**Chapter 27**

**History taking for patients who lack mental capacity**

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**Mental Capacity**

A person is said to have mental capacity when they can make and communicate their own decisions (Mental Health Foundation, 2021). People may lack capacity for several reasons including (but not limited to) having dementia, delirium, learning or neurodevelopmental disability; brain injury; mental illness; stroke; and drug intoxication. (Mental Capacity Act (MCA), 2005). Nevertheless, a person should not be assumed to lack capacity to make a specific decision just because they have one of these conditions. You must assume a person has the capacity to make a decision themselves, unless it is proved otherwise. If you are going to make a decision for someone who does not have capacity, it must be in their best interests and any treatment or care provided must be the least restrictive course of action in terms of their basic rights and freedoms (MCA, 2005). Guiding principles of the mental capacity act can be seen in Table 27.1.

### It’s important to remember that capacity is time and decision specific. Prescribers can only decide that a person lacks capacity at the time of assessment. Therefore, they must be clear what specific decision they will need them to make from the history they are taking. Prescribing practices must always be compliant with national, regional, local, and service specific prescribing protocols and guidelines.

**Principles of good prescribing**

Best practice dictates that prescribers consider ten principles of good prescribing (BPS, 2021). Prescribing is the main approach to the treatment and prevention of disease in modern healthcare. While medicines have the capacity to enhance health, all have the potential to cause harm if used inappropriately. BPS (2021) recommend that health care professionals who prescribe medicines should do so based on the following ten principles, which underpin safe and effective use of medicines. See table 27.2 for the ten principles of good prescribing. An example of principle 1 states that all prescribers should be clear about the reasons for prescribing. This includes establishing an accurate diagnosis whenever possible (although this may often be difficult), and being clear in what way the patient is likely to gain from the prescribed medicines

### A prescriber’s consultation must include thinking about a patient’s capacity in relation to adherence to medication and any subsequent decision that may be made in relation to giving medicines covertly. To take an appropriate patient history and before making any decision on capacity, prescribers must adapt a suitable consultation style to the needs of the patient, so they can be involved in decisions about their medicines. This requires the prescriber to establish the most effective way of communicating with each individual patient. This includes making all information accessible and understandable (for example, using pictures, symbols, large print, different languages, an interpreter, or a patient advocate) (NICE, 2009).

If the prescriber believes there is a need to assessment a patient’s capacity, the MCA sets out a 2-stage test of capacity (MCA, 2005):

1. Does the person have neurological impairment?
2. Does the impairment mean the person is unable to make a specific decision when they need to?

A person is unable to make a decision if they cannot:

* Understand the information relevant to the decision
* Retain that information
* Use or weigh up that information as part of the decision-making process

Following a capacity assessment, if a patient is found to lack capacity to consent for history taking, and the situation is not urgent, then delaying the decision until such a time as the person could make the decision for themselves must be considered. It may be that the person’s incapacity is temporary, or that with the right support and information presented to them in a way that they can understand, the person could make the decision if they are given more time.

If the decision is more urgent, or the person is still not going to be able to make that decision for themselves in the future, then a best Interest decision making process needs to be followed, under Section 4 of the Mental Capacity Act (MCA, 2005). A decision maker must be identified – this is normally the same person that assessed capacity, unless there is a court appointed deputy, or they are not best placed to make the decision. A practitioner or team that is responsible for providing health or social care to the individual could act as the decision maker in this instance. Table 27.3 discusses the best interest principle.

Unless there is a clear reason why this should not be the case (e.g., safeguarding concerns or clearly expressed preferences by the individual), it is important to involve family and carers in the process. These are the people that know the person the best and hold valuable information about the individual and their needs and wishes. Adults with a learning disability may have a Hospital Passport, which contains detailed information about their health needs, and well as their communication needs which could be very useful. The person may have an advocate who should be included, or may require an IMCA (independent Mental Capacity Advocate) to be called in. It should be borne in mind that making a best interest decision for an individual does not mean they should be excluded from the process. They should very much remain at the heart of it and be included as much as is possible or desirable. In effect, the decision should be what the person would have chosen for themselves if they would have had capacity.

Supported decision making

Supported decision making is fundamental to this process, as laid out in Principle 1 and 2 of the MCA and in more recent NICE clinical guidelines. Alongside local policies and training, organisations need to ensure that their procedures and forms for capacity and best interests’ assessments are congruent with an emphasis on supported decision-making (NICE, 2018). Although taking a history from a person who lacks the capacity to consent to it may be more complicated, it is crucial that they receive a full assessment, to begin to address the health inequalities experienced by many of those in the groups who are more likely to lack capacity to make certain decisions, such as those who are mentally unwell, or have a learning disability.

**Resources/References**

BPS (2021) *Ten Principles of Good Prescribing.* Available at: <https://www.bps.ac.uk/education-engagement/teaching-pharmacology/ten-principles-of-good-prescribing>

Mental Health foundation (2021) *Mental capacity.* Available at: <https://www.mentalhealth.org.uk/a-to-z/m/mental-capacity>

NICE (2018) Overview | Decision-making and mental capacity | NICE Guideline NG108. Available at: <https://www.nice.org.uk/guidance/ng108>

NICE (2009/2015/2019) Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. Clinical Guideline CG76. Available at: <https://www.nice.org.uk/guidance/cg76/chapter/Update-information>

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| **Guiding principles of the Mental capacity act 2005** |
| A person must be assumed to have capacity unless it is established that they lack capacity.  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.  A person is not to be treated as unable to make a decision merely because they make an unwise decision.  An act done, or decision made, under this Act for, or on behalf of, a person who lacks capacity must be done, or made, in their best interests.  Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be achieved as effectively in a way that is less restrictive of the person’s rights and freedom of action |

**Table 27.1:** Guiding principles of the Mental capacity act 2005

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| **1. Be clear about the reasons for prescribing**  * Establish an accurate diagnosis whenever possible (although this may often be difficult) * Be clear in what way the patient is likely to gain from the prescribed medicines |
| **2. Consider the patient’s medication history before prescribing**  * Obtain an accurate list of current and recent medications (including over the counter and alternative medicines); prior adverse drug reactions; and drug allergies from the patient, their carers, or colleagues |
| **3. Consider other factors that might alter the benefits and risks of treatment**  * Consider other individual factors that might influence the prescription (for example, physiological changes with age and pregnancy, or impaired kidney, liver or heart function) |
| **4. Consider the patient’s ideas, concerns, and expectations** Seek to form a partnership with the patient when selecting treatments, making sure that they understand and agree with the reasons for taking the medicine |
| **5. Select effective, safe, and cost-effective medicines individualised for the patient**  * The likely beneficial effect of the medicine should outweigh the extent of any potential harms, and whenever possible this judgement should be based on published evidence * Prescribe medicines that are unlicensed, ‘off label’, or outside standard practice only if satisfied that an alternative medicine would not meet the patient's needs (this decision will be based on evidence and/or experience of their safety and efficacy) * Choose the best formulation, dose, frequency, route of administration, and duration of treatment |
| **6. Adhere to national guidelines and local formularies where appropriate**  * Be aware of guidance produced by respected bodies (increasingly available via decision support systems), but always consider the individual needs of the patient * Select medicines regarding costs and needs of other patients (health care resources are finite) * Be able to identify, access, and use reliable and validated sources of information (for example, British National Formulary), and evaluate potentially less reliable information critically |
| **7. Write unambiguous legal prescriptions using the correct documentation**  * Be aware of common factors that cause medication errors and know how to avoid them |
| **8. Monitor the beneficial and adverse effects of medicines**  * Identify how the beneficial and adverse effects of treatment can be assessed * Understand how to alter the prescription because of this information * Know how to report adverse drug reactions (in the UK via the Yellow Card scheme) |
| **9.Communicate and document prescribing decisions and the reasons for them**  * Communicate clearly with patients, their carers, and colleagues * Give patients important information about how to take the medicine, what benefits might arise, * adverse effects (especially those that will require urgent review), and any monitoring that is required * Use the health record and other means to document prescribing decisions accurately |
| **10.Prescribe within the limitations of your knowledge, skills and experience**  * Always seek to keep the knowledge and skills that are relevant to your practice up to date * Be prepared to seek the advice and support of suitably qualified professional colleagues * Make sure that, where appropriate, prescriptions are checked (for example, calculations of intravenous doses) |

**Table 27.2:** Ten Principles of Good Prescribing (BPS, 2021).

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| A Best Interests decision is a decision made by applying the Best Interest principle, as set out in the Mental Capacity Act 2005. They must:   * encourage participation of the person * identify all relevant circumstances * find out the person's views * avoid discrimination * assess whether the person might regain capacity * consult others * avoid restricting the person's rights * In the case of life sustaining medical treatment, make no assumptions about the quality of the person's life and ensure that decisions are in no way motivated by a desire to bring about the person's death. |

**Table 27.3:** The best interest principle