

AN AUDIT OF DOCUMENTATION RELATING TO DECISION MAKING CAPACITY AT AN OLD AGE PSYCHIATRIC HOSPITAL IN ENGLAND

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ABSTRACT

The *Mental Capacity Act 2005* (MCA) guides clinicians in England and Wales in how to support patients to make a capacitous decision. Documentation of patients' capacity is mandatory for certain decisions in psychiatric hospitals so as to evidence the use of the MCA guidance. Given the importance of decisions such as where to live and what medication to take, the quality of clinician interview and documentation is important to monitor.

Method: The quality and quantity of decision-making capacity (DMC) documentation was reviewed in a psychiatric hospital in England for older adults. The clinical records of 49 discharged patients were examined retrospectively. All DMC documentation found was compared with existing legal guidance on capacity assessment.

Results: 46/58 DMC documents were found to be insufficient. There was little evidence of what information had been given to patients to enable autonomous decision making, what actions had been undertaken to optimise capacity and what alternative decision options were presented.

Conclusions: Consideration should be given by hospital managers to support DMC assessment by staff. Further reflection is needed on the part of regulators regarding the optimum DMC documentation standard, particularly regarding physical health medication for psychiatric inpatients. Guidance and training for all staff involved in the assessment and documentation of DMC should be made available.

I. INTRODUCTION

The statutory principles of the *Mental Capacity Act* (MCA) 2005 came into full force in October 2007 and applies to all persons over the age of 16 in England and Wales. The MCA is underpinned by 5 statutory principles:

- (i) Capacity is assumed unless there is clear evidence it is lacking;
- (ii) An unwise decision does not mean the individual lacks capacity;
- (iii) If someone lacks capacity to make a decision, all practical steps must be taken to help the person make a decision;
- (iv) Any decision made on someone's behalf because they lack capacity must be in their best interest;
- (v) Any decision made on someone's behalf because they lack capacity should consider the least restrictive option).

A capacity assessment requires an assessment of whether there is a disturbance of mind or brain. If there is, then the assessor must assess the person further to

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determine whether the person can understand, retain, use and weigh the information and communicate their decision. This is referred to as the two-stage functional test.

Both the MCA Code of Practice (issued under the Act) and guidance from the General Medical Council specify that the process and outcome of capacity assessments should be documented in the patients' records(1–3). However, in 2014, a specially convened Parliamentary inquiry identified that capacity assessments were generally not recorded and were of poor quality (4).

Mental capacity law guidance (5) suggests that documentation is explicit regarding: what are felt to be the salient details the person needs to understand, the choices that are available and in evidencing each element of the capacity test. In addition, it must be made clear how the inability to make a decision is secondary to an impairment or disturbance of mind or brain (6).

Current guidance across England is for psychiatric inpatients to have documentation to evidence that their capacity has been assessed for the decisions to be admitted to hospital and to receive treatment. Recent case law has emphasised the importance of giving accurate information on the risks and benefits of a proposed treatment, alternative treatment options, tailoring the information to the patient and allowing time and space for the patient to consider the information (7).

Despite the MCA being in force for some years, there are concerns that there are challenges facing clinicians when translating knowledge into practice (8) With this in mind, this study aimed to assess the quality of decision-making capacity (DMC) documentation at an old age psychiatric hospital in England. The implications for practice and challenges of addressing them will be discussed.

II. METHOD

A retrospective audit of the clinical records of all patients discharged from two wards at The Woodlands Unit, Rotherham, England between January and November 2016 was undertaken.

Both wards provided care for patients aged over 65. One ward specialised in the care of patients with dementia, whilst the other ward specialised in treating patients with mood disorders and psychosis.

The paper and electronic records of 49 patients were reviewed for evidence of documentation of DMC. Any documentation found was copied word for word and anonymised.

The decision being made and professional background of the person documenting the information was logged. This was carried out by authors 1 and 2 in January 2017.

All DMC documentation found was on a structured MCA1 Form: Record of Mental Capacity Assessment(9). For the purposes of analysis, this form was divided into 7 sections: the decision to be made; the disorder of mind/brain; the ability to understand, retain and weigh up the relevant information; the communication of the

decision, and the assessment outcome (Table 1).

AUDIT STANDARDS

Each section of documentation was independently rated as sufficient or insufficient by authors 1 and 2 based on the audit standards detailed in Table 1. The standards were devised from current legal guidance (5).

If the MCA1 form had 4 or more sections rated as sufficient (i.e. meeting the audit standard), the overall form was given a sufficient rating. This cut off was chosen to reflect a hypothesis that most DMC documentation would fall below the standard described in the legal guidance. Any discrepancies were discussed between the two authors until consensus was reached.

Table 1 – Audit standards used by the authors to rate DMC documentation found as sufficient or insufficient

Section of MCA1 form	Audit standard to be met in order for the section to be marked as sufficient
1. The decision capacity is being assessed for	Must be a single decision
2. Is there an impairment of or disturbance in the functioning of the person's mind or brain?	Must state more than a diagnosis alone and describe aspects of behaviour or functioning that may have an impact on decision making
3. Is the person able to understand information relevant to the decision?	Must state what are felt to be the salient details the person needs to understand Must state what was done to assist the patient in understanding information
4. Is the person able to retain the relevant information?	Must state what was done to assist the patient in retaining information e.g. offering written information
5. Is the person able to use or weigh the information as part of the decision making process?	Must state which available choices were discussed
6. Is the person able to communicate their decision?	Must state how the patient communicated their decision
7. Outcome with rationale	If the outcome is that the patient lacks capacity, the assessor must refer to which elements of the capacity test (i.e. sections 3-6 of the form) the patient failed on

This project was reviewed by the NHS Trust audit department. No ethical approval was required for the study as it was an investigation of clinical data already required as part of routine care. The only personal identification collected for each patient was an NHS number. All data was stored anonymously in a password protected file on an encrypted computer.

III. RESULTS

There were 58 assessments of DMC documented relating to 27 patients. 22 patients had no assessments of DMC for any decision documented. 12 of the 58 DMC documents were rated as sufficient overall when judged against the criteria described in Table 1.

AUDIT STANDARDS

Table 2 shows the results relating to each standard. The most common decisions for which DMC documentation was completed were whether to accept treatment, followed by a combined decision for admission and treatment (Table 3). Where MCA assessment documentation was for a dual decision (admission and treatment), this automatically led to a rating of insufficient for the “decision” section as the MCA is clear that each assessment should be for a single decision only.

Documentation on sections 2-5 of the forms was frequently judged insufficient due to the professional completing it re-stating the question rather than giving evidence specific to the patient; failing to mention what information was provided to the patient, including what options were discussed; failing to describe what was done to assist the patient in making the decision; and not describing the patient’s impairment or disability that impacted on their ability to make a decision (Table 2).

Table 2 –The proportion of each section of the MCA1 forms rated sufficient and insufficient with examples.

Section of MCA1 form	Number of Forms rated insufficient (not meeting The standard)	Number of Forms rated sufficient (meeting the standard)	Example quotes from documentation judged to be insufficient	Example quotes from documentation judged to be sufficient
1. The decision capacity is being assessed for	19	39	Admission and treatment	Informal admission to a mental health unit
2. Is there an impairment of or disturbance in the functioning of the person’s mind or brain?	10	48	X has got a diagnosis of Lewy body dementia	Attempted suicide by cutting his wrists/ paracetamol overdose
3. Is the person able to understand information relevant to the decision?	38	20	X cannot understand instruction due to Alzheimer’s disease	X was able to partake in the assessment. Her thought process was logical and rationale there was no evidence of confusion
4. Is the person able to retain the relevant information?	45	13	Unable to retain adequately to weigh up information	X was able to comprehend the information and was aware that the unit was a mental health
5. Is the person able to use or weigh the information as part of the decision making process?	45	13	She cannot understand the necessity in the first place Lack of insight limits this	X was happy for support/help. He told me he was unable to keep himself safe at home alone and insightful that he requires help/support.
6. Is the person able to communicate their decision?	30	28	X has expressive dysphasia Does not communicate	No issues identified during the assessment, able to communicate verbally, speech coherent

7. Outcome with rationale	34	24	Yes as above X lacks capacity to give her consent to stay on the ward informally	X lacks capacity as she cannot understand, retain, weigh up information or communicate a decision
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Table 3 – Decision to be made and the judged overall adequacy of DMC documentation.

Decision	Total number of documents	Sufficient evidence (more than or equal to four standards met on the MCA1 form)	Insufficient evidence (less than four standards met on the MCA1 form)
Whether to accept treatment	23	5	18
Combined admission and treatment	19	3	16
Whether to be admitted	11	3	8
Whether to participate in completion of the Decision Support Tool*	2	0	2
Whether to contribute to a decision regarding nursing interventions	2	1	1
Whether to appeal against detention in hospital under the Mental Health Act	1	0	1
Total	58	12	46

* The Decision Support Tool is a document designed to be completed a by a multidisciplinary team about a patient to identify whether their care needs meet the threshold for continuing healthcare funding.

PROFESSIONALS COMPLETING DMC

The majority of the DMC documentation was undertaken by doctors. Doctors' documentation of DMC was sufficient in only 6 out of 43 cases, whereas liaison nurses' documentation was found to be sufficient in all three cases (Table 4).

Table 4- Professionals documenting DMC assessments and judged adequacy of documentation.

Professional	Total number	Number of Sufficient forms overall (i.e. with four or more sections marked as sufficient)	Number of Insufficient forms
Consultant Psychiatrist	18	0	18
Specialty Doctor	17	5	12
Higher Psychiatry Trainee Doctor	1	0	1
Core Psychiatry Trainee Doctor	3	0	3
Foundation year 1 Doctor	4	1	3
Ward nurse	11	3	8
Liaison nurse	3	3	0
Unknown	1	0	1

IV. DISCUSSION

While several studies have previously examined the question of whether capacity is being assessed, there has been far less attention paid to the quality of capacity assessment. This study takes a step towards addressing this by focussing on the

documentation of mental capacity assessments. Documentation should be a reflection of what was discussed (10) and recording this accurately is important to protect both patients and doctors should a decision ever be challenged in the future. There have been criticisms of a doctor's record keeping in a high profile legal case relating to evidencing compliance with the MCA code of practice (11). With this in mind, documentation was classed as sufficient or insufficient based on legal guidance.

A previous audit of 68 entries relating to DMC found that in 58% of cases, the steps taken to assess capacity were described (12). In our audit, a lower proportion of documentation (12/58) was felt to sufficient. Although it is possible that detailed discussions are taking place but not being reflected in the documentation, the findings here are a cause for concern and undermine the progress that has been made in increasing the overall numbers of DMC assessments that are being conducted (13).

QUANTITY OF ASSESSMENTS

In England, the decision of whether to be admitted as a psychiatric inpatient must have associated DMC documentation. All psychiatric inpatients must also have DMC documented for treatment they receive. The Care Quality Commission monitor the standard of care provided in hospitals in England and routinely comment on MCA compliance in inspection reports(14).

22 out of the 49 patients' records reviewed for this study had no DMC documentation. This study, as have previous (17, 18) has demonstrated that there remains a significant number of patients admitted to old age psychiatric wards without documentation of their capacity to consent to admission or treatment. Previous studies have indicated that high levels of patients admitted to older adult psychiatric units lack capacity to make decisions regarding admission (48%) (17, 18) and treatment (62%) (16). Where patients are felt to lack capacity it is imperative that during DMC assessments clinicians are skilled at giving the patient the best chance to take part in decision making and can evidence this through documentation. The lack of descriptions in this sample of what was done to support patients to make capacitous decisions is concerning.

PARITY BETWEEN MENTAL AND PHYSICAL HEALTHCARE

A systematic review has found that there are similar proportions of patients who lack capacity to consent to admission and treatment on medical (34%) and psychiatric (45%) wards (17). In England, it is not mandatory for patients admitted to a medical hospital to have DMC documentation for the decisions to be admitted and receive treatment. Parity of esteem between mental and physical health care was enshrined in law in the England by the 2012 Health and Social Care Act (18). Mandating DMC assessments for those requiring admission to a psychiatric unit could be interpreted as going against this Act, section 2 (3) of the MCA (capacity cannot be established just by reference to a person's age, condition or aspect of his behaviour) and the first statutory principle of the MCA (everyone over the age of 16 should be assumed to have capacity). The question remains as to whether the requirement of admission to a psychiatric unit is enough to suggest one lacks capacity. Is it fair to expect that psychiatric facilities document these decisions for every admission when physical

health facilities do not?

PROFESSIONALS COMPLETING DOCUMENTATION

In England, a patient cannot be admitted to a psychiatric hospital against their will unless they are first assessed under the *Mental Health Act 1983* (MHA). This requires an assessment by three independent professionals: 2 doctors and an Approved Mental Health Professional (AMHP). The two doctors' role is to decide whether to make a recommendation that the patient needs to be in hospital. It is the AMHP that ultimately decides to detain the patient in hospital (provided both doctors make recommendations). 31 of the 49 patients in this sample were admitted under the MHA. No DMC documentation for admission reviewed in this study was completed by AMHPs. Instead it was completed by doctors after the decision for admission had already been made. The function of DMC assessment and documentation should primarily be to guide management and not simply an administrative chore to be completed after the event. Given that capacity assessments are time and decision specific, DMC documentation for admission completed in these circumstances does not capture the initial decision of whether to be admitted to hospital. There is a time delay until the assessment is conducted for what will then be a different decision – whether to remain admitted to hospital.

It is of note that all of the MCA documentation completed by consultants was rated as insufficient, despite the fact that consultant psychiatrists have high levels of training and experience in conducting such assessments. Previous studies have highlighted that “the accuracy and effectiveness of implementing the MCA is contingent upon sufficient staffing and resources” (19) and that use of the MCA is seen as additional paperwork (20). This result could therefore be a reflection of the high consultant workload contributed to by low junior doctor numbers and ongoing recruitment difficulties in England (21). A recent systematic review identified challenges for clinical staff in applying the MCA in everyday clinical practice and limited effectiveness of current education strategies. As a result there have been calls for education and active implementation (22). Delays in developing training and local policies, variable knowledge of the definition of DMC and factors that may trigger an assessment of DMC (22) could also explain our findings of poor quality documentation by nursing staff and junior doctors. It is also possible that our findings are a reflection that the demands of a mental health ward conflict with the way the MCA was intended to be used (in terms of the time needed for training, to perform the MCA assessment, reflect on and document it) (23).

MINIMUM INFORMATION

The MCA assessor must identify the minimum amount of relevant information a person must understand in order to make a decision. This is a challenge as the assessor must tailor the information to the patients' values and judge the amount of detail to provide (24). In general, a view is taken that the more complex and serious the decision, the higher the bar is set for decision making capacity (25). Case law has led to suggestions on the minimum amount of information required to be understood for someone to make a capacitous decision about admission (26) and treatment (27) (Box 1).

A similar study reports that just 26% of patients were given sufficient information in order to make a decision regarding admission (28). Admission to a psychiatric ward is not the same as admission to a general hospital ward. On a psychiatric ward in England, nurses can use a holding power to prevent an informal capacitous patient from leaving and the doors are nearly always locked. It is unclear what percentage of informal patients in this study were aware of these differences.

The decision of whether to take medication for physical as well as mental health conditions falls under the decision of whether to accept treatment. A large number of DMC documentation did not define what specific interventions or medications the term "treatment" encompassed. For example, the decision of whether to take warfarin requires a person to understand a very different complexity and quantity of information about risks, benefits and monitoring requirements than the decision regarding whether to take Senna. According to the MCA Code of Practice, these should be separate capacity assessments and require separate documentation. When considering the numbers of medications patients were taking in our sample (on average 6.3 physical health medications and 2.3 psychotropic medications per patient) this would be a considerable increase in work load for the ward team.

AUDIT CYCLE – THE NEXT STEP

These findings highlight that more training and guidance is needed to support clinicians in evidencing DMC. This is planned to be delivered at induction of new staff members and through regular mandatory training. Case law will be used to highlight the importance of detailed documentation. Previous studies have demonstrated improvements in documentation with a structured proforma (29). With this in mind, since this project, the local MCA1 form has been redesigned with prompts to describe options discussed with patients and information given. There are plans to repeat the audit following education and dissemination of these results.

Box 1

Minimum information suggested for the decision of whether to be admitted to a psychiatric ward (14)

1. The person will be admitted for care and treatment for a mental disorder
2. The doors to the ward will be locked
3. Staff are entitled to carry out property and personal searches
4. The person will expect to remain on the ward until seen by a doctor (at least 24 hours)
5. The person will be required to inform nursing staff whenever they leave, telling them where they are going and the time of return
6. Nursing staff may refuse to agree to them leaving the ward if they believe the person is at risk or could pose a risk to others
7. If the person leaves the ward without informing staff or does not return at the time they say the staff will contact the police
8. The person's description will be recorded by staff to enable the above
9. The consequences of not being admitted to the ward

Minimum information suggested for discussing treatment (27)

- Illness requiring treatment
- Nature of the treatment
- Purpose of the treatment
- Risks/side effects of the treatment
- Risks of not having the treatment

Alternative treatment options

LIMITATIONS

This study involved a small number of patients and professionals completing documentation from one hospital in England. Because of this, it is possible that the results presented here are not truly representative of the population of interest. The reviewers were scrutinising the work of their colleagues. Although all documentation was anonymised before being rated as sufficient or insufficient, it is possible that the rating process was not completely free from rater or confirmation bias.

FUTURE DIRECTIONS

For testamentary capacity (30), capacity to gift (31), marry (32) and litigate (33) more specific, contextual legal standards in the courts through common law are not replaced by the MCA (34). Having an equivalent for capacity to consent to admission and treatment similar to that described by Palmer et al (35) or an evidence based tool such as the MCAST (36) may make the requirements of DMC documentation more clear.

Acknowledgements

We thank Dr John Bottomley and Dr Simon Bell for giving feedback on an earlier version of the manuscript.

Disclosures

The authors have no potential conflicts of interest to disclose.

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