

Mental Capacity Act Practical Applications



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Case 1 Mrs H



- 97 lady on orthopaedic ward admitted with haemarthrosis of knee following a fall
- She is determined to go home but MDT concerned about her ability to cope in isolated cottage. Confused on the ward, “unexplained falls”
- GP very concerned, will not accept responsibility for patient in the community
- Reports of squalid home environment –vermin infested

Mrs H

Further Enquiries Made...



- Injury sustained when feeding sheep and her dog bumped into her.
- Eccentric behaviour, looks dishevelled
- Home is a cottage with small field, 5 sheep, 2 dogs, mice in the barn.
- Cottage has damp at one end, few tiles off roof. Cluttered, basic amenities. Goose indoors.
- Access is via farm track, 1 mile from main road. Nearest neighbours across the field

Mrs H



- Confused post arthroscopy. MMSE now 29/30
- Medically well, walking independently on ward. Independent in self care
- Hearing loss, poor dentition and Devon accent make conversation difficult.
- Does she have capacity to make decision about discharge plan?

Assessing capacity



The two stage test :-

1) 'Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?'

If so,

2) 'Is the impairment, or disturbance, sufficient that the person lacks the capacity to make that particular decision, at that particular time?'

(this 2 stage test must be used and you must show it has been used)

The Functional Test for Capacity



Understand the Information relevant to the Decision

Retain the Information

**Use or weigh up information as part of the
decision-making process**

Communicate their Decision

Mrs H: Outcome



- No obvious disorder of mind or brain although MDT were concerned about executive function
- She was able to understand, retain and use the information to communicate her decision.
- An unwise decision?
- Discrimination by MDT because of age and behaviour?
- Support offered via neighbours, Home Improvement Scheme, changed her GP.

Case 2 Mrs SW



- Mrs SW. 59 years old admitted with left TACS 5 days ago. Thrombolysed on admission but without effect. NIHSS 28. Aphasic, difficult to rouse, no apparent comprehension.
- Noted to have profuse vaginal bleeding 8 hours post admission and an experienced nurse thought there was evidence of vaginal trauma.
- Mrs SW lives with husband, one daughter in daily contact. Previously well with no PMH. Heavy smoker.
- Since admission has been in fast AF and has developed acute severe pulmonary oedema several times. Currently rate controlled on maximal IV therapy, no pulmonary oedema. Stroke symptoms unchanged. Family present most of the time.

Mrs SW. Questions:



- Does she have capacity to make decisions regarding the investigation of the PV bleed?
 - Is this important?
- Her husband is fully informed about her clinical situation and is happy “to leave everything to the experts”.
 - Do we need to discuss the PV bleed and suspicion of trauma with him?
 - What are the differential diagnoses of the PV bleed?
- Does she need an IMCA?
- How do we proceed?

Case 3 Mr MS



- MS 87 years old.
- Independent in first floor flat
- Private help once a week to help with domestic chores and heavy shopping because of increasing physical frailty.
- Own cooking, independent in personal care and did go out to the nearby shops.
- Doesn't drive.
- One son lives nearby, is supportive and visits regularly. There was no history of confusion prior to admission.

Mr MS



- Admitted 8 weeks ago with acute confusion and possible left sided weakness.
- UTI diagnosed, appropriate antibiotics given.
- A CT scan revealed an acute cortical infarct, marked atrophy and evidence of small vessel disease.
- Over next 2 weeks: Complete recovery from the UTI and a complete recovery of limb function but remained disorientated and confused with some neglect.
- 2 falls in the first week with no injury sustained.

Mr MS



- He was transferred to a Community Hospital for rehabilitation.
- Fell 2 days after admission and another UTI diagnosed.
- He became very confused for 3 days.

Mr MS. Last MDT Meeting



- OT: Unsafe in kitchen with complex tasks but can make cup of tea although needed help to find the milk in the OT kitchen. Needs minimal help with washing and dressing lower half. No problems with grooming or feeding.
- PT: independent in transfers from bed to chair and chair to stand. Mobilises independently, safer with a frame but needs prompts to use a frame safely. Unsafe on stairs without help
- Nurses: Needs prompts to take medication. Continent and independent in toilet. Often rummages through other patients lockers and constantly asks to go home. Needs reorientation at night as cannot find his own bed reliably. (*on further discussion this has not been an issue for past week, nor has he wandered out of the ward for 2 weeks*) Concerned about mood as frustrated and anxious.

Mr MS: Doctors notes



- Discussion regarding discharge when son present 2 weeks ago. MS unable to follow conversation, disorientated in time and place (thought he was still in acute hospital). Unable to discuss the hazards associated with discharge to home.
- Treated for a symptomatic UTI the following day. Very confused, wandering and agitated.
- Last entry: haemodynamically stable, apyrexial. Chatty and converses normally. No evidence of neglect clinically although some minimal evidence in therapy. He wants to go home.

Mr MS



- Team view about decision to go home is that he does not have capacity to make decision as he could not follow the conversation with the consultant.
- He is often confused and is at risk of falls.
- The therapists feel he should not go home and it would be in his best interests to be cared for in a RH, preferably single level.
- His son has grave concerns as it is clear that he has had difficulties with personal care whilst an in-patient.
- The OT thinks he requires an IMCA.

- What next?

Mr MS



- Is there an impairment of his mind or brain that may be impairing his ability to make a decision?
- Test of Capacity
 - When presented with the problems he was having with personal care he felt it would be OK tomorrow when he got home.

Mr MS



- Case conference
- He insisted he wanted to go home
- Acting in his best interests and the least restrictive option
 - Home with care package
 - Community support, day centre and visits
 - Pendant alarm
 - Regular reviews

