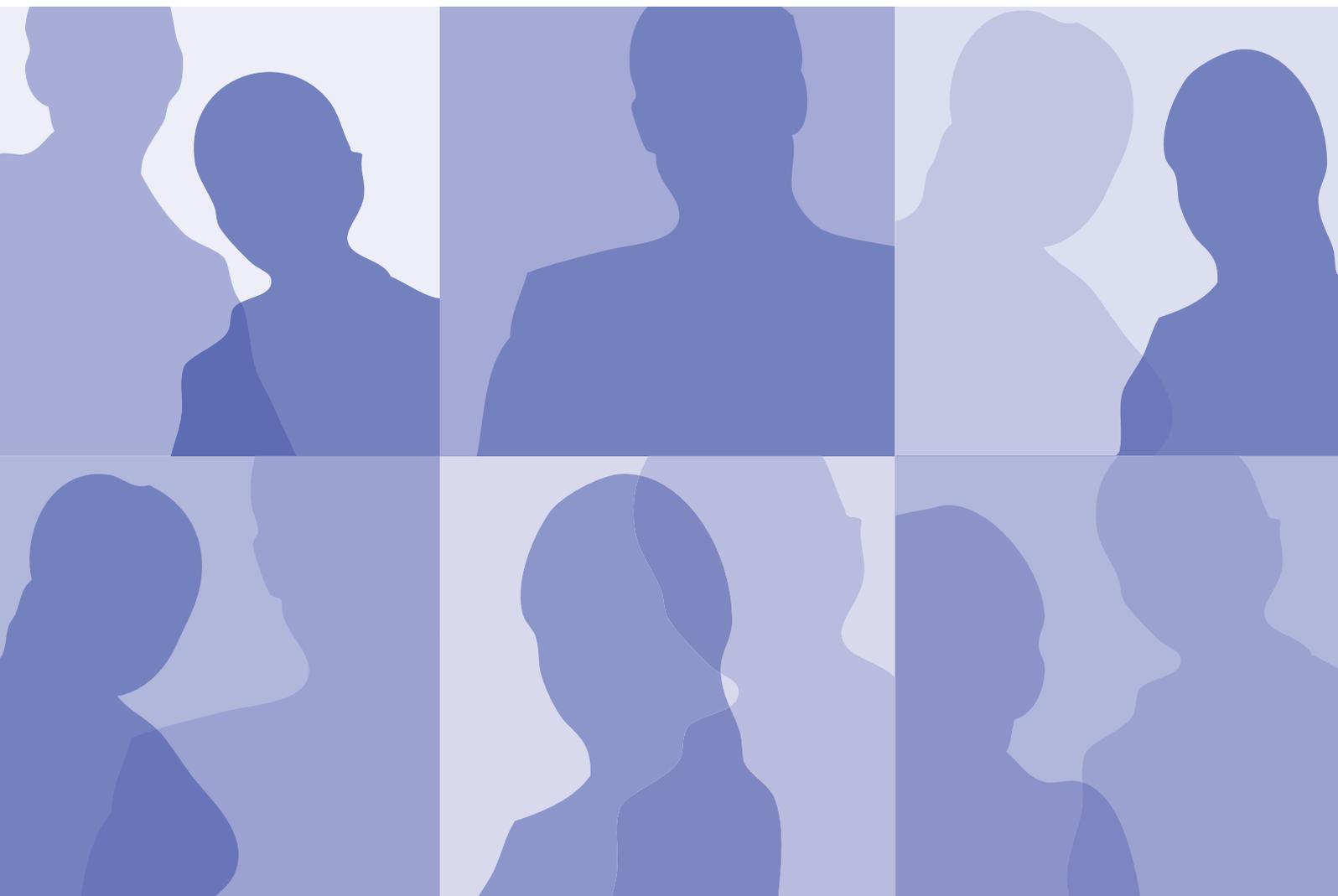


Unified Do Not Attempt Cardiopulmonary Resuscitation (uDNACPR)

How it relates to the Mental Capacity Act
(MCA) 2005



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Introduction

This leaflet provides a guide for professionals making uDNACPR decisions in relation to the MCA 2005. The requirements of the MCA should always be followed.

This leaflet covers:

- **uDNACPR and Mental Capacity Assessment**
- **A brief introduction to the MCA 2005 including best interests**
- **MCA Principles**
- **The Decision-maker's responsibilities**
- **Mental Capacity Assessment**
- **Advance Decision to Refuse Treatment (ADRT)**
- **uDNACPR Decisions and Mental Capacity in relation to South Central Strategic Health Authority (SCSHA) uDNACPR Policy**

uDNACPR and Mental Capacity Assessment

The first statutory principle in the MCA is that we presume capacity unless there is evidence to say otherwise.

Once a decision has been made by a clinician, where appropriate in conjunction with the person, not to attempt cardiopulmonary resuscitation (CPR), the person should be informed (especially if being discharged home with the uDNACPR decision) to allow them to make further decisions for themselves in light of the uDNACPR. Any such decision should be kept under review as appropriate to the patient's circumstances in response to the decision and time specific requirements of the MCA.

These decisions should involve consultation with the person's carers/relatives/ Lasting Power of Attorney (LPA) and the possible appointment of an Independent Mental Capacity Advocate (IMCA) where the patient lacks capacity and has nobody to speak on their behalf.

A Mental capacity assessment in line with the MCA - the functional and diagnostic tests must be carried out if it is believed that the person's mental capacity is in question. All details of the assessment must be clearly documented in the person's notes.

Mental Capacity Act (MCA) 2005 (Amended 2007)

The MCA 2005 came into operation in 2007. It serves 2 functions:

1. To provide a statutory framework which empowers and protects people who may lack capacity to make certain decisions for themselves
2. To provide a framework for people who wish to plan ahead for a time when they may lack capacity

Clinicians are expected to be familiar with the MCA's principles, understand the MCA, how it works in practice and the implications for people for whom a DNACPR decision has been made. <http://www.legislation.gov.uk/ukpga/2005/9/contents> Staff working with people lacking capacity for whatever reason should be familiar with the MCA's Code of Practice and follow its guidance. The MCA lays down a framework that must be followed when services are working with people who may, permanently or temporarily, lack the capacity to make all, or some, decisions about their treatment and care for themselves. The MCA gives rights to service users and those who it represents and responsibilities to staff and others working with them.

The MCA places the person who lacks capacity at the heart of decision-making, ensuring their choices are respected and that decisions made for them are in their best interests. The MCA does not fully define 'best interests' but it does give a checklist.

Best Interests Checklist

- Is there a relevant substitute decision maker LPA / Enduring Power of Attorney (EPA), Court Appointed Deputy?
- Is there a valid and applicable ADRT to refuse treatment?
- Assess whether the person may gain capacity; if so, can the decision wait?
- Involve the person in the decision as much as possible.
- Explore the person's past and present views, culture, religion and attitudes.
- Do not make assumptions based on a person's age, appearance, condition or behaviour.
- Consult interested family and friends.
- Try to find the least restrictive option that meets the need.

Decisions Reserved to the Court of Protection

Certain decisions in respect of seriously ill patients are reserved to the Court of Protection and cannot be taken without resource to the Court. It is essential that decision makers are familiar with sections 6.18 and 8.18 of the Code of Practice.

The MCA enables planning for the future where individuals can choose someone they trust to make decisions on their behalf about either their finances and property or their health and welfare. This is called the LPA. The act gives a legal format and process for Advance Decisions to Refuse End of Life Treatment.

Guiding Principles of the MCA 2005

1. A person must be assumed to have capacity unless it is proved otherwise.
2. Do not treat people as incapable of making a decision unless all practicable steps have been tried to help them.
3. A person should not be treated as incapable of making a decision because their decision may seem unwise.
4. Always do things or take decisions for people without capacity in their best interests.
5. Before doing something to someone or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way.

These principles sit on the face of legislation so a breach of the principles could be seen as a breach of the MCA and therefore, unlawful.

Decision-maker responsibilities

DNACPR decision-makers must:

- Involve the person.
- Have regard for the past and present wishes and feelings, especially written statements which may be in the form of an advance care plan (ACP). For further details on the NHS South Central regional ACP guidance please visit <http://www.southcentral.nhs.uk/what-we-are-doing/end-of-life-care>
- Consult with others who are involved in the care of the person e.g. carer, LPA.
- Not make assumptions based solely on the person's age, appearance, condition, disability or behaviour.
- Ensure a valid and applicable ADRT (see below for details) to refuse CPR is respected even if others think that this decision is not in the person's best interests.
- Respect any LPA and/or ADRT including end of life treatment.
- Involve the appointment of an IMCA were the person lacks capacity and there is no one to speak on their behalf other than a paid carer.
- Be kept under review.

Assessing Mental Capacity

The Two-stage Test (the diagnostic test)

Consider the following questions when assessing whether an individual has the capacity to make a decision:

1. Does the person have an impairment of mind or brain, or is there some sort of disturbance affecting the way their mind and brain works, either on a temporary or a permanent basis?
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

The Four-step functional test (the functional test)

According to the MCA, a person is unable to make their own decision if they cannot do one or more of the following:

1. **Understand** appropriately presented information about the decision;
2. **retain** the information long enough to
3. **use** and weigh it to make a decision, and
4. **communicate** the decision by any recognisable means e.g. by talking, using sign language, blinking an eye or squeezing a hand.

All details of a person's Mental Capacity Assessment must be documented in the person's notes. This information should be shared with all relevant health and social care staff involved in the person's care (including IMCAs).

Advance Decision to Refuse Treatment

A DNACPR is a clinical decision made on best interests relevant to the disease of the person whereas an ADRT is the person's own decision.

The MCA creates statutory rules with clear safeguards so people can make an ADRT including end of life treatment if they should lack capacity in the future. A valid and applicable ADRT is classed as a contemporaneous decision. A DNACPR is not an ADRT it is a legal document informing healthcare professionals of a medical direction. If the person has a valid and applicable ADRT a copy should be attached to the back of their DNACPR form. However, while ADRT in respect of end of life decisions have to be in writing other advance decisions need not be.

The decision maker should make reasonable efforts to ascertain whether a patient who may be considered for a DNACPR decision has made either an ADRT or an advance decision to refuse end of life treatment.

There is sometimes confusion regarding Advance Care Planning (ACP), advance decisions and DNACPR. Some basic definitions are:

Advance Care Planning	Advance Decisions to Refuse Treatment	DNACPR
This is a process of discussion between an individual and their care providers irrespective of discipline. The difference between ACP and planning more generally is that the process of ACP is to make clear a person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future, with attendant loss of capacity to make decisions and/or ability to communicate wishes to others.	These must relate to a refusal of specific medical treatment and can specify circumstances. It will come into effect when the individual has lost capacity to give or refuse consent to treatment. Careful assessment of the validity and applicability of an advance decision is essential before it is used in clinical practice. Valid advance decisions, which are refusals of treatment, are legally binding.	A DNACPR decision applies to CPR only, other ceilings of treatment need to be discussed. A DNACPR is a method of communicating a medical instruction, a clinical decision made on best interests relevant to the disease of the person.

There are no particular formalities about the format of an advance decision. It can be written or verbal, unless it deals with life-sustaining treatment, in which case it must be written and specific rules apply.

The two important safeguards of validity and applicability in relation to ADRT are:

1. The ADRT has to be specific to the circumstances documented.
2. Where an ADRT concerns treatment that is necessary to sustain life, strict formalities must be complied with i.e. the decision must be in writing, signed and witnessed.

In addition

1. There must be a statement that the ADRT stands **'even if life is at risk'** which must also be in writing, signed and witnessed.
2. The person must have been consistent with their ADRT.

uDNACPR Decisions and Mental Capacity

in relation to (SCSHA) uDNACPR Policy

Informing/ involving the person and others in DNACPR Decision

CPR is unlikely to be successful (SCSHA form Section 1a)

When a DNACPR decision has been made on the basis that CPR is unlikely to be successful it is not necessary to discuss the decision with the patient. However, best practice is that the person should be informed of the decision and why CPR is an inappropriate treatment. This allows the person to make further decisions for themselves in light of the DNACPR. If the person was not informed of the decision at time of making, due to being too unwell, it is important that they are informed at the earliest appropriate opportunity especially if they are being discharged to their home.

Any such decisions should be kept under review and involve carers/relatives/LPAs and IMCAs as indicated elsewhere in this policy.

If the person lacks capacity the relevant other/ LPA or IMCA, if appointed, **MUST** be told of the decision when it is made or prior to discharge.

CPR may be successful but will not be of overall benefit to the individual (SCSHA form Section 1b)

If the person has mental capacity the burdens and benefits of CPR need to be discussed and a decision reached in partnership.

If the person does not have capacity, their relevant others must be consulted to establish what the decision-maker reasonably believes the person would decide if able to do so. If the person has made a LPA, appointing a Welfare Attorney to make decisions on their behalf, that person must be consulted. A Welfare Attorney may be able to refuse life-sustaining treatment on behalf of the person if this power is included in the original LPA. You need to check this by reading the LPA. If there is no one appropriate to consult with and the person has been assessed as lacking capacity then an instruction to an IMCA should be considered.

The following needs to be recorded;

- State clearly in the notes what was discussed and agreed.
- If the decision was not discussed with the person, state the reason why this was inappropriate.
- State the names and relationships of relevant others with whom this decision has been discussed.
- A detailed description of such discussion should be recorded in the clinical notes.

There is a valid advance decision to refuse CPR in the following... (SCSHA form Section 1c)

This is for people who had previously or still have capacity (if they still have capacity, acknowledge the ADRT and discuss with them) that have a valid and applicable Advance Decision to refuse CPR.

Check for the validity and applicability of the ADRT.

Is the ADRT:

1. Specific to CPR?
2. In writing, signed and witnessed?
3. Contains the statement **'even if life is at risk'**
4. Has the person been consistent with their ADRT?

If the answer to all the above is 'Yes' the ADRT is valid and applicable.

If the ADRT contains specific circumstances when CPR would not be appropriate write these on the form.

If there is a valid and applicable ADRT, a copy on white paper should be kept with the DNACPR form. Ensure the ADRT still applies to the person's current circumstances.

Remember a person can change this decision at any time.

Please Note:

Nothing in this policy overrules the organisation's general MCA training/policy or the MCA itself or the MCA's Code of Practice. It is important that staff are familiar with MCA and the Code of Practice and have attended relevant training.

Further information can be obtained from:

ACP	www.southcentral.nhs.uk/what-we-are-doing/end-of-life-care
ADRT	www.adrtnhs.co.uk www.ncpc.org.uk/download/publications/ADRT.pdf
Human Rights Act 1998	www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1
MCA	www.legislation.gov.uk/ukpga/2005/9/contents
MCA Code of Practice	www.publicguardian.gov.uk/mca/code-of-practice.htm
SCSHA Unified DNACPR Policy	www.southcentral.nhs.uk/what-we-are-doing/end-of-life-care/dnacpr-acp-documents/

End of Life Care contact details: