What is mental capacity?

Mental capacity is the ability to make a specific decision. The Mental Capacity Act (2005) is the statutory framework for people who lack capacity to make decisions for themselves or who have capacity and wish to make preparations for a time when they may lack capacity to do so in the future.

MCA and treatment on the adult care wards at Addenbrooke’s Hospital

When a person becomes very unwell it can be difficult for them to fully understand discussions about their care. Individuals may also have trouble with their memory and cognition because of conditions such as Dementia or Learning Disability. Pain and anxiety can also have a significant effect upon capacity.

We have admitted you or your relative to hospital in the hope that the treatments we give will aid recovery. Where possible, we will ask a patient’s permission before carrying out treatments such as personal care, physiotherapy or inserting lines into blood vessels.

If we find that a patient is unable to give such consent because they cannot understand, retain or weigh up the information required to reach a decision or if they are unable to let us know what they have decided, then we deem that this patient lacks capacity to make such a decision.

In this situation, we will endeavour to act in the patient’s best interests and will assume that they would have agreed to these basic, routine treatments if they were able to do so. If a relative or other representative feels that this is not the case, they should let us know and this will be factored in to any decision we make. We are not asking patients relatives or representatives to give consent for treatment, but describing what we consider to be “routine care” in an acute hospital setting. If you hold Power of Attorney for Health and Welfare, please make this known to staff as this impacts on the decision making process.

What is “routine care”?

Routine care will involve nursing care such as washing, dressing, feeding, and regular repositioning of the patient, to prevent pressure sores and other complications from arising. It will also include common medical procedures such as lines into veins and possibly arteries, physiotherapy, blood tests and so on. Routine care does not include procedures with a significant risk or which are irreversible like surgery. In these cases, we will again assess a patient’s capacity and obtain their consent if possible. If this is not possible, we will discuss the
proposed treatment with a relative or representative of the patient to see what they think the patient would have wanted. We will then act on what we think is in their best interest. An exception to this could be an emergency life-saving treatment that cannot be delayed without great risk to the patient. Another exception would be an indication for treatment that would result in life-changing circumstances; in such cases we may consider application to the Court of Protection to obtain judicial support for exceptionally complex decision making.

In all cases, we will treat you and/or your relative with respect and dignity, ensuring you/they are as comfortable as possible while this care is carried out.

What if I or my relative become(s) very confused and possibly even aggressive?

Unfortunately this can happen as a result of being acutely unwell, which we call delirium, or following an acquired brain injury where cognition is impaired. Delirium is a state of confusion that can affect anyone if the strain on them is great enough. Frailer patients and those with multiple medical problems and in particular, those with underlying memory problems or dementia are more susceptible.

If a patient develops a delirium or has an altered confusional state and cognitive impairment, our first aim is to attempt to identify and treat any factors that could be making it worse. This could include any acute illness, infection, strong medications, constipation, pain or dehydration. While we treat any possible causes, we try and support the patient in the most dignified way possible. This will include frequently re-orientating them to their surroundings (hospital, ward layout, bed space etc), trying to avoid unnecessary ward moves, trying to maintain continuity of care, keeping the environment as calm and safe as possible and encouraging eating and drinking. This may involve moving a patient to a quieter side-room where distractions are fewer. It may also involve providing additional staffing for someone to be able to be with them all the time to maintain safety and provide reassurance.

Rarely, we may need to calm a patient down with sedating drugs (chemical restraint) or use special gloves to prevent them pulling out vital lines and tubes that are essential for their treatment (physical restraint).

In compliance with the MCA, we endeavour to avoid the use of restraint unless it is absolutely necessary. Where it is needed, we endeavour to use a form of restraint that is the least restrictive option available for the shortest period of time necessary. The type of intervention used will be proportionate to the risk of potential harm. We will only use restraint if we absolutely have to. If there is a less restrictive measure, we will use that instead.

If a patient needs to stay in hospital for a significant length of time in order to receive care and treatment and lacks the capacity to consent to do so, we may need to consider the legal grounds under which we are continuing to provide care and treatment to that person.

This would involve wider discussion between team members and may result in the decision to put Deprivation of Liberty Safeguards 2009 in place (DoLS).
The (DoLS) safeguards will provide legal protection for people who lack capacity to consent to the arrangements made for their care or treatment and it is only used if it can be justified to be:

- in the best interests of the person concerned to protect them from harm
- it is a proportionate response to the likelihood and seriousness of harm if the safeguard is not used
- there is no less restrictive alternative

These safeguards give us the legal framework with which to keep the patient in hospital and involve the local authority in our decision to do so, but will not affect our reassessment of each treatment decision as the need arises.

**Further contacts/information**

If you have any questions or concerns please speak to the nurse in charge or the Senior Sister/Charge Nurse.

For further information on MCA/DoLS:

The online MCA Directory - [http://www.scie.org.uk/mca-directory/](http://www.scie.org.uk/mca-directory/)
Cambridge County Council’s website - [www.cambridgeshire.gov.uk](http://www.cambridgeshire.gov.uk)

We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site.
For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

**Other formats:**

If you would like this information in another language, large print or audio, please ask the department where you are being treated, to contact the patient information team: patient.information@addenbrookes.nhs.uk.
Please note: We do not currently hold many leaflets in other languages; written translation requests are funded and agreed by the department who has authored the leaflet.

**Document history**

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</tr>
<tr>
<td>Publish/Review date</td>
<td>March 2016/March 2019</td>
</tr>
<tr>
<td>File name</td>
<td>Mental_capacity_act_v1</td>
</tr>
<tr>
<td>Version number/Ref</td>
<td>1/PIN3837</td>
</tr>
</tbody>
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