

# ADULTS WITH INCAPACITY

Medical Treatment

*A guide for  
Health Care  
Professionals*

# Adults with Incapacity (AWI) Documentation

This booklet supports the capacity assessment and treatment plan of the new four page AWI document. Assessing capacity to consent is one of the “Duties of a Doctor” as outlined by the GMC, while using the relevant legal framework is specified in both “Duties of a Doctor” and the NMC Code. Links to the national guidance are provided at the end of the booklet.

## Key principles of the Adults with Incapacity (Scotland) Act 2000

- The Act obliges all staff to understand the legislation **and** apply them appropriately.
- You cannot treat a person without consent unless in an emergency when lifesaving medical treatment can be given under “common law”.
- In order to obtain valid consent the doctor must assess capacity.
- If the person lacks capacity for particular decisions about their healthcare then in order to protect them it falls to others to make these decisions for them.
- The practitioner with primary responsibility for the patient can provide any medical treatment which promotes their physical or mental health (with a few notable exemptions discussed below).

Any decisions made must follow the key principles of the Act

1. To benefit the person
2. To use minimal intervention and the least restrictive option available
3. To take into account the wishes of the person, both past and present
4. To consult with the person’s relevant others
5. To encourage the person to use whatever skills they have to make their wishes known

If there is a legal proxy (welfare guardian or welfare attorney) they have the legal right to make the decisions. If there is no legal proxy then it falls to the healthcare team looking after the person. This may be for all or certain aspects of their medical care.

The AWI Capacity documentation formalises and documents the decision making process of the capacity assessment, the treatment that is proposed for the person and the discussions with the relevant others. It is important to remember that people may have capacity for some decisions but not others.

## **Who should have their capacity assessed whilst in hospital?**

Capacity should be considered and assessed in all adult patients. This usually is done as part of routine care when we check the persons understanding of what is happening. Valid consent is necessary throughout a person's hospital stay; from routine blood tests and physiotherapy to more specialist investigations or treatments.

Particular patient groups to consider are:

- People with evidence of confusion, either acute (i.e. delirium) or chronic (i.e. dementia). This may be picked up by cognitive screening tests (AMT4 or 4AT) or by clinical observation.
- People with reduced level of consciousness, irrespective of cause.
- Intoxicated people (drugs or alcohol).
- Those with learning difficulties or mental health illness which may affect thought processes.
- Those with complex communication difficulties such as following a stroke. Speech and Language Therapist expertise may be required to help with assessment.

Everyone aged 65 or over should have a cognitive screening test such as AMT4 or 4AT carried out on admission to hospital. If this is abnormal then there should be a search for a cause and an assessment of capacity.

## **Why is capacity assessment important?**

Assessing capacity and using the legislation correctly is a legal requirement as well as being specified under our professional codes.

If a person lacks capacity to make a decision then someone else may need to make the decision in order to protect them. For example, the decision to take an antibiotic to treat an infection.

Similarly, if they lack capacity they also lack capacity to decline care. The healthcare team needs to then assess the risks and benefits on an individual basis. There are times where declining care will be accepted and times where care will need to be encouraged or enforced using the least restrictive method. This may be by returning later to someone who has declined blood tests, encouraging someone who says they don't wish to see the physiotherapist or giving sedation to allow someone to receive life saving medical treatment.

A person who lacks capacity for discharge decisions should not be allowed to take an irregular discharge. Discharge home can still be arranged if it is felt on balance to be in their best interests. This may include deciding what degree of risk to the person should be accepted.

People who lack capacity may be vulnerable to exploitation by others - if this is a concern then they should be referred to the Social Work Department.

## **Key points to filling out the capacity documentation**

## Section A: This guides you through the process of assessing capacity

### Section A - Assessment of Capacity

Capacity is assumed unless there is evidence of incapacity

- I believe that this person has attained the age of 16 and lacks capacity with regards to the proposed interventions because of mental disorder or inability to communicate because of physical disability. This is because they are unable to: (tick at least one of the following)
- Understand that a decision about the proposed treatment is required
  - Believe, understand when presented in appropriate language, retain memory of, or weigh and balance information about the proposed treatment
  - Communicate a decision, including with help of mechanical or other aids
  - Understand appropriately the benefits, risks and alternatives including the consequences of not receiving the proposed treatment
  - Reasonably recall the previous making of a decision about treatment

If the person lacks capacity consider whether they may be a vulnerable adult – if so refer Social Work

**Capacity** - the ability to understand and use presented information to make an informed decision.

**Incapacity** - if any one of the above mentioned criteria in **Section A** apply, then the person is deemed to lack capacity for that decision. Tick as many apply.

All adults over the age of 16 have a right to make personal decisions and capacity should be assumed unless there is evidence otherwise.

Someone with full capacity may make decisions which we feel to be unwise.

## **It is important to understand that capacity is not an all or nothing concept**

- A person may have capacity to make some decisions but not others
- A person may not have capacity to make a particular decision at a certain time, but this does not mean that they will never have capacity to make that decision
- Capacity may be diminished temporarily or permanently, partially or totally
- Therefore capacity should be reviewed throughout the hospital admission

## **When assessing capacity**

- Use simple language to explain what the intervention is and why it is being proposed
- Explain the benefits, risks and alternatives in order to allow choice
- Explain the potential consequences of not receiving the proposed intervention
- Remember that how information is presented can help or hinder someone to understand and make informed decisions. All practicable steps must be taken to assist them understand and communicate.

## **If you are unsure about someone's capacity consider**

- Performing a more detailed cognitive assessment
- Imparting information then checking understanding and retention at a later time
- Asking a more experienced colleague to assess
- Speaking with the multidisciplinary team. Ask the nurses if the person needs frequent reorientation, or the physiotherapist if they recall instructions between sessions. Allied Health Practitioners often spend significant time with patients and may have very valuable information.
- Discuss with their next of kin. Have they noticed a problem with cognition or understanding?

***If capacity is unclear or whilst making further assessment, assume the person has capacity. If someone challenges your assessment follow the same steps and seek a second opinion.***

## Section B: Welfare Attorney or Guardian

There may be a guardian or legal proxy who has been appointed to act in the person's best interests when they lack capacity. This may include:

- The Power of Attorney (POA) for welfare or Welfare Attorney. POA is given by the person while they have capacity in anticipation that it may be lost in the future
- A Welfare Guardian may be appointed by the Sheriff for a person who lacks capacity
- A person may be authorised by the Sheriff to make decisions under an intervention order

A legal proxy can consent to treatment **ONLY** if the person lacks capacity to consent themselves. Give information appropriate to their needs in the same way as you would to a patient. Every reasonable effort should be made to seek consent from this person.

Remember that sometimes POA is given for financial decisions but not welfare ones - **a financial POA is not able to consent to welfare decisions**. Always review the legal document so you can check what powers have been granted. Unless it is already uploaded onto Clinical Portal ask for a copy which should be photocopied and filed in the case notes.

If there is no legal proxy then decision making falls to the healthcare team. Nonetheless every effort should be made to identify and take into account the views of those close to the person. They may also give an insight into what the person would have wanted were they competent to decide. Those close to the person (their next of kin) may be the nearest relative, closest friend or primary care giver.

## Section C: Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

This form must be completed if the person is felt to lack capacity for healthcare decisions. If they are only felt to lack capacity for one intervention then a single Section 47 form may be used, but for the more complex care that is usually given in hospital the four page document with attached treatment plan should be used.

- Ensure that all of the patient's and doctor's details are accurately filled out. This must include the name of the next of kin or legal proxy.
- Decisions regarding proposed treatment must be clear and specific. Where a treatment plan is being filled in this should say "see treatment plan".
- The duration of incapacity should be carefully considered and the least restrictive option applied. For example:
  - Delirium - one month is usually appropriate
  - Dementia - a longer duration may be appropriate. The maximum duration is usually one year
  - Where the person has a profound and severe neurological condition, learning disability or dementia which is unlikely to improve, a longer duration of three years can be specified
- For interventions such as an operation that would usually require written consent, a separate Certificate of Incapacity is necessary for the duration of that intervention. It should be attached at section C.

## Section D: Treatment plan

The doctor responsible for the treatment should tick both boxes and be confident that these apply to their patient. The proposed treatment plan should then be drawn up. The pre-printed treatment options cover general interventions which occur in inpatient hospital care

Under “The continuing management of existing long term conditions” separately list all relevant co morbidities which are being actively managed - e.g. diabetes, hypertension, ischaemic heart disease.

Then list acute conditions being managed in hospital. It is important to include where relevant the condition which has lead to the incapacity - e.g. delirium, dementia, head injury.

- If sedation for agitation is felt to be necessary it should be mentioned specifically.
- If covert medications are being proposed they should also be mentioned. A separate care plan (download from the Mental Welfare Commission (MWC)) is also needed.
- Section 47 does not authorise preventing someone from leaving hospital against their will - if this is an issue formal detention under the Mental Health Act (MHA) may be required and you should speak to psychiatry.
- Some specialist treatments as described on the notes on the back page of the document are not authorised by section 47.

Consider whether the person has capacity to consent to each individual intervention. They may be able to consent to all, some or none. All of the interventions must be assessed and marked as either C (capacity) or I (incapacity).

Where there is a legal proxy the section 47 only authorises care once it has been agreed with them if practicable.

## Discussions with others

Where a section 47 is completed, it and the proposed treatment plan must be discussed wherever practicable with the legal proxy or next of kin. This is to ensure they are aware of and agree with the plan - you may need to modify it to reflect their input into the discussion. They have a right to challenge care, and to appeal to the Sheriff if agreement can not be reached. Section D of the document asks for documentation of this conversation.

The discussion can be had by whatever member of staff has the expertise. If complex medical discussions are required then this will be a doctor, if more simple medical issues and nursing interventions are being discussed then this may be a nurse. An information leaflet for relatives about capacity, the Act and the section 47 is available on the ward to support this. Once the discussion has been had, if the person's representative agrees to the plan the staff member should fill out this part of the form. The representative is not required to sign.

<p><b>Member of staff consulting family/carers to sign:</b> I have discussed with the patient's representative as below Welfare Guardian/ Power of Attorney (if one appointed): <input type="checkbox"/> Name..... Relationship..... OR Relative/ Carer/ Other individual most involved in persons care (if no Welfare Guardian/Power of Attorney): <input type="checkbox"/> Name..... Relationship.....  <b>Signed</b> ..... <b>Print</b> ..... <b>Date</b> .....</p>
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# Frequently Asked Questions

## **What if there is no next of kin?**

This should be written on the document. Consider liaising with others who may have an insight into the best treatments for the person such as their GP, home carers or district nurse.

## **What if there is disagreement between the person's representative and the healthcare team?**

Usually disagreements can be resolved by good communication. If disagreement persists a second opinion may be useful.

If there is a legal proxy, then they can make decisions that disagree with the advice of healthcare staff providing that they are acting in accordance with the principles of the Act. If there is concern that they are not acting in the person's best interest then the Sheriff can be asked to review their suitability as a proxy. Seek advice from the MWC. Just like a patient, a legal proxy cannot demand treatment that is not medically indicated.

If there is no legal proxy then the final decision rests with the healthcare team. But the next of kin may have valuable insight into what the wishes of the person would be. If they feel the healthcare team are not acting in the person's best interest then they can appeal to the Sheriff. Advise them to contact the MWC.

## **Can Section 47 be used to restrain a patient?**

AWI legislation cannot be used to forcibly restrain a person to keep them in hospital. In an emergency common law may be used, otherwise use of the MHA may be necessary. However physical force, including brief manual restraint, may be considered necessary to allow a person to undergo essential clinical interventions. Bed rails or specialist seating (including lapstraps) to help prevent falls are also classified as restraint. These strategies could be used under AWI legislation PROVIDING they had been carefully considered in an individual and person centred way and the principles of the act (ie minimal intervention, benefit to person) were followed. The type of restraint and an evaluation of its effectiveness should be clearly described in care plans.

## **What if someone regains capacity?**

The document can be revoked on the front page. Capacity often fluctuates in delirium so it is worth ensuring mental state is steady before doing this. They will be at risk of future

cognitive decline, so if not already in place it may be a good time to suggest that they consider arranging welfare POA.

## Useful information and contacts

### **Mental Welfare Commission for Scotland**

Thistle House  
91 Haymarket Terrace  
Edinburgh  
EH12 5HE

Freephone 0800 389 6809

[enquiries@mwscot.org.uk](mailto:enquiries@mwscot.org.uk)

<http://www.mwscot.org.uk/>

### **Scottish Government**

<http://www.gov.scot/Topics/Justice/law/awi>

### **NHS Greater Glasgow and Clyde**

For queries on using the new four page AWI document in GGC

[awiadvice@ggc.scot.nhs.uk](mailto:awiadvice@ggc.scot.nhs.uk)