouble with his memory and that staff should speak with his sister, who had LPA. Unfortunately, when subsequently consented there was no documentation in the notes of the discussion the doctors had with the patient. It was therefore unclear and could not be evidenced if, when being consented, the patient had shown any issues with making the decision or his retention of the information.

HEALTH & SAFETY RISK

Health & Safety risks identified through the local risk assessment process should be communicated to all staff though the existing ward and department forums, including the control measures staff need to follow for their safety and the safety of others. It is also important to ensure that any new environmental hazards and any patient specific risks, such as the potential of violence or known blood-borne viruses, are communicated to all relevant staff so that any additional control measures can be taken.

ADVANCED DECISIONS

Advanced Decisions are not something that we see very often, but it is important that staff should be aware of the principles and what to do when caring for a patient who has made an Advanced Decision.

An Advanced Decision allows an individual an opportunity to share their wishes and gives them the right to refuse medical treatment at a future time when they may no longer have the capacity to be involved with the decision making process. The process allows only for refusal of treatment and patients cannot insist on specific care or treatment that they would like to receive. A well drafted Advance Decision will provide clear and unambiguous directions to the treating team who can legallyrely on the terms of the Decision when deciding what treatment can or cannot can be provided to a patient. For an Advanced Decision to be considered valid the patient must be over the age of 18, have capacity at the time that the Decision was made, be specific about the circumstances that it applies to, and be witnessed. This is particularly important if the care relates to life saving or sustaining treatment. If a patient you are caring for has an Advanced Decision, and now lacks capacity to consent to treatment, please seek advice from the Legal Services Team as to whether the terms of the Advanced Decision remain valid and therefore should be followed.

INFORMED CONSENT: CASE STUDY

Lack of informed consent is an issue that we see raised many times as part of compensation claims made against the Trust. Patients can claim that they did not appreciate the reality of the risks associated with their treatment or understand the limits of what treatment can achieve.

It is easy for a solicitor to claim that their client would never have undergone a surgical procedure if they had really appreciated the risks involved or had known that treatment would not necessarily resolve all of their symptoms. Even when a complication occurs that could not have been avoided in the best of hands, a patient can succeed with their claim if they can demonstrate that, on the balance of probability, they did not have all the relevant information provided to them in a way that they could fully understand.

Medical staff are still documenting 'risks and benefits explained' without recording the substance of this conversation. A shortcut with documentation can leave the Trust unable to defend a claim when the very instance that we advised could happen, actually does happen, but we have no clear record that the patient was given and understood this information before agreeing to treatment. Remember that the patient does not have the same clinical knowledge that you have. What does 'risk of nerve damage' or 'risk of infection' actually mean to the person who suffers it? Do they really know what to expect and do we know that they understand what to look out for and bring to our attention?

"Remember that the patient does not have the same clinical knowledge that you have. What does 'risk of nerve damage' or 'risk of infection' actually mean to the person who suffers it?"

Example

A patient was seen in the dermatology clinic, reassured and discharged with advice to seek a further clinical opinion if a mole increased in size. You would think that that was clear and sensible advice, but how does a patient know when a mole is increasing in size when they see it every day? How big does it need to get, and how quickly, before they need to see their doctor? What could happen to them if they missed an opportunity for further review by a week, a month, three months or a year? In short, does your patient know and truly understand what they need to know or have you told them something that makes sense to you, but not necessarily to them?

RESOLVING CONCERNS FROM PATIENTS AND RELATIVES

When patients or relatives contact WUTH's Patient Experience Team they will sometimes say that they have already tried to raise their concern with frontline staff but have just been told to 'speak to PALS'.

Many matters that trouble such enquirers could have been dealt with as they arose, and it should always be the aim of staff to try to resolve such concerns promptly at departmental or ward level. When dealing with a concern, staff should:

- Stay calm, professional, and courteous.
- Listen carefully and find out the nature of the problem.
- Try to solve the problem themselves and confirm that the enquirer is satisfied with the outcome.
- Involve a senior for assistance if unable to resolve themselves.
- Address their own personal safety.
- Ensure that the patient's immediate healthcare needs are being met, and give assurance that care will not be compromised.
- Note any necessary follow-up action and pass to an appropriate manager or the Patient Experience Team
- Advise the enquirer of these actions and of any timescales involved.

USEFUL LINKS

Safeguarding

https://capacityguide.org.uk/

https://www.gmc-uk.org/ethicalguidance/ethical-guidance-fordoctors/decision-making-andconsent

https://www.gov.uk/government/publications/liberty-protectionsafeguards-factsheets

https://www.gov.uk/government/consultations/changes-to-the-mcacode-of-practice-and-implementation-of-the-lps

https://www.wuth.nhs.uk/media/19723/pol-237-role-of-themental-capacity-act-2005-in-acutehealthcare-delivery-v4.pdf

https://www.wuth.nhs.uk/media/20879/pol-217-deprivation-of-liberty-safeguards-policy-v31-extended-to-31102022.pdf

Complaints

https://www.wuth.nhs.uk/media/16159/pol-023-concerns-andcomplaints-handling-policy-v15.pdf

https://www.wuth.nhs.uk/media/20447/patient-experienceleaflet-2021-v7.pdf