Using the Mental Capacity Act

Policy

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1.0 FLOW DIAGRAM – CAPACITY ASSESSMENT FLOWCHART

A decision needs to be made

Are there any factors that create doubt about the patient’s capacity to make the decision? (Section 8)

Yes

Consider the Statutory Principles (Section 6)

Is there still doubt about the patient’s capacity to make the decision?

Yes

Patient makes the decision

No

Am I the right person to assess capacity? (Section 9)

Yes

Refer the assessment to the right person (Section 9)

No

Is a comprehensive assessment of capacity required? (Section 10)

Yes

RiO Users: Assess and document capacity using the RiO Consent and Capacity form

Non-RiO Users: Assess and document capacity using the Mental Capacity and Best Interests Assessment Form, or Mental Capacity and Best Interests Assessment Form – Age 16-17. (Available on the Trust Mental Capacity Act Intranet page)

Assess capacity using the Two-Stage Capacity Test (Section 11) and document simply in appropriate professional documentation (Section 10)

No

Does the patient have the capacity to make the decision?

Yes

Patient makes the decision

No

Is there a valid and applicable Advance Decision? (Section 19)

Yes

The Advance Decision is used

No

Is there a valid Power of Attorney (section 18) or a Court of Protection Deputy? (Section 21)

Yes

Does the Power of Attorney’s / Deputy’s responsibilities cover the decision to be made?

Yes

Power of Attorney / Deputy makes the decision

No

Complete a Best Interest Assessment (Best Interests Flowchart)
BEST INTERESTS FLOWCHART

A Best Interest assessment is required (see Capacity Flowchart)

Is there a chance that the patient will regain the capacity to make this decision?

- Yes
  - Can the decision wait until capacity is regained?
    - Yes
      - Postpone the decision
    - No
      - Is a comprehensively documented assessment of best interests required? (Section 12)
        - Yes
          - Assess best interests using the Best Interests Checklist (Appendix B) and document in the appropriate professional record (Section 12)
        - No
          - Does the patient have someone to support or represent them?
            - Yes
              - Is the decision about serious medical treatment, a move to a care home or between care homes, or have they been in hospital for 28 days? (Section 23)
                - Yes
                  - You must refer to an IMCA to support and represent the patient (Section 23)
                - No
                  - Is the decision related to a care review or adult protection case?
                    - Yes
                      - You may refer to an IMCA to support and represent the patient (Section 23)
                    - No
                      - Complete the best interest assessment
            - No
              - Make the decision using the result of the best interest assessment

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2.0 INTRODUCTION

2.1 “The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves” Department of Constitutional Affairs (2007).

2.2 “Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks capacity to make a particular decision for themselves at the time the decision needs to be made” Department for Constitutional Affairs (2007).

2.3 The same rules apply whether the decisions are life-changing or everyday matters” Department of Constitutional Affairs (2007).

2.4 The Mental Capacity Act 2005 Code of Practice (2007) supports the Mental Capacity Act (2005) “The Code has statutory force, which means that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves” Department of Constitutional Affairs (2007).

3.0 DEFINITIONS

3.1 **Advance Decision:** This refers to a decision to refuse specific treatment in advance that is made by someone with capacity. This decision will then apply when the person lacks capacity (if it is applicable and valid). If an advance decision is found to be applicable and valid it will have statutory force under the Mental Capacity Act. See section 19.

3.2 **Best Interests:** Any decision made for a person who lacks capacity must be in their best interests. When we talk about best interests this always means best interests within the context of the Act’s best interest checklist. See section 12.

3.3 **Capacity:** “The ability to make a decision about a particular matter at the time the decision needs to be made” Mental Capacity Act Code of Practice (2007). See section 7.

3.4 **Court of Protection:** This is a specialist court that deals with legal decisions related to the Mental Capacity Act. See section 21.

3.5 **Decision-maker:** Is the person making a decision on behalf of someone lacking capacity and is required to assess the individual’s best interests in forming this decision. See section 12.

3.6 **Deprivation of Liberty:** This is a restriction of an individual’s rights as outlined in Article 5: Right to Liberty and Security of the Human Rights Act 1998. For a deprivation of liberty to be lawful, it must satisfy the legislation that applies to the particular deprivation of liberty that is required. For some patients in hospital or care homes this will be covered by the Deprivation of Liberty Safeguards. See section 16.
3.7 **Deputy:** A person appointed by the Court of Protection with ongoing legal authority to make decisions outlined by the court, on behalf of a person who lacks capacity to make particular decisions for themselves. See section 21.

3.8 **Enduring Power of Attorney (EPA):** Is a power of attorney appointed to deal with property and financial issues. Existing EPA’s will remain valid, but the new Lasting Power of Attorney will be used for any new powers of attorney. See section 18.

3.9 **Independent Mental Capacity Advocate (IMCA):** An IMCA is someone who supports and represents someone who lacks capacity, where there is no one else to support them for particular categories of decision making. See section 23.

3.10 **Lasting Power of Attorney (LPA):** Is an attorney appointed under the Mental Capacity Act, with authority to make decisions in relation to property and financial affairs and / or personal welfare (including healthcare). See section 18.

3.11 **Office of the Public Guardian (OPG):** Will supervise deputies and keep a register of deputies, Lasting Powers of Attorneys and Enduring Powers of Attorneys. They will check on attorneys and investigate complaints made about deputies or attorneys. They can also make a check of their register to see if an LPA is in place. See section 22.

3.12 **Patient:** Within the policy, the term patient has been adopted as the most commonly used descriptor of a person using our services. This will also apply to people described as service users and for people who may be referred to differently within specific services.

3.13 **Restraint:** To “use force, or threaten to use force, to make someone do something that they are resisting or restrict a person’s freedom of movement, whether they are resisting or not” Mental Capacity Act 2005 code of practice (2007). See section 15.

3.14 **Additional definitions:** Can be obtained from the Mental Capacity Act 2005 code of practice (2007).

4.0 **ROLES and RESPONSIBILITIES**

4.1 **Chief Executive:** On behalf of the Trust Board has ultimate responsibility for all aspects of the application of the Mental Capacity Act within the Trust.

4.2 **Executive Lead for Safeguarding Adults (Director of Patient Care):** Is responsible for ensuring that a clear strategy for the application of the Mental Capacity Act is in place, and to make sure that this conforms to the Act.

4.3 **Safeguarding Committee:** Is responsible for the approval of the policy and for overseeing policy monitoring and review.

4.4 **Mental Capacity Act, Deprivation of Liberty Safeguards and Consent Lead:**

- To provide professional leadership, support, advice and challenge to both internal colleagues and external providers
- Is responsible for identifying and implementing changes to the policy following changes in legislation and case law
- To raise awareness of the policy and its contents
• To identify the training requirements of staff and to provide appropriate training opportunities
• To monitor the effectiveness of the policy through a programme of audit and through monitoring training compliance.

4.5 All staff involved in the care of patients with impaired capacity:
• Have a legal duty to “have regard to” the Mental Capacity Act code of practice. This means that decisions that are made in regard to capacity must follow the code of practice. If staff act outside of the code they will be expected to give good reasons why they have departed from it
• To document assessments of Mental Capacity and Best Interests in line with the policy requirements
• To participate in any role specific training provided and to apply the knowledge gained to their clinical practice
• To request advice for complex Mental Capacity Act situations from the Mental Capacity Act, Deprivation of Liberty Safeguards and Consent Lead.

5.0 CONSENT

5.1 When making decisions about care or treatment with patients, the Mental Capacity Act will only apply if there are concerns about the patient’s ability to consent to or decline the proposed care and treatment.

5.2 Consent is the voluntary and continuing permission of the person to receive particular treatment or care and support, based on an adequate knowledge of the purpose, nature, likely effects and risks including the likelihood of success any alternatives to it and what will happen if the treatment does not go ahead.

5.3 Permission given under any unfair or undue pressure is not consent.

5.4 By definition, a person who lacks capacity to consent cannot consent to treatment or care and support, even if they co-operate with the treatment or actively seek it.

6.0 STATUTORY PRINCIPLES

6.1 The Act sets out five statutory principles. These principles are the values that underpin the Act. Staff must consider these principles whenever they are using the Mental Capacity Act.

6.2 Principle 1: A person must be assumed to have capacity unless it is established that they lack capacity.
• An assumption of capacity remains until an assessment of capacity has been completed in line with the two-stage capacity assessment and this assessment shows that the patient lacks capacity
• This assumption of capacity is not a valid reason not to assess capacity when there are clear reasons to feel that a capacity assessment is required (see section 8).

6.3 Principle 2: A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
See Appendix A for ways in which we might support patients in making their own decisions.

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

- Although an unwise decision cannot be used as evidence of a lack of capacity, it may under some circumstances, represent a reason to undertake an assessment of capacity.

6.5 **Principle 4:** An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

- Decisions made with people who lack capacity must be made in their best interests as defined by the best interest checklist.

6.6 **Principle 5:** Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

- When considering best interests we need to consider the least restrictive option that would still be effective
- The least restrictive option will be the option that fits most closely with the wishes of the patient.

7.0 **WHAT IS MENTAL CAPACITY?**

7.1 The Mental Capacity Act code of practice describes mental capacity as:

- The ability to make a decision.

- This includes the ability to make a decision that effects daily life – such as when to get up, what to wear or whether to go to the doctor when feeling ill – as well as more serious or significant decisions.
- It also refers to a person’s ability to make a decision that may have legal consequences – for them or others. Examples include agreeing to have medical treatment, buying goods or making a will.

8.0 **WHEN SHOULD YOU ASSESS CAPACITY?**

8.1 An assessment of capacity is undertaken when a specific decision needs to be taken, when there is doubt about a person’s capacity to make the decision. This doubt may be triggered by:

- The person’s behaviour or circumstances cause doubt as to whether they have the capacity to make the decision
- Somebody else says they are concerned about the person’s capacity
- The person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works and it has already been shown they lack capacity to make other decisions in their life.
If there is no reason to question a patient’s ability to consent to or decline a specific treatment, they should be assumed to have capacity for the decision in question and their consent or refusal should be accepted. See section 5.

9.0 WHO SHOULD ASSESS CAPACITY?

9.1 The person who assesses an individual’s capacity to make a decision will usually be the primary person who will be acting upon the result of the decision.

This means that many people may need to assess capacity. For example:

- Capacity to agree to have a bath – the assessment of capacity needs to be undertaken by the person who will be helping with the bath (e.g. Health Care Assistant)
- Capacity to agree to have a dressing changed – the assessment of capacity needs to be undertaken by the person who will change the dressing (e.g. Registered Nurse)
- Capacity to agree to participate in rehabilitation – the assessment of capacity needs to be made by the person who will assist with rehabilitation (e.g. Physiotherapist / Occupational therapist)
- Capacity to agree to have a medical treatment – the assessment of capacity needs to be made by the person who is going to give the medical treatment, or the person who has decided that the treatment is required (e.g. the Doctor)
- Capacity to decide that family members/carers are not to be given any information about the patients care or treatment – the assessment of capacity needs to be undertaken by the person who would be sharing the information
- Capacity to decide to undertake actions that would put the patient at risk of harm – the assessment needs to be undertaken by the person who would act to prevent these actions
- Capacity to decide about care or treatment in the patient’s own home – the assessment of capacity needs to be undertaken by the person who will provide the care or treatment
- Capacity to agree to move into a Nursing Home – the assessment of capacity needs to be undertaken by the person arranging / funding the transfer (e.g. Social Worker). For decisions about discharge it is normally appropriate to work together to consider capacity
- Capacity to agree to a legal transaction – the assessment needs to be undertaken by the person who will do the legal transaction (e.g. Solicitor)
- People responsible for assessing capacity can get support from other people.

9.2 Advice / support in undertaking the assessment may be available from, for example:

- A Doctor
- A Psychiatrist
- A Psychologist
- A Speech and Language Therapist or other therapist
- A Social Worker
- The Mental Capacity Act, Deprivation of Liberty Safeguards and Consent Lead.

9.3 For some complex decisions, there may be a number of members of a multi-disciplinary team who will act on the result of the decision, in which case different members of the multi-

disciplinary team may be involved in the process. Even in these cases, there is usually a key individual who retains overall responsibility for the completion of an appropriate assessment of capacity.

9.4 It is not appropriate for the person responsible for the assessment of capacity to delegate this responsibility to the person who is providing support.

9.5 The final decision about a person’s capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity and not by a professional who is there to advise or support.

10.0 ASSESSMENT OF CAPACITY

10.1 An assessment of an individual’s capacity should never be based on:

- Their age
- Their appearance
- Assumptions about their condition
- Any aspect of their behaviour.

10.2 An assessment of capacity should be about a specific decision at the point when that decision needs to be made.

10.3 The standard of proof required to claim that somebody doesn’t have capacity is a “reasonable belief”. This means being able to show, on the balance of probabilities, that it is more likely than not that the person lacks capacity to make the particular decision at the point when the decision is required. This reasonable belief should be supported by objective reasons for believing that the person lacked capacity (what was the information from your assessment that gave you your reasonable belief that capacity was lacking).

10.4 An assessment of capacity does not always need to follow a process with formal documentation. However, if somebody challenges an assessment of capacity the person who undertook the assessment must be able to describe the steps they have taken.

10.5 Assessments of capacity should be recorded in a proportionate way. For decisions that could have a significant impact on the person, this should be documented comprehensively.

- RiO Users: Assess and document capacity using the RiO Consent and Capacity form
- Non-RiO Users: Assess and document capacity using the Mental Capacity and Best Interests Assessment Form, or Mental Capacity and Best Interests Assessment Form – Age 16-17. (Available on the Trust Mental Capacity Act Intranet page).

A documentation guide for RiO and Non-RiO users is available on the Trust Mental Capacity Act Intranet page.

Significant Decisions that should be documented comprehensively, include:

10.6

- Admission for care and treatment as an inpatient
- Decisions about invasive procedures (e.g. surgery, endoscopy)(This would need documenting on Consent Form 4, but additional details may need to be documented separately)
- Decisions about care or treatment that the patient may be objecting to or resisting
- Decisions about care or treatment that are expected to cause the patient distress (either significant, repetitive or more than transitory)
• Decisions about care or treatment when there are disagreements over either capacity or best interests
• Discharge decisions involving discharge to a new residence (the Social Worker may be responsible for this assessment)
• Discharge decisions where the circumstances around the discharge include risks of harm (the Social Worker may be responsible for this assessment).

10.7 For decisions about engaging with a service provided by the Trust (e.g. admission to hospital), a patient must either be able to consent / decline, or if their capacity to make this decision is in doubt, there should be an assessment of capacity.

10.8 Some staff working outside of the acute hospital in areas where RiO is not used, may have service specific documentation processes in place (e.g. sexual health, dental and Minor Injury Units). These processes must still meet the documentation requirements of the Mental Capacity Act.

10.9 For decisions that are not expected to have a significant impact on the person, it is more appropriate to document these decisions in the patient’s clinical record.

Decisions that will not normally require to be comprehensively documented, include:
• Outpatient attendance (unless one of the conditions in section 10.6 is met)
• Ongoing episodes of care or treatment as an outpatient or in the patients home (unless one of the conditions in section 10.6 is met)
• Provision of basic care (unless one of the conditions in section 10.6 is met)
• Provision of therapy (unless one of the conditions in section 10.6 is met)
• Provision of simple treatment (unless one of the conditions in section 10.6 is met)
• A consultation (unless one of the conditions in section 10.6 is met)
• Clinical examination (unless one of the conditions in section 10.6 is met)
• Clinical tests (unless one of the conditions in section 10.6 is met)
• Simple discharges (unless one of the conditions in section 10.6 is met)

10.10 If a comprehensively documented assessment of capacity is not required, then:
• The assessment must still use the two-stage assessment process, but a briefer process will be appropriate
• The assessment must be documented in the appropriate professional documentation (e.g. the running record)
• The person who has made the decision about capacity must be able to explain their decision about capacity and best interests if requested to do so
• For all episodes of care and treatment, documentation needs to be clear whether care or treatment was delivered with consent, whether it was not delivered due to a valid refusal, or if the care or treatment was delivered in a patient’s best interests.

10.11 All assessments of capacity should be conducted in a proportionate way, based on the significance of the decision to be made. This will mean that capacity assessments about simple decisions will require a less comprehensive approach when compared to decisions associated with a significant impact upon the person.

10.12 The person assessing capacity should inform the patient (using appropriate language or information in an accessible format):
• That their capacity to make a particular decision is being assessed
• Why their capacity is being assessed
• The outcome of the assessment
• What they can do if they are unhappy with the outcome

10.13 If a patient refuses to engage with in some aspects or all aspects of a capacity assessment, the assessor should try to establish the reasons for this and identify what can be done to help them participate fully. This may involve consulting with other involved in their care and support, reviewing records or giving the person a choice about who else can be involved.

Staff should be aware that patients could be distressed by having their capacity questioned, particularly if they strongly disagree that there is a reason to doubt their capacity. Staff should take all reasonable steps to minimise distress and encourage participation.

10.14 Staff should be careful of documenting that capacity was absent due to a lack of insight into their condition. Capacity and insight are two distinct concepts. If a member of staff believes a person’s insight/lack of insight is relevant to their assessment of the person’s capacity, they must clearly record what they mean by insight/lack of insight in this context and how they believe it affects/does not affect the person’s capacity.

11.0 TWO-STAGE CAPACITY TEST

11.1 A test of capacity must use the two-stage test; a comprehensively documented test must be undertaken in the circumstances indicated in section 10.

11.2 Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?

This requires proof that the person has an impairment of the mind or brain, or some sort of disturbance that affects the way their mind or brain works

This could include:

• Conditions associated with some forms of mental illness
• Dementia
• Significant learning disabilities
• The long term effects of brain damage
• Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
• Delirium
• Concussion following head injury
• The symptoms of alcohol or drug use

If a person does not have an impairment or disturbance of the mind or brain, they will not lack capacity under the Act

11.3 Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make a decision when they need to. Before an assessment of capacity takes place people must be given all practicable and appropriate support to help them make the decision for themselves. Stage 2 can only apply if all practicable and appropriate support to help the person make the decision has failed.
11.4 A person will be considered to lack capacity if an assessment shows that they cannot process the information about the decision that is presented to them. This is called the functional test and assesses the patient’s ability to:

- **Understand** information about the decision to be made (the Act calls this “Relevant Information”)
- **Retain** that information in their mind
- **Use or weigh** that information as part of the decision-making process
- **Communicate** their decision (by talking, using sign language or any other means).

11.5 The relevant information that needs to be shared with the patient may include the nature of the decision, why the decision is needed and the likely effects of deciding one way or another, or making no decision at all. This would include any risks and benefits associated with the decision and information about any options that the patient needs to consider.

11.6 When we have assessed a patient as lacking capacity, we need to consider why the person was unable to make this decision. If this was due to the condition identified in stage 1 of the assessment then this will fall within the decision-making of the Mental Capacity Act. If however this lack of ability is due to coercion, threats or undue pressure, this will not fall under the Mental Capacity Act and may need to be referred to the Court via the Trust solicitors. Staff may also need to refer these cases to the Safeguarding Team.

11.7 The NICE guideline: Decision-making and mental capacity says we should also consider collecting extra information to support our assessment of capacity. This information can support assessments of capacity, but should not be used instead of an appropriate two-stage assessment. This could include:

- Discussing with people who know the patient well (family, friends)
- The views of specialist staff or advocates
- Cognitive screening information
- The persons decision making history (the extent they felt involved and listened to, the outcomes of previous assessment and decisions reached)
- Real life observations of the persons functioning and decision-making ability. This can be particularly useful when there is executive dysfunction. Executive dysfunction involves a range of difficulties in everyday planning and decision-making, which can sometimes be hard to detect using standard clinical tests and assessments.

12.0 **BEST INTERESTS**

12.1 Principle 4 of the Mental Capacity Act requires us to act in a patient’s best interests when an assessment demonstrates a lack of capacity.

12.2 Exceptions to best interests can include:

- A valid advance decision is in place refusing the proposed treatment
- In specific circumstances, the involvement of a person who lacks capacity in research.

12.3 Best interest assessments are carried out by the “Decision Maker”; this is largely the same person who is responsible for the assessment of capacity. Exceptions could include:
• If a Lasting Power of Attorney, Enduring Power of Attorney or Court appointed
  Deputy exist, then they are the decision maker within the scope of their different
  levels of authority
• Joint decisions on best interests can be made by a team of healthcare staff or social
  care staff, which can then be implemented by different members of the group.

12.4 Factors that must be considered when assessing best interests are set out in the best
  interest checklist. See appendix B.

12.5 Assessments of best interests should be recorded in a proportionate way. For decisions that
  could have a significant impact on the person, this should be documented comprehensively.
  
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    Interests Assessment Form, or Mental Capacity and Best Interests Assessment Form –

  A documentation guide for RiO and Non-RiO users is available on the Trust Mental
  Capacity Act Intranet page.

12.6 It is important to remember that best interests go beyond the person’s medical interests.

12.7 In the event that there is nobody close to the patient to support them in working out the best
  interests, an Independent Mental Capacity Advocate may need to be involved. Please refer
  to section 23.

12.8 Patients should be asked if there is anyone that they would like to support them through the
  decision-making process. If they can’t identify anyone to support them and an Independent
  Mental Capacity Advocate is not required, they should be advised that they may be able to
  gain support in the decision-making process from a general advocate.

  During the decision-making process, it is important to ensure that the patient is given time
  during decision-making to communicate their needs and that they feel listened to. This may
  involve meeting with the patient on more than one occasion.

12.9 Once the best interest decision is made, the decision-maker should consider when this
  decision should be reviewed. This could be through identifying a specific date for review, or
  circumstances that could lead to a review being required. The review should consider if the
  initial best interests decision remained in the patient’s best interests.

12.10 The decision-maker should also consider identifying timeframes for actions required as part
  of the best interest decision.

13.0 DECISIONS IN AN EMERGENCY / URGENT SITUATION

13.1 In all normal circumstances, assessments of capacity and best interests must be completed
  in a way that is proportionate to the magnitude and significance of the decision. However, in
  emergencies where decision-making is urgent a more limited assessment process may be
  appropriate.

13.2 If an urgent decision were needed, where a delay in decision-making could lead to harm to
  the patient, it would be appropriate to complete an assessment process that is as
  comprehensive as the emergency time frame allows. In some circumstances, it may not be
possible to undertake a comprehensive consultation as part of an urgent best interest’s decision.

14.0 LEGAL PROTECTION

14.1 The Act provides protection for actions carried out in connection with care or treatment of a person who lacks capacity. To get protection the actions need to be carried out in the person’s best interests and following the statutory principles.

Actions that might be covered include:

14.2 Personal Care –
- Helping with washing, dressing or personal hygiene
- Helping with eating and drinking
- Helping with communication
- Helping with mobility
- Helping someone take part in education, social or leisure activities
- Going into a person’s home to drop off shopping or to see if they are alright
- Doing the shopping or buying necessary goods with the person’s money
- Arranging household services (for example, arranging repairs or maintenance for gas and electrical supplies)
- Providing services that help around the home (such as homecare or meals on wheels)
- Undertaking actions related to community care services (for example day care, residential accommodation or nursing care)
- Helping someone to move home (including moving property and clearing the former home).

14.3 Healthcare and Treatment –
- Carrying out diagnostic examinations and tests (to identify an illness, condition or other problem)
- Providing professional medical, dental and similar treatment
- Giving medication
- Taking someone to hospital for assessment and treatment
- Providing nursing care (whether in hospital or in the community)
- Carrying out any other necessary medical procedures (for example, taking a blood sample) or therapies (for example, physiotherapy or chiropody)
- Providing care in an emergency.

15.0 RESTRANIMENT UNDER THE MENTAL CAPACITY ACT

15.1 The Act states that someone is using restraint if they:
- Use force – or threaten to use force – to make someone do something that they are restricting
- Restrict a person’s freedom of movement, whether they are resisting or not.

15.2 Any restraint of a person who lacks capacity will not get protection under the Act unless the following conditions are met:
The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity
The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

15.3 A person who lacks capacity who has challenging behaviour, or is in the acute stages of illness causing them to act in a way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

15.4 The common law does not allow for an action that would deprive someone of their liberty (see section 16).

16.0 DEPRIVATION OF LIBERTY SAFEGUARDS

16.1 The Deprivation of Liberty Safeguards were introduced to prevent breaches in peoples Human Rights. This is specifically around their rights to liberty and security under Article 5 of the Human Rights Act 1998.

16.2 The Supreme Court has provided us with an acid test to use when considering if someone’s care and treatment amounts to a Deprivation of Liberty. Is the person under complete supervision and control in respect of their care and movement and not free to leave?

The Deprivation of Liberty Safeguards became law in April 2009. Further guidance is available from the Trusts Deprivation of Liberty Safeguards Policy.

17.0 ADVANCE CARE PLANNING

17.1 The NICE Guideline: Decision-making and Mental Capacity (2018), says that support with advance care planning should be offered to everyone who is at risk of losing capacity, as well as those with fluctuating capacity. This could be through:

- Appointing a Lasting Power of Attorney (see section 18)
- An advance decision to refuse treatment (see section 19)
- An advance statement (see section 20)
- Joint crisis planning – this is planning that is undertaken with a patient. It seeks to get agreement between the person and their mental health team about what to do if they become unwell in the future.

17.2 When approaching discussions about advance care planning staff should:

- Be prepared to postpone discussions until a later date, if the person wishes
- Recognise that people have different needs for knowledge, autonomy and control
- Talk about the purpose, advantages and challenges of this type of planning.

If the person has agreed for carers, family or advocates to be involved in discussions about advance care planning, staff should take reasonable steps to include them.

17.3 Staff should help everyone to take part in advance care planning and co-produce their advance care plan if they choose to have one (including people with fluctuating or progressive conditions) They should:

- Work with the person to identify any barriers to their involvement, and investigate how to overcome these
17.5 Staff should ensure that all notes taken are agreed with the person at the time and agreement should be sought from the person to share the information with others as appropriate (including external services who may be involved in the delivery of the plan).

17.6 Advance care plans should be reviewed with the patient whilst they have capacity and amend if necessary if the person wishes.

18.0 POWERS OF ATTORNEY (LASTING AND ENDURING)

18.1 A power of attorney is a legal document that allows the attorney to make decisions that are as valid for the donor (person who gives the authority) as if they had made the decision themselves. This authority is dependent on the conditions of the power of attorney.

18.2 There are two categories of decision that may be authorised with a Lasting Power of Attorney:

- Property and affairs (including financial matters)
- Personal welfare (including Healthcare and consent to medical treatment).

18.3 An Enduring Power of Attorney was the type of power of attorney that was available prior to the Mental Capacity Act. Although no more of these will be issued, the ones already in existence will remain valid. The primary difference between a Lasting Power of Attorney and an Enduring Power of Attorney is that Enduring Powers of Attorneys can only be for property and affairs (including financial matters).

18.4 The holder of a Personal Welfare Power of Attorney may make decisions, which might include:

- Where the patient should live and who they should live with
- The patient’s day-to-day care, including diet and dress
- Who the patient may have contact with
- Consenting to or refusing medical examination and treatment on the patient’s behalf
- Arrangements needed for the patient to be given medical, dental or optical treatment
- Assessments for and provision of community care services
- Whether the patient should take part in social activities, leisure activities, education or training
- The patient’s personal correspondence and papers
- Rights of access to personal information about the patient
- Complaints about the patient’s care or treatment.

18.5 Attorneys do not have the right to consent to or refuse treatment in situations where:

- The patient has the capacity to make the particular healthcare decision
- The patient has made an advance decision to refuse the proposed treatment
- A decision relating to life-sustaining treatment, unless the Lasting Power of Attorney expressly authorises this
- The patient is detained under the Mental Health Act

18.6 Before accepting that an Attorney has the power to make decisions on behalf of the patient staff MUST:
- Verify that the person does lack capacity
- Ask to see the written document giving Power of Attorney
- Check that the public guardian has stamped the Power of Attorney document
- Check to see if the patient has appointed more than one attorney, and see if they must act jointly or if they can act independently
- Check to see if there are any restrictions or conditions placed on what decisions the Attorney has the authority to make a decision on
- Check to see if the authority includes decisions on life-saving treatment

18.7 Property and affairs attorneys, if the patient has not restricted their decisions, they can make decisions that may include:
- Buying or selling property
- Opening, closing or operating any bank, building society or other account
- Giving access to the patient’s financial information
- Claiming, receiving and using (on the patient’s behalf) all benefits, pensions, allowances and rebates (unless the Department of Work and Pensions has already appointed someone and everyone is happy for this to continue)
- Receiving any income, inheritance or other entitlement on behalf of the patient
- Dealing with the patient’s tax affairs
- Paying the patient’s mortgage, rent and household expenses
- Insuring, maintaining and repairing the patient’s property
- Investing the patient’s savings
- Making limited gifts on the patient’s behalf
- Paying for private medical care and residential care or nursing home fees
- Applying for any entitlement to funding for NHS care, social care or adaptations
- Using the patient’s money to buy a vehicle or any equipment or other help they need
- Repaying interest and capital on any loan taken out by the patient.

18.8 If an attorney appears to be making decisions that are not in the patient’s best interests, it may be appropriate to refer the situation to the Office of the Public Guardian. In cases with such concern please refer to the Trust safeguarding service as per Trust Safeguarding Adults Policy and process and also seek advice from the Trust MCA, DoLS and Consent lead via SPOC tel: 0300 3230035 email: mcadolsandconsent@sompar.nhs.uk

19.0 ADVANCE DECISIONS

19.1 An advance decision enables someone aged 18 and over, while still capable, to refuse medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.
19.2 An advance decision can only decline treatment, it cannot insist upon treatment (see Advance Statement – Section 20).

19.3 An advance decision cannot decline basic care (such as being offered oral nutrition and fluids, warmth, shelter or action to keep the person clean and free from distress).

19.4 An advance decision must be valid and applicable to the current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity. Healthcare staff must follow advance decisions that are found to be valid and applicable.

19.5 Healthcare professional will be protected from liability if they:
   - Stop or withhold treatment because they reasonably believe that an advance decision exists, and that it is valid and applicable
   - Treat a person because, having taken all practicable and appropriate steps to find out if the person had made an advance decision to refuse treatment, they do not know or are not satisfied that a valid and applicable advance decision exists.

19.6 People can only make an advance decision under the Act if they are 18 years or over and have the capacity to make the decision. They must say what treatment they want to refuse, and they can cancel their decision – or part of it – at any time, whilst they have the Mental Capacity to do so.

19.7 If the advance decision refuses life-sustaining treatment, it must:
   - Be in writing (it can be written by someone else or recorded in healthcare notes)
   - Be signed and witnessed
   - State clearly that the decision applies even if life is at risk.

19.8 To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:
   - Has done anything that clearly goes against their advance decision
   - Has subsequently conferred the power to make the decision on to an attorney
   - Would have changed their decision if they had known more about the current circumstances.

19.9 If it is determined that an advance decision is not binding, as it is assessed as being either invalid or inapplicable, it may still be possible to consider this as an expression of the person's wishes and therefore weighed as part of a best interest decision.

19.10 Some healthcare professionals may disagree in principle with patient’s decisions to refuse life-sustaining treatment. They do not have to act against their beliefs. However, they must not simply abandon patients or act in a way that affects their care. In these circumstances, it may be necessary to transfer care to another professional.

19.11 Advance decisions to refuse treatment for mental disorder may not apply if the person who made the advance decision is, or is liable to be, detained under the Mental Health Act. Further advice and guidance can be provided by the Trust MCA, DoLS and Consent Lead.
20.0 ADVANCE STATEMENT

20.1 A document that contains information about the patient’s wishes and preferences for treatment is an advance statement. An advance statement is not legally binding, but should be used and weighed as part of a consideration of the person’s best interests.

20.2 If a patient’s advance decision to refuse treatment also includes information about the patient’s preferences or wishes, these parts of the advance decision can be considered to be an advance statement.

21.0 COURT OF PROTECTION

21.1 The Court of Protection is a specialist court to deal with decision-making for adults with powers to:
   - Decide whether a person has capacity to make particular decisions for themselves
   - Make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decision
   - Appoint deputies to make decisions for people lacking capacity to make those decisions
   - Decide whether a Lasting Power of Attorney or Enduring Power of Attorney is valid
   - Remove deputies or attorneys who fail to carry out their duties.

21.2 An application can be made to the court for:
   - Particularly difficult decisions
   - Disagreements that cannot be resolved in any other way
   - Situations where ongoing decisions may need to be made about the personal welfare of a person who lacks capacity to make decisions for themselves.

21.3 The Court might appoint a deputy to deal with property and affairs when there is no Lasting or Enduring Powers of Attorney, applications to the Court are necessary:
   - For dealing with cash assets over a specified amount that remain after any debts have been paid
   - For selling a person’s property
   - Where the person has a level of income or capital that the court thinks a deputy needs to manage.

21.4 Deputies for personal welfare decisions will only be required in the most difficult cases where:
   - Important and necessary actions cannot be carried out without the court’s authority
   - There is no other way of settling the matter in the best interests of the person who lacks capacity to make particular welfare decisions.

21.5 If the involvement of the Court of Protection may be required, staff can get advice from the Mental Capacity Act, Deprivation of Liberty Safeguards and Consent Lead. Ultimately, advice on whether an application to the Court of Protection is required may need to be discussed with the Trust solicitors.
21.6 The Court of Protection can make urgent judgements regarding treatment decisions. There is a 24-hour phone line available to contact the Court in urgent circumstances. This may lead to an urgently convened hearing or in the most urgent circumstances a decision over the phone.

22.0 OFFICE OF THE PUBLIC GUARDIAN (OPG)

22.1 The Office of the Public Guardian is responsible for supervising and supporting deputies.

22.2 If there is a suspicion that a deputy is abusing their position, the OPG can appoint a Court of Protection Visitor to visit the deputy and investigate any concerns. It can also apply to the court to cancel a deputy’s appointment.

22.3 The OPG keeps a register of all Powers of Attorneys.

22.4 The OPG web site has a downloadable copy of the Code of Practice, other information leaflets and the forms for creating a Lasting Power of Attorney and how to register a Lasting Power of Attorney.

22.5 They can make a search of their registers to identify if an individual has appointed a power of attorney. If somebody claims to be the holder of a power of attorney and attempts to see the power of attorney document fail, a request should be made to the OPG for a search of their register to take place.

23.0 INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)

23.1 The aim of the IMCA service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no-one else (other than paid staff), to support or represent them or be consulted.

23.2 An IMCA must be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), whenever:

- An NHS body is proposing to provide serious medical treatment (see section 23.6)
- An NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home
- The person will stay in hospital longer than 28 days (or 8 weeks in a care home).

23.3 An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:

- Care reviews, where no-one else is available to be consulted
- Support for people under a Deprivation of Liberty Safeguards authorisation
- Adult protection cases, whether or not family, friends or others are involved.

23.4 The IMCA’s role is to support and represent the person who lacks capacity. Because of this, IMCA’s have the right to see relevant healthcare and social care records.

23.5 Any information or reports provided by an IMCA must be taken into account as part of the process of working out whether a proposed decision is in the person’s best interests.
Serious medical treatment is defined as treatment which involves giving new treatment, stopping treatment that has already started or withholding a treatment that could be offered in circumstances where:

- If a single treatment is proposed there is a fine balance between the likely benefits and burdens to the patient and the risks involved
- A decision between a choice of treatments is finely balanced
- What is proposed is likely to have “serious consequences” for the patient.

Decisions with “serious consequences” could include, treatment that:

- Could cause serious and prolonged pain, distress or side effects
- Could have potentially major consequences for the patient (e.g. life sustaining treatment decisions)
- Could have a serious impact on the patient’s future life choices (e.g. treatment for ovarian cancer).

The IMCA service for Somerset is provided by Swan Advocacy, who can be contacted on Tel: 03333 44 7928. Details of referrals to the IMCA should be copied to the Trust MCA, DoLS and Consent Lead for Trust monitoring and reporting purposes via email: mcadolsandconsent@sompar.nhs.uk

**24.0 RESEARCH PROJECTS INVOLVING A PERSON WHO LACKS CAPACITY**

24.1 The Act’s rules for research that includes people who lack capacity to consent to their involvement, cover:

- When research can be carried out
- The ethical approval process
- Respecting the wishes and feelings of people who lack capacity
- Other safeguards to protect people who lack capacity
- How to engage with a person who lacks capacity
- How to engage with carers and other relevant people.

24.2 More information can be found on research involving people who lack capacity in chapter 11 of the code of practice.

**25.0 HOW THE ACT APPLIES TO CHILDREN AND YOUNG PEOPLE**

25.1 Children under 16:

- The Act does not generally apply to people under the age of 16
- There are two exceptions:
  - The Court of Protection can make decisions about a child’s property or finances (or appoint a deputy to make these decisions) if the child lacks capacity to make such decisions and is likely to still lack capacity to make financial decisions when they reach the age of 18
  - Offences of ill treatment or wilful neglect of a person who lacks capacity can also apply to victims younger than 16.
25.2 Young people aged 16-17 years:

- Most of the Act applies to young people aged 16-17 years, who may lack capacity to make specific decisions
- There are three exceptions:
  - Only people aged 18 and over can make a Lasting Power of Attorney
  - Only people aged 18 and over can make an advance decision to refuse medical treatment
  - The Court of Protection may only make a statutory will for a person aged 18 and over.

26.0 THE MENTAL CAPACITY ACT VS THE MENTAL HEALTH ACT

26.1 Professionals may need to think about using the Mental Health Act to detain and treat someone who lacks capacity to consent to treatment for a mental disorder (rather than use the Mental Capacity Act), if:

- The person needs treatment that cannot be given under the Mental Capacity Act (for example, because the person has made a valid and applicable advance decision to refuse an essential part of treatment)
- The person may need to be restrained in a way that is not allowed under the Mental Capacity Act
- It is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might refuse to give consent)
- The person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so
- There is some other reason why the person might not get treatment, and they or someone else might suffer harm as a result.

26.2 Compulsory treatment under the Mental Health Act is not an option if:

- The patient’s mental disorder does not justify detention in hospital
- The patient needs treatment only for a physical illness or disability.

26.3 More information can be found on the relationship between the Mental Capacity Act and The Mental Health Act in chapter 13 of the MCA Code of Practice, or in the Mental Health Act 1983: Code of Practice.

27.0 CRIMINAL OFFENCES INTRODUCED BY THE MENTAL CAPACITY ACT

27.1 Ill-treatment or wilful neglect of a person who lacks capacity to make relevant decisions.

27.2 The offences may apply to:

- Anyone caring for a person who lacks capacity – this includes family carers, healthcare and social care staff in hospital or care homes and those providing care in a person’s home
- An attorney appointed under a Lasting or Enduring Power of Attorney
- A deputy appointed for the person by the court.
27.3 Someone may be guilty of an offence if they ill-treat or wilfully neglect the person they care for or represent. Penalties will range from a fine to a sentence of imprisonment of up to five years – or both.

27.4 For a person to be found guilty of ill treatment, they must either:

- Have deliberately ill-treated the person
- Be reckless in the way they were ill-treating the person or not.

27.5 For a person to be found guilty of wilful neglect, they must:

- Have deliberately failed to carry out an act they knew they had a duty to do.

28.0 DISAGREEMENTS AND DISPUTES ABOUT ISSUES COVERED IN THE ACT

28.1 Sometimes people will disagree about:

- A person’s capacity to make a decision
- Their best interests
- A decision someone is making on their behalf
- An action someone is taking on their behalf.

28.2 Disagreements can involve:

- HealthCare Professionals
- Social Workers
- Care Providers
- Family members / friends / other interested in the patients welfare
- Independent Mental Capacity Advocate (IMCA)
- The patient who lacks capacity.

28.3 It is in everybody’s interests to settle disagreements and disputes quickly and effectively, with minimal stress and cost.

28.4 To resolve disagreements and disputes staff should consider:

- Involving an advocate
- Getting a second opinion
- Holding a formal best interest meeting
- Attempting mediation
- Getting specialist support:
  - Mental Capacity Act, Deprivation of Liberty Safeguards and Consent Lead
  - A staff member with special expertise around issues related to the decision (e.g. mental health, anaesthetist, etc.).

28.5 If attempts to resolve disputes are unsuccessful, it may be necessary to involve the Court of Protection (see section 21).

29.0 TRAINING/COMPETENCE REQUIREMENTS

29.1 All trust staff, regardless of role or status, are required to have regard for the Mental Capacity Act Code of Practice when involved with decision making for patients who may
lack capacity to make those decisions for themselves. Some staff in specific roles, will have further training needs to equip them with enhanced knowledge and skills.

29.2 The Mental Capacity Act, Deprivation of Liberty Safeguards and Consent Lead will identify training needs and ensure appropriate training opportunities are made available for staff.

29.3 It is the responsibility of managers to identify and plan for the specific training needs of their staff and ensure that staff attend Mental Capacity Act training that is required for their role.

29.4 All staff are responsible for attending required training, engaging with the training and for applying new knowledge and skills in the workplace.

29.5 Evidence of training activity, content, evaluation and outcomes will be presented to the Safeguarding Committee and is the responsibility of the Mental Capacity Act, Deprivation of Liberty Safeguards and Consent Lead.
## 30.0 MONITORING

<table>
<thead>
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<th>Element of policy for monitoring</th>
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<th>Monitoring method - Information source (e.g. audit)/ Measure / performance standard</th>
<th>Item Lead</th>
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<td>Review of training figures in line with staff mapping of requirements</td>
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<td>Reporting to the Safeguarding Committee as a regular update at each meeting</td>
<td>Create actions to address any shortfall in training numbers and add the action to the Mental Capacity Act, Deprivation of Liberty Safeguards and Consent work plan</td>
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<td>Completion of an annual audit in relation to the use of the Mental Capacity Act</td>
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<td>Reporting to the Safeguarding Committee on completion of the audit</td>
<td>Create actions to address any concerns identified through audit</td>
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### 31.0 REFERENCES

31.1 Parliament: 2005; Mental Capacity Act; TSO; London

31.2 Parliament: 2007; Mental Capacity Act 2005 Code of Practice; TSO; London

31.3 National Institute for Health and Care Excellence (NICE): 2018; Decision-making and mental capacity (NG108)

### 32.0 DOCUMENT CONTROL

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<td>Hayley Peters</td>
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Appendix A:

HOW SHOULD PEOPLE BE HELPED TO MAKE THEIR OWN DECISIONS?

When supporting people to make their own decisions staff should consider factors that may affect the person’s ability to make a decision. This could include:

- The person’s physical and mental health condition
- The person’s communication needs
- The person’s previous experience (or lack of experience) in making decisions
- The involvement of others and being aware of the possibility that the person may be subject to undue influence, duress or coercion regarding the decision
- Situational, social and relational factors
- Cultural, ethnic and religious factors
- Cognitive (including the person’s awareness of their ability to make decision), emotional and behavioural factors, or those related to symptoms
- The effect of prescribed drugs or other substances.

Providing relevant information:

- The person should be provided with all of the information relevant to the decision that needs to be made
- If they have a choice of options, they should be given information on all of the alternatives.

Communicating in an appropriate way:

- Could information be explained or presented in a way that is easier for the person to understand (for example, by using simple language or visual aids?)
- Have different methods of communication been explored if required, including non-verbal communication including sign language?
- Could anyone else help with communication (for example, a family member, support worker, interpreter, translator, speech and language therapist or advocate)? Can this person also help or support the person to make choices or express a view?
- Be aware of any cultural, ethical or religious factors that may have a bearing on the person’s way of thinking, behaviour or communication
- Try to avoid background noise or distractions, such as the television or radio, or people talking
- Don’t rush people
- Make one decision at a time.

Making the person feel at ease through reducing their anxiety and stress:

- Are there particular times of day when the person’s understanding is better?
- Are there particular locations where they may feel more at ease?
- Could the decision be put off to see whether the person can make the decision later when circumstances are right for them?
- Is there someone else who may make the person more at ease?
- Give the person the time they need to consider the issues, but be sure to avoid tiring or confusing them.

Supporting decision-making:

- The person should be asked if there is anyone they would like to support them with decision-making
- If the patient does not have anyone to support them, it is best practice to tell them about support that they could potentially gain from advocacy services.
Appendix B: BEST INTEREST CHECKLIST (with guidance):

- **Working out what is in someone’s best interests cannot be based simply on someone’s age, appearance, condition or behaviour** (this highlights that an assessment of best interests must be an individualised assessment reflecting the uniqueness of the individual and their circumstances and not based on assumptions)

- **All relevant circumstances should be considered when working out someone’s best interests** (in healthcare decision-making, this could include: risks, benefits, complications, side-effects, options, effectiveness, impact on quality of life or length of life)

- **Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision** (the patient’s involvement in the best interest’s process should be supported and encouraged. This involvement should be at a level appropriate for the individual patient)

- **If there is a chance that the person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent** (if there is a reversible cause of the patients lack of capacity, such as an infection, electrolyte imbalance, low oxygen levels, low blood glucose etc., it is often appropriate to treat this condition prior to making a decision about the patients capacity. In other circumstances, a more general improvement in the patient’s overall health may allow the patient to regain capacity. Where the decision to be made is urgent it may not be possible to delay the decision making)

- **Special considerations apply to decisions about life-sustaining treatment** (a best interest’s decision about whether to provide life-sustaining treatment cannot be motivated by a desire to bring about the persons death. In normal circumstances, all reasonable steps should be taken to prolong life, but in circumstances where treatment would be futile, overly burdensome to the patient of where there is no prospect of recovery it would be reasonable to come to a best interest decision that is palliative)

- **The person’s past and present wishes and feelings, beliefs and values should be taken into account** (this could include previously written statements made by the person when they had capacity, cultural background, religious beliefs, political convictions or any past behaviours or habits)

- **The views of other people who are close to the person who lacks capacity should be considered, as well as the views of an attorney or deputy.** (this should include anyone previously named as someone the person wants to be consulted, anyone in caring for the person, anyone interested in their welfare such as family or friend, the holder of a Power of Attorney or a Court appointed deputy)

When consulting with others the decision-maker should try to find out:

- What the people think is in the person’s best interests, and
- If they can give information on the person’s wishes and feelings, beliefs and values

- **Other relevant factors** (this could include any other factor the person would consider if they were able to).
Appendix C – CONSENT SUPPLEMENT FOR SOMPAR STAFF

General Points

- When making decisions about care and treatment with patients, the Mental Capacity Act will only apply if we have concerns about the patient’s ability to consent to or decline the proposed care and treatment.
- Consent is the voluntary and continuing permission of the person to receive particular treatment and support, based on an adequate knowledge of the purpose, nature, likely effects and risks including the likelihood of success, any alternatives to it and what will happen if the treatment does not go ahead.
- Permission given under unfair or undue pressure is not consent.
- By definition, a person who lacks capacity to consent cannot consent to treatment or care and support, even if they co-operate with the treatment or actively seek it.

Consent – Patients subject to the Mental Health Act (MHA)

- Part IV of the MHA provides the express power to treat certain patients for their Mental Disorder whether or not they are consenting to it.
- Once it has been decided to assess and use the provisions of the MHA, the person lacking capacity can be treated for their mental disorder without consideration of the MCA. However, where treatment is necessary for a physical condition unrelated to their mental disorder, then the provisions of the MCA will still apply.
- During the initial three-month period, the MHA allows medication to be given for a mental disorder. However, the patient’s consent should still be sought before any medication is administered, wherever practicable. This should be documented in the case notes by the approved clinician in charge of treatment. If a person has capacity to consent, but consent is not forthcoming or is withdrawn during this period, the clinician in charge of the treatment must consider carefully whether to proceed in the absence of consent, to give alternative treatment or stop treatment.
- Clinicians authorising or administering treatment without consent under the MHA are performing a function of a public nature and must comply with the Human Rights Act 1998, which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights.

Who is responsible for seeking consent?

- The health professional carrying out the procedure or intervention is ultimately responsible for ensuring that the patient is consenting to what is done.
- As part of consent in circumstances where a team is involved it may be appropriate for more than one member of the team to be involved with the process of seeking consent.

Consent Forms

- Standard consent forms are available from Somerset Partnership NHS Foundation Trust Headquarters. There are four versions of the standard consent form
  - Form 1: for adults or competent children
  - Form 2: for parental consent for a child or young person
  - Form 3: for cases where it is envisaged that the patient will remain alert throughout the procedure and no anaesthetist will be involved in their care. The use of form 3 is optional but may be thought more appropriate than form 1 in situations where patients do not need to make any advance decisions about additional procedures because they will be in a position to make any such decisions at the time if necessary.
  - Form 4: for adults who are unable to consent to investigation or treatment.
Completing consent forms

- The standard consent form includes space for a health professional to provide information to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have received specialist training in advising patients about this procedure, have been assessed and are aware of their own knowledge limitations.
- If the patient signs the form in advance of the procedure (for example in out-patients or at pre-assessment clinic), a health professional involved in their care on the day should signs the form to confirm that the patient still wishes to go ahead and has had further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot answer themselves.

Documentation

- For significant procedures, it is essential for health professionals to document clearly both a patient’s agreement to the intervention and the discussions that led up to that agreement. This may be done either using a consent form (with further detail in the patient’s notes if necessary), or through documenting in the patient’s note that they have given verbal consent (when a written consent is not required).
- It is good practice to seek written consent when:
  - The treatment or procedure is complex, or involves significant risks
  - The procedure involves general/regional anaesthesia or sedation
  - Providing clinical care is not the primary purpose of the procedure
  - There may be significant consequences for the patient’s employment, social or personal life
  - The treatment is part of a project or programme of research approved by Somerset Partnership NHS Foundation trust.
- For decisions about issues of basic care, comprehensive documentation will not be necessary, but documentation should be clear when consent has been obtained or if care is being delivered in best interests under the Mental Capacity Act. This documentation only needs to make reference to consent or capacity/best interest, but if challenged afterwards staff would need to be able to explain how consent was obtained or how capacity / best interests was considered.

Competence to consent (Gillick Competence) – children under 16

- Children who have sufficient understanding and intelligence to enable them to fully understand what is involved in a proposed treatment are considered to be competent (or “Gillick competent”) to consent to it. Practitioners with expertise in working with children and young people should be consulted in relation to these assessments.
- Children under 16 should be assessed to establish whether they have competence to make a particular decision at the time it needs to be made.
- A child may have the competence to consent to some interventions but not others.
- When considering whether a child has competence, it can be useful to consider:
  - Does the child understand the information that is relevant to the decision that needs to be made?
  - Can the child hold the information in their mind long enough so that they can use it to make the decision?
  - Is the child able to weigh up that information and use it to arrive at a decision?
• Is the child able to communicate their decision (by talking, using sign language or any other means)?

• The consent of a competent child or young person will be sufficient, without the need for consent from someone with parental responsibility. It is good practice to involve the child or young person’s parents and others involved in their care in decision-making, if the child or young person consents to the sharing of information.

• Unlike adults, the refusal by a competent child or young person with capacity to consent may in some circumstances be overridden by a court. Staff may need to seek legal advice under these circumstances.

Fraser Guidelines

• The Fraser guidelines specifically relate only to contraception and sexual health for those under 16 without parental consent. Advice can be given if:
  - He/she has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment
  - He/she cannot be persuaded to tell her parents or to allow the doctor to tell them
  - He/she is very likely to begin or continue having sexual intercourse with or without contraceptive treatment
  - His/her physical or mental health is likely to suffer unless he/she received the advice or treatment
  - The advice or treatment is in the young person’s best interests.

• Health professionals should still encourage the young person to inform his or her parent(s) or get permission to do so on their behalf, but if this permission is not given, they can still give the child advice and treatment. If the conditions are not met, however, or there is reason to believe that the child is under pressure to give consent or is being exploited, there would be grounds to break confidentiality.

• Fraser guidelines originally just related to contraception advice and treatment but, following a case in 2006, they now apply to decisions about treatment for sexually transmitted infections and termination of pregnancy.

Capacity to consent – 16 and 17 year olds

• Young people aged 16 -17 can consent in the same way as those aged 18 and over.

• Where the young person lacks capacity, the MCA will apply in the same way as it does for those aged 18 and over, and treatment may be given in accordance with the MCA, unless it amounts to a deprivation of liberty.

• A person with parental responsibility may also be able to consent on behalf of the young person who lacks capacity to make decisions about their treatment. It is not possible for someone with parental responsibility to consent to care or treatment that would amount to depriving the young person of their liberty.

• If it is not possible to provide treatment relying on the MCA or parental consent, consideration should be given to whether admission or treatment under the Mental Health Act is necessary.

Parental responsibility

• Someone with parental responsibility who can provide parental consent should be consulted with about decisions concerning their child (subject to the child or young person’s rights to confidentiality).
• Whether a particular intervention can be undertaken based on parental consent will need to be viewed in light of the circumstances of the case. This may include considering:
  • Does the decision go beyond the kind of decisions that parents routinely make? This could include considering:
    • What type of intervention is it and how invasive it is?
    • If invasive, is it to prevent a serious deterioration in the child’s health?
    • Is the child resisting the intervention?
    • Is the treatment controversial?
    • How old the child is and how mature they are will affect how much weight the child’s view should be given.
  • Are there factors that might undermine the validity of parental consent?
    • The parents are unable to make the decision (e.g. due to a lack of capacity)
    • Where there is conflict between those with parental responsibility.
• Someone with parental responsibility cannot authorise a Deprivation of Liberty for a young person who is 16 or 17 years old.
• Persons with parental responsibility can arrange for some or all of that responsibility to be met by others. Staff are expected to request written permission from a person claiming to have been given authority by someone with parental responsibility.