

Consent: Guidance on mental capacity decisions in diagnostic imaging and radiotherapy

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Background

An extract from the key lines of enquiry for diagnostic imaging [1], which all CQC inspectors use as a framework when inspecting imaging services in England, is useful to help practitioners/staff including students to understand their responsibilities with regards to the Mental Capacity Act (2005)[2] (MCA) which applies in England and Wales:

- Do staff understand the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004 and other relevant national standards and guidance?
- How are people supported to make decisions in line with relevant legislation and guidance?
- How and when is possible lack of mental capacity to make a particular decision assessed and recorded?
- How is the process for seeking consent monitored and reviewed to ensure it meets legal requirements and follows relevant national guidance?
- When people lack the mental capacity to make a decision, do staff ensure that best interests decisions are made in accordance with legislation?
- How does the service promote supportive practice that avoids the need for physical restraint? Where physical restraint may be necessary, how does the service ensure that it is used in a safe, proportionate, and monitored way as part of a wider person centred support plan?
- Do staff recognise when people aged 16 and over and who lack mental capacity are being deprived of their liberty, and do they seek authorisation to do so when they consider it necessary and proportionate?

Further and most recent information about key lines of enquiry is available online via this link:

<https://www.cqc.org.uk/guidance-providers>

The guidance in this document refers to three areas of legislation, the MCA which applies to cases in Wales and England; The Adults with Incapacity (Scotland) Act 2000 [3] which is applicable for practitioners in Scotland and; the Mental Capacity Act (Northern Ireland) 2016 [4] which applies in Northern Ireland. An ethos of all three acts is to empower those with impaired capacity. For example, people living with dementia, communication difficulty, learning difficulty or autism must be supported in making their own decisions as much as possible; to enable their right to a normal life in society. In particular, radiography practitioners will find it useful to keep a key point in mind:

The three UK acts which govern capacity legislation do not advocate a blanket judgement of a person's mental capacity, this is because;

- a. Mental capacity is both time and decision specific and;
- b. Capacity to consent can fluctuate.

A SCoR document, Obtaining consent: a clinical guideline for the diagnostic imaging and radiotherapy workforce [5], provides an overarching recommendation with regards to capacity. Recommendation four, 'Capacity', is copied from the document and pasted below:

"Every adult has the right to make their own decisions and must be assumed to have capacity to do so, unless it is proven otherwise. Individuals have the right to be supported in making

their own decisions and must be aided to do so. They retain the right to make what may seem as eccentric or unwise decisions.

Consent principles must apply to all patients and service users and where a patient or service user has a diagnosis that may affect their capacity to consent, it must not be automatically assumed that they are then unable to make any decision for themselves. Any decisions made on behalf of people without capacity must be in their best interests and done in the least restrictive manner possible, to preserve their basic rights and freedoms.

It is important that practitioners keep up to date and comply with the laws and codes of practice that apply to their work place. If there is any uncertainty about how the law applies in a given situation, they should consult with their employer, the SCoR or seek independent legal advice.” [5]

With respect to the recommendation, four points of note are made here:

- Every adult retains the right to make a decision contrary to clinical advice, unless there is evidence of coercion, control, or the adult has been deemed to lack capacity.
- A diagnosis that may affect the capacity to consent is one that involves an impairment of the mind or brain. Impairment may be temporary, due to acute illness; therefore it is important to know the clinical presentation and history of a patient. For example, a urinary tract infection may lead to lack of capacity for a patient until that person is successfully treated.
- Any decision that is made on behalf of someone without capacity must always be recorded according to local protocol and justified.
- Advice may also be sought locally via mental capacity legislation leads.

[Purpose of further guidance](#)

The purpose of this further guidance is to offer advice about implementation of the consent process in clinical practice, obtaining written or verbal consent, with respect to an adult's capacity to make decisions. The ethos of the guidance across the three acts, which legislate across the UK, is essentially the same. The advice here is not meant to be prescriptive; ultimately, responsibility for the consent process rests firmly with the individual practitioner and the employer. Members of the diagnostic imaging and radiotherapy professional and support workforce, including those in training, will collectively be referred to hereafter in this document as the 'practitioner'. This further guidance document is intended to establish a base line of advice. It will illustrate the importance of understanding and implementing mental capacity legislation in a manner that is tailored in partnership with each individual patient. An intention is also to reinforce that consent and capacity are context dependent.

In clinical practice the practitioner who is seeking a patient or service users consent must consider specific detail in relation to the person, the area of practice and the healthcare pathway concerned. The advice in this document therefore provides initial assurance to

patients, families and carers that the individual practitioner undertaking an examination or treatment in radiography is expected to consider background context and they are also expected to have: a) adequate knowledge and ability to apply the principles of mental capacity legislation, and b) recognise when adults who lack capacity may be deprived of their liberty and understand relevant legislation; for example, practitioners in England and Wales should understand the Deprivation of Liberty Safeguards (DoLS) process contained in the MCA. This guidance is therefore intended to support effective and safe practice for the benefit of the patient, their family and carers.

Ethos of Mental Capacity Legislation

Adults with Incapacity (Scotland) 2000, the MCA (2005) and the Northern Ireland mental Capacity Act (Northern Ireland) 2016 are the basis of laws designed to protect adults who are unable to make decisions for themselves in the UK. The capacity legislation directs how decisions about consent to examinations, care and treatment may be made.

People may lack the capacity to make a decision on either a temporary or permanent basis. Examples of possible fluctuating incapacity include situations where a patient appears to be intoxicated, has a head injury or presents with a mental health problem. Having a condition that may affect the ability to make a decision is not absolute or fixed; capacity to consent can change. This is an important point, which reinforces that it must be assumed that everyone is able to make a decision and also that some people may need more support than others. Broadly the UK capacity legislation is underpinned by five principles:

Principle 1: It must be assumed that a person has capacity unless it is established that they lack capacity. This presumption of capacity is statutory in England and Wales, implied in Scotland and a common law presumption in Northern Ireland. Practitioners are directed to their relevant legislation for more detail but in sum:

- In practice establishing a lack of capacity would result in the practitioner being aware of an impairment of the mind or brain on the part of the patient. This could be temporary or permanent and would mean the person is unable to make a specific decision at a specific time as they are unable to make, retain, weigh up or communicate their decision by any means. An important point to note is that a person may lack capacity in some areas but still be able to make a decision.
- Sometimes a practitioner may not have prior knowledge of an impairment of the person's mind or brain, however if the person is unable to understand the information given to them, weigh up that decision (for example to consent to treatment/imaging or not), retain the information long enough to make that decision, or communicate the decision back to you, that would raise suspicions that the person potentially has a mental impairment.

Principle 2: A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.

- In practice this would mean ensuring that differing communication needs are considered, i.e. interpreter services used, information written in different languages, picture cards etc. Example questions to consider include: Does the person have a hearing impairment? Does their hearing aid have working batteries? Do they need additional time for a clearer, slower explanation of the situation? Can a family member/carer or chaperone offer advice about the person's preferred communication style? Does the person have a communication passport with details of their preferences?

Principle 3: A person is not to be treated as unable to make a decision merely because they make an unwise decision.

- If the person has mental capacity and makes what could be considered an unwise decision not to proceed with treatment/imaging etc. then this must be discussed with the person informing them about the pros and cons of not having the treatment/procedure. If, following relevant legislation, it is established that the person lacks capacity then care must be given to the person's previous wishes and beliefs. For example: if the person has claustrophobia and previously declined an MRI scan; if a person wears a headscarf and does not wish to remove it in the presence of male staff. Previous wishes and beliefs must still be taken into account when the person lacks capacity.

Principle 4: The MCA states that an act done, or decision made, for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

- Practitioners can only act in a person's best interest if it is first established that the person lacks capacity. As with Principle 3, practitioners should ensure the person's past wishes and beliefs are taken into consideration. In pre-planned imaging and treatment for a person who lacks capacity you would expect that a best interest meeting has taken place to establish all of these facts and the best course of treatment/care for the person. This would usually be a duty carried out by the referring team. If in doubt contact your local mental capacity legislation lead. In emergency situations where decisions are made quickly for life saving purposes it is not always possible to establish these facts. If this is the case you must record your decision and justification for it as per local protocol.

Principle 5: Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.' (Mental Capacity Act, Code of Practice, 2007)

- In practice this would mean looking at alternative ways to achieve the same outcome, while causing the least amount of distress to the person. For example, could you change the projection of your X-ray primary beam rather than using sandbags and restraints? Or perhaps, consideration needs to be given to whether the outcome of

the imaging is going to change the treatment already planned/been given; thinking about if anything more is being added to the patient's care? Discussion with the multidisciplinary team, radiologist, referrer, patient and family member/carer is encouraged in cases of uncertainty.

The Human Rights Act [6] underpins this work with regards to people's decisions and rights. A possible issue is that practitioners may find it difficult to differentiate between an unwise decision and the inability to make a decision by a person lacking capacity; issues of empowerment and safeguarding are diverse in nature but can be difficult to distinguish between in practice. Ultimately, the further advice in this document is written with the caveat that a practitioner must always consult organisational leads for capacity legislation and for safeguarding if the practitioner has any concern or confusion about how to proceed. Organisations that do not have this service available should offer alternative means for access to advice for their employees. If immediate access to advice is not possible then it may be necessary to delay a decision to proceed with an examination or treatment.

Guidance actions for the diagnostic imaging and radiotherapy workforce with regards to capacity legislation

1. SCoR considers that an individual practitioner seeking to obtain a patient's consent must have underpinning knowledge of capacity legislation relevant for the country in which they are working alongside the associated code of practice. Codes of practice are available online for Wales and England: <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice> and for Scotland: <http://www.gov.scot/Topics/Justice/law/awi/010408awiwebpubs/cop> Northern Ireland legislation is available: <http://www.legislation.gov.uk/ni/2016/18/contents> Local mandatory training for mental capacity legislation must be in place for practitioners. It is recommended that access to the relevant code of practice document and legislation is also readily available in all clinical areas.
2. Employers and colleagues in the imaging and therapeutic workforce are advised to review their practice and procedures in light of guidance, for example, SCoR consent advice document [5], guidance in the MCA Code of Practice (2007) [7], advice from the Care Quality Commission (2016) [8] and the National Institute for Health and Care Excellence (2018)[9]. An initial review should look at what happens currently and embed, together with advice from local capacity legislation and safeguarding leads, any changes that need to be made locally. The implications of any changes must be considered for all imaging and radiotherapy modalities in the local service.
3. The individual practitioner must follow their local employer's policies, protocols and procedures for consent, clearly documenting that this has taken place. Documenting

actions on a local Radiology Information System (RIS) is considered the minimum level of documentation that can be taken. Local organisations will have specific requirements for mandatory/statutory training and documentation of actions in clinical practice. Practitioners must know who the mental capacity legislation lead is for their organisation and how to contact them for advice.

4. The individual practitioner must take responsibility for their continuing professional development in this area. A starting point is to ask critical questions and to challenge own practice. e-learning for health offers a number of relevant online modules: <https://portal.e-lfh.org.uk/login> As an individual practitioner you are responsible for implementing the mental capacity legislation in your everyday practice. Your employer has a duty to ensure that you are trained to do so.
5. The mental capacity legislation codes of practice (online links in point 1 above) detail the country specific guidance with regards to tests that can be used to consider whether a patient lacks capacity. In cases where it has been proven that a patient lacks the capacity to understand, practitioners must understand who can make a decision on the patient's behalf; the details of which are contained in the relevant codes of practice and legislation.
6. In particular response to CQC enquiry, with respect to England and Wales, it is important to point out that practitioners must know the process of when and how people who lack capacity to take decisions about their care can be deprived of their liberty (in a hospital or care home) following DoLS procedures. Generally for a person with established incapacity and DoLS in place, the appropriate use of diagnostic and therapeutic procedures for the individual, taking their wishes into account, would normally be considered during a best interest meeting held prior to their attendance. It is important to note that a multi-disciplinary team making best interests decisions on behalf of a person, for example a patient with profound and multiple learning disabilities, must also consult with the persons family and friends in partnership (if the person has family and friends). If a person required restraint in the form of heavy sedation for a diagnostic or therapeutic procedure during their treatment then this would need further investigation by the practitioner and multidisciplinary team – it should be included and clearly documented in the best interest plan. Practitioners are advised to contact the local mental capacity legislation and safeguarding leads for advice about any concerns with regards to mental capacity prior to planning patient examination, care or treatment for example in the case of radiotherapy, breast screening and interventional procedures. Examples where DoLS may apply in radiography, with a level of restraint required for a period of time, include gamma knife procedure in radiotherapy or an interventional radiology procedure.

7. There must be a method of recording any decisions that are made together with clear rationale. Audit systems must be in place to ensure that clear records are made in practice and systems are followed. If there is a lack of clarity at any stage of the process then SCoR advise the head of department to contact their mental capacity legislation lead and safeguarding lead for advice on how to implement systems locally. There needs to be a clear audit trail of who has made decisions.

NHS England (2014) [10] offer four points for clinical practice that re-iterate the principles of the mental capacity legislation across the UK:

- Begin each meeting with a patient by thinking that they can make their own decision;
- Give each person both the time and support that they need to make their own decision about consent to treatment (diagnostic and therapeutic procedures);
- If you or someone else does not agree with the patient's decision you cannot decide that the patient is incapable of making that decision. A person is not to be deemed incapable to consent because of an unwise decision;
- When a patient cannot make a decision then they will need help from someone to make it in the best way for them. A decision must be the least restrictive option that does not limit the person's rights of freedom more than necessary. It may be necessary to delay procedures that are not emergencies in cases where there are any concerns.

[Amendment to mental capacity legislation and ongoing work with regards to safeguarding.](#)

In March 2017, the Law Commission produced a proposal replacement for DoLS and suggested amendments to the MCA for England and Wales. The law commission proposes that the Liberty Protection Safeguards (LPS) will strengthen people's rights in areas such as best interest decisions. The Law Commission final report and draft Bill were published on 14 March 2018. A copy of the final report with recommendations to government for reform is available at: <http://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/> The first reading of the Mental Capacity Act Amendment Bill took place in the House of Lords on 3rd July 2018. The second reading took place on 17th July 2018 with the bill due to proceed to the House of Commons in October 2018 and presented for Royal Assent in April 2019. Once complete it is likely that the amendment bill will have implications for the guidance with respect to deprivation of liberty in England and Wales. The information presented to date indicates that DoLS are predicted to change to Liberty Protection Safeguards (LiPS) from 2020 onwards. Additionally, The Royal College of Nursing (RCN) is leading a consultation on behalf of Health Education England (HEE) that will result in a cross-country intercollegiate document 'Safeguarding for adults; roles and competencies'. The document is due to be published

online in Autumn 2018; it will provide an intercollegiate competency framework. SCoR have contributed to the consultation process for the document, which supports the workforce in the delivery of safeguarding. It aligns to the competencies currently in use for safeguarding children and young people. The document is intended for all healthcare professions and social care colleagues. It is designed to be used in all organisations that care for adults regardless of sector, setting or size. The document will clearly state the need for the healthcare workforce to be familiar with the relevant legislation and guidance that supports adults to make decisions.

Two scenarios and questions to guide practitioner reflection on local procedures and practice:

1. An elderly patient has attended your department from a ward; the person's referrer has requested a chest X-ray examination for the patient. The patient has a diagnosis of dementia, does not want to stand or sit in a stationary position, and states that they do not want the X-ray.
 - What is the process for assessing the person's mental capacity?
 - What needs to be considered in the process to continue or stop the examination?
 - How do you record the decision that was made?

2. A twenty-year-old person with severe physical and learning disabilities attends for an outpatient CT scan accompanied by a parent. The person would require restraints during the examination to ensure that they could keep still.
 - How do you establish who will provide consent to the examination?
 - How is consent obtained for the scan? For the use of restraints (Velcro® straps)?
 - How are the decisions recorded?

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