Implications of the mental capacity act in preoperative clinics

Jason Cross
Advanced nurse practitioner
Dept of ageing and health
Guy’s and St Thomas’, London

“Improving the care of older surgical patients through collaboration, education and research”
The Preoperative Association

Guy’s and St Thomas’ NHS Foundation Trust

Nurse Practitioner Led Pre-Admission Service

Streamlining Admission Services for Surgery

Providing a quick accessible & efficient service

A holistic patient-centred pre-assessment service including:

- Nurse Practitioner led services
- Comprehensive assessment
- Multi-disciplinary team
- Patient information

Impact on other Services

Providing Pre-Operative Assessment to meet the demands of a 21st Century National Health Service
Implications of the mental capacity act in preoperative clinics

Jason Cross
Advanced nurse practitioner
Dept of ageing and health
Guy’s and St Thomas’, London

“Improving the care of older surgical patients through collaboration, education and research”
Questions / expectations

- How is this relevant to my practice?
- How do I assess capacity and fit it into the assessments I already do?
- What do I do when I highlight a problem?
The changing population...

Projected change in proportion of population aged 75 and over from 2010 to 2035

<table>
<thead>
<tr>
<th>Age</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>65</td>
<td>18.9</td>
<td>21.4</td>
</tr>
<tr>
<td>75</td>
<td>11.7</td>
<td>13.5</td>
</tr>
<tr>
<td>85</td>
<td>6.1</td>
<td>7.2</td>
</tr>
<tr>
<td>90</td>
<td>4.3</td>
<td>5.0</td>
</tr>
</tbody>
</table>

... with potential health-related problems...

- **Life Expectancy (LE) and Healthy Life Expectancy (HLE) at Age 65 (Years)**
  - Source: Government Actuary's Department
  - The chart compares LE and HLE across different regions and genders.

- **PAD Prevalence by Age Group**
  - The prevalence of PAD (Peripheral Arterial Disease) is shown for different age groups (60-64, 65-69, 70-74, >75) for both men and women.

- **Percent of New Cases by Age Group: Esophageal Cancer**
  - The chart illustrates the percentage of new cases for esophageal cancer across various age groups from <20 to >84 years.

The data suggests that there is a significant focus on health-related problems, particularly in older age groups, with high prevalence rates for PAD and a notable distribution of esophageal cancer cases.
...that require surgery...

Increased access
Change in attitudes
Improved surgical techniques

Birrell, Ann Rheum Dis 1999
...but we know older patients have specific age related CNS issues...

**Neurobiologic changes of aging**

<table>
<thead>
<tr>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreased brain weight &amp; volume</td>
</tr>
<tr>
<td>Decreased neurotransmitter system function</td>
</tr>
<tr>
<td>Decreased neuronal gene expression</td>
</tr>
<tr>
<td>Alzheimer type changes</td>
</tr>
</tbody>
</table>
...and pathology...

- Diagnoses are likely to increase
  - National Dementia Strategy, NICE delirium guideline, CQUIN

By 2025 >1 million people in UK will have diagnosis of dementia
...which is often undiagnosed...

Mean preoperative MoCA score 21

68% had MoCA <24

Only 9 patients had any prior mention of cognitive issues

88% of those with MoCA <24 were previously undiagnosed

Partridge 2015
...increasing the risk of perioperative delirium

- **Differs across surgical groups** (J Am Ger Soc 2006;54:1578-89)
  - 13-61% after hip fracture
  - 35% after vascular surgery
  - <5% of older people after cataract surgery

- **In comparison with other complications**
  - 0.1% fatal PE in 3 months following hip fracture surgery
  - 1% significant wound infection following elective THR/TKR

These issues can affect capacity...

Underlying /co-existing...
- psychiatric disease
- learning disability or deficiency
- established cognitive impairment, dementia
- delirium

...can affect capacity
- to consent to surgery/procedure
- to consent to other in-patient interventions/treatments
- to participate in decisions regarding longer term issues e.g. discharge destination
So...
What can we do?

“Improving the care of older surgical patients through collaboration, education and research”
Mental Capacity Act (MCA) 2005

- Overview
- The MCA...
  - applies to everyone involved in the care, treatment and support of people aged 16 (England and Wales)
  - is designed to protect and restore power to those vulnerable people who lack capacity.
  - supports those who have capacity and choose to plan for their future (aged over 18)
Overview

The MCA...

- provides a checklist work out the best interests of the individual concerned if capacity is lacking
- highlights all professionals have a duty to comply with the Code of Practice.
- sets out five statutory principles that must underpin all parts of the act
Mental Capacity Act (MCA) 2005

- Five principles
  1. A presumption of capacity
  2. Individuals being supported to make their own decisions
  3. Unwise decisions
  4. Best interests
  5. Less restrictive option
Assessing capacity

Two stages of assessment:

Stage 1 - Does the person have any disturbance of the brain that may limit their decision making process?

Stage 2 - Does that person have a general understanding of the decision they need to make and why they need to make it? Also, does that person have a general understanding of the consequences of making, or not making that decision?

Can the patient?
Understand the information relevant to the decision
Use or weigh the information as part of the decision process
Communicate this decision

- Dementia
- Cognitive impairment
- Delirium
- Brain injury
- Learning deficit
Clear cut when documented dementia or learning deficit diagnosed already
  ▪ Already promoted to consider capacity

What do you do?
  ▪ Maybe family report memory issues
  ▪ PMH in clinic is difficult to ascertain
  ▪ Have a gut feeling something’s not quite right
So...
What can we do in the preop setting?

“Improving the care of older surgical patients through collaboration, education and research”
Assessing cognition pre op

- Why are you here. What operation are you having.?
- ‘Have you noticed any change in you memory in the past 12 months?’....
- The 4 AT
  - Validated in diagnosis of delirium and cognitive impairment

The 4 'A's Test: screening instrument for delirium and cognitive impairment

**4AT**

- **Alertness**
  - Normal (fully alert, but not agitated throughout assessment)
  - Mildly agitated for <10 seconds after waking, then normal
  - Clearly abnormal

- **AMT4**
  - Age, date of birth, place (name of the hospital or building), current year:
  - No mistakes
  - 1 mistake
  - 2 or more mistakes/untestable

- **Attention**
  - Ask the patient: ‘Please tell me the months of the year in backwards order, starting at December.’
  - Untestable (cannot start because unwell, shoveling, mistaken)

- **Acute change or fluctuating course**
  - Evidence of significant change or fluctuation in: awareness, cognition, other mental function (e.g. paranoia, hallucinations) among over the last 2 weeks and still evident in last 24hrs:
  - No
  - Yes

- **4AT Score**

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely (but delirium still possible if [4] information incomplete)
Assessing cognition pre op

- Detailed history
- Clock drawing
- MMSE (Mini Mental State Examination)
- MoCA (Montreal Cognitive Assessment)

**BUT**, having cognitive impairment doesn’t mean you don’t have capacity. **One doesn’t equal the other.**
But should lead to...

- More direct questions about treatment
  - Expectations
  - Understanding
  - Can they repeat back what you’ve explained (remember to use non medical language)
  - Do they understand what the risks are?
  - What would happen if they didn’t have treatment?
The patient who lacks capacity

- Document what you have done
- Look to your local policy/guidelines
- Escalate your concerns
- Start the process

What happens next?

Trust Procedures

Safeguarding Adults at Risk Procedure: Chapter 02 – Guidance on the Mental Capacity Act 2005: Identifying and caring for patients who may lack capacity

Policy Summary
Guy’s and St Thomas’ NHS Foundation Trust will ensure a safe environment for patients and staff. It will ensure that adults who lack capacity to make decisions about their care and treatment receive high quality dignified care delivered in compliance with the Mental Capacity Act 2005.

Document Detail

<table>
<thead>
<tr>
<th>Document Date</th>
<th>Trust Procedures</th>
</tr>
</thead>
</table>

Superseded documents

Related documents
- Safeguarding Adults at Risk Policy
- Safeguarding Adults at Risk Procedure: Chapter 01

Keywords
- Mental capacity, Mental Capacity Act 2005, Incapacity, inability to consent

Supporting References

Change History

<table>
<thead>
<tr>
<th>Date</th>
<th>Change details</th>
<th>Approved by</th>
</tr>
</thead>
</table>

Preview History

<table>
<thead>
<tr>
<th>Date</th>
<th>Change details</th>
<th>Approved by</th>
</tr>
</thead>
</table>
Who can advocate...

- Family or Friend

- Independent mental capacity advocate (IMCA)
  - Paid representative
  - Support the individual in the decision making process
    - Gather information
    - Evaluate
    - Make representations
    - Challenging decisions

Can only advocate
Best interest...

- Meeting of MDT
- Patient advocate

- Least restrictive option
Deprivation of liberty...

- Authorisation for certain restraint and restrictions.
- Allow treatments to take place in the patient's best interest.
- Valid in a hospital or care home environment.
- Applied/authorized through local authority.

"Care providers don't have to be experts about what is and is not a deprivation of liberty. They just need to know when a person might be deprived of their liberty and take action."

- Applying due process to ensure proper legal authority.
So...

How does this all look in practice?
Case 1. Gynae-onc cancer, clear lack of capacity, very involved family member

Surgical consult
- Grade 1 endometrial cancer
- Dementia
- Referred for comprehensive pre op assessment

PAC consult
- Dementia
  - 5 year history
  - Secure 8 bedded unit for 1 year
  - Does not have capacity to make a decision regards surgery

Best interests meeting necessary
- Surgeon, POPS, Gynae ward sister, CNS, Niece
ES – benefits and risks of surgery

- **Benefit of surgery (surgeon)**
  - Curative treatment – TAH, BSO, BPLND
  - Stop PV bleeding
  - Improved survival - If left >6/12 likely spread, renal obstruction (anecdotal)

- **Risk of surgery (surgeon and PAC)**
  - Oedema (5-10:100), bleeding, bowel injury (1:1000)
    (based on case series from >10 yrs ago)
ES – benefits and risks of surgery

- Risk related to surgery/in-patient surgical stay
  - Cognitive decline
  - Functional decline
  - Possibility of being unable to return to current residence

Nadelson Br J Anaes 2014

Lawrence J Am Coll Surg 2004
ES – best interests meeting

- Considerations
  - Benefit versus risk of surgery
  - Other treatment options
    - Radiotherapy/Chemotherapy
  - Clinician reported outcomes
    - Morbidity/mortality
  - Patient reported outcomes
    - Functional/cognitive/return to residence
  - Previously expressed patient wishes
ES - outcome

- Admitted on day of surgery with NOK present
  - This is me document
  - Anaesthetist informed.

- Surgery
  - Minimally invasive

- Interventions
  - Side room with HELP model in place
  - Delirium pathway
  - Relaxed visiting hours
Case 2. Elective urology. Acutely unwell. Best interest. DoLS.

Surgical consult
- Benign enlarged prostate
- Recurrent urinary infection
- Needs TURP

PAC consult
- HTN, CKD 3A – stable
- Wife reports not as chatty recently, low mood, withdrawn
  - MSU taken
  - Bloods
  - Sent home
Results

- AKI from baseline
- UTI on MSU

Patient / wife contacted

- Wife reports husband aggressive
  - Won’t take his medications
  - Has a temperature and not passing urine
- Discussed with urology team
  - Decision to admit for review and treatment
  - Admitted via A&E to urology ward

<table>
<thead>
<tr>
<th>Chemical Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Chemical Pathology</td>
</tr>
<tr>
<td>Sodium Level</td>
</tr>
<tr>
<td>Potassium Level</td>
</tr>
<tr>
<td>Urea Level</td>
</tr>
<tr>
<td>Creatinine Level</td>
</tr>
<tr>
<td>Calcium Level</td>
</tr>
<tr>
<td>Corrected Calcium Level</td>
</tr>
<tr>
<td>Estimated GFR</td>
</tr>
</tbody>
</table>
Admission to ward

Ward review
- Urinary retention / UTI / outflow obstruction
- Delirium

Treatment
- Catheter
- IV fluid supplementation
- IV Antibiotics
- Repeat bloods
- Expedite TURP

Delirium hindering intervention
Best interest / DoLS

Lacks capacity
- Declining treatment
- Not able to make decisions
- Best interest meeting
- Wife / medical team / surgeon

Deprivation of liberty safeguards (DoLS)
- Application to local authority
- Same day decision
- urgent DoLs granted for 7 days
**Outcome**

- Initially required sedation
- IVAB / IDC and Fluids (least restrictive option)
- Delirium settles 3 days
  - Supported by family on the ward
  - Capacity reassessed
  - No need to extend DoLS
- Home with catheter
Questions / expectations

- How is this relevant to my practice?
- How do I assess capacity and fit it into the assessments I already do?
- What do I do when I highlight a problem?
Implications of the mental capacity act in preoperative clinics