Section seven
Mental Health

Mental Capacity Act 2005 - Five Principles

1 A presumption of capacity
Start by thinking I can make a decision.

2 Individuals supported to make their own decisions
Do all you can to **help** me make a decision.

3 Unwise decisions
You must not say I lack capacity just because my decision seems unwise.

4 Best interests
Use a best interest checklist for me if I can't make a decision.

5 Less restrictive option
Check the decision made **does not** stop my freedom more than needed,

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Capacity Assessment

North Somerset - Capacity Assessment

Name of service user / patient -

DoB of service user / patient -

Name / Profession of Capacity Assessor(s) –

A) Why is a capacity assessment being completed ?

B) What is the *specific* decision to be made ?

C) Does the service user / patient have a suspected or diagnosed *Mental Impairment* ?
If the answer is NO then move to Part G

D) What *relevant information* does the service user / patient need to understand in order to make this decision ?

E) Record how you gave this *relevant information* to the service user / patient and steps you took to help them understand the issue.

F) Interview - Assessment

F1. Does the person ***understand*** the relevant information detailed above? *Does the person understand the purpose of the assessment and what the decision is to be made ? Do they understand the individual elements of the 'relevant information' as they are discussed with them ?*	Assessor's Judgement
Assessors observations & person's response -	Yes / No

F2. Can the person ***retain*** the relevant information detailed above ? *Can the person give an account of the salient details at the end of the assessment. The person only needs to retain the information for the duration of the discussion (Please see guidance notes for fluctuating capacity if person is unlikely to retain information over a longer period.)*	Assessor's Judgement
Assessors observations & person's response -	Yes / No

F3. Can the person ***use and weigh*** the relevant information detailed above ? *Can the person weigh up the pro's and con's of the decision OR can they give an account of professional's concerns and forward reasons why they disagree with them? Is there evidence of 'reasoning' being used to guide the person's decision?*	Assessor's Judgement
Assessors observations & person's response -	Yes / No

F4. Can the person ***Communicate*** their decision ? *Only if the person has no verbal or non verbal communication will they fail this element of the test (e.g. the person is unconscious or in a permanent vegetative state, minimally conscious state)*	Assessor's Judgement
Assessors observations & person's response -	Yes / No

G) Capacity Assessment Decision

Only one element must be ticked from the 3 choices below

{ } - There is no evidence, diagnosis, or suspicion of a Mental Impairment. Therefore the person **HAS** capacity to make the decision.

{ } - The 4 elements above are *all marked YES* therefore the person **HAS** capacity to make the decision.

{ } - *One or more* of the 4 elements above are marked NO therefore the person **LACKS** capacity to make the decision.

H) Follow on work

Any elements that apply should be ticked from below.

{ } - The person's cognitive state is stable or deteriorating and in my view they are unlikely to regain capacity in relation to this matter in the near future.

{ } - The person's cognitive state is improving and I believe capacity should be re-assessed shortly.

{ } - I believe the person could regain capacity to make the decision with support and advice from others.

{ } - The person's cognitive state is fluctuating on an hourly / daily / weekly * basis. In my view there is a reasonable possibility they will have capacity in relation to the decision shortly.
** delete as applicable*

{ } – As the person lacks capacity I am now going to organise a Best Interests meeting discussion.

{ } – As the person lacks capacity I am going to prompt a fellow professional to organise a Best Interests meeting / discussion.

{ } – The person has capacity and is subject to restrictions upon their choices that require urgent review.

{ } – I will refer on to a relevant health professional to establish or not the existence of a mental impairment.

{ } – I will seek a 2nd opinion on this individual's capacity.

If necessary please provide further detail on the boxes ticked above. Please also use this space to record any other thoughts or recommendations you have regarding the issue.

H) Signature(s) & date

Best Interests

North Somerset - Best Interests

Name of service user / patient -

DoB of service user / patient -

Date of meeting / discussion -

A) What is the Best Interests decision to be made ?

B) Has a capacity assessment been completed in relation to this decision ?
If answer is 'No' then stop best interests process & initiate capacity assessment.

C) Does the authority for making this decision lie under other provisions of the Mental Capacity Act (Lasting / Enduring Power of Attorney, Deputyship or Declarations made by the Court of Protection, Advance Decision to Refuse Treatment)
If answer is 'Yes' detail Authority below move to Part P , detail any follow up work in part R

D) If there is no other Authority identified in C) above who is the 'Decision Maker' in regard to this issue ?

E) Is the decision one that can only be considered by directly the Court of Protection OR is the decision one that is excluded from the remit of the Mental Capacity Act ?
If Yes then move to part P , record follow up work in part R

F) Is the Best Interests discussion taking place as a formal meeting / individual discussions / telephone conversation / written communication ? More than one may apply

G) Detail who has been consulted as part of this Best Interests discussion / meeting.

H) If unable to ascertain an interested parties views on this matter detail the reason for this here.

I) Are the conditions for appointing an IMCA met ? If so please detail the IMCA consulted.
If there are no interested parties to consult and the decision involves a serious medical treatment or a change of residence then the decision maker must appoint an IMCA. (NB IMCA's may also be appointed if there are safeguarding concerns or doubts around family / friends acting in the individual's best interests)

J) Consider the different options for the person considering the available resources.

K) What are the person's views on this matter, What decision would they have made if they had capacity ? How have you ascertained this ?

L) Consider the pros and cons of each option. Risks and benefits must include psychological & emotional elements alongside physical factors.

M) Considering boxes J, K, & L above what do the group feel is the ***least restrictive option*** considering, ***best interests***, ***what the person would have wanted*** & ***available resources.***

N) Follow on work - All parties **do** agree (tick all that apply)

{ } – Additional individuals need to be consulted and a repeat Best Interests decision made.
{ } – The individual's cognition is fluctuating or improving and their capacity requires re-assessing shortly.

O) Follow on work – One or more parties ***do not*** agree (tick all that apply)

{ } – I will organise a formal 'round table' Best Interests Meeting.
{ } – I will make a referral for Advocacy Services.
{ } – I will refer the matter to my line manager.
{ } – I will investigate a referral to the Court of Protection.
{ } – There is a dispute as to the individual's capacity and I will organise a re-assessment.
{ } – The individual's cognition is fluctuating or improving and their capacity requires re-assessing shortly.

P) Other Decision Making Authority

{ } – The authority to make the decision lies under the following provisions of the Mental Capacity Act (Lasting /Enduring Power of Attorney, Deputyship / Declarations under the Court of Protection, Advance Decision to Refuse Treatment)
{ } - The decision is so serious it may only be considered by the Court of Protection.
{ } – The decision is one that is excluded from the remit of the MCA.
{ } – The decision made is likely to constitute a deprivation of liberty and a referral to the appropriate supervisory body must now be made.

Q) Review

The Best Interests decision should be reviewed by the following date : _____

The individual's capacity should be reassessed by the following date : _____

R) Please provide detail here regarding any follow up work.

S) Signature(s) & date

Delirium

DELIRIUM

ACUTE CONFUSION IS A SIGN THAT SOMEONE IS PHYSICALLY UNWELL

1) SPOT IT

- Sudden change in behaviour
- More confused over the past few hours or days
- Confusion varies at different times of day
- Difficulty in following a conversation
- Rambling and jumping from topic to topic
- More sleepy or more agitated than usual

IF ANY ANSWERS ARE 'YES' IT COULD BE DELIRIUM,

IF IN DOUBT CHECK IT OUT

"My mind seemed to have gone…
I was in a different world...
I didn't want them thinking
I was potty"

2) TREAT IT

Remember the six common causes of Delirium: 'P.IN.C.H. M.E'!

PAIN – INFECTION - CONSTIPATION- HYDRATION- MEDICATION - ENVIRONMENT

3) STOP IT

EXPLANATIONS AND REASSURANCE:
Introduce yourself and explain what you are doing.
Be calm and patient, avoid being confrontational

REORIENTATION:
Remind the person of the time, date or season
Set clocks and calendars to the right time and date
Turn down noisy TVs or Radios

LOOK AFTER PHYSICAL NEEDS
Drinking, eating, toileting, sleep time, prevent falls
Check for signs of infection or pain

STOP DELIRIUM! © 2007

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PINCH ME

Resident more confused or not their usual self ? – Use "PINCH ME"

P → **PAIN**
Are they in pain?
Use numerical pain tool or PAINAD

IN → **Infection**
Are there any signs of infection?
Urinary, chest, skin?

C → **Constipation**
Are they constipated?

H → **Hydration**
Are they drinking enough?
Is their mouth dry?

M → **Medication**
Have they started any new medication?
Have they stopped any medication recently?

E → **Environment**
Have they moved rooms? Are they a new resident? Have they had a fall? Are they bored?

Fluctuating Change

FLUCTUATING CHANGE / ACUTE EPISODE CONFUSION SCREENING TOOL

Patient's Name: _____ D.O.B: _____

NHS Number: _____ GP: _____

Address: _____

Single Question in Identifying Delirium (SQUiD) a single prompt question which asks:
Is the person more confused than before?

No.	Patient Problem / Need
	Fluctuating Change/ Acute Episode of Confusion - describe

GOAL/AIM

Identify Possible Causes of Confusion		Review date A date must be entered to coincide with the time span of goal/aim

NURSING ACTION/INSTRUCTION

		RESULTS
1.	-Blood pressure -Pulse -Respirations -Oxygen saturations -Temperature Measurement -Blood Glucose Measurement **All these tasks to be completed by district nurses**	
2.	Medication Check. Are they taking their medication? At the right Time? The right Dose? Possible Side effects.	
3.	Urinalysis, send for M, C and S if indicated	
4.	If they have wound/s, swab if indicated **to be completed by district nurses**	
5.	Assess bowel function (constipation/Diarrhoea)	
6.	Assess Pain Score 1-10 **or use PAINAD**	
7.	Assess nutritional and Hydration status	
8.	If nothing abnormal detected in action 1-7 consider contacting the G.P to discuss possibility of Dementia Screen Blood Test. FE/B12/Folate/ FBC in a green haematology bag. **PLEASE ACT ON ALL RESULTS IF CLINICALLY INDICATES AND DOCUMENT**.	

AVON & WILTSHIRE MENTAL HEALTH - BEHAVIOUR CHART
DAYTIME PRESENTATION CHART

Date	8am	9am	10am	11am	12noon	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm

KEY:
1 = Sleeping
2 = Awake & resting in bed
3 = Awake & Waling around
4 = Restless
5 = Restless & Agitated
6 = Calling out
7 = Agitated
8 = Agitated Verbally
9 = Agitated Physically
10 = Shouting out
11 = Violent
0 = SETTLED

W drive/officepaperwork/behaviour chart April 2014

Night Time Presentation Chart

AVON & WILTSHIRE MENTAL HEALTH - BEHAVIOUR CHART
NIGHT TIME PRESENTATION CHART

Date	9pm	10pm	11pm	Midnight	1 am	2 am	3 am	4 am	5 am	6 am	7 am

KEY:
1 = Sleeping
2 = Awake & resting in bed
3 = Awake & Waling around
4 = Restless
5 = Restless & Agitated
6 = Calling out
7 = Agitated
8 = Agitated Verbally
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W drive/officepaperwork/behaviour chart April 2014

Challenging Behaviour

Understanding and Treating Behaviour that Challenges

Dudley and Walsall NHS
Mental Health Partnership NHS Trust

Innovation and Outcomes in Psychological Therapies

Background

What are behaviours that challenge?

They are behaviours that have an adverse effect on the person with dementia and their carers. It may be physical, emotional or environmental. Typically, behaviours that challenge are as a result of an unmet need the person is trying to communicate. Over time this can become a habitual response.

Current guidelines

Current guidance recommends the use of non-pharmacological, psychological and psychosocial approaches in the initial stages of managing behaviours that challenge (NICE/SCIE, 2006; Banerjee, 2009; National Dementia Strategy, 2009). Consequently, these are now recommended as a first line treatments (NICE/SCIE 2006; NHS Institute for Innovation and improvement, 2011; Banerjee, 2009).

Newcastle Model (James & Stephenson, 2007)

Why do behaviours that challenge occur?

A person with dementia may be unable to recognise their needs, know how to meet them, or communicate what they need to others. This may cause them to act in ways that are seen as challenging, including aggression. The behaviour might be the person's way of expressing a need, an attempt to communicate it, or an outcome of the unmet need.

It may be:

- an inability to communicate fears and or distress
- a direct result of the changes in the brain caused by the dementia
- frustration at no longer being able to carry out tasks
- depression
- feeling unwell
- being unable to express pain

Remember — all behaviour, challenging or not, is for a reason

There can be many reasons why a person with dementia's behaviour changes. It is through numerous **systematic and innovative investigations**, specific to each person, that we can understand why the behaviours occur.

STEP 1: Information Gathering

What information are we looking for and how do we gather it?

THE ENVIRONMENT
- Does the environment cater to the person's needs? (bright, loud, visually confusing)

PHYSICAL HEALTH
- Medical examinations: pain scales, urinary testing
- Medical history

APPEARANCE:
- Observations and record keeping: look angry, anxious, scared, depressed

COGNITIVE IMPAIRMENT
- Neuropsychological assessment/ observations

MENTAL HEALTH
- Mood assessments
- Anxiety
- Delusions/hallucination

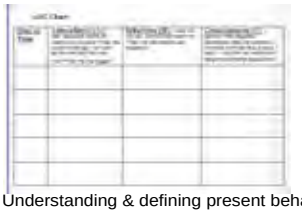
BEHAVIOURS
- Define it!
- ABC charts, frequency and intensity of behaviour charts

MEDICATION
- Side effects of medication

PERSONALITY
- 1-1 conversation with client
- Speak to family

LIFE HISTORY
- Life Story Work: life experiences, relationships, attachments, loss, trauma, occupation, coping
- Speak to family

VOCALISATIONS:
- Observations and record keeping



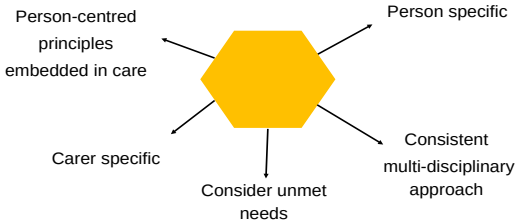
Understanding & defining present behaviour

Life History

Current Mood State

Cognitive ability

When gathering this information, keep the following principles in mind...



STEP 2: Putting it all together

From this information, we can find out:

1) The **triggers** of the behaviours
e.g. death of wife, admission to ward, unable to exercise due to pain

2) The **needs** of the patient i.e. 1:1 reminiscence and validation about his loss, pain management, opportunities for appropriate physical activity (Walk around garden)

STEP 3: Interventions

- **Meet the need**
- **Life story work**
- **Medical assessment**
- **Consistency of approach**
- **Mindfulness**
- **Support groups**
- **Reminiscence therapy**
- **Anxiety management**
- **On-going monitoring and reviewing**
- **Validation therapy**
- **Activity Planning**
- **Doll therapy**
- **Effective interagency working**
- **Cognitive Stimulation**
- **Meaningful occupation**
- **Psychoeducation**
- **Carers support**
- **Individualised person centred approach**

To find out more...take a look at these references:

James, I.A. & Stephenson, M. (2007). Behaviour that challenges us: The Newcastle support model. Journal of dementia care, 15 (5), 19-22.

Dexter-Smith, Sarah. (2010). Integrating psychological formulation into older people's services - three years on (Part 1). *PSIGE Newsletter.* 112 (1), 8-15.

Environment

Environment

Prevent Disorientation

How well do you know your residents?

Each resident should have a baseline assessment of their mental and physical ability. Check the resident's life plan and update it as you find out more about them.

Find out what activities the resident enjoyed doing before they joined your home e.g:

- Where did they live before?
- Who are their friends and relatives?
- Did they have PETS they care about and miss?

How alert is your resident?

Are they better at some times during the day than others?

- The resident may be more alert and more responsive in the morning.
- It is natural to be more drowsy in the afternoon after lunch
- Residents may become more confused toward the evening- the 'sundown effect'

? **Observe the resident's body language- What does it tell you?** **?**

Signs of relaxation

- Sitting well back in the chair
- Relaxed head and shoulders
- Feet flat on the floor or legs stretched
- Loose limbs, head resting back
- Engaged in normal activities

Signs of distress

- Knees clenched together
- feet up on toes,
- Tense- tight shoulders,
- Holding their head in their hands
- Frowning or looking about anxiously
- Rocking, fidgeting or picking at clothing

YES

INVESTIGATE! Think about the environment, How is it affecting the resident?

- Is the noise from the TV or radio too much for them?
- Are other people being noisy?
- Is the lighting or bright sunlight shining directly onto their face
- Has there been a change in daily routines or activities?
- Is there a change in circumstances that has affected their usual freedom?
- Are there unfamiliar personnel around or workmen in the area?
- Have you checked the patient's pressure areas? (refer to pressure relief plan or policy)

What can YOU do to help the resident?

1) Reassurance – *Use good communication skills*

- Get down to the resident's height to reduce intimidation- do not tower over them
- Engage eye contact and smile, hold their hand, tell them your name
- Use their name and speak to them calmly but clearly
- Make sure you talk TO the resident and not AT the resident.
- Listen to what the resident is saying, how do they feel?

If you are struggling, get a person who has already bonded with them e.g. key worker, relative or friend

Unusual sensory experiences

Listen to your resident try to find out if they are experiencing something unpleasant

Hallucinations – Unusual sensory experiences are frequently found in delirium e.g. seeing things, hearing things or feeling things that aren't there e.g. spiders in the bed.

Delusions - False beliefs that persist despite contrary evidence e.g. The resident refuses to eat because they think the their food is poisoned, even though they can see everyone else eating.

Paranoia *(common in dementia)* -Unrealistic blaming beliefs. The resident cannot separate fact from fiction e.g. the resident has lost an item or money they hid under a pillow. They have forgotten they took it from under the pillow yesterday and hid it in the drawer. When it is found the staff are accused of moving it or replacing the item.

Reference:http:// www.bendigohealth.org.au / Regional-Dementia Management / Word documents/Strategies.doc 12/12/2006

Also Investigate other causes of Delirium P.In.C.H. M.E!

Maintain their abilities….
Some residents may have difficulty thinking and planning which affects their abilities to complete tasks and activities they enjoy.

To help people remain active the Pool Activity Level Instrument (Pool,1999) breaks day to day activities such as ashing or dressing into four main levels depending on the resident's cognitive abilites:

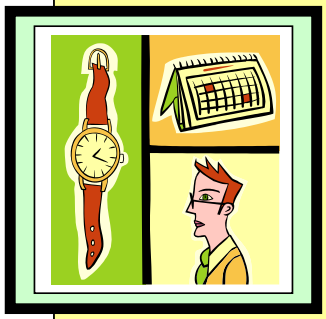
Planned activity- The resident works towards completing a task e.g dressing independently, but may need help with grooming their hair and doing their finishing touches. They may be able to work on craft projects like making a card or hat.

Exploratory activity- The resident gets dressed but things may be in the wrong place. Try breaking the task into small chunks for them and provide prompts- they may join in craft projects but need prompting and will enjoy the social time doing the task than the end product.

Sensory activity- The person may not have many thoughts about performing an activity at all and will need a lot of prompting.
They may be able to dress themselves if prompted at every step of the task but they may still enjoy very simple repetative acitivites like winding wool or colouring in.

Reflex activity- The resident is completely dependent and may not be aware of their surroundings- any movement they make may be a response to a stimulus.
Excessive stimuli can cause great distress e.g noise, bright light, sudden movement. Try focussing on single sensations- e.g stroking a hand, combing hair, imititating a gesture such as waving

For more information refer to *Jackie Pool, Bradford Dementia Group, (1999) The Pool Activity Level (PAL) Instrument: a practical resource fot carers of people with dementia, London: Jessica Kingsley Publishers.*



2) Reorientation – *more communication: who we are, where we are, what we are doing….*

If the resident uses glasses or a hearing aid, check that they are on, clean and working.

Take the person away from the noisy environment to a quieter room or their own room and point out their familiar things e.g.*"Look this is your room… and here's your photograph of…."*

Orientation with daily living activities –

Bring the resident back to the here and now. Encourage them to notice things around them that act as cues to tell the time of day such as meal times, bath time, tea times e.g:

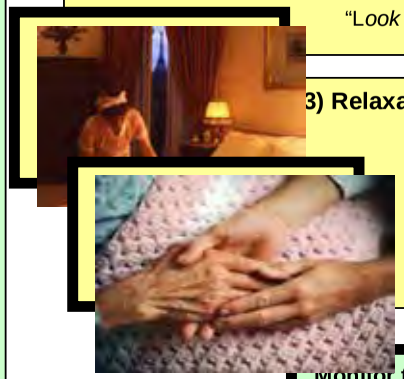
"*12 o'clock, it's dinner time… look the table is all set for lunch, are you feeling hungry?"*

Orientation with the time of year and the environment outside-

Help the resident to look at the clock & calendar, if they haven't these things ask a relative to bring them.

Help them to notice the time of day through the window and what is happening outside e.g.

"L*ook at the rain outside this afternoon, can you see the workmen? They're getting wet…"*



3) Relaxation – *communicate that YOU care:*

- Reduce unnecessary volume from the TV or turn on to something soothing like classical music
- Reduce very bright lighting, or shade the resident from strong sunlight
- Use a very calm and soothing tone of voice
- Wash their face and hands gently with warm water, use slow soothing strokes
- Tuck their knees in a small blanket to help them feel secure and cosy

Monitor the resident's confusion level,

- **Remember that delirium can *fluctuate*, changes occur *suddenly***
- **Keep a close eye on the resident, there is a greater risk of them falling.**
- **Make sure that all the resident's physical needs are being met**
- **Be on the alert for other causes of delirium**

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