NHS
Somerset
NHS Foundation Trust

This document is an abridged version of the Somerset Treatment Escalation Plan (STEP) & Resuscitation Policy. It contains information specifically about how the Mental Capacity Act relates to STEP.

4.0 THE MENTAL CAPACITY ACT

4.1 The STEP document is comprised of two elements. The MCA applies in a different manner to each.

i) The Treatment Escalation element
ii) The Resuscitation Decision element

4.2 Treatment Escalation and Resuscitation Decisions comprise both clinical and patient decision making. Aintree University Hospitals NHS Foundation Trust v James { 2013 } UKSC 67 clarifies that "...no patient can demand particular medical treatment which clinicians do not consider appropriate to offer". Put another way patient choices are limited by clinical decision making in regard to the appropriateness of treatments. A futile treatment cannot be demanded. An appropriate treatment can be refused.

5.0 THE MENTAL CAPACITY ACT AND TREATMENT ESCALATION

5.1 The treatment escalation element records the wishes and preferences of patients in regard to issues such as hospital admissions, health care treatments, and ceilings of care.

5.2 It is important to note that the Treatment Escalation element relates to future treatments and is hypothetical in nature. Treatment Escalation is a part of advance care planning and gathers general information to be used in future specific decisions related to medical care. The form itself cannot be considered a 'decision' as defined under the MCA as it may relate to a number of decisions and the concrete nature of these is not yet known. The Treatment Escalation element gathers information to inform future decisions (including MCA based ones) at the time they need to be made. It is not a record of a legally binding decision.

5.3 At the point of making the specific decision (with the concrete information at hand) the information detailed in the Treatment Escalation element can be used as an aide memoir for the health care professional and patient should the patient HAVE Mental Capacity. In this situation the individual may change their mind and not

follow what they have detailed in the Treatment Escalation element of their STEP if that is their wish.

5.4 The information in the Treatment Escalation element may also be used to inform a Best Interests decision at the time the decision needs to be made where the person is deemed to LACK capacity.

5.5 The Treatment Escalation element therefore does not ask for an explicit statement regarding the person's capacity when writing, as there is no concrete decision to assess capacity against. However, the person's views and wishes must remain central to the Treatment Escalation element of the STEP and considered in the context of clinical views in regard to available or indicated treatment.

5.6 Rather than assessing capacity to determine an on/off position in regard to their capacity healthcare professionals should simply start with the person themselves in order to gather the necessary information. If the person is unable or unwilling to discuss the Treatment Escalation element of the STEP then the healthcare professional may move onto other interested parties (family, friends, IMCA) to gather the information. There is space to document those consulted during these conversations on the form.

5.7 The source of the gathered information should be clearly recorded In the Treatment Escalation element of the STEP. Was it from the person directly or indirectly via other interested parties? What was the standing of those other people e.g. family, friend, lasting power of attorney for health?

6.0 THE MENTAL CAPACITY ACT AND THE RESUSCITATION DECISION

6.1 Decisions in regard to resuscitation are informed by case law (Elaine Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB) & R (Tracey) v Cambridge University Hospitals NHS Foundation Trust Ors [2014] EWCA Civ 822) and national policy (Decisions relating to cardiopulmonary resuscitation, joint guidance from the BMA, RCN, & Resus Council). This policy can not replicate the case law and guidance in full and offers a pertinent brief summary.

6.2 The starting assumption in regard to resuscitation is that a person is for CPR.

6.3 Where a decision is made not to resuscitate or Allow a Natural Death (AND) it will fall into one of three categories;

i. There is no prospect of CPR being effective in respect of extending a person's life.
ii. There is some prospect that CPR will be effective but the burdens on the person post CPR outweigh the benefits.
iii. The person has capacity to refuse an offer of CPR or a valid and applicable Advance Decision to Refuse Treatment (ADRT) is present and does not wish to have CPR.

i) There is no real prospect of CPR being effective in respect of extending a person's life - An appropriately qualified health care professional may make a clinical decision as to if CPR is an available treatment option. The professional may decide that due to other factors (e.g. frailty, multiple co-morbidities) that CPR would be ineffective in restoring life. In this situation the professional's role is to **inform** the person and/or their family of this decision and the existence of the AND decision. Capacity is not a 'live' issue here as the decision as to the clinical availability of treatments is not dependent upon the person's capacity. If the person and / or their family do not agree however they should be supported to obtain a 2nd opinion.

ii) There is some prospect that CPR will be effective but the burdens on the person post CPR outweigh the benefits - If CPR has been identified as an available treatment option (That is to say that there is a clinical view that it could be successful) then a decision regarding resuscitation should be made through considering the benefits and burdens of CPR. A benefits and burdens decision is more than a narrow clinical judgement. It is an ethical decision which must consider the wishes, feelings, beliefs, and values of the person involved. Whilst not strictly speaking a MCA based patient decision case law suggests that the framework of the MCA should be used to structure the consideration of the issue. In this context the person and / or the family involvement is through being **consulted**.

iii) The person has capacity or a has a valid and applicable Advance Decision to Refuse Treatment (ADRT) and does not wish to have CPR. If CPR is an appropriate treatment option then a person may **decline** it should they a) possess the relevant mental capacity or b) lack capacity and have an ADRT in regard to this decision. Should the person express this wish and there are doubts about their ability to make this decision then a formal capacity assessment should be completed alongside the STEP form. In this context the patient involvement is through being **consulted** then **declining** the offer of CPR.

6.4 Case Law and national guidance detailed in 6.1 details that patients and / or their families should be involved in resuscitation decisions. The nature of the involvement depends on the grounds for the decision and the abilities of the person. It is **essential that a rationale for the resuscitation decision is recorded**. Responsibilities in regard to the Mental Capacity Act will not be clear unless the rationale for the decision is made explicit.

6.5 Discussions about CPR can be difficult for the professional and distressing for the person. However, case law has made clear that this cannot be a reason for failing to have this discussion. There may be situations where discussion would cause actual physical or emotional harm to the person. Of note here is that 'distress' as a reason on its own would be insufficient. In these cases, professionals need to detail their rationale as to how and why the person will come to harm. Otherwise, case law articulates a strong presumption in regard to patient & interested party involvement.

6.6 AND decisions are not legally binding but are used to guide and inform professional's decision making at the time the treatment needs to be given. Within the context of CPR decisions these will need to be made in urgent circumstances and the information readily at hand. Professionals are able to divert from AND documents if there is a justified clinical reason to do so e.g., reversible choking witnessed in a dining room. ADRT decisions around CPR however are legally binding and have the same stature as a capacitated person's refusal of treatment. In order to carry this weight then an ADRT must be valid and applicable. As AND decisions relate to life sustaining treatment they must also be in writing, signed & witnessed. Further advice may be found regarding ADRT's here: Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk) Alternatively contact the trust's MCA lead.

17.0 APPENDIX B – FLOW DIAGRAM OF HOW TO UNDERTAKE A STEP DISCUSSION WHEN A PATIENT LACKS CAPACITY