Pennine Care NHS
NHS Foundation Trust

Policy Document Control Page

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Supersedes

Supersedes: Electro Convulsive Therapy Policy V2

Description of Amendment(s):

- Further clarification on ECT for informal patients
- Further clarification on ECT for patients subject to the MHA
- Updated MCA guidance

Originator

Originated By: ECT Forum

Designation: On behalf of the Mental Health Law Scrutiny Group

Equality Impact Assessment (EIA) Process

Equality Relevance Assessment Undertaken by:

ERA undertaken on:

ERA approved by EIA Work group on:

Where policy deemed relevant to equality-

EIA undertaken by: Mia Majid, MHL Manager

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Integrated Governance Group

Referred for approval by: Mental Health Law Manager

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Circulation

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Policy to be uploaded to the Trust's External Website? YES

Review

Review Date: November 2015

Responsibility of: Mental Health Law Manager

Designation: On behalf of the Mental Health Law Scrutiny Group

An e-copy of this policy is sent to all wards and departments

This policy is to be disseminated to all relevant staff.
This policy must be posted on the Intranet.

Date Posted: 8th April 2014

To be updated at the end of the review

Pennine Care NHS
NHS Foundation Trust

ELECTRO CONVULSIVE THERAPY

1. Introduction

1.1 Electro Convulsive Therapy (ECT) is one of the therapeutic treatment options available to patients within Pennine Care NHS Foundation Trust. ECT remains an essential tool in the treatment of mental disorders.

1.2 Pennine Care NHS Foundation Trust is dedicated to providing a high quality service which all patients rightly expect. All patients who have been prescribed ECT as a treatment option can be assured that:

a) Their illness has been properly assessed
b) Other treatment options have been considered and discussed with them
c) They are properly advised about the process of ECT and its possible side effects
d) The consent policy and process is fully explained
e) The treatment is delivered by Practitioners competent to do so
f) There is full recording of the process for each client
g) There is periodic review of the treatment via the audit process

1.3 This Policy reflects current standards in the practice of ECT, and is liable to be updated as standards and practice change.

1.4 This policy must be read in conjunction with the CL2 Consent to Examination or Treatment Policy and where applicable the CL58 Treatment of Patients Subject to the Mental Health Act 1983 - Part 4 & Part 4A.

2. Indications for ECT

2.1 ECT may be administered for the relief of conditions contained in

(i) the NICE Guidelines Technology Appraisal 59, Guidance on the Use of Electro Convulsive Therapy published April 2003 or

(ii) the ECT Handbook Council Report CR176 published by the Royal College of Psychiatrists 2013 and

(iii) The NICE Guidelines for Depression GC90 2009

2.2 Clinicians who wish to prescribe ECT for conditions not included in the NICE Guidelines or the ECT Handbook from the Royal College of Psychiatrists must obtain a second consultant opinion which must confirm that the proposed treatment is in the best interest of the patient, notwithstanding any consent the patient may give.

3. Consent to Treatment and Provision under the Mental Health Act (MHA)

3.1 Informal Patients Adult

3.1.1 Informal patients must give consent to treatment and this must only be done on the current consenting documentation within the ECT Care Pathway, (see Pathway Document). Consent shall be given without duress and the patient shall be advised that consent can be withdrawn by them at any time. Although documentation will be used to initiate the consent process prior to commencing ECT the patient will be asked to confirm consent at the time of each application.

3.1.2 Informal patients may make an Advance Decision refusing treatment. It is the responsibility of the patient or their representative to notify the clinician of this.

3.1.3 Informal patients who do not have capacity and for whom ECT is recommended are unable, by definition, to give consent. ECT may be given if the provisions of the Mental Capacity Act (MCA) are followed (the person does not have to be detained). A test of capacity and best interest's decision under the MCA could provide authority to give treatment as long as it does not conflict with an advance decision made by the patient or the views of an attorney, deputy or the court of protection and there is no reason to believe that the patient would object to the treatment. Otherwise consideration should be given to such patients being assessed under the Mental Health Act (MHA), and if detained, treated under sec. 3.2.4.

Richard Jones in his 16th edition of the Mental Health Act Manual states that there is a practice of making applications to detain patients who require medical treatment for their mental disorder despite the fact that such patients are both mentally incapable and compliant, in that they are not exhibiting dissent to being in hospital or to being treated at the time when an application is made.

In particular it is felt that a compliant patient who needs to be given ECT as a treatment for depression must be detained under the Act

before the treatment can be given, even though the effect of the depression has been to render the patient mentally incapable.

The provision of medical treatment to a mentally incapable patient who is not being deprived of his/her liberty is authorised under s5 and s6 of the Mental Capacity Act (MCA) if the treatment is to be considered to be in the patient's best interests.

The 'sectioning' of the patient solely for the purpose of providing 'authority' for medical treatment for his/her mental disorder to be given is both unnecessary and unlawful as the statutory criteria for detention cannot be satisfied.

3.2 Adult Patients Detained in Hospital under the MHA 1983

3.2.1 ECT is covered under section 58A of the MHA 1983 (as amended). Chapter 24 of the MHA Code of Practice (CoP) refers to treatment under the MHA.

Patients with Capacity to Consent

3.2.2 Patients who have the capacity to consent may not be given ECT unless they consent to it (except in urgent cases see para 3.5 below).

3.2.3 Before ECT is given to a capacious patient (except in an urgent case) the Approved Clinician (AC) / Responsible Clinician (RC) in charge of the patients' treatment **or** a Second Opinion Appointed Doctor (SOAD) must provide a certificate under Part 4 of the Act (Form T4) confirming:

- That the patient is capable of understanding the nature, purpose and likely effects of the treatment
- That the patient has given their consent

Patients Lacking the Capacity to Consent

3.2.4 In order that an incapacitated patient may be legally given ECT, (except in an urgent case), a SOAD must, after appropriate consultation, provide a certificate under Part 4 of the Act (Form T6) that:

- They are not capable of understanding the nature, purpose and likely effects of the treatment **but**
- it is appropriate for the treatment to be given **and**

- giving them treatment would not conflict with an advance decision which is valid and applicable, or a decision made by the lasting power of attorney or deputy or by the Court of Protection.

3.2.5 An attorney or deputy may not give consent on the patient's behalf if that patient is detained under the MHA.

3.3 Patients on Community Treatment Orders (CTOs)

3.3.1 For CTO patients who are aged 18 years or over, Form CTO12 can be used to certify consent to ECT treatment in the rare circumstances where this might be considered by the AC/RC.

3.3.2 ECT treatment cannot be given to any patient who is not yet 18 (regardless of whether or not the patient is detained or subject to a CTO) unless a second opinion appointed doctor has certified that the patient consents to ECT and that the treatment is appropriate (using form T5).

3.4 CTO Patients Recalled to Hospital

3.4.1. ECT may be given to a patient where a CTO has been revoked when:

- A Part 4A Certificate (Form CTO11) explicitly approves continued treatment in the circumstances, or;

- Treatment already being given on the basis of a Part 4A Certificate may be continued, even though it is not authorised for administration on recall, if the approved clinician in charge of the treatment considers that discontinuing such treatment would cause the patient serious suffering. Treatment may however only be administered pending a new certificate being provided by a SOAD.

3.5 Urgent Cases Where Certificates are Not Required (S62 Treatment)

3.5.1 Section 58A does not apply in urgent cases where treatment is immediately necessary. Similarly a Part 4A certificate is not required in cases where treatment is immediately necessary. However Approved and/or Responsible Clinicians authorising treatment under S62 must be aware that the circumstances under which S62 treatment can be given are different from the circumstances allowing medical treatment under S62, and are given in 3.5.2.

3.5.2 ECT under S62 may only be given if the treatment is immediately necessary to:

- Save the patient's life, or;
- Prevent a serious deterioration of the patient's condition and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed.

3.5.3 Treatment may only be given for as long as immediately necessary. When treatment ceases to be immediately necessary, the usual requirements for certificates apply.

3.6 Circumstances Where a Certificate Ceases to Authorise Treatment

3.6.1 A certificate provided under Part 4 or Part 4A will cease to authorise treatment when:

- The clinician who provided the certificate stops being the approved clinician in charge of the patient's treatment
- The patient stops being detained in hospital or liable to a CTO (even if only temporarily) (except for patients under the age of 18)
- The patient regains capacity where they previously lacked capacity or the patient loses capacity.
- The patient consented to treatment but is now refusing.
- A clinician treating the patient becomes aware that treatment would conflict with an advance decision to refuse treatment.
- A clinician treating the patient becomes aware that the Court of Protection or an attorney or deputy makes (or has previously made) a decision that treatment should not be given.
- The SOAD has specified a time limit and that time expires, or limits the number of treatments and the number is reached.
- Change of laterality of ECT administration

3.6.2 Unless in an urgent case (see section 3.5 above) treatment may not be continued whilst a new certificate is obtained.

3.6.3 All expired or ended certificates must be clearly marked as expired and copies kept with the ECT Pathway with the patient's Health Records.

3.7 Special Provisions applicable to young persons under the age of 18

3.7.1 Section 58A of the MHA 1983 (as amended) applies to all patients under the age of 18 regardless of their legal status.

Detained Patients and Informal Patients under 18 with capacity

3.7.2 No person under the age of 18 may be given ECT unless all the following 3 requirements are met.

- If the patient is competent consent must be given.
- A SOAD must certify the patient is capable of understanding and consents.
- A SOAD must agree the treatment is appropriate

A competent child refusing consent cannot be given ECT unless it is a life threatening emergency in which case refusal can be overridden.

Detained Patients under the age of 18 without capacity

3.7.3 The process applied to adult incapacitated patients (3.2.4) applies, except that no one under 18 can make an Advance Decision to refuse medical treatment.

Informal Patients under the age of 18 without capacity.

3.7.4 ECT can be given if a SOAD certifies it on Form T6 **AND** if the person is over 16 the provisions of the MCA are applied (best interest decision and the use of an Independent Mental Capacity Advocate (IMCA) if there is no one appropriate to consult for the best interest decision).

There is nothing in the Act itself to prevent a person with parental responsibility consenting to ECT on behalf of a child or young person who lacks the ability to consent for themselves and who is neither detained nor on SCT patient. However, it would not be prudent to rely on such consent, because it is likely to fall outside the parental zone of control. Therefore if the person is under 16 the Code of Practice suggests court authorisation – except in an emergency – should be sought and that this should occur before a SOAD visit is arranged (s58A(7)).

4. Side-Effects

4.1 All patients for whom ECT is considered must be warned of adverse effects both short term and potentially long term, and this must be done within the consenting process incorporated in the ECT Pathway Document. All patients will be offered both written and verbal information.

5. Pre-Treatment Protocol

5.1 All patients must enter the ECT treatment process via the current ECT Pathway which is in use at all Trust sites delivering ECT. The Pathway includes a mandatory physical examination and other investigations determined by age and physical health together with a baseline mental state examination.

The Pathway has an anaesthetic checklist which takes note of the anaesthetic risk and quantifies that risk using the American Society of Anaesthesiologists classification. ASA categories 1 and 2 need not be reported to the Anaesthetist before the patient presents for treatment, subject to the results of other investigations being in place. Patients with ASA classification 3, 4, or 5, or with a significant concurrent medical disorder, will always require notification to the Anaesthetist before the treatment session. Such patients will not be treated in remote sites without prior discussion with the Anaesthetist.

6. Prescription of ECT

6.1 ECT will be prescribed on a weekly basis by the consultant in change of the patients care or their nominated deputy. A maximum of two applications may be prescribed at any one time. The total number of treatments in any one course would not normally be expected to exceed twelve applications. Should it be considered necessary to give more than twelve applications, then a second opinion from a Consultant colleague is advised. The patient's Consultant is responsible for the prescription of ECT.

6.2 Electrode placement will be decided by the prescribing clinician. In making that decision he or she will be aware of the urgency to achieve a therapeutic result, the potential for adverse effects and any previous history.

6.3 If a patient requires more than 12 treatments a new consent form should be completed.

7. Delivery of ECT

7.1 ECT will be administered in clinical areas suitable for the purpose. All sites will match standards of the Electro Convulsive Therapy Accreditation Service (ECTAS) of The Royal College of Psychiatrists. High risk patients (ASA 3 or greater or pregnant or with significant concurrent medical disorders) will not be treated in remote sites without prior discussion with the Anaesthetist and a

risk analysis being done. Inpatients attending for ECT should be accompanied throughout the treatment process by a Nurse escort who is familiar with the patient. The escorting Nurse should always be a registered nurse. If the escort role is delegated to an unqualified member of staff/care assistant, then it is the delegating nurse who will be accountable for the consequences of that delegation.

The number of escorts and grade of staff accompanying patients shall be decided according to individual patient need and consideration of their physical and mental health risks. Individual needs shall be determined by the multidisciplinary team before a course of ECT starts and be reviewed prior to each session by the Nurse in charge of the Ward. The escorting Nurse will know the patient and have knowledge of the ECT procedure and suite layout so that they are able to provide informed support for the patient. Escorts should be available to respond to patients' needs during the journey so should not be driving and fulfilling the role of escort at the same time. Outpatients receiving ECT as day cases will need to be collected from the ECT suite following their treatment by an informed responsible adult who is aware of the requirements of the Guidance for Day Patients Receiving ECT.

7.2 Both first and second stage recovery will be monitored using the paperwork of the current Care Pathway document.

Post Anaesthetic Management

7.3 Patients recovering from anaesthesia for ECT will be supervised by a Recovery Nurse where regular and appropriate observations will be made in both first stage and second stage recovery. The Anaesthetist must satisfy himself that patients are fully recovered before the Anaesthetist leaves the Department.

After anaesthetic recovery patients should have a supervised sitting area where appropriate refreshments can be obtained.

7.4 Following treatment and recovery the patient will be discharged from the ECT Treatment Suite. Patients must fulfil the criteria on the Recovery Record Sheet (Discharge) within the Care Pathway. Responsibility for discharge will rest with the ECT team. Different criteria apply to the discharge of inpatients returning to the Ward and outpatients returning to their own home.

8. Equipment

8.1 The ECT machine will be of sufficient standard to meet the current requirements of The Royal College of Psychiatrists' recommendations.

8.2 Machines will be replaced in a planned schedule at regular intervals by the Trust. The estimated lifetime of the Thymatron ECT machine is 10 years on average.

8.3 Thymatron IV machines will be used conforming to ECTAS standards.

8.4 Each machine should have an annual service by an approved engineer

8.5 Anaesthetic standards when ECT is performed on "remote sites" will always conform to the standard set in the Interim Statement from The Royal College of Anaesthetists on "Electro Convulsive Therapy provided in Remote Sites".

9. Stimulus Dosing and Electrode Placement

9.1 The threshold of convulsive stimulation will be determined by stimulus dosing agreed by this Trust. This should be routinely measured by an empirical titration method and this should ideally be determined at the first or second treatment in a course of ECT. The purpose of stimulus dosing is two-fold, first, to achieve sufficient electrical discharge to cause a therapeutic fit and second, to avoid excessive dosage which has a proportionate impact on the side-effects experienced.

9.2 Electrode placement is a clinical decision made by the prescribing consultant, the patient and sometimes the ECT consultant. The one foreseen exception to this procedure will be those clients for whom ECT is viewed as an emergency or life-saving situation in which case, bilateral ECT without the full regime of stimulus dosing may be employed to achieve a therapeutic fit at first application. It is not expected that all patients treated under Section 62 would necessarily or routinely fall into this category.

10. Continuation and Maintenance ECT

10.1 The NICE Guidelines for Depression 2009 support the use of Maintenance ECT in specific clinical circumstances. Pennine Care NHS Foundation Trust recognise that it is likely that all Consultant Psychiatrists will have experience of patients whose illnesses relapse, who are not controlled by medication or cannot tolerate medication or are poorly compliant with medication. Some of these patients will benefit from maintenance ECT treatment.

A protocol for maintenance ECT is appended at the end of this Policy at Appendix lll.

11. Record Keeping and Audit

11.1 The standards determined by the Trust for record keeping should be regarded as a minimum when prescribing and administering a potentially controversial treatment. The process of consent must fall within the Trust's Consent to Examination or Treatment Policy, CP16, and take into account the provisions of the Mental Capacity Act (2005) where these apply. For patients subject to the provisions of the MHA staff must also refer to CL58 Treatment of patients Subject to the Mental Health Act 1983 - Part 4 & Part 4A V2. Information must be recorded in an accessible and auditable manner.

11.2 The Trust ECT Forum will regularly monitor its service to ensure that Clinical Governance and standards are maintained. It will publish its findings and recommendations to the Trust Medical Director. The forum will review and monitor ECT incidents quarterly. ECT activity across the Trust will be monitored and collated annually.

12. Monitoring

12.1 It is recommended that the patient's mental state be monitored and documented at a minimum between every two ECT treatments by the prescribing team. It is expected that the prescribing Psychiatrist or a nominated deputy shall review the patient on a weekly basis. The patient's mental state must be evaluated at the end of a course of treatment in accordance with the standards determined by the Care Pathway.

13. Training

13.1 All personnel in the ECT Treatment Team must have received appropriate training which ensures they are competent to carry out their particular role within the procedure. Patients will only be taken through the consent process by Doctors who have been

specifically trained and are competent to fully answer questions posed by patients. The Doctor delivering the treatment will have received both theoretical and practical training and be supervised when he or she first begins to administer ECT. Only when the Consultant Psychiatrist responsible for the Department is satisfied in the competence of the Doctor will they be allowed to administer the treatment unsupervised. All junior doctors will be expected to attend Core Skills Group and Medical Device training as well as training and observation by local ECT Lead.

13.2 Nursing members of the ECT Team will receive specialist training before being given responsibility for a treatment session. All ECT staff will have specialist training in appropriate procedures which will be evidenced at appraisal.

This may include Consenting the patient, Stimulus Dosing, the physical monitoring requirements in anaesthesia and recovery and medical device training.

13.3 It is recommended that the Lead Nurse attends the North West ECT Forum Special Interest Group for ECT and The Royal College of Psychiatrists ECT training events on a regular basis.

14. Information to Patients

14.1 Information must be given to all patients in an appropriate manner for their needs. Where English is not the patients first language translation services must be used in accordance with Trust policy.

15. References

National Institute for Clinical Excellence, Guidance on the use of Electro Convulsive Therapy. Technology Appraisal 59 April 2003.

National Institute for Clinical Excellence, GC90, 2009: Depression

The ECT Handbook, Second Edition, The Royal College of Psychiatrists Council Report CR128 2005. Electro Convulsive Therapy (ECT) for Depressive Illness, Schizophrenia, Catatonia and Mania, The School of Health & Related Research (ScHARR)

University of Sheffield, Nuffield Institute of Health University of Leeds, May 2002.

Interim Statement from The Royal College of Anaesthetists on Electro Convulsive Therapy provided in remote sites

(http://www.rcoa.ac.uk/index.asp?PageID=402)

Hampshire Partnership NHS Trust Consent to Examination or Treatment Policy CP 16.

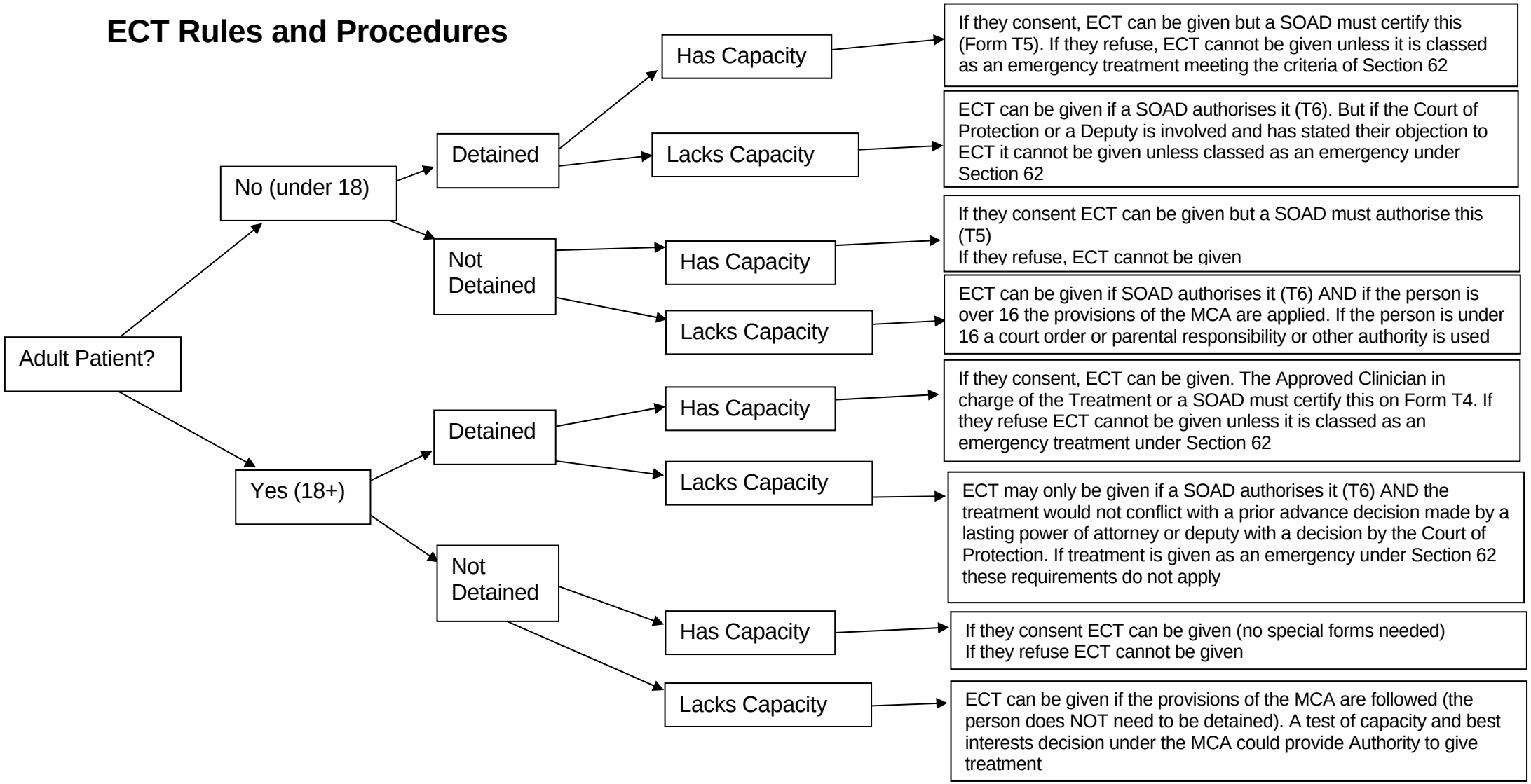
Health Record Policy and Procedures NCP 8 and CP 21.

Mental Health Act 1983 (as amended)

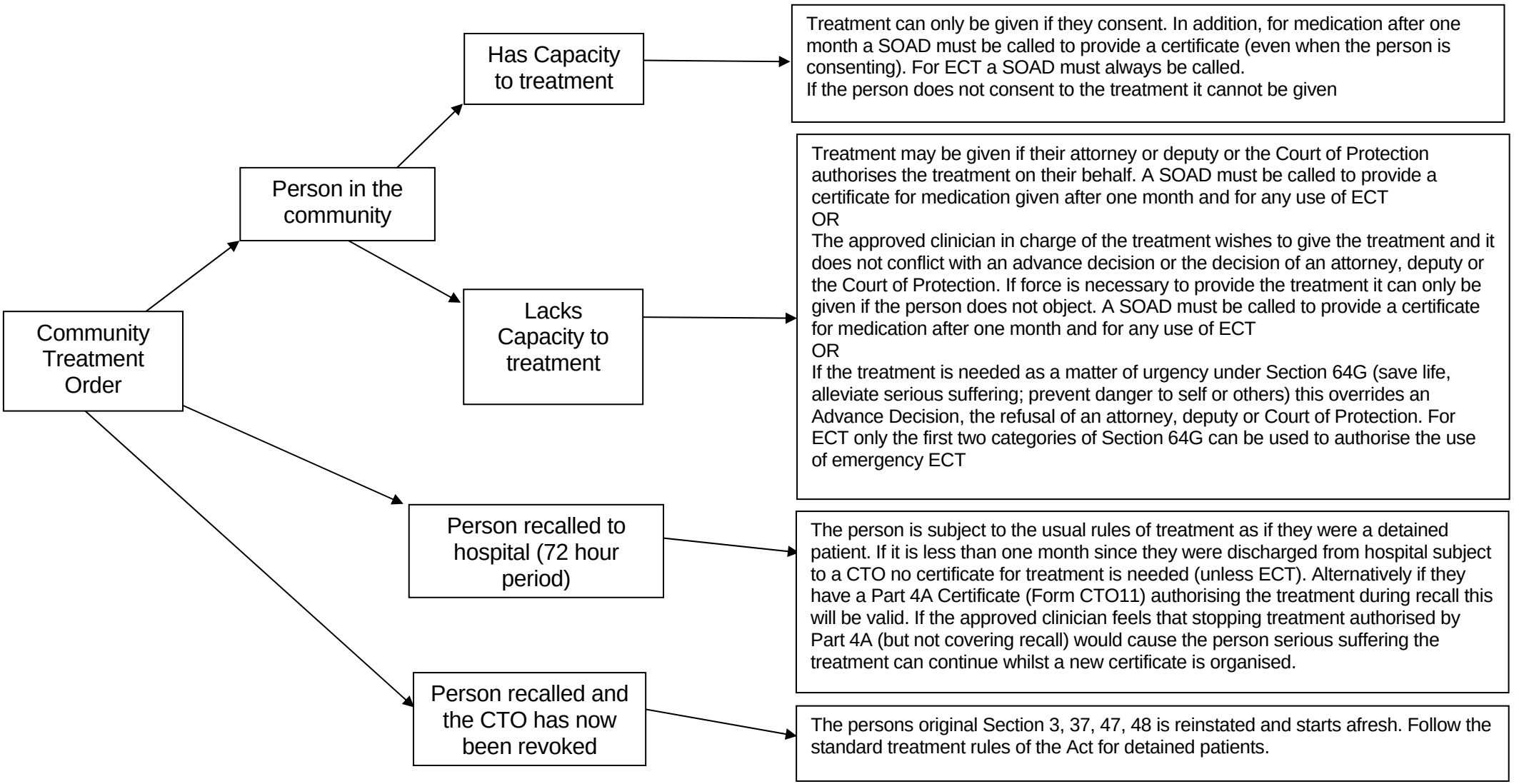
Mental Health Act Code of Practice (2008)

Mental Capacity Act 2005

ECT Rules and Procedures



Treatment Rules for Community Treatment Orders



APPENDIX 3

Consent Form 4

Form for adults who are unable to consent to investigation or treatment

Patient Surname		**First Name**	
Date of Birth		**NHS Number**	
Male / Female		**Special Requirements?**	
Date of Birth		**NHS Number**	
Responsible Health Professional (PRINT NAME)			
Job Title		**Contact Number**	

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)	
Assessment of Capacity	
I confirm that the patient lacks capacity to give or withhold consent to this procedure or course of treatment because:	
❑	the patient is unable to comprehend and retain information material to the decision; and/or
❑	the patient is unable to use and weigh this information in the decision-making process; or
❑	the patient is unconscious
Further details (excluding where patient unconscious): for example how above judgements' reached; which colleagues consulted; what attempts made to assist the patient make his or her own decision and why these were not successful.	
Assessment of Patients Best Interests	
To the best of my knowledge, the patient has not refused this procedure in a valid advance directive. Where possible and appropriate, I have consulted with colleagues and those close to the patient, and I believe the procedure to be in the patient's best interests because:	
The treatment cannot wait until the patient recovers capacity because: (Where incapacity is likely to be temporary, for example if patient unconscious, or where patient has fluctuating capacity)	

Involvement of the patient's family and others close to the patient

The final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (eg spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. "Best interests" go far wider than "best medical interests", and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

(To be signed by a person or persons close to the patient, if they wish)

I/We have been involved in a discussion with the relevant health professionals over the treatment of……(patient's name). I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form. I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision)

Name		**Relationship to Patient**	
Address			
Signed		**Date**	

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?) **Details**	

Signature of health professional proposing treatment

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion.

Signature		**Date**	
Name (PRINT)		**Job Title**	
Where second opinion sought, s/he should sign below to confirm agreement:			
Signature		**Date**	
Name (PRINT)		**Job Title**	

Guidance to health professionals

(to be read in conjunction with consent policy and Consent Form 4)

This form should only be used where it would be usual to seek written consent but an adult patient (18 or over) lacks capacity to give or withhold consent to treatment. If an adult **has** capacity to accept or refuse treatment, you should use the standard consent form and respect any refusal. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If treatment is being provided under the authority of Part IV of the *Mental Health Act 1983*, different legal provisions apply and you are required to fill in more specialised forms (although in some circumstances you may find it helpful to use this form as well). If the adult now lacks capacity, but has clearly refused particular treatment in advance of their loss of capacity (for example in an advance directive or 'living will'), then you must abide by that refusal if it was validly made and is applicable to the circumstances. For further information on the law on consent, see the Department of Health's *Reference guide to consent for examination or treatment* (www.doh.gov.uk/consent).

When treatment can be given to a patient who is unable to consent

For treatment to be given to a patient who is unable to consent, the following **mus**t apply:

- the patient must lack the capacity ('competence') to give or withhold consent to this procedure AND

- the procedure must be in the patient's best interests.

Capacity

A patient will lack capacity to consent to a particular intervention if he or she is:

- unable to comprehend and retain information material to the decision, especially as to the consequences of having, or not having, the intervention in question; and/or
- unable to use and weigh this information in the decision-making process.

Before making a judgement that a patient lacks capacity you must take all steps reasonable in the circumstances to assist the patient in taking their own decisions (this will clearly not apply if the patient is unconscious). This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates or supporters.

Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be quite able to take other more straight-forward decisions or parts of decisions.

Best interests

A patient's best interests are not limited to their best medical interests. Other factors which form part of the best interests decision include:

- the wishes and beliefs of the patient when competent
- their current wishes
- their general well-being
- their spiritual and religious welfare

Two incapacitated patients, whose *physical* condition is identical, may therefore, have different best interests. Unless the patient has clearly indicated that particular individuals should not be involved in their care, or unless the urgency of their situation prevents it, you should attempt to involve people close to the patient (spouse/partner, family and friends, carer, supporter or advocate) in the decision-making process. Those close to the patient cannot require you to provide particular treatment which you do not believe to be clinically appropriate. However they will know the patient much better than you do, and therefore are likely to be able to provide valuable information about the patient's wishes and values.

Second opinions and court involvement

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. Donation of regenerative tissue such as bone marrow, sterilisation for contraceptive purposes and withdrawal of artificial nutrition or hydration from a patient in PVS must never be undertaken without prior High Court approval. High Court approval can also be sought where there are doubts about the patient's capacity or best interests.

Questions to ask health professionals

As well as giving you information health professionals must listen and do their best to answer your questions. Before your next appointment, you can write some down in the space below.

Questions may be about the **treatment itself**, for example:

- What are the main treatment options?
- What are the benefits of each of the options?
- What are the risks, if any, of each option?
- What are the success rates for different options – nationally, for this unit or for you (the surgeon)?
- Why do you think an operation (if suggested) is necessary?
- What are the risks if I decide to do nothing for the time being?
- How can I expect to feel after the procedure?
- When am I likely to be able to get back to work?

Questions may also be about how the treatment might affect your future state of health or style of life, for example:

- Will I need long-term care?
- Will my mobility be affected?
- Will I still be able to drive?
- Will it affect the kind of work I do?
- Will it affect my personal/sexual relationships?
- Will I be able to take part in my favourite sport/exercises?
- Will I be able to follow my usual diet?

Health care professionals should welcome your views and discuss any issues so they can work in partnership with you for the best outcome.

The Mental Capacity Act also provides you with the ability to make Advance Decisions refusing treatments or allows you to appoint a deputy to make these decisions for you if you become incapacitated. If you would like to find out more about this then you should speak to a Health Care Professional who can get you more details.

Mental Capacity Assessment Form

Patient Name:		**Completed by:**	

Reason for Assessment:

What triggered the need for assessment?

What is the decision to be made? (decision specific i.e. a "matter… at the material time")

Who needs to be consulted?

Functional Test of Capacity

Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?	**Permanent** ☐	**Temporary** ☐	**No** ☐
If yes comment on the impairment or disturbance:			
Does the person have the ability to UNDERSTAND information relevant to the decision? **Comment:**		**YES** ☐	**NO** ☐
Is the person able to RETAIN that information? **Comment:**		**YES** ☐	**NO** ☐
Can the person USE or WEIGH that information as part of the process of making the decision? **Comment:**		**YES** ☐	**NO** ☐
Can they COMMUNICATE their decision? i.e. talk, sign language or any other means. **Comment:**		**YES** ☐	**NO** ☐
Can the decision be delayed because they are likely to regain capacity in the near future? **Comment:**	**YES** ☐	**Not likely to regain** ☐	**Delay Not appropriate** ☐

Support in Decision Making

Does the person have ALL the relevant information about the decision and what practicable steps have been taken to enable the person to make the decision?

Has the information been explained or presented in a way that is easier for the person to understand and are there times of day or environmental factors that make decision making easier for the person?

Can anyone else help or support the person to understand the information or make a choice?

Additional Assessment Required

☐	***Clinical Psychology*** *Reason for referral (e.g. assessment of IQ, memory & concentration, information processing, reasoning, problem solving, fluctuating capacity, behaviour, mood)*	
☐	***Communication Therapy*** *Reason for referral (e.g., assessment of communications skills, and alternative ways to support communication)*	
☐	***Other***	

Advanced Decisions

Does the person have an advance decision relevant to the decision?

Yes ☐	*No* ☐	*If Yes:*	*Similar Treatment?*	☐	*Similar Circumstances?*	☐

Advance Decision Type	***Written*** ☐	***Verbal*** ☐	***Date***	**Location**	

What was the decision?

Is this still applicable?	**Yes** ☐	**No** ☐	**If No, Why not?**

AD Withdrawn	☐	**Lasting Power of Attorney**	☐
Unexpected Circumstances	☐	**Inconsistent Behaviours**	☐
Detained under the MHA	☐	**Other**	☐

Reasons		
FINAL DECISION		
The person has capacity to make this decision	**Yes ☐**	**No ☐**
If they do not have capacity then proceed to Best Interests Meeting Checklist for Decision Makers		
Signed:	**Date:**	

Best Interest Checklist for Decision Makers

Service User Name		**Completed by:**	

There is documented assessment and evidence that the individual has:	
☐	An impairment of, or a disturbance in the functioning of, the mind or brain disturbance, AND
☐	Lacks capacity to make the decision/s for themselves at this time

What is the decision that needs to be made? If more than one then define each separately here

Who is involved in considering this best interest decision? Provide Name, Designation, Relationship to individual and what information it is expected they will bring

Can the decision be delayed because they are likely to regain capacity in the near future?	Yes ☐	Not likely to regain ☐	Delay Not appropriate ☐

Have steps been taken to permit and encourage the person to participate or improve their ability to participate as fully as possible in terms of the act being done or decisions being made that affect them?

Yes ☐	Comments:
No ☐	

Has the decision maker considered as far as reasonably ascertainable the service users past or present wishes or feelings?

Yes ☐	Comments:
No ☐	

Has the person got a valid and applicable Advance Decision or Lasting Power of Attorney?

Yes ☐	Comments:
No ☐	

Have issues around non-discrimination been considered?

Yes ☐ No ☐	Comments:
Is there a least restrictive option?	
Yes ☐ No ☐	Comments
Have you considered what beliefs or values would be likely to influence the decision if the person had capacity?	
Yes ☐ No ☐	Comments
Is there a need to involve an IMCA?	
Yes ☐ No ☐	Comments
What are the views of the relevant people?	
Yes ☐ No ☐	Comments
Have all the considerations been fully recorded and <u>all</u> relevant circumstances taken into account?	
Yes ☐ No ☐	Comments
FINAL AGREED BEST INTEREST DECISION	
If someone involved in the meeting did not agree with the final decision then please record the reasons and their signature below:	
Signed:	

mental health law
mental capacity act

Pennine Care NHS
NHS Foundation Trust

Guidance Note for Staff and Patients

Advance Decisions

What are they?
The Mental Capacity Act 2005 (MCA) allows for an Advance Decision (also referred to as Advance Directives or Living Wills) to refuse treatment to be made by any person who has capacity to make that decision. It is a statement by that person setting out a refusal of future treatment in the event they lose capacity at a later time. It should be noted they cannot be used to request a particular treatment and you may wish to refer to the Trust guidance note on Written Statements of Wishes and Feelings for more information on requests.

Who can make an Advance Decision?
Anyone over the age of 18 who has capacity. If an Advance Decision is being considered it would be best to discuss this with a healthcare professional or an Advocate so the person understands all the implications of making the Advance Decision.

How do you make an Advance Decision?
There are two types of Advance Decision. The first is a verbal Advance Decision that does not apply to a life-sustaining treatment. To ensure people know this has been made it is best to do this with a healthcare professional. Staff should then take a record of the treatment being refused, the person's capacity and who was present when it was said. A template for this has been developed at the end of this guidance.

If it is refusing life-sustaining treatment this has to be a written Advance Decision that is signed and witnessed (the witness can be a member of staff). This needs to include a statement that it applies even if the person's life is at risk. Appropriate advice should be sought from legal or advocacy services if a decision of this type is needed.

What can be included in an Advance Decision?
Advance Decisions can be made about any type of treatment but it must be specific. A refusal of 'all anti-psychotic' drugs may not be specific enough and the individual names of medication should be included to avoid confusion.

Do they have to be followed?
Yes, the MCA provides that a valid Advance Decision has to be followed if it applicable to the treatment plan. It is the same as someone with capacity refusing treatment and takes precedence over a court decision, lasting power of attorney decision and best interests decision made by healthcare staff if these are made before the Advance Decision. If staff ignored a valid Advance Decision they could face legal charges either criminal or civil. There are exceptions to this:

- If a Lasting Power of Attorney is made after the Advance Decision. They would be able to accept or refuse treatment and their decisions take precedence although they don't invalidate the Advance Decision.
- If the person has since acted in a way contrary to the Advance Decision i.e. in the case of a Jehovah's witness refusing blood but has since changed faith. Although

mca

in these situations it may be that a court has to decide and advice should be sought from the Mental Health Law Office declaring it invalid.
- If circumstances have changed for the person to an extent that their decision may be affected i.e. if new medications are available and if the person had known about this they wouldn't have refused
- If the treatment is to be provided under the Mental Health Act. With the exception of Electro Convulsive Therapy any treatment given under the Mental Health Act can be continued regardless of an Advance Decision although this would form part of the information a consultant has to consider when deciding the treatment plan.

All queries relating to the applicability of an Advance Decision should be referred to the Mental Health Law office in the first instance.

Can an Advance Decision be changed or cancelled?
Yes, the person who made the Advance Decision can withdraw or change the details at anytime as long as they still have capacity to do so. Staff should record any cancellation and although it doesn't have to be in writing (even if it was for a refusal of life-sustaining treatment) staff should ask the person to sign to say they wish to cancel. If it is a change to the details then it doesn't need to be in writing either unless it is now a refusal of life-sustaining treatment. Again to ensure people are clear about the changes made it would be preferable if this was signed and dated by the person making the change.

Where are they kept?
Any type of Advance Decision should be communicated as widely as possible. It is the responsibility of the person making the Advance Decision to make sure people are aware of this. Staff should advise and assist the person to send the Advance Decision to their consultant (medical records), Care Co-ordinator (community records) and Mental Health Law office. This should also be sent to the persons GP and they should keep a copy for themselves and give to any other people involved i.e. family members, legal representatives or advocates. This will avoid the situation where people do not adhere to the Advance Decision because they are not aware of its existence. Staff are not obliged to delay any treatment that is provided while checking whether there is an Advance Decision so to avoid that treatment being given steps must be taken before the person loses capacity. It is good practice for all staff to ask patients whether they have an Advance Decision in place.

Any Advance Decisions should form part of the persons care plan and records should clearly state there is an Advance Decision in place.

How long do they last for?
The Advance Decision will remain in place unless cancelled or changed. It is recommended they are reviewed and updated at least once a year. This would also prevent anyone challenging that the persons views have changed since the Advance Decision was made.

THIS TEMPLATE IS INTENDED AS A GUIDE ONLY
THIS IS NOT INTENDED FOR USE FOR THE REFUSAL OF LIFE-SUSTAINING TREATMENT AND FURTHER ADVICE SHOULD BE SOUGHT IF THAT IS THE PURPOSE OF YOUR ADVANCE DECISION

Advance Decision Template

Name:		**Date of Birth:**	
Address:		**Contact number:**	
Consultant Psychiatrist:		**Care Co-ordinator:**	
GP Name:		**GP Surgery:**	
Next of Kin:		**Contact Number:**	

Treatment Advance Decision	
I declare that if I ever lack capacity to make decisions for myself, this advance decision should be followed.	
Treatment Refusal Medication and Treatment that I don't want including the type, circumstances and route of administration if applicable (Be as detailed and specific as possible)	
Any other information I would like to be known and anyone I wish to be contacted or involved in treatment decisions about me	
Statement	

I confirm that I am over 18 years of age or over, I currently believe myself to have capacity to make this decision and understand that this will remain effective until I change or withdraw this decision. I also understand that it is my responsibility to ensure people are aware of my decision and that I should review this document regularly and let people know if I need to change the details of my refusal.			
Signed:		Date:	
Witness (Optional)			
I am signing below to confirm that I witnessed the making of this Advance Decision and believe they have capacity regarding their decision at this time.			
Signed:		Date:	
Role:			

Copy to be sent / stored in:

- ☐ Care Plan
- ☐ Mental Health Law Office
- ☐ Community Notes
- ☐ Medical Notes
- ☐ General Practitioner
- ☐ Family Member _____

REVIEWS			
Date of Review	**Signed**	**Date of Next Review**	**Review Sent to all parties (as above)**