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Consultation on Adults with Incapacity (Scotland) Act 2000 Proposals for Reform

The Royal College of Nursing (RCN) is the UK's largest professional association and union for nurses with more than 435,000 members, of which over 40,000 are in Scotland. Nurses and health care support workers make up the majority of those working in health and care services and their contribution is vital to the delivery of the Scottish Government's health and care policy objectives. RCN Scotland welcomes the opportunity to respond to the proposals for reform of the Adults With Incapacity (Scotland) Act 2000.

We are responding in the form of a letter as we have drawn out some cross-cutting issues that span across the consultation questions. Our main comments are below, followed by our response to specific sections of the consultation document that are of particular relevance to nursing.

Our main comments are:

- The legislation is complex and it is vital that the provisions within it are communicated to practitioners, as well as the general public, in a clear and succinct manner. We would expect to see the development of robust guidelines, to accompany the legislation, which support professionals to understand and utilise the reforms being proposed. We recommend that the guidance includes case studies, which illustrate potential scenarios.
- There must be investment in training and development for practitioners, including Registered Nurses and health care support workers, on the implications of the legislation and how they will carry out their roles. For Registered Nurses, this should involve planned and coordinated training and development, commencing at pre-registration education level. Further, the delivery of specific training for professionals undertaking capacity assessments should be reviewed to understand why current uptake and awareness is low amongst nursing.
- The human rights implications of depriving someone of their liberty are profound. Any legislative process must be robust, person-centred, based on human rights and have the appropriate safeguards in place.

- There must be appropriate capacity and resource to implement the proposals. The impact that the proposals will have on the workforce, for example the increased use of mental health tribunals, which are already under pressure, must be assessed to ensure that this is properly resourced, with people with the right skills and expertise.

Restrictions on a person's liberty (p.14)

The RCN broadly agrees with the definition of 'significant restrictions on liberty'. However, there needs to be more detail to reflect the range of environments people may be living in and all the potential barriers and restrictive practices that may impact them, for example the use of swipe fobs and the use of locked front doors in care homes. This would help provide clarity to professionals providing care.

The use of the term 'restraints' should be replaced by 'restrictive interventions' or 'restrictive practices'. These too should be clearly defined. Practical case studies to help disseminate and promote good practice would be helpful in this respect. These should cover a range of care settings and encompass issues such as alcohol and drug dependence, or eating disorders, for example. Where restrictive interventions are used, there must be documented evidence of a lack of capacity, that it is being conducted in the best interests of the individual, and that the least restrictive option is being used.

It is important to remember that not everyone on particular premises will be there involuntarily and/or lack capacity. Their rights too must also be taken into account.

Principles of the adults with incapacity legislation (p.16)

The RCN is broadly content with the proposed new principle of the AWI legislation, however we suggest wording of the principle could be refined to make it clearer. In addition, there must be clarity about whose responsibility is it to demonstrate that all practical help and support has been given, and how in practical terms they might demonstrate that this has been achieved.

Consideration to extending the range of professionals who can carry out capacity assessments for the purposes of guardianship orders (p.24)

We agree that the range of professionals who are able to carry out capacity assessments should be extended to include Registered Nurses, with appropriate training. Nurses are often those who know the patient best and who are best placed to act as an advocate and provide support. Legislation recently passed by the Northern Ireland Assembly has enabled Registered Nurses to carry out this role.

Capacity assessments must be conducted by appropriately trained, qualified, experienced and accountable practitioners. Key to this is planned and coordinated training and development, commencing at pre-registration education level, embracing not just capacity assessment but a range of associated issues concerning adults with incapacity such as best interests and restrictions on a person's liberty.

At present, section 47 of the Act ('Authority of persons responsible for medical treatment') allows Registered Nurses to 'do what is reasonable in the circumstances…to safeguard or promote the physical or mental health of the adult'. However, talking to our members, it has become clear that there is a low awareness of this provision and a low uptake of nurses undergoing training and carrying out assessments. It would be worth investigating why this is the case, as this may have

implications for these current proposals. We understand that there is currently only one training course available, at Edinburgh Napier University. If this proposal is to go ahead, there needs to be consideration to how appropriate training will be delivered to professionals, including Registered Nurses.

In addition, if Registered Nurses are to carry out this role, it must be done in a way that avoids making further demands upon the nursing workload through excessive paperwork and bureaucracy. If this changes the roles and responsibilities of a Registered Nurse, then their job description may need to go through the re-evaluation process. It must also be responsive to immediate patient or client need, particularly in respect of emergency care settings, for example.

Graded guardianship (p.25)

Our members raised a number of issues concerning the proposals for graded guardianship that should be considered:

- While members acknowledge that the proposals have the potential to speed up the process for applying for guardianships, there is a reduced level of scrutiny. For example, for Grade 1 guardianships, how do you know that someone has made the application appropriately in the given timeframe? Some members raised that there might be the potential for misuse and for financial mismanagement. For any proposals, there need to be appropriate safeguards and accountability in place.
- the complexities of delivering it in practice, especially in care homes where there might be a high number of residents who would be on graded guardianships, and ensuring that staff fully understand the process and implications
- the potential conflict of interest if a care home manager is also able to manage a resident's funds to the extent outlined in the proposals
- in some circumstances, for example an older person with dementia in a care home, the proposed five year time limit for a grade 2 application, may mean that there is a need to undergo the process repeatedly. However, members acknowledge that there is a wide range of circumstances that the proposals will have to apply to and shorter time limits will be more appropriate for some people

Short term placement (p.61)

We agree that there is a need for a short term placement order within the legislation to allow someone to be moved quickly for their own safety, where they lack the capacity to consent to such a move. There are advantages in not having to refer the order to a Sheriff or tribunal, in terms of ensuring the process is swifter, meaning that individuals are less likely to remain in a setting inappropriate to their needs. We would welcome clarification on how the wishes of carers and families would be included.

Advance directives (p.63)

We support that there should be clarity in the legislation for advance directives, setting out a person's wishes about future healthcare in the event that they become incapable to take decisions about treatment. However, there are a number of issues that need to be considered and addressed:

- Who issues the advance directive, and therefore who is accountable?
- Where does the advance directive 'sit' and how will it be accessible to all practitioners, including in Out Of Hours?

- How do the proposals sit alongside existing Anticipatory Care Plans and Do Not Attempt Cardiopulmonary Resuscitation decisions?
- What does a practitioner have to do to demonstrate that they have tried to follow the advance directive?
- What guidance will be given to practitioners to support them in using Advance Directives and in the circumstances where they need to make a decision that means they do not follow the Advance Directive?
- Where does the practitioner stand if they decide to not follow the Advance Directive, for example because it is not clinically appropriate to do so?

Authorisation for medical treatment (p.65)

The proposals outlined in the consultation document around introducing a legislative process to prevent a patient leaving hospital, while they are undergoing treatment or assessment relating to their physical health, are complex. There are potentially huge implications and possible unintended consequences for patients, professionals and families/carers, which need to be fully thought through. The legislation needs to be very clear how you assess someone's capacity in these circumstances and any process needs to have appropriate safeguards in place.

We feel that the following issues need further consideration before the RCN can decide whether or not it supports this proposal:

- What is meant by "medical treatment" and in what circumstances will this be authorised? For example, will it only be authorised to prevent harm to a patient/keep them safe? Decisions will need to be in the best interests of that patient and be based on their individual clinical needs
- How will the adult with incapacity be "supported to participate in the decision" and how will their wishes be reflected?
- There needs to be further detail about how families/carers/guardian are involved in the decision process and what happens when there is disagreement between them and the practitioner. The consultation document refers to the Mental Welfare Commission providing a "Nominated Practitioner" to provide a further (2nd) opinion. However it does not detail what happens if there is further disagreement between the two practitioners and the family/carers, or if the two practitioners disagree.
- There needs to be more detail about the appeals process and who makes the final decision
- What is the legal framework around discharging the decision made? This is especially important as the staff who may be preventing someone from leaving hospital may not be the person who originally authorised the decision
- How will practitioners be supported to understand the measures and feel confident in taking action to prevent an adult patient from leaving hospital? Guidance and training for practitioners will be vital to support implementation if this proposal goes ahead. This is especially important because the practitioner who makes the decision that someone should remain in hospital and the staff member who may have to prevent a person leaving
- How will the "end date" be set to remove the authority for imposing restrictions?
- The consultation document briefly mentions the need for a "mechanism to provide for discharge with the aim of reducing the risk of an adult being kept in hospital". This is crucial because we know of the high proportion of people whose discharge from hospital is not reported within the main discharge figures (Code 9) are adults with incapacity and that they are awaiting a place in suitable

accommodation. There needs to be more detail over what this mechanism would be to make sure people do not remain in hospital for long periods of time unnecessarily. Discharge from hospital, when safe and where appropriate accommodation arrangements are available in the community, should be a priority and legal process should not delay or prevent the delivery of good practice and person centred care.

For further information or to discuss any of the points raised please contact Helen Malo or Lisa Mackenzie, Policy Officers (job share) on sharedpolicy@rcn.org.uk.

Yours sincerely,

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