

The Mental Capacity Act 2005: implementation within Special Care Dental services

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Abstract

There are certain patient groups within Special Care Dentistry for whom the Mental Capacity Act 2005 will have particular relevance. Once the principles and legal implications of the Mental Capacity Act (MCA) have been understood, the dental team must apply and integrate these principles into their patient assessment and oral health care plans. Implementation of the Act will involve raising awareness amongst patients, family, friends and others who provide care for vulnerable adults.

Factors that may affect capacity are discussed including how they may impact on the delivery of oral healthcare, and some of the challenges which clinicians may face in assessing capacity. The importance of the Capacity Test and the Best Interest Checklist, along with their documentation is discussed.

The role of the Independent Mental Capacity Advocacy Service (IMCAS) and the situations when they may be required are outlined, with particular reference to what may be defined as serious medical treatment within the context of special care dentistry.

Key words: *Mental Capacity Act, Code of Practice, documentation, implementation, Independent Mental Capacity Advocacy Service (IMCAS)*

Introduction

The Mental Capacity Act 2005 came fully into force in October 2007 in England and Wales. This legislation has relevance for all those involved in the care of vulnerable adults, and within dentistry it is of particular relevance to Special Care Dentistry. It is the responsibility of the clinician to ensure that this legislation is implemented with due regard to the accompanying Code of Practice.

The Act is derived from previously existing common law, hence many of the principles will already be familiar. One of the aims of the legislation is to clarify the responsibilities of those who provide care for persons lacking in decision making capacity.

Many health authorities and primary care trusts (PCTs) raised awareness and provided training around the time the Act was introduced. This article discusses how the Act can be implemented within a Special Care Dental Service, and integrated into the patient assessment and treatment planning process. It also considers how good documentation can promote patient autonomy, and continuity of care. This in turn can facilitate multi-disciplinary care, particularly with the Independent Mental Capacity Advocacy Service (IM-

CAS). This service has been created by the Act to assist people who lack capacity and who do not have the support of friends and/or family.

Implementation – the Special Care Dentist

The first point of contact with many patients is the referral. This may provide a brief patient summary. An example of this would be a 'patient with severe learning disabilities in full time residential care'. This indicates that the initial visit will require sufficient time for a detailed socio-behavioural assessment. Here the assessment process will be most productive if the patient attends with carers or healthcare professionals who are regularly involved in the patient's care. A request to bring along relevant information such as the patient's health and social care plan, where one exists, will prove useful.

The assumption is always that the patient has capacity (MCA part 1). However, during the history-taking process, the dentist can assess the patient's:

- Methods of communication
- Language skills
- Levels of understanding

- Ability to engage in discussions
- Interaction with the dental team
- Attention span.

The relationship between the patient and any escort should be clarified at the very start of the visit. It is good practice to ask the patient if s/he would like the escort to remain, and also to determine what assistance, if any, they may be able to provide for the patient.

The dynamics of any interview will evolve, and if necessary the escort can be invited into the discussion with questions being directed to the patient, and the escort supporting the patient as required. It cannot be assumed that the presence of an escort or carer will facilitate the patient assessment process (*Box 1*).

The patient's health and social care plan may provide further insight into their day-to-day care, and the level of support that is required. It may include strategies known to assist with decision making, or information on individuals who have legal powers to act on the patient's behalf. It would be good practice to determine who, if anyone, should be involved in discussions regarding the patient's oral health care (*Box 2*).

With a well maintained healthcare plan and information from key workers, social services, and health care professionals, a profile of the patient and his/her needs, can be constructed. Where it is deemed appropriate, a formal capacity test can then be undertaken.

Patients who are cared for within their own homes, relying on family and friends, i.e. informal carers, may present different challenges. The carers may not have a formalised care plan, and may have more limited involvement with medical and social support services. In these cases it may be necessary to discuss the MCA 2005, explaining the importance of identifying individuals with legal authority to influence the patients care. This will be of importance for dental care decisions and also financial decisions which may be associated with dental treatment.

Informal, unpaid carers are not legally required to have regard for the Code of Practice, and may be unaware of the associated legislation. However, health and social services professionals who have contact with these informal carers should make them aware of the Code. Where an assessment of mental capacity is being made some discussion may be required prior to the assessment. If family and carers are not familiar with the legislation they may find some of the questions intrusive or irrelevant.

In 2003, a National Opinion Poll conducted on behalf of Mencap and a number of other charities revealed 92% of respondents thought that partners, wives or husbands had the right to make decisions on their partner's behalf if they were unable to do so. A further 73% thought another family member could make such a decision. This demonstrates how widely out of step the public's views about this topic are compared to the legal position.

A full medical history will determine any medical condi-

tions which may impact on the patient's decision making abilities and whether additional support during the decision-making process may be necessary. Examples of these include:

- Acquired brain injury (stroke, dementia, trauma)
- Physical disabilities (inability to communicate wishes)
- Intellectual disabilities
- Mental health problems
- Substance misuse
- Dehydration
- Confusion, drowsiness, or delirium because of an illness or treatment
- Sensory deficits
- Impaired literacy.

Communication can be facilitated by those who are known well by the patient and are familiar with his/her needs. It has been the authors' experience that the presence of a carer who is unfamiliar with the patient can adversely impact on the consultation, the patient's behaviour, and his/her sense of well being and security.

From this initial assessment the dentist may consider seeing the patient in the home environment where he/she may feel more comfortable and less anxious. Carers may be able to advise on the most appropriate time of day for the consultation, i.e. when the patient is at his/her most cooperative and advise on the most appropriate communication style.

Once the socio-behavioural history has been completed the clinician is in a clearer position to determine whether a capacity test is required. This assessment process should be continued throughout the patient's episode of care. The capacity test is decision-specific and is carried out at the time the decision is to be made, i.e. the clinician may feel that the patient has capacity to consent to a dental examination, but may lack the capacity to consent to extractions with general anaesthesia, and at this juncture decide to carry out the capacity test.

Where capacity fluctuates and information is retained only for a short time it will be necessary to review the patient's ability to make the decision and gain valid consent at each visit (*Box 3*). In this situation it may also be appropriate to delay treatment. For example, in the case of a patient with bipolar disorder the clinician may make the decision to delay treatment when he/she feels capacity is reduced until a time when the patient has entered a more stable phase in the cycle of their condition.

This assessment of potentially vulnerable adults will assist in establishing a good rapport with the patient, carer and dental team. In such an environment the capacity test can be delivered with a more complete and holistic understanding of the patient, keeping his/her autonomy at the heart of the assessment process.

Box 1

A referral to the Special Care Dental Service states the patient has severe Parkinson's disease with dementia, and that he exhibits challenging behaviour. However, at his initial dental assessment the patient is found to be communicative, and able to discuss his oral health care needs. The patient is asked if he would like the carer to remain; he prefers that they leave. When the carer does so the patient explains he is deeply unhappy with the residential home and its staff, and feels very inhibited in their presence.

Box 2

A patient living in a residential home attends a dental appointment with care workers. The health plan indicates that the parents are actively involved in all decisions relating to the patient's well being, and wish to be informed of all medical and dental visits.

Box 3

A patient with dementia has requested new dentures as the current set are ill fitting. The patient attends each visit with a family member and asks what treatment is required, seemingly unaware of all the previous dental visits. The treatment plan is discussed, and consent gained prior to continuation of treatment.

Box 4

A patient detained under the Mental Health Act (1983) refuses general treatment for their dental condition. You decide to assess their capacity and due to the complexities of assessing capacity a case conference is organised with other health care professionals who are involved in the patient's care. This multi disciplinary meeting allows you to more clearly assess the patient's capacity.

Implementation - the importance of documentation

Section 5 of the Act protects clinicians and those providing personal care from legal liability provided they have 'reasonable belief' that the person lacks capacity and their actions are in the best interest of the patient. An assessment of capacity and the findings of that assessment should be recorded in the relevant professional records, since, under the Code of Practice, the clinician may be required to justify decisions made on behalf of patient who lacks capacity.

It is good practice to document a full socio-behavioural history, as discussed above; including where a patient's mental capacity is already known to be impaired, and specific support is known to be needed, and whether the patient's capacity is chronic or fluctuating (*Table 1*).

Any refusal to take part in the capacity test either by the patient or by carers, should also be recorded, along with all attempts at mediation or advocacy. The Patient Advice and Liaison Service (PALS) may assist where there is disagreement between staff, family, or patient (Code of Practice, page 262). In these cases good documentation may help to facilitate a resolution. Case conferences may be required

and may prove to be beneficial where there is a dispute or difficulty in assessing a patient's capacity (*Box 4*).

As the seriousness of the decision increases it can be argued that the need for documentation increases. Examples in a dental setting may involve:

- Use of physical intervention
- Use of sedation
- Use of general anaesthesia
- Complex treatment plan such as multiple extractions, soft tissue surgery (e.g. biopsy) or the management of maxillo-facial tumours
- Patients experiencing pain or sepsis i.e. preventable suffering
- Management of self injurious behaviour.

What is known of the patient's wishes, hopes, and desires, and the source of this information should be recorded (*Table 3*). The efforts, which have been made to encourage and support the patient to participate in the decision making process as well as the details of those who have assisted in this process, should be documented.

Implementation – independent mental capacity advocate

It is a legal duty to refer eligible patients to the service. The aim is to develop better decision making for vulnerable adults who are without friends or family. However, the first annual report for the service (Department of Health, 2008) suggests it is underused, with referrals for serious medical treatment being described as particularly low, "raising concerns about the extent to which the NHS is at present complying with the requirements of the Act."

In the first year that the service was established 5,175 people who lacked capacity were represented by an IMCA. Of these, 675 referrals were for "serious medical treatment", with 33 for "serious dental work". The reasons for the low number of referrals (sic) are unknown, however the report speculates that this may be due to a lack of understanding, or just a disregard for the statutory duty to make these referrals; however, the report does not make clear the number of referrals they were expecting. Within dentistry it may be that clinicians are struggling to define what serious medical treatment is within our speciality. Unfortunately the report does not go on to describe what "serious dental work" constitutes.

Implementation – the Special Care Dental Service

The implementation of the Act within a Special Care Dental Service can be facilitated and then monitored by appointing an implementation lead who would be responsible for the delivery of specific training, raising awareness, as well as developing information for patients and carers. The lead can also be responsible for monitoring implementation through

audit tools. These are currently being developed by the Department of Health and may be available towards the end of 2010 (personal communication; Steve Chamberlain, London Lead, MCA and Deprivation of Liberty Safeguards). These audits may include:

- Referrals made to IMCAS with the reasons and outcomes
- The use of templates where these have been developed (*Figure 1*), developing minimum recording standards and monitoring record keeping where there is no template (*Tables 1-3*)
- Best interest meetings and their outcomes.

Any factors that have affected the implementation of the MCA should be reported to the Lead, with analysis of the issues raised. Audit can be a valuable mechanism to ensure the Act is implemented, it can raise awareness amongst all dental staff, and it can highlight problems and difficulties

Table 1

Elements of the socio-behavioural assessment relevant to assessing decision making capacity

Medical history

- Conditions affecting the functioning of the mind or brain
- Specialist services which may be community or hospital based
- Conditions which may impair cognitive functions e.g. medication
- Cognitive function stable/fluctuates
- Medications which may impair communication or brain function
- Sensory impairments

Social history

- Carers – formal and informal
- Social services/local authority involvement
- Next of kin
- Individuals with a legal right to represent the patient
- Review health and social care plans
- Dental history
- Communication needs and ability
- General intellectual ability/literacy
- Memory
- Attention and concentration
- Reasoning/information processing
- Comprehension – verbal and other types of communication
- Culture

Table 2

Documenting the capacity test

- Description of the decision to be made
- Details of the decision maker, name, job title
- How has the patient been assisted in the decision making process?
- Who has assisted the patient in an informal capacity?
- Who has assisted the patient in a formal capacity?
- Diagnosis of brain disorder or impaired brain function
- Can the patient understand the information about the decision?
- Can the patient retain the information about the decision?
- Can the patient use the information about the decision?
- Can the patient communicate their decision?
- Will the patient regain capacity and if so, when?
- Can the decision be delayed until such a time?
- What is the outcome of this assessment?
- What decision has been made and why?

Table 3

Documenting the Best Interest process

- Is there an Advance Decision, Lasting Power of Attorney or Deputy appointed by the Court of Protection; have they been consulted?
- Have the patients past, and present wishes, and feelings been considered as far as possible?
- Has account been taken of the patients known beliefs and values?
- Have the patient's relatives and friends been consulted?
- Does an IMCA need to be appointed?
- Do any other advocates need to be consulted?
- Document the proposed course of action and reasons

Figure 1 An example of a template which can be used for the documentation of the mental capacity test

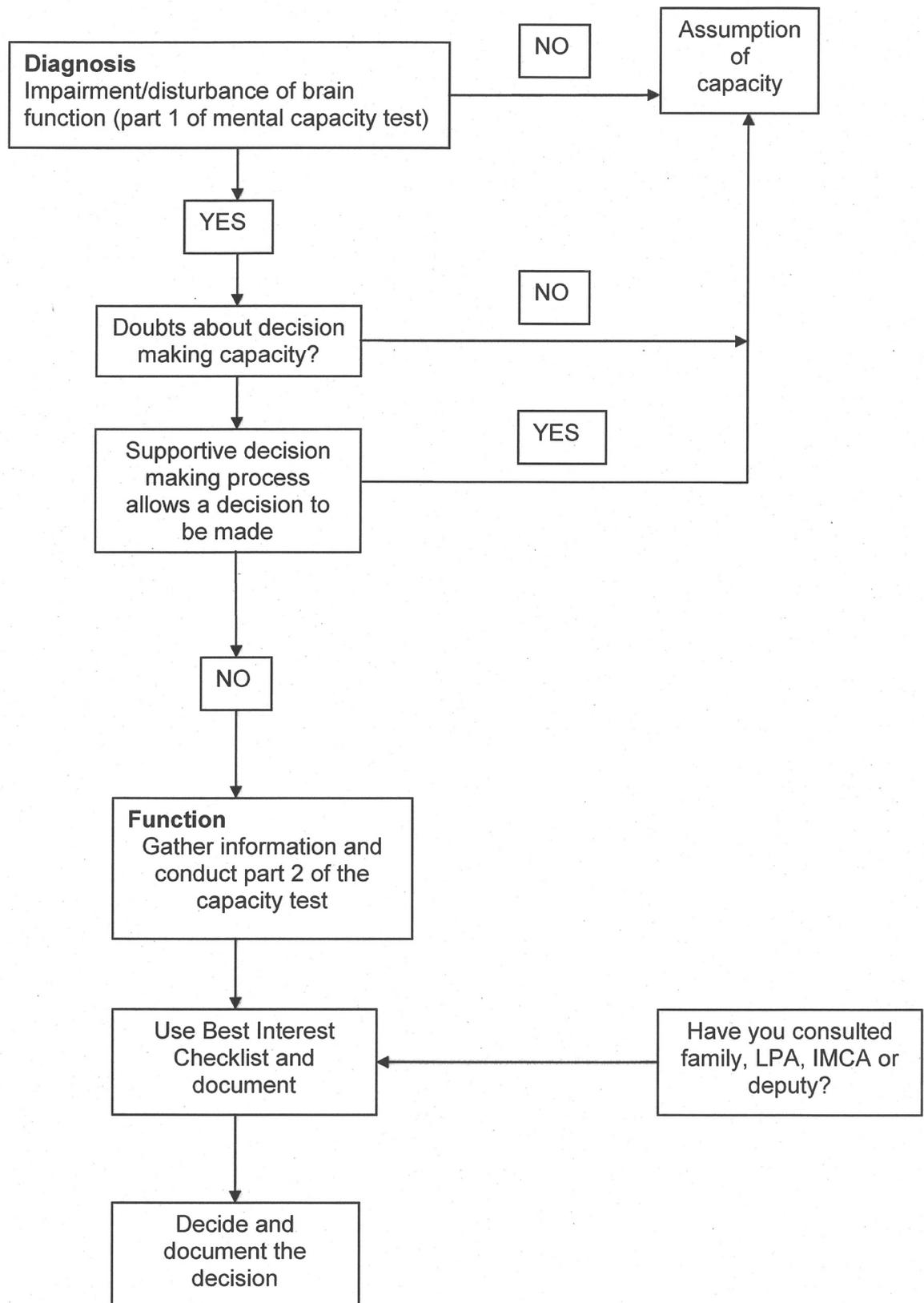
DETERMINATION OF CAPACITY AND BEST INTEREST

To be completed for all people assessed who have an "impairment of, or a disturbance in the functioning of, their mind or brain" that may prevent them from making decisions about how they are cared for. Please ensure you have read the PCT's Consent and DNAR policies before completing.



PATIENT'S TITLE (Mr, Ms, Mrs, Dr): NAME:.....		Delete as applicable FRAMEWORK / RIO / CERNER / NHS NO.
DOB:		
DECISION TO BE MADE (Delete as applicable) CAPACITY / BEST INTEREST		
DIAGNOSTIC TEST 1. Is this condition temporary?		
YES <input type="checkbox"/> NO <input type="checkbox"/> i. Can this decision wait? NO <input type="checkbox"/> YES <input type="checkbox"/> If YES then do not proceed at this time. i. Whodiagnosed? ii. When? iii. Date to be reviewed?		The condition is a result of: • Mental illness <input type="checkbox"/> • Dementia or confusion <input type="checkbox"/> • Brain injury <input type="checkbox"/> • Learning Disability <input type="checkbox"/> • Other please describe: _____
CAPACITY TEST		
Can the person:		OBJECTIVE EVIDENCE: explain why you are saying either yes or no
understand information about the decision to be made? YES <input type="checkbox"/> NO <input type="checkbox"/>		
retain that information in their mind? YES <input type="checkbox"/> NO <input type="checkbox"/>		
use or weigh that information as part of the decision-making process? YES <input type="checkbox"/> NO <input type="checkbox"/>		
What practical steps have been taken to assist the person to understand the decision to be made and communicate their response?		
LASTING/ENDURING POWERS OF ATTORNEY AND ADVANCE DIRECTIVES Is there an LPA / EPA or Advance Directive in place? NO <input type="checkbox"/> LPA (CARE) <input type="checkbox"/> ADVANCE DIRECTIVE <input type="checkbox"/> If yes please obtain a copy where possible and place on file and provide: - details and the names and contact details of those named in the LPA or AD - where the original is lodged (or reference to electronic record details)		
Who has been involved in this decision making process? Is there anybody else involved in the person's care or treatment (either formally or informally) who could have been consulted but wasn't? Please explain who and why not consulted.		

Figure 2 Flow chart to aid implementation of the Mental Capacity Act



experienced by the dental team, patients, or carers.

Conclusion

As part of our day to day work we regularly assess our patients on a number of levels and adapt our communication style and behaviour to suit their needs. In the past we may not have documented some aspects of these assessments. However it is now incumbent on us to implement the Mental Capacity Act and record that an appropriate process has been followed which respects patient autonomy (*Figure 2*).

Good documentation and record keeping demonstrates appropriate compliance with the legislation, and more importantly, due regard and consideration for the vulnerable adults with whose care we are entrusted.

Sources

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