TRANSFORMING NURSING PRACTICE

Mapped to the 2018 NMC Standards

3rd Edition

Mental Health Medicines Management for Nurses

Stan Mutsatsa

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Mental Health Medicines Management for Nurses

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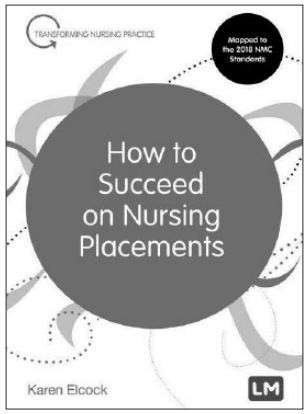

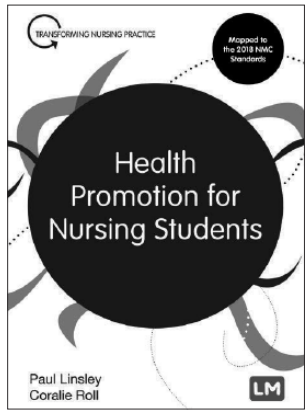

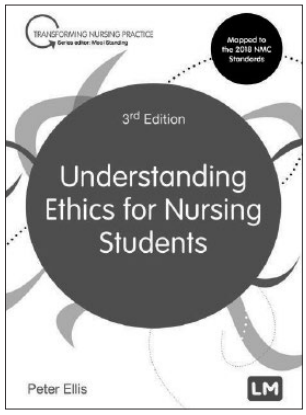

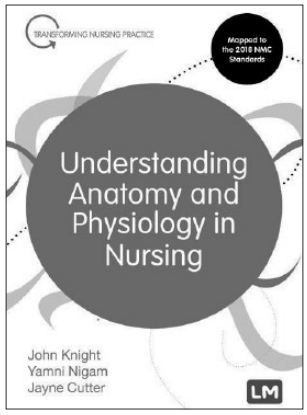

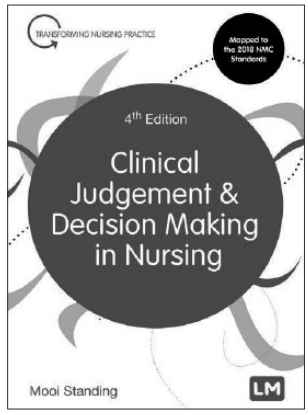

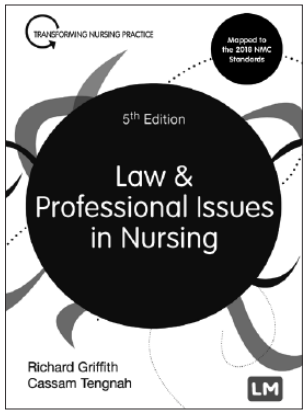

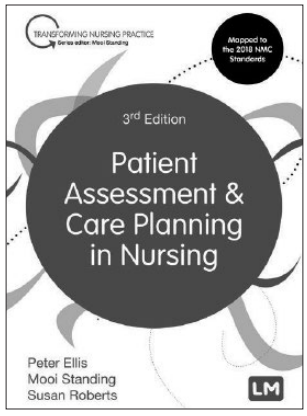

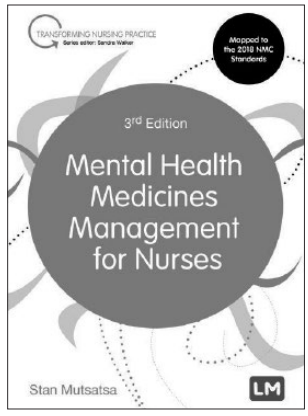

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About the author

Stan Mutsatsa, PhD, RMN, has extensive experience of working in both the clinical and academic settings of mental health. Additionally, he has researched and written extensively on the subject of medicines management. Currently, he is a senior lecturer in mental health nursing at City, University of London.

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Introduction

About this book

This book is aimed at supporting pre-registration mental health nursing students to meet the NMC competencies for medicines management. It is structured around the standards of proficiency for registered nurses (NMC, 2018a) to prepare students for a formative and summative assessment for entry into the nursing register. Although the book is primarily aimed at mental health nursing students at the pre-registration level of training, it is important for student nurses of all fields to have an understanding of mental health, and so the book will also serve as a useful reference guide for nursing students of other fields and post-registration nurses, as well as serving as a useful reference for registered nurses throughout their careers. A link between theory and practice is made explicit, and the book is written in a style that is easy to understand, offering academic challenge without diluting academic integrity.

Why is mental health medicines management important for nurses?

Despite the demonstrable importance of psychotropic medication, existing evidence suggests that registered nurses' knowledge and skills in medicines management are deficient. Nurses feel that their practice is hampered by a lack of appropriate educational preparation. In particular, they cite poor knowledge of psychopharmacology as one of the main reasons for a lack of confidence in their role.

Medicines management is a prominent focus of the standards of proficiency for registered nurses (NMC, 2018a). It is a mandatory requirement that all student nurses demonstrate competency in medicines optimisation, administration and calculation, as well as having some knowledge of medicines prescribing prior to registration. This textbook meets the requirements for the application of specific competencies in mental health medicines management. Throughout this third edition, there is an increased emphasis on prescribing to support student nurses' readiness to progress to a prescribing qualification upon registration.

Book structure

The book has 12 chapters. Chapter 1 covers the legal and ethical aspects of medicines management in mental health. Key principles of bioethics, such as consent and autonomy, are described in detail, and legal issues, such as capacity, are also covered in detail. Chapter 2 covers issues relating to the therapeutic alliance, including the health belief model, the self-regulatory model (SRM), the problem of adherence to medication, factors that influence adherence, service barriers to adherence, decision-making capacity, and the use of concordance skills to promote medication adherence.

Chapter 3 provides the necessary baseline knowledge of anatomy and physiology of the brain, as well as forming the basis for an understanding of how psychotropic medications work. Chapter 4 builds on this by looking more closely at the principles of pharmacology and medicine interactions.

Chapter 5 covers the role of the multidisciplinary team (MDT) in medicines management, which includes prescribing, storing and dispensing medicines, as well as administration and record-keeping.

Chapters 6 to 11 cover the management and treatment of various mental health problems: depression, bipolar disorder, psychosis, dementias, anxiety states, and substance use disorders. In these chapters, I cover knowledge of the main clinical features and differential diagnoses of each condition before discussing specific treatment and management options. Each chapter outlines common errors to avoid during treatment and management, as well as summarising how to inform the patient.

Chapter 12 deals with adverse drug reactions (ADRs) and the classification and common side effects of psychotropic medicines, as well as how to manage these with the patient.

Learning features

Activities

Throughout the book, you will find activities that will help you to make sense of – and learn about – the material being presented. All of the activities require you to take a break from reading the text, think through the issues presented, and carry out some independent study, possibly using the internet. Where appropriate, there are outline answers presented at the end of each chapter, which will help you to understand more fully your own reflections and independent study. Remember that academic study will always require independent work; attending lectures will never be enough to be successful on your programme, and these activities will help to deepen your knowledge and understanding of the issues under scrutiny, as well as giving you practice at working on your own.

Case studies and scenarios

Within each chapter, there are case studies that describe real-life situations from the practice environment. The case studies have been included so that you may further understand the material being presented. You may wish to discuss and reflect on the case studies with senior students, as they may have experienced similar situations and could provide valuable insights through their experience.

Scenarios are presented to find a fictitious but realistic perspective on the information being discussed. These have been included so that you may develop the skill of thinking about issues from a number of different viewpoints. For this reason, some of the scenarios require you to put yourself in another person's shoes, considering how and why you would react to a given situation.

There are explanations in the glossary for words in **bold** in the text.

Chapter 1 Legal and ethical aspects of medicines management in mental health

Chapter aims

By the end of this chapter, you should be familiar with:

- accountability as a concept and the four different areas of accountability;
- legislation that impacts on prescribing and medicines management;
- ethical considerations in treatment.

Introduction: a little history

Before 1919, there was no register of nurses, and no national regulations or standards for nurse training. At that time, nurse training was normally for one year, and the general view was that most of what was essential could be learned in that short time; but it became clear that a longer period of training for nurses was necessary to produce a 'professional' nurse.

The Nurses Registration Act 1919 ended many years of conflict within the profession, and set standards for training, examination and registration. This introduced to nursing the concept of legal accountability, which serves to protect the public from malpractice. This chapter will outline the concept of accountability in nursing before discussing specific legislation. It will then discuss the Human Rights Act 1998, the Mental Capacity Act 2005 and the Mental Health Act 1983 before reviewing legislation that deals directly with medicines, such as the Medicines Act 1968, the Misuse of Drugs Act 1971 and the Prescription by Nurses etc. Act 1992. In addition, this chapter will discuss key ethical issues relating to medicines management and prescribing in practice.

Accountability

In common language, accountability may simply mean responsibility to someone or for some activity. In ethics and governance, the term is often used synonymously with

concepts such as responsibility, answerability, blameworthiness and liability. However, Swansburg and Swansburg (2002) define accountability as:

> *The fulfilment of a formal obligation to disclose to referent others the purposes, principles, procedure, relationship, results, income, and expenditure for which one has authority.*
>
> (p364)

The Nursing and Midwifery Council (NMC) states that you should 'be accountable for your decisions to delegate tasks and duties to other people' (NMC, 2018b). Although the word 'accountability' is often used interchangeably with 'responsibility', it is important to make a clear distinction. Responsibility means having control or authority over someone or something. You can choose to take responsibility, but you have no power to decide to whom you should be accountable.

Scenario

Tom, a registered nurse who had no prescribing powers, altered a dose on the patient's prescription chart, from 15 mg of diazepam per day to 20 mg per day, without consulting the prescriber. He administered this dose to the patient for a week before it was brought to his manager's attention. Tom defended his action by saying that he knew the patient well and that he was always on a maintenance dose of 20 mg of diazepam. He was adamant that he acted the right way to 'correct' the dose. He was disciplined by his employer and dismissed from his post.

In the above scenario, Tom was responsible for adjusting the patient's dose, and it was his choice to do so. However, he was accountable to his employers for his action, and it was his employers – not him – who decided to terminate his employment.

The purpose of accountability

The nursing profession requires nurses to be accountable for what you do, as it is nurses' obligation to give explanations for their actions and omissions. This is to ensure that the public and patients are not harmed by a nurse's actions and omissions, as well as providing redress to those who have been harmed. Healthcare workers, including nurses, have a moral, professional, ethical and legal obligation to provide care to the highest standard, because patients are entitled to this, irrespective of who is delivering that care. For these reasons, even student nurses are accountable for their actions and omissions.

To achieve this, accountability has the following aims:

- The public must be protected from a nurse's actions and omissions that might cause harm. The nurse can be called to account for their conduct and competence if it is thought that they have fallen below the standards required of a nurse.

- The nurse must be held to account to protect the public and patients by discouraging acts that the professional body (the NMC) considers as misconduct or unlawful. Registered nurses must always act in a manner worthy of a nurse at work, both in public and in private.
- To make the nurse accountable to a range of higher authorities, the law regulates the nurse's behaviour. The regulatory framework makes it clear what standards of conduct and competence a registered nurse should comply with.
- To be accountable, the nurse must: (1) be able to perform the task; (2) accept the responsibility for doing the task; and (3) have the authority to perform the task within the job description, as well as within the policies and protocols of the organisation.

The registered nurse can be called to account and be asked to justify their actions. The public can hear the case, with a view to reassuring patients that the professional body only tolerates the highest standards of nursing. Public scrutiny of a nurse's conduct allows other members of the profession to learn from the mistakes and misconduct of others (Griffith and Tengnah, 2017).

Scenario

A registered nurse was struck off the professional register in 2010 after he was found sleeping on duty and had failed to administer medication to patients in a nursing home. He initially denied the charges, but later admitted to the offence after other employees had testified that he had been caught sleeping on three separate occasions within two months. The committee found him unworthy of being a registered nurse.

Because the registered nurse has a formal obligation to answer for their actions to several higher authorities, they must justify their actions to these authorities, and if they fail to do so sanctions can be applied against them. For example, during training, a university or an NHS trust can take disciplinary action against a nurse or student nurse, which in extreme cases can result in dismissal for the individual. In this regard, the nurse is accountable to:

- the patient;
- the professional body;
- society;
- the employer.

Accountability to the patient

Registered nurses are accountable to the patient who is under their care, and for this reason civil law allows the patient to seek redress if they believe they have suffered harm due to the nurse's actions. Over the years, the NHS has been paying out

increasingly large sums of money – over £0.5 billion per year – because of the clinical negligence of staff. A fundamental ethic of healthcare is that you should do your patients no harm. Where harm occurs because of a nurse's negligence, patients can seek compensation from the nurse and the nurse's employer through the courts. The nurse–patient relationship gives rise to a duty of care.

Quite often nurses have argued that they are accountable to themselves for their practice. Although it is accepted that a nurse who harms a patient through their acts will feel remorse, if the definition of accountability is considered, we see that nurses cannot impose sanctions on themselves.

Accountability to the professional body

Registered nurses are accountable to their professional body in accordance with the Nurses, Midwives and Health Visitors Act 1997. This legislation's aim is to protect the public by establishing standards for education, training and conduct. The basis of the NMC's role is to place those who intend to practise on a nursing register. A detailed description of the role of the NMC is beyond the scope of this book, so you are advised to consult a more appropriate textbook in this regard or visit the NMC's website (**www.nmc.org.uk**).

Accountability to society

Registered nurses are subject to the laws of the country they work in, like everyone else. If a nurse is accused of committing a crime at work or outside of work, the country in which they reside may call them to account under its laws. This can have a bearing on the nurse's ability to practise, as the following scenario demonstrates.

Scenario

Bridget was a registered nurse working in a prison, but she was later arrested and convicted of supplying class A drugs to a prison inmate. She was sentenced to three years in prison and was subsequently removed from the professional register.

Accountability to the employer

A registered nurse is accountable to their employing organisation through the terms and conditions of their employment contract. An employer is vicariously liable for the actions of its employees. For example, if a nurse commits a civil wrong, the employer is responsible for the nurse's action. The following scenario gives an example of what this means in practice.

Scenario

Hamid is a patient on phenobarbitone who was found unconscious after a nurse, Shelley, gave him three times the prescribed dose. Hamid had to be admitted to a hospital intensive care ward and fully recovered four days later. The mistake occurred because Shelley did not follow the correct procedures for the administration of medicines. Although Hamid survived, his family persuaded him to take legal action through the courts, and he won a substantial settlement from the hospital. In turn, Shelley was disciplined and was sent for retraining in medicines management.

In the scenario above, we see that Hamid came to some harm because of Shelley's carelessness. However, it was the hospital, not the nurse, that was sued and paid compensation to the patient. The hospital is vicariously liable. 'Vicarious liability' is a legal term that holds one person liable for the actions of another when engaging in some form of joint or collective venture. Both the hospital and the nurse are engaged in a collective venture, but the hospital has vicarious liability. As the number of nurses who prescribe increases, the concept of accountability assumes greater importance, as we will discuss later.

Human Rights Act 1998

Rights can be defined as claims or entitlements that deserve respect. After the Second World War, nations around the world were determined to take steps to guarantee the protection of human rights in national and international law. The first concrete manifestation of this was the American Declaration of the Rights and Duties of Man in 1948. This was followed by the Universal Declaration of Human Rights drawn up by the UN in the same year. These documents concentrate on protecting civil and political rights, such as freedom of expression, freedom of religion and freedom of association.

In the UK, human rights are enshrined in the Human Rights Act 1998, which has its basis in the European Convention on Human Rights (ECHR). All public authorities have a legal duty to act compatibly with the ECHR (and hence the Human Rights Act 1998). The NHS is a public authority and therefore must adhere to the Human Rights Act 1998. Domestic courts are obliged to interpret all laws consistently with the Act. In mental health, courts and mental health tribunals have an obligation to interpret the Mental Health Act 1983 (amended 2007) consistently with the Human Rights Act 1998. The Human Rights Act 1998 thus has the effect of bringing human rights to the centre of both the legal and health systems. The ECHR is divided into 'Articles', which set out the rights that are protected by the Convention. For medicines management and prescribing in mental health, only Articles 2, 3 and 8 are relevant, so it is these that we will discuss next.

Article 2

This Article states:

1. *Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.*
2. *Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:*
   (a) *in defence of any person from unlawful violence;*
   (b) *to effect a lawful arrest or to prevent the escape of a person lawfully detained;*
   (c) *in action lawfully taken for the purpose of quelling a riot or insurrection.*

The Article imposes on the state the obligation to protect the lives of its citizens, and this responsibility extends to the healthcare system. Before you go any further, complete Activity 1.1.

Activity 1.1 Reflection

You are working on a ward where a patient, detained under section 3 of the Mental Health Act 1983, attacked a fellow patient, causing serious harm. The aggressor was physically restrained and placed in seclusion to allow time for him to 'cool down'. He was then given an injection of 10 mg of olanzapine and a concomitant (augmenting) dose of 2 mg of lorazepam. Two hours after the administration of the injection, the patient fell asleep (at 1900 hours). Although the hospital policy stipulates that a patient who is administered an intramuscular (IM) olanzapine injection must have their vital signs monitored regularly for the first 24 hours, this was not complied with for fear of waking the patient. There were also insufficient staff on duty to cope with any potential acts of violence during the night.

Five hours later, a member of staff found that the patient could not be roused, and immediately sent him to the local general hospital where he was taken to the intensive care unit. After a period in hospital, he fully recovered, but he sued the hospital for breaching his rights under the Human Rights Act 1998.

- Is the hospital in breach of Article 2 of the Human Rights Act 1998?

An outline answer is provided at the end of the chapter.

The most obvious example of the application of Article 2 is in cases where a member of staff deliberately kills a patient, as in the Harold Shipman cases (see the useful websites section at the end of the chapter), but Article 2 extends beyond that, as exemplified by a test case (*Stewart v United Kingdom* [1984]). Moreover, it is not necessary for the victim to die to be in breach of Article 2. It is enough to put the person at 'material risk', as

the scenario above demonstrates. Clearly, it was the responsibility of the nursing staff to observe the patient's vital signs regularly after administering an IM injection of olanzapine and lorazepam, but this was not done. As such, the staff placed the patient at material risk by their act of omission, therefore breaching Article 2.

Article 2 further stipulates that where there is a threat to the life of someone in state custody (in this case, the hospital), there is an increased responsibility to provide care and protection. In the UK, this was brought about by a test case (*Osman v United Kingdom* [2000]). After the death of a family member in custody, the family sued the police for failing to protect the family member adequately even though there were clear warning signs of risk to the individual. The judge in the case commented that where the authorities know of a 'real and immediate threat' to a person's life, there is an obligation to take preventive operational measures to protect that person.

The responsibility to protect life is not an unlimited one. Specifically, there is only a breach of Article 2 where there is demonstration that the authorities knew or ought to have known that the person posed a real risk to life. Where the authorities can demonstrate that they took reasonable steps to protect the person, after being deemed to be at risk of losing life, or where there were no indications that the person was at risk of losing life, the death will not result in a breach of Article 2.

In summary, Article 2 imposes both positive and negative responsibilities. It is possible to breach the negative duty not to deprive an individual of life by using excessive or unnecessary force against the person. Another example of a breach of negative duty is when there are failures within the system that may lead to a failure to provide adequate procedures and trained or qualified staff to ensure safety. The positive duty to protect life arises wherever the authorities know or ought to know of a real and immediate risk to the life of a person or group of people. In Activity 1.1, the patient was administered IM olanzapine and should have had his vital signs monitored, but this was not done. This breached the positive duty to protect life under Article 2.

Article 3

Article 3 of the ECHR is the only absolute right, and it states: 'No one shall be subjected to torture or to inhuman or degrading treatment or punishment'. In the UK, the courts have defined degrading treatment as follows:

> *Where treatment humiliates or debases an individual, showing lack of respect for, or diminishing, his or her human dignity, or arouses feelings of fear, anguish, or inferiority capable of breaking an individual's moral and physical resistance, it may be characterised as degrading and fall within the prohibition of Article 3. The suffering that naturally flows from naturally occurring illness, physical or mental, may be covered by Article 3, where it is, or risks being, exacerbated by treatment, whether flowing from conditions of detention, expulsion, or other measures, for which the authorities can be held responsible.*

Before you go any further, complete Activity 1.2.

Activity 1.2 Reflection

Having read the definition of degrading treatment, can you list situations in mental health nursing that could be described as degrading treatment, therefore breaching Article 3 of the ECHR?

Read on for a discussion of this topic.

Although Article 3 is an absolute right that is stated in very simple terms, the problem is that its interpretation can vary. Whether an action is inhuman or degrading treatment will depend on several factors and the unique circumstances of each case. In mental health practice, Article 3 is most likely to be relevant to complaints arising from the conditions of detention, seclusion, forced medication, control and restraint.

Case study: Mr Herczegfalvy

In *Herczegfalvy v Austria* [1992], Mr Herczegfalvy was a Hungarian citizen living in Austria who had served two prison sentences in succession for assaulting his wife, public officials, and customers of his television repair business. In prison, he carried on assaulting fellow prisoners and prison staff. After an assessment, he was deemed to be suffering from a paranoid psychotic disorder, and not responsible for his actions, and was therefore sent to a psychiatric hospital.

Following an assessment in the psychiatric hospital, he was returned to prison, but he protested his detention by staging a hunger strike. He collapsed four weeks later and needed intensive medical care, so was sent to a general hospital for treatment.

On his return to the psychiatric hospital, he was still on hunger strike but was in an extremely weak state. Therefore, he was force-fed in accordance with Austrian hospital law. He refused all medical treatment and was given IM sedation against his will. At this time, he was attached to a security bed, but he managed to cut through the net and straps. He continued his hunger strike, which caused further deterioration of his physical and mental condition, and he was again transferred to a medical intensive care unit.

He was returned to the psychiatric hospital after two weeks and handcuffed, with a belt placed around his ankles because of the continued risk of aggression. Previous physical resistance to forced administrations of antipsychotics had resulted in injuries to him, including loss of teeth, broken ribs, and bruises. He remained in these restraints for 15 days but continued his hunger strike and was force-fed. Gradually, his physical and mental condition improved, and he stopped the hunger strike after a doctor explained to him how it was endangering his life.

(Continued)

(Continued)

Mr Herczegfalvy subsequently took the Austrian government to the European Court of Human Rights, alleging that violent and excessively prolonged measures were used to treat him, in violation of Article 3 of the ECHR. He also argued that these measures contributed to the worsening of his condition. The judge ruled that the established principles of medicine are admittedly decisive in such cases, but concluded, as a rule, that a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading, and the court must satisfy itself that such medical necessity has been convincingly shown to exist. The court accepted that, according to psychiatric principles accepted at the time, medical necessity justified the treatment at issue, and therefore there had been no violation of Article 3.

The above case study demonstrates that the courts can interpret inhuman or degrading treatment in several ways that are dependent on the unique circumstances of each case. In many ways, the treatment of Mr Herczegfalvy could be regarded as harsh and degrading. However, the sole aim and focus were therapeutic. In other words, the aim was always to try to treat Mr Herczegfalvy in the best possible way, and there was never any intention to ill-treat him. Therefore, the judge ruled that Article 3 was not applicable in his case. This court ruling heavily influences UK and European practice in respect of detention of the mentally ill and the deprivation of liberty of a person with no capacity to make a competent decision.

In psychiatric practice, Article 3 is most likely to be relevant to complaints arising from the conditions of detention, seclusion, control and restraint, as the following case study demonstrates.

Case study: Judith McGlinchey

In *McGlinchey and Others v UK* [2003], Judith McGlinchey died in a hospital in West Yorkshire while in the care of the UK Home Office as a convicted prisoner. She had asthma and a long history of intravenous heroin addiction. Soon after arriving in prison, she developed severe opiate withdrawal symptoms with repeated vomiting, leading to dehydration and weight loss. Despite her physical state, there was a gap in monitoring over the weekend. There was a failure to take more effective steps to transfer her to hospital for specialist assessment when her condition deteriorated significantly. She died in hospital after two weeks on a life-support machine. Because of these deficiencies in Judith's treatment, Article 3 was deemed to have been breached.

In this case, it was found that the inadequacy of medical treatment in prison for Judith McGlinchey was deemed to be inhuman and degrading. The prison was found not to have provided necessary healthcare, and it was therefore in breach of Article 3. Although this happened in a penal environment, the case of Judith McGlinchey equally applies in any situation where people are detained, and this includes psychiatric hospitals.

In summary, the general principles of Article 3 are that authorities have an obligation to provide adequate and necessary medical care. However, a treatment or intervention that convincingly shows to be a therapeutic or medical necessity will usually not be regarded as inhuman or degrading, as in the case of Mr Herczegfalvy, and a delay in providing care may be in breach of Article 3, as in the case of Judith McGlinchey. Further, clinical interventions need to balance the potential effect of the intervention with the severity of the presenting clinical problem. In other words, you should respond proportionately to a clinical scenario to avoid the risk of breaching Article 3.

Article 8

This Article states:

1. *Everyone has the right to respect for his private and family life, his home and his correspondence.*
2. *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.*

The key area of Article 8 is to protect the individual's right to privacy and prevent a public authority from intruding unnecessarily into a person's private life. For example, it is possible to breach Article 8 in some cases where people are subjected to undue surveillance, or the interception of their telephone calls, or the publication of newspaper accounts of their private life. Article 8 also protects the right to family life, which means that decisions regarding custody or adoption must consider the right to family life of all those involved. It also protects the individual's right to physical integrity and the right to respect for their home.

Article 8 has been one of the most dynamically applied provisions of the ECHR. It has an extremely wide application (e.g. the use of medical records in court, the right to practise one's sexuality). Before you go any further, complete Activity 1.3.

Activity 1.3 Evidence-based practice and research

A patient detained under section 3 of the Mental Health Act 1983 complained to the European Court of Human Rights that his human rights under Articles 8 and 3 of the ECHR had been breached because he was made to take antipsychotic medication that had unpleasant side effects which had interfered with his private life.

- Can you explain why both Articles 8 and 3 may be relevant in this case?
- What do you think was the outcome of the case?

Outline answers are provided at the end of the chapter.

Article 8 has been used to assess such common, everyday issues as the provision of personal care by same-gender staff, assistance to move to suitably adapted accommodation, the appropriate use of bedpans, and complex end-of-life decisions. Because of the nature of Article 8, it will continue to be tested in many and varied clinical situations, as well as around research. Now we can turn our attention to the key principles of ethics.

Key ethical theories

It is possible to argue that *ethical* and *moral* considerations influence the way we live and interact with others. In turn, our thinking, attitudes, values and beliefs influence our actions. Therefore, when we care for patients, we do so not only because of our professional and legal duty, but because of our moral and ethical values and beliefs. Therefore, who we are and what values we hold influence our professional judgement and reasoning to a degree.

The NMC demands that some specific ethical principles, such as respect for autonomy, confidentiality, compassion, and individual rights and freedoms, should inform nursing practice. Other principles that inform nursing practice include respect for diversity, cultural differences and different values. In this respect, it is important for nurses to be aware of how their value system can impact on the patients they care for (Wheeler, 2013). Above all, the NMC reminds nurses that caring can at times be a very difficult task which involves making difficult decisions, and this in turn demands that nurses make a continuous assessment of their own moral and ethical standpoints. Wheeler (2013) suggests that nurses owe it to their patients to 'do the right thing', including working with them and being guided by a sound moral, ethical and professional code of conduct. In the process, they should show respect for the patient's moral values and belief system, as these help the patient to achieve their health goals. Nurses and healthcare professionals alike cannot justify placing their own autonomy and beliefs ahead of those of the patient. Moreover, if they disproportionately preoccupy themselves with their own values, this may create the potential for conflict with the patient, as well as

devaluing the patient as an individual without a belief system and values of their own. In summary, ethical and moral values form the foundation of our care. The following sections cover basic ethical theories that guide and develop us as professionals.

Utilitarianism

This theory bases itself on making decisions from a 'common sense' standpoint by considering the likely outcome of an action. In utilitarianism, a morally correct decision is the one that is likely to produce a more favourable outcome for the person. In other words, it is the the one that produces the best possible outcome and the greatest pleasure to the patient. A well-known utilitarian was John Stuart Mill (1806–1873), who championed that the most important outcome when choosing between two opposing actions is to choose the one that results in people being happy. This philosophy also champions 'the greatest good for the greatest number'. Furthermore, a utilitarian considers that telling the truth to a patient would be dependent on the consequences of the truth. If the truth results in undue sadness or harm to the patient, then telling the truth cannot be the morally correct thing to do in this aspect. However, there are clearly many situations in medicines management and prescribing where this approach may conflict with established values. For example, the ethics of deontology challenges utilitarianism, and we discuss this next.

Deontology

The basis of deontology is the belief that there are basic rules which we should follow. Irrespective of the consequences, duties and responsibilities should be the overriding issue when deciding on an action. Unlike utilitarians, deontologists emphasise that it is important to tell the truth to a patient because it is the right thing to do, not because it will result in happiness. For deontologists, there are certain acts that are wrong or right in themselves. This is because of the sort of acts they are, not because of the consequences they produce. For example, a nurse can justify maintaining patient confidentiality from a deontological viewpoint. Using this example of confidentiality, a deontologically driven nurse may respect a patient's basic right to autonomy irrespective of the consequences. However, like all theories, there are certain instances where the application of deontology can be problematic in practice. For example, if a patient discloses suicidal intentions to a nurse but stresses that the nurse keeps this confidential, then the application of deontology can pose a dilemma for the nurse. It is also important to note that some aspects of deontology can be diametrically opposed to consequentialism (utilitarianism), though there is an overlap between deontology and virtue ethics.

Virtue ethics

The origins of virtue ethics lie in ancient Greek philosophy. Aristotle, Socrates and Plato advocated virtue ethics and defined those characteristics that make a person a good person. For example, the characteristics of a good nurse or a good doctor include virtues such as kindness, honesty, caring, self-discipline, compassion, courage and loyalty (Nuttall and Rutt-Howard, 2015).

These virtues allow nurses to perform with compassion and understanding in all interactions with patients. Furthermore, it can be difficult to manage medicines or prescribe safely and effectively if the nurse does not have some virtuous characteristics. However, according to some authors, virtuous characteristics solely based on religion invite debate and may need to be evaluated, considering the dynamic nature of societies. For example, some religions may be in favour of heterosexual relationships only, but current societal developments favour and respect diversity (Wheeler, 2013). In summary, the application of any form of ethical approach should consider and reflect on patients' needs more holistically, sensitively, widely and deeply.

Bioethics/principlism

Bioethics – or principlism – was advanced most by Beauchamp and Childress (2001), and this is the mainstay ethical approach in healthcare delivery. The four major parts of principlism are autonomy, beneficence, non-maleficence, and justice and veracity.

Autonomy

Autonomy refers to a person's ability to come to their own decisions without undue external influence. Respect for autonomy is one of the most fundamental moral principles that reigns supreme in healthcare ethics because it has important ramifications for a person's health and well-being (Beauchamp and Walters, 1999). In healthcare, behaviours that are contrary to a patient's right to autonomy are typically paternalistic in nature and generally unwelcome.

For this reason, every nurse must respect the patient's right to self-determination. In other words, the patient has a right to choose between agreeing to take part in or refusing treatment. However, in medicines management and prescribing, the concept of autonomy can be fraught with difficulties because each patient is unique and cultures are diverse. In addition, there is a significant group of people for whom autonomy may be absent, compromised or undeveloped.

Scenario

Mrs P attended an outpatient clinic dressed in the style of her immigrant community. She was accompanied by her husband, who greeted the doctor as they entered the consulting room, while Mrs P glanced modestly downward. Upon consultation, it was apparent that Mrs P was suffering from depression and was suicidal. She was experiencing difficulties in coping with activities of daily living (ADLs). It was evident that Mrs P needed a period of being in hospital. When this was suggested to her, her husband responded by saying that they ('we') did not want to be admitted to hospital; rather, they would prefer to get a prescription and go home. When Mrs P was asked what she herself wanted, she merely pointed in the direction of her husband.

For example, a patient may say to the nurse, 'I know you've explained the advantages and disadvantages of each medication to me, but I still can't make up my mind. Can you choose for me, since you're more knowledgeable about treatments than me?' Is the patient giving away their autonomy? Nuttall and Rutt-Howard (2015) argue that by choosing the best medicine for the patient, the nurse is not acting in a paternalistic manner. Rather, the patient is showing respect and trust for the nurse's knowledge and skill, and is willing to accept their professional judgement in deciding what is the best treatment. It is likely that the patient is aware that they control the right to decide, but they pass this responsibility to the nurse because of the respect they have for the nurse.

It is also argued that in theory, non-violation of a person's rights to autonomy is honourable, but it is often difficult to achieve in practice. Moreover, in many circumstances, healthcare professionals may be best placed to make treatment decisions (Fallowfield et al., 1994). In this context, the skills and knowledge relating to medicines management and prescribing could be the rationale underpinning this school of thought. However, an opposing view is that although the knowledge and skills of the healthcare professional are not in question, the professional is likely to lack the ethical understanding and qualifications to allow them to make decisions for others (Kottow, 2004). Overall, our duty and default position as nurses is to respect a patient's right to self-determination but also acknowledge the complex nature of autonomy. Because of this complexity, it is also important to assess whether the patient is sufficiently autonomous. In other words, we need to assess the patient's capacity to consent, a subject we will focus on in later sections.

Dimond (2014) identifies different forms of consent, stating that 'Consent is the agreement by a mentally competent person, voluntary and without deceit or fraud, to an action which without the consent would be a trespass to the person'.

Obtaining consent is a fundamental consideration for the nurse or the prescriber. For prescribers, not only is it necessary to take a thorough patient history (see Chapter 5), but it may be necessary to examine the patient and order clinical investigations to confirm a diagnosis. To be able to perform all aspects of this process, it is important to gain appropriate consent from the patient. However, consent is only valid if the patient is competent to give it. Therefore, gaining a patient's consent is an important part of nursing and prescribing.

First, for consent to be valid, the patient needs to voluntarily give it. Second, the patient must be mentally competent or have capacity to give consent. This latter point poses special problems in mental health, and later sections will discuss this in more detail. Third, the person obtaining consent must not act in a way that could be understood as being deceitful. If any of these elements are absent, then the person obtaining consent may be vulnerable to accusations of infringing on the patient's rights. A closer look at these three components may rightly make the nurse feel unsure, since each component alone is complex and full of ambiguity, inaccuracy and possible misinterpretation. Therefore, it is good practice for nurses to document the process of obtaining consent, even if this may be laborious. Because of the complex nature of consent, it warrants further discussion.

Implied consent

The best illustration of implied – or non-verbal – consent is when a patient displays behaviours of acceptance. For example, if a patient offers their arm to the nurse during subcutaneous injection administration, it can mean that the patient has given consent for the nurse to administer the injection. This is because the patient is acting cooperatively despite not having verbally consented. In mental health, such a scenario is not uncommon because some symptoms of mental health problems may disrupt effective communication. However, some professional bodies, such as the General Medical Council (GMC), warn against relying on a patient's compliance as a form of consent (GMC, 1998). Just because the patient is cooperating with the injection procedure does not in itself indicate that the patient understands what you propose to do and why. Further, in prescribing practice, the reliance on implied consent has limitations and is unsafe, because during an ideal prescribing process a discussion between the prescriber and the patient normally takes place. However, we may use implied consent in some situations during our practice if the consent is valid. If the nurse is not sure about what to do in a specific situation, they should seek advice from their employer, professional indemnity insurance provider, trade union or the NMC, or even independent legal advice. In many situations, obtaining explicit consent from the patient is preferable to implied consent.

Explicit consent

Explicit consent, also known as express or direct consent, is when a patient gives a healthcare professional specific permission to do something. In other words, the nurse presents the patient with clear choices to agree or decline the planned treatment. This type of consent is common in healthcare. In explicit consent, there is a reliance on patients voicing their consent and responding to questions that the nurse may ask. A categorical 'yes' or 'no' from the patient easily confirms or refutes agreement to the planned treatment. However, the problem with this type of consent is that in cases of misunderstanding as to whether the nurse sought consent or not, in the absence of a witness it would simply be the word of the nurse against that of the patient (Dimond, 2014). Therefore, in practice, it is important for the nurse to apply more vigorous approaches to obtaining consent to protect both themselves and the patient. In this respect, explicit written consent offers protection for both parties.

As the name suggests, explicit written consent is the most transparent form of consent. It is an agreement that the patient gives in writing. Written consent is good evidence that the patient agreed to the treatment by providing a signature (Dimond, 2014). Further, in cases that involve higher-risk treatment, such as electroconvulsive therapy (ECT), it is important to gain written consent from the patient (GMC, 1998). This is so that all parties involved understand what was explained and agreed. Written consent forms should include details of the treatment or procedure, and this information forms the basis of consenting or not consenting to treatment. A good example of written consent is the clinical management plan (CMP) in supplementary prescribing. The

CMP usually details enough information for the patient to agree to it. Although written consent is the ideal in supplementary prescribing, and is easy to arrange, such arrangements can be fraught with difficulties in many independent prescribing situations, mainly due to time constraints. In written consent, the nurse or prescriber should provide the patient with details of any significant risks from the treatment or procedure, in addition to gaining the patient's signature. There is no legal requirement to obtain written consent, but it may be advisable in specific cases (BMA, 2018). Ideally, nurses should seek explicit informed consent, a critically important area in clinical practice that we will discuss next.

Informed consent

Informed consent is a term that has wide usage in healthcare law and ethics. The Royal College of Nursing (RCN) defines informed consent as 'an ongoing agreement by a person to receive treatment, undergo procedure or participate in research, after risks, benefits and alternatives have been adequately explained to them' (RCN, 2011).

Informed consent is a difficult principle that many healthcare professionals have problems in understanding. There is some evidence to suggest that nurses and other healthcare professionals seem to show an inadequate understanding of the term 'informed consent' (Nuttall and Rutt-Howard, 2015). This is mainly due to varying levels of information that nurses should provide patients before and during treatment. Therefore, at times, nurses tend to obtain consent imprecisely, without the patient truly understanding the benefits or risks of treatment. For example, many patients receiving psychotropic medication may be doing so without the knowledge of the risks and benefits of these regimens (Gray et al., 2005). Obviously, this is unsatisfactory practice, and for this reason the following section explores the concept of informed consent in more detail to promote a better understanding.

Informed consent has become central to the way that nurses practise. It assumes respect for the individual's right to make free decisions and it is a duty that originates from the moral principle of respect for persons (Tsai, 2008). Further, standard 4.2 of *The Code* says, 'make sure that you get properly informed consent and document it before carrying out any action' (NMC, 2018b). However, many nurses may fail to recognise situations in which patients' ability to provide informed consent may be compromised. Therefore, it is important to give information to patients in a way that they understand. This allows them to exercise their rights and make informed decisions about the care they receive. Whether in medicines or prescribing, it is necessary to assess how much information is enough. There are some situations where the nature of the information is such that the patient's understanding and capacity for decision-making is overwhelmed. In such cases, it is possible that the patient may lack the necessary capacity for informed decision-making (Bester et al., 2016). To compound matters, it may be difficult in practice to establish whether the patient has correctly understood the information and the implications. The following case study illustrates the problematic nature of informed consent.

Case study: *Montgomery v Lanarkshire Health Board* [2015]

Nadine Montgomery, a woman of small stature (5 feet tall), had diabetes. She gave birth to a larger than average-sized baby. The baby suffered from severe disabilities after birth due to shoulder dystocia. Before giving birth, Mrs Montgomery expressed concern to her doctor about whether she would be able to deliver her baby vaginally. The doctor failed to warn Mrs Montgomery of the possible risk of serious injury from shoulder dystocia. Further, the doctor did not suggest the possibility that Mrs Montgomery could opt to have a caesarean section. Lanarkshire Health Board argued that only in circumstances where there is a risk of grave adverse outcome should there be a duty to warn of such risks. They further argued that because the risk of such an outcome was so low and Mrs Montgomery merely expressed concern, this is not the same as asking a direct question that requires an answer. In their view, no warning was required. The lower courts ruled against Mrs Montgomery's claim and staunchly stuck to the view that the failure to warn of risks and alternative procedures would only be negligent if it was not supported as proper by a responsible body of medical opinion (the **Bolam principle**).

However, Mrs Montgomery won her case on appeal to the UK Supreme Court. The Supreme Court ruled that the question should have been about Mrs Montgomery's likely reaction if informed of the risk of shoulder dystocia. The obvious position was that she would have chosen to give birth by caesarean section: 'The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor should reasonably be aware that the particular patient would be likely to attach significance to it.' The court emphasised that 'whether a risk is material cannot be reduced to percentages, and instead is based on a variety of factors such as: (1) nature of the risk; (2) effect on the life of the patient; (3) the importance to the patient of the benefits of the treatment; (4) any possible alternatives; and (5) the risk of those alternatives.'

As can be seen from the above case study, the process of informed consent can be fraught with difficulties. The ruling in this case firmly states that the need for 'informed consent' is now part of UK law (England, Northern Ireland, Scotland and Wales). Nurses and other healthcare professionals are now under a clear duty to take reasonable care to ensure that patients are aware of all significant risks to treatment. Previously, it was enough for healthcare professionals to simply explain treatment in broad terms for consent to be valid. In medicines management and prescribing, it is now essential to adequately inform a patient of the potential risks, interactions, contraindications and side effects of medication. The law may regard failure to provide adequate information as negligence. Therefore, nurses and prescribers may find themselves accounting for their practice in a court of law.

Generally, to impose care or treatment on an individual without respecting their wishes and right to self-determination is not only unethical, but illegal. This is also against *The Code*, which states that you must 'respect, support and document a person's right to accept or refuse care and treatment' (NMC, 2018b). However, an exception to this is if the healthcare professional reasonably considers that the disclosure of a risk would 'be seriously detrimental to the patient's health', or in circumstances of necessity. However, lawmakers warn against abuse of this exception.

In prescribing, a general rule to follow is to explain the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. The prescriber may recommend an option that they believe to be best for the patient, but they must not put pressure on the patient to accept their advice. The patient can then weigh up the potential benefits, risks and burdens of the various options, as well as any non-clinical issues that are relevant to them. The patient then decides whether to accept any of the options, and if so which one. However, deciding how much information is enough to tell the patient remains a contentious issue.

Healthcare professionals, including nurses, should make their own professional judgement regarding what information to communicate – and to what level. However, the information should be within the sphere and limit of the patient's understanding. This allows the nurse to argue and defend the judgement by saying that it is truly informed. Furthermore, by respecting the patient's right to autonomy, it allows them the dignity of being in control of their own lives and masters of their own well-being (Hendrick, 2000). In prescribing practice, patient participation is high on the agenda, as different healthcare professional bodies ascribe. Platform 4.2 of the standards of proficiency for registered nurses states, 'at the point of registration, the registered nurse will be able to … work in partnership with people to encourage shared decision making in order to support individuals, their families and carers to manage their own care when appropriate' (NMC, 2018a). As discussed earlier, for consent to be valid, the person giving it must do so voluntarily in an uncoerced and non-threatening manner. Above all, the person must be mentally competent to grant such consent.

Patients may not be sufficiently autonomous to make competent healthcare decisions, and in such cases the nurse is best guided by the Mental Capacity Act 2005. We will now turn our attention to beneficence, another key area of bioethics.

Beneficence

The ethical principle of beneficence is about ensuring that patients benefit from the caring relationship. It is the principle of doing good, and refers to the duty of the nurse to act for the benefit of the patient, which is set out by *The Code* (NMC, 2018b). Beneficence also involves the nurse balancing out benefits against risks and costs, thus ensuring that the patient receives the best care. The effects of beneficence

should involve both the physical and psychological benefits of caring. Standards set for professionals by their regulatory bodies, such as the NMC, can be higher than the law requires. Therefore, in cases of negligence, the standard that applies is often that set by the relevant statutory body for its members. However, it is worth noting that the 'best care' may be relative to the overall situation which we may encounter in clinical practice. This is because in healthcare, we work within certain restrictions, such as budgetary constraints, and these can be decisive in our decision-making process.

Non-maleficence

At the heart of the principle of non-maleficence is the notion of not knowingly causing harm to the patient. This principle is expressed in the Hippocratic oath. The duty not to harm patients is separate from the duty to help them. Although codes of conduct for various health professions outline duties not to harm patients, many interventions result in some harm to patients, however temporary. In pharmacological treatments, we can describe many interventions as having 'double effect' (i.e. one good effect – the intended pharmacological effect – and one harmful effect – unintended adverse side effects). We can allow the harmful effect if it is, on balance, less impactful than the good effect. In medicines management and prescribing, it is therefore important to review both the potential positive effects of treatment (e.g. symptom control) and the harmful effects (e.g. adverse side effects).

Justice

The concept of justice is not the law in the narrow sense. Rather, this principle involves ensuring that everyone benefits from treatment, as well as the distribution of access to it. To apply this principle, we need to accept and value differences and diversity in our patients. Patients come from different cultural, racial and religious backgrounds. Therefore, fairness and justice in this respect involves respecting and recognising their differences, not acting in a way that disadvantages the patient. In this regard, we need to consider other people's cultural differences when treating them. Importantly, justice is about advocating on behalf of all patients, whether they come in with a Western philosophical perspective or another philosophical perspective. Justice is not about treating all patients the same because it is not possible to justifiably treat all patients the same, since all patients are different and present with different ailments or complaints. We will now return to the issue of capacity to consent and its legal implications.

Mental capacity and consent

A definition of mental capacity is the ability to use and understand information to decide, as well as communicating any decision made. In medicines management or

prescribing, it is important to establish if a person has capacity or not. Certain groups of people, such as those with mental health problems, those that are unconscious and those under the influence of alcohol or drugs, may have limited capacity to consent to treatment. However, determining if an individual has mental capacity can be a contentious issue, as the following case study demonstrates.

Case study: Ms B

Ms B was a 43-year-old who suffered from a completely disabling condition, and she requested that her life-support machine be turned off. She did not want to live on a ventilator and had made a living will. Two psychiatrists at the hospital established that she was not competent to refuse ventilation. But later that year, an independent psychiatric reassessment concluded that she was competent to give consent. Thereafter, the hospital regarded Ms B as competent, but her doctors continued to refuse to withdraw her ventilation.

Ms B sought relief from the High Court to refuse life-prolonging medical treatment, as well as attesting that the hospital had been treating her unlawfully. The High Court judge identified that the central issue was whether Ms B was competent to refuse ventilation. In other words, was Ms B able to understand and maintain the information important to the decision, as well as the likely consequences of having or not having the treatment? Furthermore, was she able to use the information and weigh it in the balance as part of the process of arriving at a decision?

The judge ruled that Ms B was competent to make all relevant decisions about her medical treatment including the decision to seek to withdraw from artificial ventilation. Her mental competence was proportionate to the enormity of the decision she made.

Although the case of Ms B occurred in a physical health setting, the key principles of mental capacity to consent to treatment apply equally to medicines management and prescribing in any setting. If we give treatment to a mentally competent person despite their objection, this can be regarded as a trespass – and even an assault – upon the individual. The Mental Capacity Act 2005 reflects the principles of judgement in Ms B's case, and it came into force in October 2007. In English law, a mentally competent person has a right to refuse treatment, even if medical opinion supports the fact that by refusing treatment the patient will die. Outside of the Mental Health Act 1983, a mentally competent person cannot be forced to accept treatment. This is the principle applied by the judge in Ms B's case. However, this situation changes when an individual is deemed not to have capacity to decide. The provisions for lack of capacity are provided for in the Mental Capacity Act 2005.

Mental Capacity Act 2005

Case study: Alan

Alan was a 68-year-old male patient who suffered from paranoid schizophrenia and was detained in a psychiatric hospital. He developed gangrene in one foot but refused to have the leg amputed to save his life. He believed that God would help him through his illness. However, he agreed with the doctors about the consequences of refusing amputation. Further, he issued a court injunction to stop the hospital from amputating his foot without his consent. He won the case in court because the hospital was unable to establish that he lacked adequate understanding of his problem and the medical treatment proposed. The court believed that he possessed mental capacity as: (a) he was able to understand and retain relevant treatment information; (b) he believed the information; and (c) he had arrived at a clear conclusion, for better or worse.

The Mental Capacity Act 2005 covers all personal decisions on the welfare of people who temporarily or permanently lack mental capacity to decide for themselves. It defines someone as lacking in capacity if 'at the time, he [*sic*] is unable to decide for himself because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

Despite its title, the Mental Capacity Act 2005 applies to anyone who lacks capacity to make decisions, as well as those who wish to plan for others to make decisions on their behalf in the event of losing capacity to make their own decisions in the future. Anyone who delivers care or treatment to a person who lacks capacity aged 16 years and over living in England or Wales should consider the Act. For example, informal carers, health and social care professionals, and the emergency services may rely on the Act.

The term 'decision-maker' is used for those who make decisions on behalf of incapacitated people.

The five principles of the Mental Capacity Act 2005

Section 1 of the Act outlines five principles that intend to protect people who lack capacity to make their own decisions, as well as maximising people's ability to make their own decisions as far as possible. These five principles are as follows:

1. An individual must be assumed to have capacity unless it is determined otherwise.
2. An individual is not to be regarded as unable to decide unless all practicable steps to help the individual to do so have been taken without success.
3. An individual is not to be regarded as unable to decide merely because he or she makes an unwise decision.

4. An act done, or a decision made under the Act, for or on behalf of a person who lacks capacity, must be done in their best interest.
5. Before the act is done, or the decision is made, consideration must be given as to whether the purpose for which the decision or act is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The Act enshrines in law best practice and common law principles concerning people who lack mental capacity to decide for themselves and those who make decisions on their behalf. It also deals with the assessment of a person's capacity and those who may act on the patient's behalf. The law does this by setting out a clear test to assess whether someone lacks capacity to make a decision at a specific time. You cannot label someone 'incapable' simply because of a medical condition or diagnosis.

In section 2 of the Act, you cannot establish a lack of capacity merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour that might lead others to make unjustified assumptions about capacity. In other words, a mentally ill adult can refuse treatment if they are mentally competent when they make the decision, as in the case of Alan above. Being mentally ill by itself does not automatically deprive the person of capacity. Section 2 of the Act requires the person making the decision to establish two facts: (1) Is there a specific decision to be made now? (2) Is the person unable to make that decision because of an impairment of – or a disturbance in the functioning of – the mind or brain, whether temporary or permanent? If the decision-maker answers 'no' to one or both questions, then the Act will not apply to the person. In Alan's case, a decision to amputate his leg had to be made, but he understood what his condition was and the likely consequences of refusing treatment. Therefore, the Act did not apply in his case, even though he suffered from paranoid schizophrenia. The judge ruled that Alan was able to decide competently.

Another important consideration relating to consent is that when a patient refuses treatment, we must be sure that they have the capacity to make that decision, and have not been unduly influenced by other persons. The following case study clearly demonstrates this point.

Case study: Ms Re T

Ms Re T, a pregnant woman who was injured in a road traffic accident, needed a life-saving blood transfusion following a caesarean section. Before the operation, she informed the medical staff that she would not accept a blood transfusion and signed a form to that effect. Her mother was a Jehovah's Witness and influenced her into refusing the transfusion. The patient's partner applied to the court for permission for the medical staff to give her the transfusion. The court ruled that the blood could be given. This was because the evidence showed that at the time of deciding, she did not have the necessary capacity to make a valid decision because her mind was unduly influenced by her mother.

What is important here is not that the court consented for a mentally competent adult by proxy, but rather at the time of making the decision Ms Re T was not in a competent state of mind due to her mother's influence. For the best interest of her child and herself, Ms Re T was given the blood to save her life. This decision may sit uncomfortably with many nurses and healthcare professionals. However, where possible, the competent person's wishes must be respected.

Section 3 of the Act sets out a legal test to determine whether the person is competent of making their own decisions. As previously discussed, just because someone has a mental illness or a disorder in the functioning of the mind does not necessarily mean that they have no capacity to make all of their own decisions. Section 3 of the Act states that an individual has an 'inability to make decisions' if they are unable to:

(a) understand the information relevant to the decision;

(b) retain the information;

(c) use or weigh that information as part of the process of making the decision;

(d) communicate his decision (whether by talking, using sign language or any other means).

The decision-maker must decide what information is relevant and impart with that information in a way that the person can understand.

If the decision-maker is satisfied that the person fulfils all four of the above requirements (a–d), then that individual must have capacity to make the decision. However, if the decision-maker believes that the person is unable to demonstrate one or more of the four requirements, then the person is deemed to lack capacity to decide. The decision-maker is then able to make decisions on the individual's behalf, acting in the person's 'best interest'.

Section 4 of the Act does not define 'best interest', but sets up a list of factors that the decision-maker must consider. The purpose of the list is to ensure that any decisions made – or actions taken – are in the best interest of the incapacitated person. Aspects to consider are broad, allowing them to be applied to all decisions and actions. When determining what is in the patient's best interest, a quick summary of the code of practice offers guidance for the decision-maker.

Code of practice guidance

Encourage participation. Whenever possible, encourage the person to participate, or enhance their ability to participate, in the decision-making process. Identify all relevant situations and try to find out all the things that the person who has no capacity would have considered if they were making the decision or acting for themselves.

Find out the person's views. Try to find out the views of the person who is lacking capacity, including:

- their past and present desires (these may have been expressed orally, in writing, or through behaviours or habits);
- any credible ideals (e.g. religious, cultural, moral, political) that would have been likely to impact on the decision in question;
- any other aspects the person would likely have considered if they were making the decision or acting for themselves.

Avoid discrimination. Do not make assumptions about the person's best interest simply based on their age, appearance, condition or behaviour.

Assess whether the person might regain capacity. Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?

If the decision concerns life-sustaining treatment, then it should not be motivated in any way by the wish to bring about the person's death. Further, the decision-maker must not make assumptions about the person's quality of life.

Consult others. If it is practical and appropriate to do so, consult other people for their views about the person's best interest, as well as seeing if they have any information about the person's wishes, feelings, beliefs and values. Specifically, try to consult:

- anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues;
- anyone engaged in caring for the person;
- close relatives, friends or others who may take an interest in the person's welfare;
- any attorney appointed under lasting power of attorney or enduring power of attorney made by the person;
- any deputy appointed by the Court of Protection to make decisions for the person.

For decisions relating to major medical treatment or where the person should live, and where there is no one who fits into any of the above categories, the decision-maker must consult an independent mental capacity advocate (IMCA). When consulting, the decision-maker should remember that the person who is lacking in capacity has a right to keep their affairs private. Therefore, it is inappropriate to share every piece of information with everyone.

Avoid restricting the person's rights. The person making the decision should see if there are other alternatives that may be less restrictive of the person's rights.

To determine a person's best interest, the decision-maker should take all of the above into account. There are no statutory forms for either the best interest checklist or the capacity test. Nevertheless, the advice to the decision-maker is to document their decision-making process, as this will

provide weight for their actions and help protect them from liability. In addition to the best interest decision-making checklist, an important area to cover is the Mental Capacity Act 2005 checklist from Barber et al. (2016), which I will turn to next.

Case study: Mental Capacity Act 2005 checklist

Has the decision-maker:

- applied the five principles?
- established that the person's age is 16 years or over?
- established that there is a specific decision to be made?
- established that the person is lacking capacity because of an impairment of – or a disturbance in the functioning of – the brain or mind?
- ensured that the person is lacking capacity in relation to a specific matter at a specific time?
- ensured that the decision is not based on assumptions about the person's age, appearance, behaviour, etc.?
- established that the person is unable to make their own decisions because they have not been able to respond positively to one or more of the of the following questions?
    - Do they understand the relevant information?
    - Can they retain it?
    - Can they weigh up the information?
    - Can they communicate a decision?
- taken all practicable steps to help the person make their own decision?
- ensured that this is a genuine lack of capacity, not merely an unwise decision?
- applied the best interest checklist?
- considered whether there might be a less restrictive option?
- ensured that the care or treatment is a mere restriction of movements rather than a deprivation of liberty?

Before reading any further, complete Activity 1.4.

Activity 1.4 Critical thinking

May is a 25-year-old chemistry graduate who has had numerous admissions to hospital, usually on a section order of the Mental Health Act 2005. She suffers from schizophrenia, and on her last discharge from hospital the consultant psychiatrist prescribed a depot injection instead of the usual tablets. The doctor wanted May to break

the cycle of hospital admissions by ensuring compliance with medication. May was unhappy about taking a depot injection and argued that she suffers worse side effects on a depot than she does while taking oral medication. The consultant psychiatrist refused May's request, arguing that she has made similar promises in the past without honouring them. In his view, she lacked capacity.

- Does May lack capacity?
- What other factors might be leading May to refuse medication?

Outline answers are provided at the end of the chapter.

Section 5 of the Act allows decision-makers to carry out actions in relation to care or treatment if they follow the requirements of the Act. However, there are restrictions, which in effect means that certain actions are not permitted under Section 5. Going beyond these restrictions would amount to unlawful practice. Section 5 of the Act allows persons to make decisions and carry out acts for or on behalf of the incapacitated person, provided that:

- before carrying out the act, the decision-maker takes reasonable steps to determine whether the person lacks capacity specifically to the matter;
- when carrying out the act, the decision-maker believes the person lacks capacity specifically to the matter;
- the act is in the person's best interest (determined in accordance with section 4 of the Act).

If these criteria are met, the decision-maker should be protected from liability, if they do not exceed the limitation detailed below and do not act negligently.

Limitation section 5

Section 6 of the Act sets out several conditions that must be met to ensure that section 5 of the Act is lawful. If the decision-maker follows the procedure explained above and does not exceed the limitation detailed below, their acts of care or treatment will fall within the scope of section 5 of the Act.

Section 6 of the Act defines restraint as 'the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement whether the person resists'. If restraint is needed to prevent harm to others, then the decision-maker needs to establish if the Mental Health Act 2005 or the common law would provide more appropriate means of meeting the person's needs or safeguarding others.

Restraint can be used provided the following criteria are met:

- the decision-maker believes that the restraint is necessary to prevent harm to the person and the act is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.