Birmingham Community Healthcare NHS
NHS Trust

# Mental Capacity Act Policy

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| **BCHC Policy Reference Number** | CH 387 |

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| **Title:** | Mental Capacity Act Policy |
| **Version Number:** | Version 2 |
| **BCHC Policy Reference Number:** | CH 387 |
| **Is this document new or a replacement for existing? If replacement state full title and version number:** | Replacement for Mental Capacity Act Policy – Version 1 – CH 387 |
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| **Target Audience:** | All staff working for BCHC must be aware of this Policy/Code of Practice when acting on behalf of, or making decisions for, someone who lacks capacity to make a decision for themselves and should be able to explain how they have had regard to the Code when acting or making decisions |
| **Subject Category:** | Clinical<br>Safeguarding |
| **Summary:** | The Policy provides a guide to the assessment of mental capacity in clinical practice. The Policy applies to all adults aged 16 years and above but the principles can also be applicable to younger people whose mental capacity is being assessed |

**Commencement of Consultation Date:**

**Consultation History:**

The following committees, groups or individuals have been consulted in the development of this Policy:

| Name: | Date: |
|---|---|
| Compliance & Assurance | December 2013 |
| BCHC Safeguarding Adults team | April 2014 |
| Compliance & Assurance | April 2014 |

**Version History:**

| Version No: | Lead: | Date Change Implemented: | Reason for Change: |
|---|---|---|---|
| 1 | Anne McGarry | 11/02/2012 | New for BCHC |

# 1. Introduction

Two million people in the UK are estimated to lack capacity through mental illness, learning difficulties, dementia or physical illnesses that affect brain function (such as delirium or head injury) (MCA, 2005). In general hospitals, more than 30% of patients on acute medical wards may lack capacity (Raymont et al, 2004). A slightly higher proportion (44%) of psychiatric in-patients (Cairns et al, 2005) lack capacity to make the primary decision for which they were admitted. The decisions are also wide ranging covering many areas of health and well-being, as well as financial decisions.

Clinicians are often confronted with decisions about mental capacity. Healthcare workers need to have a knowledge and understanding of how capacity is assessed and the ways that adults lacking capacity are dealt with since the implementation in 2007 of the MCA. An assessment that a person lacks capacity has major implications; it gives clinicians and some informal carers influence over that person and this influence could potentially be abused. The MCA provides important safeguards to patients' rights and it also provides help for clinicians in dealing with capacity problems. The Mental Capacity Act (2005) (MCA) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with or caring for an adult who may lack capacity to make decisions must comply with the MCA when making decisions or acting for that person. The purpose of the Act is to set out the guidance, legislation and recommendations required to support service provision as specified within the Act.

The MCA Code of Practice (2007) clearly states that all those working with people who may lack capacity are legally required to have regard to relevant guidance in the Code of Practice. This means that all those working for Birmingham Community Healthcare NHS Trust (BCHC) must be aware of the Code of Practice when acting on behalf of, or making decisions for, someone who lacks capacity to make a decision for themselves and they should be able to explain how they have had regard for the Code when acting or making decisions.

All those working within BCHC have a duty and commitment to protect adults at risk. Where an adult may lack capacity to make a specific decision, a formal assessment of capacity may be necessary to determine capacity. Specific decisions or actions may need to be taken where an adult may lack capacity. Where an adult is at risk and may be being abused, the BCHC Safeguarding Adults Policy must be followed. The MCA has implications for all aspects of the work of BCHC related policies and procedures

# 2. Purpose

The purpose of this document is to provide the agreed policy guidance for assessing the capacity of service users under the care of BCHC and to identify the service governance framework within the Trust relating to safeguarding adults who lack capacity to make decisions. This Policy is closely related to the BCHC Safeguarding Adults Policy.

## 3. Scope

The Policy applies to all adults aged 16 years and above but the principles can also be applicable to younger people whose mental capacity is being assessed.

The MCA applies to all personal welfare decisions, health care decisions and financial decisions taken on behalf of people who permanently or temporarily lack capacity to make decisions for themselves .All professionals working with adults who lack , or who may lack capacity to make such decisions need to be familiar with the underlying principles and main provisions of the act and must also have regard to the MCA code of Practice

**Summary Points**

- The MCA has resulted in increased formalisation of capacity law and assessment
- the Act has increased the expectation that healthcare workers should be competent at assessing capacity
- the Act has also increased the need for training and education in regard to the Code of Practice, Independent Mental Capacity Advocates (IMCAs) and advance decisions so that staff have a raised awareness and understanding.

## 4. Objectives

The Policy provides a guide to the assessment of mental capacity in clinical practice. This document contains the following information:

- the Policy
- procedures and assessments
- appendices.

## 5. Duties & Responsibilities

### 5.1 Clinical Governance Committee (CGC)

CGC is the committee responsible for ratifying this Policy and will receive assurance through the monthly compliance document presented by the Associate for Safeguarding.

### 5.2 Safeguarding Adult Committee (SAC)

SAC is the committee responsible for approving this policy and will ensure governance including feedback and required actions and will oversee the effective implementation of the MCA.

### 5.3 Direct of Nursing & Therapies

The Director of Nursing & Therapies will monitor the effectiveness of the implementation of this policy

### 5.4 Divisional Directors

The Divisional Director will ensure that the MCA is implemented and adhered to across the organisation

### 5.5 Lead Specialist for Safeguarding Adults and the Mental Capacity Act:

Lead Specialist for Safeguarding Adults and the Mental Capacity Act will monitor, review and audit implementation of the Policy. The Lead will provide expert, specialist advice to the organisation.

### 5.6 Safeguarding Adults Practitioners

Safeguarding Adults Practitioners will support implementation of the policy within the divisions and give advice and promote continued awareness and use of the MCA in relevant clinical settings.

### 5.7 Managers

All managers are responsible for:

- ensuring that staff are made aware of and comply with the Policy
- ensuring that the Policy is implemented
- ensuring that any operational difficulties are brought to the attention of the Policy Lead
- ensuring that staff receive appropriate training relevant to role and receive guidance and support to recognise, assess and plan care/intervention to the highest standard that is in patients' best interests and in accordance with the MCA and the Code of Practice.

### 5.8 Staff

Staff have a responsibility to:

- comply fully with aspects of the Policy that are relevant to their role
- report any difficulties or problems that arise with the Policy
- ensure they have a basic understanding of and adhere to the MCA and the Code of Practice
- know where to seek appropriate guidance when necessary.

## 6. Definitions

Please refer to **Appendix 8** for a list of definitions.

## 7. Procedures/Process

### 7.1. What Has the Mental Capacity Act Changed?

The MCA has introduced a legal framework to support and protect people who lack capacity to make decisions relating to their care and treatment and their financial affairs.

The Act introduces several new concepts and services:

- a Code of Practice
- a criminal offence of wilful neglect or ill-treatment of someone without capacity
- an IMCA
- Advance Decisions
- it has expanded the role of the Court of Protection (CoP) and introduced frameworks for Lasting Power of Attorneys (LPAs) and Court Appointed Deputies (CADs).

### 7.2. What is the Code of Practice?

The Code accompanies the MCA and it is designed to guide those responsible for interpreting the Act. Clinicians and others involved in making decisions on behalf of someone who lacks capacity are legally required to 'have regard to' (have read and understood) its guidance and if later asked prove they did. A copy of the Code of Practice can be downloaded from www.publicguardian.gov.uk.

### 7.3. Key Principles of the Mental Capacity Act

The five key principles of the MCA are:

- **assumption of capacity** – a person must be assumed to have capacity unless it is established that he/she lacks capacity
- **assisted decision-making** – a person must not be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success. Give all appropriate help before concluding someone cannot make their own decisions
- **unwise decisions** – a person is not to be treated as unable to make a decision merely because he/she makes an unwise decision. Accept the right to make what might be seen as eccentric or unwise decisions
- **best interests** – this is any action taken, or decision made under the MCA, for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests
- **least restrictive alternative** – before any action is taken, or any decision is made, regard must be given 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. Decisions made should be those that least restrict the individual's basic rights and freedoms.

### 7.4. What Legal Protection Do I Have Under the Mental Capacity Act?

Section 5 of the Act protects from liability those providing healthcare (and personal care) for people without capacity, provided that they have had 'reasonable belief' that they could demonstrate that the person lacked capacity and their actions were in the person's best interests. Documentation is key in such situations. However, the Act does not protect from liability those professionals who have been negligent or have gone against the wishes of an Attorney (or Deputy) acting within the scope of their power. The Act introduces a new criminal offence (Section 44 of the MCA) of ill-treatment/neglect of a

person who lacks capacity by someone who is caring for them, or acting as a Deputy or Attorney for them. The person can be guilty of ill-treatment if they deliberately ill-treat a person who lacks capacity or have been reckless as to whether they were ill-treating the person or not. This can apply to formal and informal carers.

### 7.5. The Mental State in Relation to Capacity

Examination of the mental state is fundamental to the assessment of capacity as there are many conditions and treatments that can enhance/reduce someone's capacity. Examples include agitation, over activity that make it impossible to impart relevant information to them, difficulty with communication may reflect abnormality of thought processes common in depression and other mood disorders, lability of mood common after stroke/brain injury may render a patient unable to make consistent decisions and abnormality of thought processes such as obsessional thoughts, delusions and hallucinations may substantially distort a person's ability to make a decision.

Defects in cognitive functioning can have a profound significance for capacity as decision-making requires attention (the ability to focus on the matter in hand) and concentration (the ability to sustain information) – both are necessary for effective thought and for capacity. Confusion and memory difficulties which may occur as a result of chronic alcoholism, a stroke or Alzheimer's disease are likely to affect capacity for some, but not necessarily all decisions.

People can lack insight into one aspect of their lives but retain it for others. Lack of insight as to the presence of an illness might not deprive a person of the capacity to make decisions about treatment of the illness, if the person has insight into the need for such treatment. Furthermore, insight may not be completely absent. The person with reduced insight may have specific awareness of their condition so as to have the capacity necessary for decisions about treatment.

Assessment of capacity in some patients may prove to be extremely difficult and some professionals will often perceive that they are not making decisions in the way that an ordinary person would. However, there should be no automatic assumption that this necessarily indicates lack of capacity.

Any treatable medical condition which affects capacity should as far as possible be treated. Additional expert opinion should be obtained if necessary from a Psychologist or expert practitioner before a final assessment is made.

### 7.6. Who Assesses Capacity?

Section 4 of the MCA states that the person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make decisions at different times. For most day to day decisions, this will be the person caring for them at the time a decision must be made. For example, a care worker might need to assess if the person can agree to be bathed and a District Nurse might assess if the person can consent to having a dressing changed.

The more serious the decision, the more formal the assessment of capacity is likely to be. In a healthcare setting, the healthcare professional proposing the particular treatment or medical procedure is responsible for assessing capacity. The MCA requires that any assessment that a person lacks capacity must be based on a 'reasonable belief' backed by objective reasons. This requires taking reasonable steps to establish that the person lacks capacity to make the decision in question. Professionals should keep careful records of the steps they have taken and their reasons for believing that the person lacks capacity to make that particular decision. Where there are disputes about whether a person lacks capacity and these cannot be resolved using more informal methods, the CoP can be asked for a declaration about the person's capacity.

Assessing, advising or treating people who may lack capacity to make relevant decisions are complex matters, often giving rise to professional or legal dilemmas in both medical and legal practice. As a general rule, the more complex the decision, the more expert advice may be needed dependent on the type of decision to support the assessment. Where appropriate, it might be advisable to refer to a Psychologist/expert practitioner for a second opinion. Ultimately it is the person seeking the decision who must decide whether on balance the individual is more likely to have capacity, or more likely to lack capacity to do something.

### 7.7. How is Capacity Assessed?

The test of capacity is both decision specific and time specific. Assessing capacity is a two stage assessment process:

**Stage 1: Diagnostic Assessment** – for a person to lack capacity, he or she must have an impairment of, or disturbance in, the functioning of the mind or brain and;

**Stage 2: Functional Assessment** – this defect must result in the inability to understand, retain, use or weigh up information relevant to a decision or communicate a choice. Capacity must be assessed only in relation to a specific decision. Capacity needs to be reassessed for each decision, particularly if the impairments fluctuate over time, as in delirium.

**Summary Points**

The five principles of the MCA:

1. presume capacity
2. use least restrictive alternative
3. right to make unwise decisions
4. maximise capacity
5. act in person's best interests.

### 7.8. Assessing Capacity

If you are concerned that a person aged 16 years or over may not have the capacity to make a specific decision, then an assessment of capacity must be conducted and documented in the clinical notes.

Actions are taken and decisions are made on a day to day basis for some adults who may lack the capacity to make decisions. These include decisions about the food a service user might wish to eat or the clothes a service user might wish to wear. All adults must be presumed to have capacity unless proven otherwise. Adults should be facilitated to make whatever decisions they can make for themselves. An assessment of capacity with regard to day to day decisions or actions can be made by a single carer or professional, **but**:

- the service user should be facilitated to make whatever decisions they remain able to make for themselves
- the rationale for any decisions must be clearly documented
- the least restrictive decision or action must be taken
- the decision made or action taken must be in a service user's best interests.

Such decisions must be documented in the service user's clinical notes. Form MCA 1 (**Appendix 1**) must be used for documenting day to day assessments of capacity.

Where an assessment of capacity involves a significant decision and there are concerns that the service user may not have capacity, a formal assessment must be completed by two appropriately qualified registered professionals. Exceptions to this include circumstances requiring urgent treatment/admission to hospital – it would be the decision-maker who assesses capacity. The following list provides examples of significant decisions (the list is not exhaustive and professional judgment will be required):

- consent to serious medical treatment (see Sections 6.15 to 6.19 of the Code of Practice)
- consent to an informal admission to hospital, nursing or care home
- consent to arrange accommodation (or to change of accommodation, for example move from an in-patient bed to a different hospital or care home and they will remain in hospital for more than 28 days or in a care home for more than eight weeks)
- request a tribunal hearing when detained under the Mental Health Act (MHA, 1983, amended 2007)
- manage their property or financial affairs, health or welfare
- consent to their confidentiality being breached
- consent to remain in an in-patient setting, i.e. hospital or care home and in some circumstances may be deprived of their liberty
- any other significant decision that carries significant risks/benefits for the individual.

The above list is not exhaustive and professional judgement must be used.

All mental capacity assessments for significant decisions (see **Appendix 2** for form MCA 2) must be undertaken jointly by two professionals who jointly fulfil the following criteria:

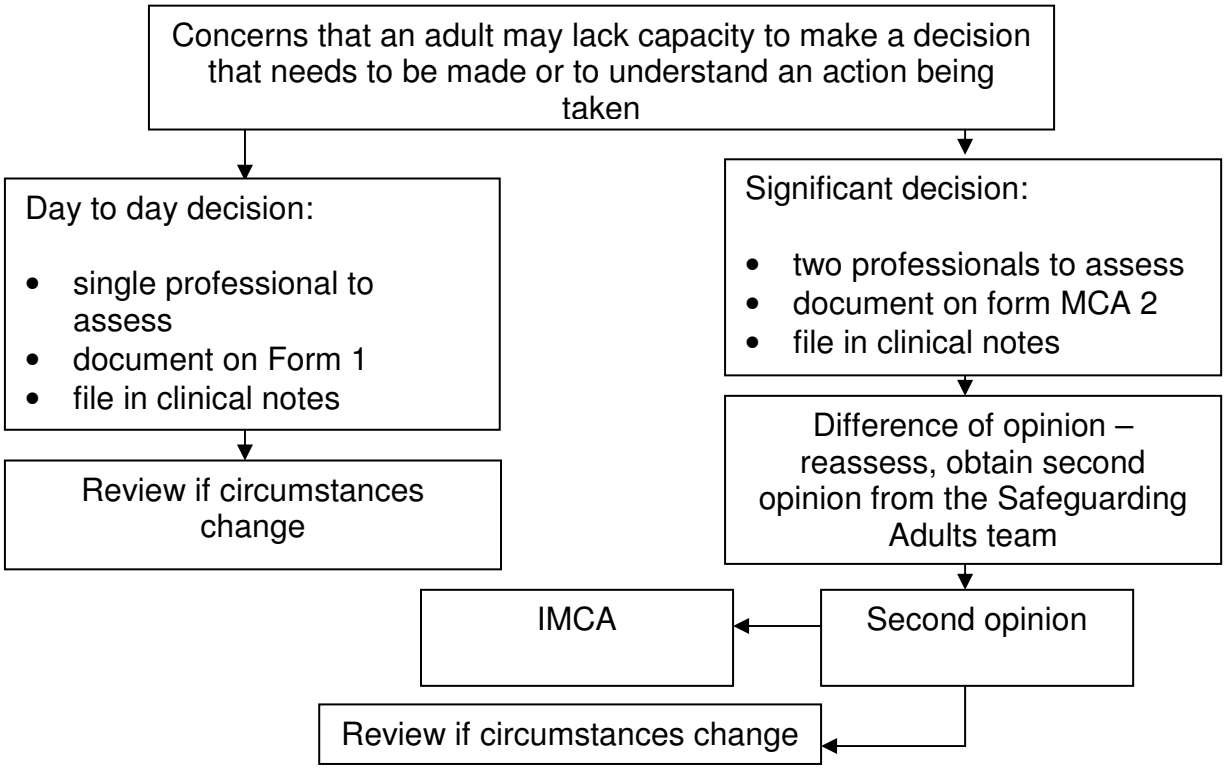
- one must be the decision-maker
- one must be a registered qualified professional
- wherever possible, one must have an established relationship with the individual.

In exceptional circumstances the assessment may be conducted where only one needs to be a registered qualified professional (for example a Nurse, Doctor, Psychologist, Speech and Language Therapist, Physiotherapist, Occupational Therapist or Social Worker) and the second may be a Care Assistant/Support Worker. Where the second assessor is a Care Assistant/Support Worker, they should only be involved in the assessment when they have an established relationship with the service user and where their knowledge of the service user will contribute to the assessment.

A professional is a person with a registered qualification who is willing to give evidence in court and to testify that they have sufficient training and experience to undertake an assessment of capacity in accordance with the MCA Code of Practice.

Clearly, some professionals will have considerable involvement or experience with assessing capacity, while others may not. Where consultation or advice is required, this should be sought from the clinical team and the Safeguarding Adults team. It must be noted that all assessments of capacity are decision/issue specific, it is therefore probable that a service user may have several different assessments of capacity in respect to different issues and decisions documented and recorded. Professional judgement should be used to determine whether an assessment of capacity should be repeated if an adult's capacity appears to change in respect of a specific decision (**Appendix 3**).

Where, following a joint assessment of capacity by two professionals, there is a difference of opinion regarding whether an adult has the capacity to make a specific decision and it has not been possible to obtain a second opinion, then the Safeguarding Adults team must be consulted.



**Summary Points**

In assessing capacity:

- wherever possible one professional should have an established relationship with the service user
- the timing of the assessment, location, use of communication aids and sufficient information to make an informed decision should all be considered in any assessment of capacity
- outcomes of assessments in respect of significant decisions must be documented on form MCA 2
- where there is a difference of opinion, re-assess and consult the Safeguarding Adults team.

### 7.9. How do I decide what is in someone's Best Interests?

Clinical problems have a variety of management options, ranging from doing nothing to radical treatments and the least restrictive option should be used (principle 5 of the MCA, 2005). For more complex decisions which carry a greater risk or benefit, clinicians should consider obtaining expert opinion to support the assessment.

In view of the wide range of decisions and actions covered by the Act and the varied circumstances of the people affected by its provisions, the concept of best interests is not defined in the MCA. Instead, the MCA sets out a checklist of common factors which must be considered when determining what is in a person's best interests. The checklist can be summarised as follows:

- **Equal consideration and non-discrimination**

  The person determining best interests must not make assumptions about someone's best interests merely on the basis of their age or appearance, condition or an aspect of their behaviour

- **All relevant circumstances**

  Try to identify all the issues and circumstances relating to the decision in question which are most relevant to the person who lacks capacity to make that decision

- **Regaining capacity**

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

  Capacity should always be reviewed:

  - whenever a care plan is being developed or reviewed
  - at other relevant stages of the care planning process, and;
  - as particular decisions need to be made

- **Permitting and encouraging participation**

  Do whatever is reasonably practicable to permit and encourage the person to participate or to improve their ability to participate, as fully as possible in any act done or any decision affecting them

- **The person's wishes, feelings, beliefs and values**

  Try to find out the views of the person lacking capacity including:

  - the person's past and present wishes and feelings – both current views and whether any relevant have been expressed in the past, either verbally, in writing or through behaviours or habits
  - any beliefs and values (for example religious, cultural, moral or political) that would be likely to influence the decision in question
  - any other factors the person would be likely to consider if able to do so (this could include the impact of the decision on others)

- **The views of other people**

  It is important to consult:

  - anyone previously named by the person as someone to be consulted on the decision in question or matters of a similar kind
  - anyone engaged in caring for the person or close relatives, friends or others who take an interest in the person's welfare
  - any Attorney or a Lasting or Enduring Power of Attorney (EPA) made by the person
  - any Deputy appointed by the CoP to make decisions for the person
  - for decisions about serious medical treatment or a change of residence and where there is no one who fits into any of the above categories, the NHS body or the local authority has a duty to appoint an IMCA who must be consulted before any decision is made.

See **Appendices 4 and 5** for the Best Interests Checklist and Care Plan for Best Interest Decisions.

### 7.10. Use of Restraint Under the Mental Capacity Act

Restraint is the use of force (or threat of force) to make someone do something that they are resisting. Under the MCA, restraint is permitted if it is reasonably believed to be necessary to prevent harm to the person lacking capacity. Restraint must be proportional to the likelihood and seriousness of harm. Where the use of restraint is cumulative and ongoing then this may result in the person being deprived of their liberty and a Deprivation of Liberty Safeguards (DoLS) authorisation may be required. In such

**Summary Points**

Use of restraint under the MCA:

- restraint is the use of force or threat of force to make someone do something that they are resisting
- restraint is also the restriction of a person's freedom of movement, whether they are resisting or not
- restraint must reasonably be believed to be necessary to prevent harm to the person lacking capacity
- restraint must be proportional to the likelihood and seriousness of harm.

## 7.11. What are Advance Statements and Decisions?

Advance Statements are declarations whereby people with capacity make known their views on what should happen if they lose the capacity to make decisions for themselves. Advance statements can take a variety of forms, ranging from general lists of life values and preferences to specific requests for or refusals of treatment. They can be written or oral. The purpose of an Advance Statement is to provide a means for people to exercise their autonomy by expressing an opinion in advance about future medical treatments or any other aspect of their life. Individuals who are aware of a terminal illness or a progressive condition which may affect their capacity often seek to discuss with clinicians how they wish to be treated. Advance Statements enable a structured discussion and recording of the person's views to take place. The test for capacity to make an Advance Statement about medical treatment is similar to that for capacity to make a contemporaneous medical decision, that is the statutory test of capacity in the MCA. The treatment options, their implications and alternatives should be broadly understood. Individuals should be aware that circumstances and medical science may develop in unforeseen ways in the interval before the Advance Statement becomes operative.

### Advance Decisions to Refuse Medical Treatment

An Advance Decision to refuse medical treatment enables adults aged 18 years or over to refuse specified medical treatment at a future time when they lack capacity to give or refuse consent to that treatment. An Advance Decision cannot be used to give effect to an unlawful act, such as euthanasia or assisted suicide or any intervention with the express aim of ending life.

### Making an Advance Decision

Except for decisions relating to life sustaining treatment, the MCA does not impose any particular formalities concerning the making of Advance Decisions to refuse treatment. For other types of treatment, both written and oral decisions are acceptable and legally valid, so long as they are supported by appropriate evidence to confirm their existence, validity and applicability. Although there is no prescribed form for making an Advance Decision, the MCA recommends that it is helpful to include:

- full details of the person making the advance decision, including date of birth, home address and any distinguishing features (in case healthcare professionals need to identify an unconscious person, for example)
- the name, address of the person's General Practitioner (GP) and whether they have a copy of the document
- a statement that the document should be used if the person ever lacks capacity to make treatment decisions
- a clear statement of the decision, the treatment to be refused and the circumstances in which the decision will apply
- the date the document was written (or reviewed)
- the person's signature (or the signature of someone the person has asked to sign on their behalf and in their presence)
- the signature of the person witnessing the signature, if there is one (or a statement directing somebody to sign on the person's behalf)

- where an Advance Decision is made verbally, health professionals should make a record in the patient's notes. This record should include:

  - a note that the decision should apply if the person loses capacity to make the decision in the future
  - a note of the decision and the treatment to be refused and the circumstances in which the refusal is to apply
  - details of somebody who was present when the refusal was made.

Advance Decisions that refuse life sustaining treatment (such as ventilation) have to be written, signed and witnessed to be valid. It is incumbent on clinicians to find out if an Advance Decision exists and assess whether it is valid.

**Summary Points**

Best interests checklist:

- ensure decisions are based on equal consideration and are non-discriminative
- consider all relevant circumstances
- consider regaining capacity
- permit and encourage participation
- consider persons wishes, feelings, beliefs and values
- consult others.

### 7.12. Life Sustaining Treatment

Where the decision concerns the provision or withdrawal of life sustaining treatment (defined in the MCA as being treatment which a person providing healthcare regards as necessary to sustain life), the person determining whether the treatment is in the best interests of someone who lacks capacity to consent must not be motivated by a desire to bring about the individual's death.

### 7.13. Unlawful Killing or Assisted Suicide

It is made clear in the MCA that the Act does not affect the law relating to unlawful killing such as euthanasia, murder, manslaughter or assisted suicide.

### 7.14. What is a Lasting Power of Attorney?

This replaces the EPA, where a person could appoint a named person ('the Donee') with the authority to make decisions on their behalf if they lose capacity. Previously this only applied to property and affairs. The MCA widens this authority to decisions about personal welfare, including healthcare and social affairs. It includes all decisions except those about the withdrawal of life saving treatment, unless explicitly authorised in the agreement. Existing EPA agreements will continue as before. Property and affairs LPA agreements can start before a person has lost capacity, but personal welfare ones cannot. Clinicians treating people without capacity must follow the decision of a Donee, unless they are thought not to be acting in the person's best interests or to be abusing the person lacking capacity, in which case clinicians should follow the guidance of the Code of Practice. In serious cases a decision may need to be sought from the CoP.

When making a LPA agreement, the limits of the powers granted are specified – this is known as 'nature and effect'. Decisions about life sustaining treatment must be specified in the LPA agreement and a signed statement from the Attorney and a certificate completed by an independent third party are required.

A parallel system exists where the CoP can appoint a Deputy for someone who already lacks capacity. The Deputy is likely to be a family member or director of social services. The Deputy can consent on the person's behalf but can never consent to decisions that will shorten the person's life.

Where a relative states that he/she has a LPA, staff should request to see this evidence in writing and receive a copy for the clinical file. **Appendix 6** provides a checklist for assessing LPA. Staff are also advised to confirm/seek clarification on a LPA by contacting the contact the Office of the Public Guardian (OPG) in Birmingham. Advise can be obtained from Trust Safeguarding Adults team .

**Summary Points**

Advance Decisions:

- it is incumbent on clinicians to find out if an Advance Decision exists and assess whether it is valid
- the MCA provides guidance on drawing up an advance decision
- Advance Decisions that refuse life sustaining treatment have to be written, signed and witnessed to be valid.

### 7.15. What is the Court of Protection?

The CoP makes decisions about the property and affairs and personal welfare of adults (and children in a few cases) who lack capacity. The Court has the same powers, rights, privileges and authority in relation to mental capacity matters as the High Court and can:

- decide whether a person has capacity to make a particular decision for themselves
- make declarations, decisions and orders about financial or welfare matters affecting people who lack capacity
- appoint Deputies to make decisions for people who lack capacity
- decide whether a LPA or EPA is valid
- remove Deputies or Attorneys who fail to carry out their duties and hear objections to register an LPA or EPA
- the Court must apply the principles set out in the MCA.

This specialist Court has been greatly changed by the MCA. It previously only adjudicated on the financial matters of people without capacity, but its role has widened to include health and welfare decisions. It will be more accessible and available to arbitrate on disputes and is now able to 'establish precedent' with the same powers as the High Court.

### 7.16. The Office of the Public Guardian

The OPG is an agency of the Ministry of Justice. The head of the OPG is the Public Guardian. The Public Guardian is responsible for:

- supervising Deputies appointed by the Court
- keeping registers of Deputies, LPAs and EPAs
- investigating representatives, including complaints about Deputies and Attorneys acting under registered LPAs or EPAs.

### 7.17. What is an Independent Mental Capacity Advocate?

An IMCA should be appointed to support and represent unbefriended people who lack capacity and who have no-one to act on their behalf. Each local authority has appointed its own IMCA service. In Birmingham this is Advocacy Matters.

IMCAs can be instructed for care reviews or adult protection cases, but they must be instructed and then consulted when serious medical treatment is being proposed (such as ventilation, major surgery, chemotherapy and discontinuation of artificial nutrition or hydration). They must be involved when accommodation for more than 28 days in hospital or eight weeks in a care home is being arranged or changed. IMCAs can be involved where there are safeguarding concerns involving a person who lacks capacity. IMCAs have the right to have access to all records, the responsible decision-maker should give due regard and consideration to the IMCA's report. The IMCA referral form can be accessed via: The IMCA Referral Form.

**Summary Points**

The MCA introduced new rules and procedures including:

- a LPA
- extended powers for the CoP for financial and health and welfare decisions
- the OPG
- the IMCA.

For advice and support with decisions you can contact the OPG and the CoP on PO Box 15118, Birmingham, B16 6GX.

Telephone – 0300 456 0300 (phone lines are open Monday to Friday from 9am to 5pm).

### 7.18. How do the Mental Capacity Act and the Mental Health Act Interact?

This is a complex area, the MHA is relevant only when treating a mental disorder and in most circumstances it is not relevant when treating physical illnesses. Patients detained under the MHA who refuse physical treatment need to have their capacity assessed. Incapacity should not be assumed in such patients (principle 1 of the MCA).

The MCA cannot be used to give care involving a deprivation of liberty without a proper assessment and authorisation. Treatments that are prohibited in Advance Decisions or

treatments that are not consented to by an Attorney can still be given under the MHA if they are to treat a mental disorder.

### 7.19. When is the Mental Health Act applicable?

Health professionals should consider using the MHA to detain and treat an individual without capacity where:

- it is not possible to provide care or treatment without depriving the individual of his liberty
- Advance Decision
- restraint in a way that is not permitted by the MCA is required
- assessment or treatment cannot be undertaken safely and effectively other than on a compulsory basis
- the individual lacks capacity in respect of some parts of the treatment but has capacity in respect of other parts and refuses a key element
- there is another reason why the individual may not receive treatment and as a result the individual or someone else may suffer harm.

For advice and support on the interface between the MCA and the MHA contact the Safeguarding Adults team. If a mental health assessment is required, a referral should be made the relevant mental health team.

### 7.20. Research

A person's capacity to consent to research is assessed in the same way as capacity to consent to medical treatment according to the statutory test in the MCA. Ideally, all research subjects should give well informed and considered consent to participation, but in practice research cannot be limited to people who are able to decide for themselves, since the effect would be to deprive people who lack capacity of proven therapies for the conditions which specifically affect them. The presence of mental disorder or disability does not in itself mean that an individual lacks the capacity to consent. As with all other areas where an individual's capacity may be in doubt, it is important to try and enhance as far as possible their decision-making capacity. Under the MCA, research cannot include incapacitated adults unless it has first received the authorisation of an appropriate body. In England the 'appropriate body' must be a Research Ethics Committee recognised by the Secretary of State.

### 7.21. Consent

In almost all cases where the patient has the capacity to make a decision as to whether they wish to be treated or examined, legally and ethically, their informed consent is required before the treatment or examination can proceed (the main exceptions apply in mental health legislation and in cases of infectious disease). It is good practice to assess a person's capacity to consent to admission to hospital. In general, it is unlawful and unethical to treat a person who is capable of understanding and willing to know without first explaining the nature of the procedure, its purpose and implications and obtaining that person's consent. People who refuse information must still be provided with some basic information, since without this they cannot make a valid choice to delegate treatment decisions to a professional or relative. Where there are concerns regarding

physical abuse/neglect and the person has demonstrated a lack of capacity to consent to being body mapped, then a body mapping assessment/clinical photography can be undertaken in the person's best interests under the MCA. See **Appendix 7** for the Body Map Assessment Tool.

### 7.22. Refusal to be assessed

There may be circumstances in which a person whose capacity is in doubt refuses to undergo an assessment of capacity. It will usually be possible to persuade someone to agree to an assessment if the consequences of refusal are carefully explained. If the client appears to lack capacity to consent to or refuse assessment, it will normally be possible for an assessment to proceed so long as the person is compliant and this is considered to be in the person's best interests, however in the face of outright refusal no one can be forced to undergo an assessment of capacity. Where there are serious concerns about a person's mental health, an assessment under the MHA may be warranted.

### 7.23. Capacity to Refuse Medical Procedures

Competent adults have the right to refuse medical diagnostic procedures or treatments for reasons which are 'rational, irrational or for no reason'. This principle has been legally established. The person's capacity to refuse must be assessed in relation to the specific treatment proposed and the gravity of the decision to be made, applying the statutory test of capacity under the MCA. It is irrelevant whether refusal is contrary to the views of most other people if it is broadly consistent with the individual's own value system.

**Summary Points**

- Incapacity should not be assumed in patients with a mental illness
- where the patient has the capacity to make a decision as to whether they wish to be treated or examined, legally and ethically, their informed consent is required before the treatment or examination can proceed
- where someone refuses to be assessed, no-one can be forced to undergo an assessment of capacity.

### 7.24. Mental Capacity and the Deprivation of Liberty Safeguards

In 2009, the MCA was amended to include the DoLS which applies to people in hospital, nursing and residential homes who lack capacity to consent to the arrangements made for their care and treatment but for whom are receiving care or treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them from harm and appears to be in their best interests. Depriving someone who lacks the capacity to consent to the arrangements made for their care or treatment is a serious matter and the decision to do so should not be taken lightly. The DoLS make it clear that a person may only be deprived of their liberty if it is:

- in their own best interests to protect them from harm
- if it is a proportionate response to the likelihood and seriousness of the harm and;

- if there is no less restrictive alternative.

Managing authorities should have a procedure in place that identifies:

- whether deprivation of liberty is, or may be, necessary in a particular case
- what steps they should take to assess whether to seek authorisation for their supervisory body (where this applies to BCHC in-patient facilities, the supervisory body is the Birmingham local authority)
- whether the managing authority have taken all practical and reasonable steps to avoid a deprivation of liberty
- what action they should take if they need to request an authorisation
- how they should review cases where authorisation is, or may be, necessary
- who should take the necessary action.

Further information can be obtained from the BCHC DoLS Policy or for further guidance and advice on circumstances that may warrant a deprivation of liberty, contact the Trust Safeguarding Adults team.

### 7.25. Decisions Not Covered by the Mental Capacity Act

There are decisions which cannot, under any circumstances, be taken on behalf of the person who lacks capacity, either because they are covered by other legislation or are personal to the individual. The MCA does not permit decisions concerning family relationships or enforced marriages to be made on behalf of a person who lacks capacity. These decisions are detailed in the Code of Practice.

### 7.26. Adults Who Self-Neglect/Refuse to Engage with Interventions

Adults who self-neglect fall into two domains; those where there is a degree of cognitive impairment and those who are cognitively intact self-neglectors. The MCA makes no provision for adults with capacity who self-neglect/refuse interventions. Despite this, self-neglect is a complex problem that requires clinical, social and ethical decisions in its management. Complex dilemmas can arise when people appear to rationally or intentionally choose to self-neglect. It is important that health professionals accept peoples' autonomy and their right to make lifestyle choices and refuse services but are able to recognise, evaluate and treat self-neglect, whether it stems from an underlying medical or psychiatric disorder (for example, dementia or depression) or the unwillingness or inability to seek help. Critical to this is assessing peoples' decision-making capacity. Therefore adults who self-neglect should have their cognitive and functional mental capacity assessed and expert advice should be sought as appropriate to assist with the assessment. A mental health assessment may also be required to determine evidence of mental illness that affects the person's capacity to make decisions.

### 7.27. Young People Aged 16 and 17 Years

The main provision of the MCA applies to adults, which includes young people aged 16 years or over. The starting point for assessing whether a young person aged 16 or 17 years has the capacity to make a specific decision is therefore the test of capacity in the MCA. Young people aged 16 and 17 years are presumed to have capacity to consent to

surgical, medical or dental treatment. If a young person suffers from an impairment of, or a disturbance in, the mind or brain which may affect their ability to make a particular healthcare decision, an assessment of capacity under the MCA will be required. However, if there is no such impairment or disturbance, the MCA will not apply if it can be established that the young person's ability to make a decision is because:

- they do not have the maturity to understand fully what is involved in making the decision (i.e. they lack Gillick competence) or;
- the lack of maturity means that they feel unable to make the decision for themselves (for example where particularly complex or risky treatment is proposed they may be overwhelmed by the implications of the decision).

In cases where the MCA applies, decisions about a young person's care or treatment may be made under the provisions of the MCA in the person's best interests without the need to obtain parental consent (although those with parental responsibility should generally be consulted).

The CoP may become involved in decisions about medical treatment where there is a disagreement between the young person and the treating health professionals or in decisions about welfare matters, for example where a young person's parents do not appear to be acting in the best interests of the young person. The MCA makes provision for the transfer of cases affecting anyone under 18 years from the CoP to the children's courts and vice versa.

### 7.28. Adults Caring for Young Children

Staff will encounter adults or parents responsible for young children. Where there are concerns over an adult's mental capacity and if this is affecting their parental ability to care for young children, an assessment of their mental capacity should be undertaken. The same process of assessing mental capacity will apply. Where there are concerns over an adult's mental health affecting their capacity, an appropriate referral should be made to local mental health services.

### 7.29. Associated Policies

- Safeguarding Adults Policy
- Deprivation of Liberty Safeguards Policy
- Restrictive Physical Interventions Policy
- Management of Violence and Aggression Policy
- Use of Chaperones Policy
- Privacy, Dignity and Respect Policy
- Consent Policy
- Suicide Prevention Policy

## 8. Implementation

Following ratification the procedural document's author/lead will ensure (in discussion with the Committee's Secretary) that the document is forwarded to the Compliance and Assurance Team (C&AT). The C&AT will make final checks, amend the footer and forward to the Library for uploading to the intranet. Once uploaded to the intranet the

Library will inform the Communication Team to ensure notification appears in the next Staff E-Newsletter

The objective for BCHC is for the assessment of capacity to be part of routine clinical practice. Implementation of the MCA Policy will continue to be monitored across BCHC, any difficulties with implementation identified by practitioners through audit or directly to Policy Leads/service managers will be addressed.

## 9. Implications

### Legal and Financial Implications

There are likely to be occasions when someone may wish to challenge the results of a capacity assessment and/or the care and treatment provided by the Trust.

The following situations could result in legal and financial implications for the Trust:

- failure to assess capacity or apply the principles of the MCA
- where a professional or clinical team have failed to adhere to a valid and applicable Advance Decision
- where it is found that there has been ill-treatment and wilful neglect of a person who lacks capacity by someone who is caring for them
- where the use of restraint was not proportionate to the likelihood and seriousness of harm and has resulted in harm to the person
- where the Trust as a managing authority has been found to be depriving a person/persons of their liberty which has not been authorised by the supervisory body.

If a disagreement cannot be resolved, the person who is challenging the assessment can apply to the CoP.

## 10. Monitoring & Audit

**Please see the monitoring table below**

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements | Acting on recommendations and lead(s) | Change in practice and lessons to be shared |
|---|---|---|---|---|---|---|
| **What key element(s) need(s) monitoring as per local approved policy or guidance? Where NHSLA criteria exist, these elements will be the criterion's minimum requirements (those itemised a, b, c etc)** | **Name the lead and what is the role of the Multi-Disciplinary Team or others if any** | **What tool will be used to monitor/check/ observe/assess/ inspect/ authenticate that everything is working according to this key element from the approved policy? This could be an audit or risk assessment document** | **How often is the need to monitor each element? How often is the need complete a report? How often is the need to share the report?** | **Who or what committee will the completed report go to and how will this be monitored? How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes?** | **Which committee, department or lead will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes?** | **How will system or practice changes be implemented, the lessons learned and how will these be shared?** |
| Implementation of the MCA Policy in particular – assessments of capacity and applying the principles of the MCA | Lead Specialist Nurse for Safeguarding Adults and the MCA<br><br>Divisional, service and team managers | Audit tools | Audits will be undertaken by the Lead Specialist on a case by case basis or as issues arise as agreed with the AD and SA team. | Safeguarding Adults Sub-Committee will ensure governance including feedback and required actions | Safeguarding Adults Sub-Committee, Divisional committee leads | System and practice changes will be implemented via the Divisional structures with governance through the Safeguarding Adults Sub - Committee |

| | | | | | | |
|---|---|---|---|---|---|---|
| Training compliance | Divisional, service and team managers<br><br>Learning and Development and the Lead Specialist for Safeguarding Adults and the MCA | reports compiled by Learning and Development team showing compliance with TNA? | Quarterly | Safeguarding Adults Sub-Committee<br><br>Divisional committee structures | Learning and Development | System and practice changes will be implemented via the Divisional structures with governance through the Safeguarding Adults Sub - Committee |

## 11. References/Evidence/Glossary

Cairns R, Maddock C, Buchanan A, David AS, Hayward P, Richardson G et al. Prevalence and Predictors of Mental Incapacity in Psychiatric In-patients. British Journal of Psychiatry 2005, **187:379-85.**

Court of Protection.

Deprivation of Liberty Safeguards: Code of Practice (2009).

Mental Capacity Act 2005 and Mental Capacity Act: Code of Practice (2007). http://www.dca.gov.uk

Mental Health Act 2007: Code of Practice.

Office of the Public Guardian.

Raymont V, Bingley W, Buchanan A, David AS, Hayward P, Wessley S et al. Prevalence of Mental Incapacity in Medical In-Patients and Associated Risk Factors: Cross Sectional Study.
Lancet 2004, **364:142-7.**

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## Mental Capacity Assessment for Day to Day Decisions
## (Mental Capacity Assessment 1)

**Examples of day to day decisions are provided on page 29**

If a person does not have an impairment or disturbance of the mind or brain, they will not lack capacity under the Mental Capacity Act 2005.

**NB** The Mental Capacity Act's first principle is that a person must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack capacity in relation to those matters. The assessment must be about a particular decision that has to be made at the time the decision needs to be made.

### Details of Individual to be assessed

Name: _____

Date of Birth: _____

Present Address/Location: _____

Home Address (if different): _____

### Decision Requiring Assessment of Mental Capacity

| Provide details |
|---|
| |

**NB** Before deciding that someone lacks capacity to make a particular decision, it is important to take all practical and appropriate steps to enable them to make that decision themselves.

### Two-Stage Test of Mental Capacity (see Code of Practice, chapter 4)

a) Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works (it does not matter whether the impairment or disturbance is temporary or permanent)? Yes ☐ No ☐

b) Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? Yes ☐ No ☐

| Provide details |
|---|
| |

### Four-Stage Test of Mental Capacity

Can the person:

| | |
|---|---|
| Understand the information relevant to the decision? | Yes ☐ No ☐ |
| Retain that information? | Yes ☐ No ☐ |
| Use or weigh that information as part of the process of making the decision? | Yes ☐ No ☐ |
| Communicate his/her decision (whether by talking or any other means)? | Yes ☐ No ☐ |

| Provide evidence in respect of the person's ability in relation to each of these four elements of the test |
|---|
| |

**NB** If a person cannot do one or more of these four things, they are unable to make the decision.

**Outcome of the Mental Capacity Assessment**

On the balance of probabilities, there is a reasonable belief that (place a tick in the appropriate box):

The person **has** capacity to make this particular decision at this time. ☐

The person **does not have** capacity to make this particular decision at this time. ☐

Proceed in Best Interests. ☐

**Details of Assessor**

Assessor Name: _____

Signature: _____

Designation: _____

Date and Time: _____

Review Date: _____

## This Form Must Be Filed in the Person's Clinical Notes

## Examples of Day to Day Decisions

The list is not exhaustive, but examples of day to day decisions can include:

**Personal Care**

- Helping with washing, dressing or personal hygiene
- Helping with eating and drinking
- Helping with communication
- Helping with mobility (moving around)
- Helping someone take part in education, social or leisure activities
- Undertaking actions related to community care services (for example, day care, residential accommodation or nursing care)

**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 or 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.

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## Mental Capacity Assessment for Significant Decisions (Mental Capacity Assessment 2)

**Examples of significant decisions are provided on page 36.**

All adults (16 years and over) are presumed to have capacity.

Assessment of capacity for significant decisions should be conducted by two people who jointly fulfil the following criteria:

- One must be the decision-maker
- One must be a registered qualified professional
- Wherever possible, one must have an established relationship with the individual.

**If a decision needs to be made urgently then the assessment of capacity can be made solely by the decision-maker.**

Assessment of capacity must be recorded on the Mental Capacity Assessment 2 form, signed and dated by both people who have jointly undertaken the assessment.

| **1. Individual's Details** | |
|---|---|
| First name: | Surname: |
| Date of birth: | Ethnicity: |
| Date of assessment: | |
| Home address:<br><br>Postcode: | |
| Address of where individual is at the moment (if not at home):<br><br>Postcode: | |
| Telephone number: | |
| Nature of address:<br><br>Residential home ☐ Hospital ☐ | |

| | |
|---|---|
| Nursing home ☐ | Supported living ☐ |
| Own home ☐ | Prison ☐ |
| | Other ☐ |
| **2. Lasting Power of Attorney (LPA)** | |
| Is there a LPA (If YES, complete form):<br><br>Yes ☐ No ☐ | |
| **3. Family and/or Friends** | |
| Please provide details and nature of relationship for known family or friends who may be appropriate to consult if a decision needs to be made in an individual's best interests. | |
| Name: | Name: |
| Address: | Address: |
| Postcode: | Postcode: |
| Telephone number: | Telephone number: |
| Nature of relationship: | Nature of relationship: |
| If not appropriate to consult, the decision-maker must record the reason here and refer to an Independent Mental Capacity Advocate (IMCA): | If not appropriate to consult, the decision-maker must record the reason here and refer to an Independent Mental Capacity Advocate (IMCA): |
| **4. Basis of this Assessment** | |
| Serious medical treatment ☐ | Safeguarding procedures ☐ |
| Care review ☐ | Other ☐ |
| Change of accommodation ☐ | If other, please state: |
| **5. Advance Decisions** | |
| Is there an Advance Decision relevant to the decision:<br><br>Yes ☐ No ☐ | |

| Does the person have an impairment/disturbance of the mind or brain: | |
|---|---|
| Unconscious ☐ | Dementia ☐ |
| Learning disability ☐ | Other cognitive impairment ☐ (i.e. stroke) |
| Learning difficulty ☐ | Acquired brain injury ☐ |
| Mental health issues ☐ | Other ☐ |

**6. Decision**

Details of the decision or action that needs to be taken (include precise details of proposed serious medical treatment, change of accommodation, adult safeguarding, health and welfare, property or financial concerns, requesting an IMCA for an accommodation or care review or other proposed action/decision that is being considered):

**7. Decision-Maker's Details**

Name of the decision-maker:

Relationship to the individual:

**8. Mental Capacity Assessment**

All individuals aged 16 years and over are presumed to have capacity. An assessment of capacity should only be conducted where a concern has been raised that an individual does not have capacity make a specific decision or to consent to a specific action. All assessments of capacity are issue specific.

Assessments of capacity for significant decisions should be conducted by two people who jointly fulfill the following criteria:

- One must be the decision-maker
- One must be a registered qualified professional
- Wherever possible, one must have an established relationship with the individual.

If a decision needs to be made urgently then an assessment of capacity can be made solely by the decision-maker.

Care should be taken to ensure that all practicable steps are taken to facilitate an individual's optimum performance in this assessment, including provision of communication aides. Where an interpreter is required, this should be a professional interpreter.

**Every question is Section 8 must achieve a positive response before it can be determined that an individual has capacity.**

Have you explained to the individual the purpose of this assessment, including the provision of all necessary information to help them to make a decision:

Yes ☐ No ☐

If YES, how has this been discussed and how has this conclusion been reached?
Please record what practical steps have been taken to support the individual.

| |
|---|
| Does the individual understand the information given to them:<br><br>Yes ☐ No ☐<br><br>If YES, how has this been discussed and how has this conclusion been reached? |
| Does the individual have the capacity to retain the necessary information on which to make a decision:<br><br>Yes ☐ No ☐<br><br>How has this been discussed and how has this conclusion been reached? |
| Is the individual able to weigh up and discuss the potential advantages and disadvantages of the decision/action (in their own words):<br><br>Yes ☐ No ☐<br><br>How has this been discussed and how has this conclusion been reached? |
| Is the individual able to communicate a decision on the matter in question (this may be non-verbal (i.e. writing or through non-verbal communication) but it is important that there is consistency of response):<br><br>Yes ☐ No ☐<br><br>How has this been discussed and how has this conclusion been reached? |
| **9. Outcome of Capacity Assessment** |

| |
|---|
| It is legally the sole responsibility of the decision-maker to determine if the individual has capacity in respect of the specific question detailed in Section 6 – reason for capacity assessment.<br><br>A positive answer must have been achieved for all parts of Section 8. if a conclusion about an individual's capacity in respect of a specific decision cannot be reached, assessors working within Birmingham Community Healthcare NHS Trust can request a consultation (second opinion) through the Mental Capacity and Specialist Safeguarding Adults team. |
| Does the individual have capacity in respect of the specific decision:<br><br>Yes ☐ No ☐<br><br>**If No, Complete Best Interest Checklist (Mental Capacity Assessment 2.1)** |
| **10. Decision maker's and Assessor's Details** |
| Names and signatures of the two people conducting the joint assessment of capacity. |

| **Decision maker's details:** | **Assessor's details:** |
|---|---|
| Name: | Name: |
| Designation: | Designation: |
| Address:<br><br>Postcode: | Address:<br><br>Postcode: |
| Telephone number: | Telephone number: |
| Fax number: | Fax number: |
| E-mail address: | E-mail address: |
| Established relationship with individual: | Established relationship with individual: |
| Signature: | Signature: |
| Date: | Date: |

## Examples of Significant Decisions

The list is not exhaustive, but examples of significant decisions can include:

- Move of residence/accommodation
- Complex decisions around care and treatment, this will also include disagreements with family/carers
- Consent to admission to hospital, nursing or care home

- Management of their property or financial affairs
- Capacity to consent to a sexual act
- Capacity to consent to remain in an in-patient setting and may be subject to being deprived of their liberty
- Use of restraint
- Safeguarding cases that need an IMCA, advocacy, appointeeship or appropriate adult services
- Where there is a dispute over a LPA relating to health and welfare decisions and/or finances
- Request for a tribunal hearing when detained under the Mental Health Act (1983)
- Any other significant decision that carries significant risks or benefits for the individual.

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# Care Plan for Mental Capacity to Make Decisions

| | |
|---|---|
| **Name of Patient:** | **Identified Need:**<br><br>An assessment of mental capacity relating to **(state decision)** was completed on **(state date)**.<br><br>The conclusion of the assessment is that **(name of patient)** has the capacity to make the decision. |
| | **Intervention:**<br><br>**(Name of patient)** has understood and agreed/not agreed to **(state intervention)**.<br><br>This will be reviewed on **(state date)** to discuss with **(name of patient/patient's representative)** regarding future care and management in the event that **(name of patient)** loses mental capacity. |
| | **Name:** **Title:**<br>**Signature:** |
| | **Date:** |
| | **Date of Review:** |

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# Best Interests Checklist
# (Mental Capacity Assessment 2.1)

**Best Interests Checklist**

To be completed where individual does NOT have capacity in relation to the specific action/decision to be made. If any area of the checklist is not complete, please add comment.

If the individual does not have capacity, they cannot consent, therefore decisions about proceeding will need to be made on the basis of the individual's best interests. Consultation must occur where appropriate with any person holding Lasting Power of Attorney, Enduring

Power of Attorney, Court Appointed Deputy, Independent Mental Capacity Advocate (IMCA), family and friends.

Decisions made by the decision-maker in an individual's **best interests** must be the **least restrictive** possible.

The best interests decision and the assessment as a whole should show that the decision-maker has made a decision on the best available evidence and has taken into account conflicting views.

The Mental Capacity Act (MCA) provides legal protection from liability for carrying out care if:

- The principles of the MCA have been observed
- The decision-maker can demonstrate they assessed capacity
- The decision-maker reasonably believes the person lacks capacity with regard to the decision
- The decision-maker reasonably believes the action is in the best interests of the person.

Ordinarily a person representing the interests of the person should be consulted before making a decision. However, in emergency situations it will be often in the best interests of the person to provide urgent care without delay.

If there is a dispute then it should be clearly identified. If there is a dispute then the following things can assist the decision-maker:

- Involve an advocate who is independent of all parties involved
- Get a second opinion
- Hold a case conference
- Go to mediation.

An application can be made to the Court of Protection for a ruling.

**In determining the least restrictive final decision in an individual's best interests, the following factors should be considered where possible:**

☐ Involved individual as far as practically possible – please state how this has been achieved

| | |
|---|---|
| ☐ | Consulted records – please identify which records and identify any relevant information |
| ☐ | Consulted family and/or friends as appropriate – please identify who and records their views |
| ☐ | Used generic advocate as appropriate – please identify who and record their views |
| ☐ | Consulted other staff as appropriate – please identify who and record their views |
| ☐ | Considered past wishes and feelings (retrieve evidence of any previously recorded wishes and feelings) – please detail and identify the source |
| ☐ | Consulted with the IMCA – the IMCA's report should be recorded in the individual's case record and a copy of the record attached to the MCA2 |

| |
|---|
| |
| **Decision made by the decision-maker after consideration of all relevant factors in the individual's best interests:** |
| |
| **Names and signatures of the two people conducting this joint assessment of capacity:** |
| One person must be the decision-maker. One person must be a registered qualified professional. Please indicate which person has an established relationship with the individual. |
| **Decision maker's details:** |
| Name: |
| Designation: |
| Address:<br><br>Postcode: |
| Telephone number: |
| Fax number: |
| E-mail address: |
| Established relationship with individual: |
| Signature: |
| Date: |
| **Assessor's details:** |
| Name: |
| Designation: |
| Address:<br><br>Postcode: |

| |
|---|
| Telephone number: |
| Fax number: |
| E-mail address: |
| Established relationship with individual: |
| Signature: |
| Date: |

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# Care Plan for Best Interest Decisions

| | |
|---|---|
| **Name of Patient:** | **Identified Need:**<br><br>An assessment of mental capacity relating to **(state decision)** was completed on **(state date)**.<br><br>The conclusion of the assessment is that **(name of patient)** lacks capacity to make the decision. |
| | **Intervention:**<br><br>Any interventions (i.e. care and treatment) relating to **(state decision)** will be implemented in **(name of patient)**'s best interests following a Best Interest Meeting involving the decision-maker, other interested professionals and the patient's representative. |
| | **Name:** **Title:**<br>**Signature:** |
| | **Date:** |
| | **Date of Review:** |

**Lasting Power of Attorney Checklist**

Birmingham Community Healthcare NHS
NHS Trust

# Mental Capacity Act 2005

## Checklist for Assessing Lasting Powers of Attorney for Service Users Aged 18 Years and Over

Service User's Name: _____

Service User's Date of Birth: _____

Service User's NHS Number: _____

Under a Lasting Power of Attorney (LPA) the donor (the service user) confers upon individuals named in the document known as the 'Donee' or 'Donees', if more than one, authority to make decisions about the donor's personal welfare, property and affairs or specified matters concerning those.

This includes authority to make decisions when the donor no longer has capacity. However the following conditions must be satisfied for a valid LPA to be created:

- The donor must be 18 years old or above and have capacity when executing an LPA
- The Donee must be at least 18 years old
- The instrument conferring authority (LPA) must be in specific terms and have been registered with the Office of the Public Guardian.

Where the LPA allows decisions to be made as to the donor's personal welfare and these decisions concern life-sustaining treatment, a Donee cannot refuse life sustaining treatment unless the LPA expressly allows for this.

Where there is any doubt as to the validity of an LPA or whether a Donee under LPA is acting in the best interests of the donor (service user), legal advice should be sought and an application made to the Court of Protection if necessary.

Any decision in relation to powers conferred on the Donee of a LPA should be considered in reference to the principles in section 1 of the Mental Capacity Act and section 4 'best interests' provisions in the Act.

Please document clearly in the service user's clinical case notes your reasons for answering 'yes' or 'no' for any of the questions below.

**1. Have you seen the LPA and is it registered with the Court of Protection?**

Yes ☐ No ☐

If Yes, proceed to question 2.

If No, the LPA is not valid and the views and wishes of the Donee do not have to be followed.

**2. Does the donor/service user have capacity in respect of this specific decision or action?**

Yes ☐ No ☐

If Yes, then the service user can make the decision.

If No, proceed to question 3.

**3. Has the service user made any subsequent advance decision that is valid and applicable to this decision?**

Yes ☐ No ☐

If Yes, then follow the advance decision.

If No, proceed to question 4.

**4. Does the LPA cover the service users property and affairs only?**

Yes ☐ No ☐

If Yes, the Donee does not have the power to make decisions affecting the service user's welfare.

If No and it is clear that it covers welfare issues also proceed to question 5.

**5. Does the LPA allow for a second Donee and if so have they been consulted?**

Yes ☐ No ☐

If Yes and the document states that the Donees have joint and several responsibility then either donee may give the necessary authority. If it is only joint then both must agree to the proposed management.

If No, then proceed with the relevant authority from the single Donee.

**6. Has the Donee been fully informed of the nature, risks and consequences of the treatment/actions being proposed as well as the consequences of accepting or refusing the treatment/actions on behalf of the service user?**

Yes ☐ No ☐

If Yes, proceed to question 7.

If No, you must do so before the Donee or Donees take any decision.

**7. Does the decision of the Donee conflict with the views of health professionals looking after the service user or do you believe that the service user's best interests have not been properly considered (see Best Interests Checklist)?**

Yes ☐ No ☐

If Yes, consideration should be given to referring the matter to the Court of Protection and the case should be reported to senior staff in order to obtain legal advice in the first instance.

If No, then proceed in accordance with the wishes of the Donee.

**Life Sustaining Treatment**

**8. Does the Lasting Power of Attorney contain express provision authorising the Donee to give or to refuse consent to the carrying out or continuation of the life sustaining treatment?**

Yes ☐ No ☐

If Yes, then this is valid but consider question 9.

If No and life-sustaining treatment is necessary then it must be given.

Where there is any dispute with the health professional about the assessment of the service user's capacity which remains unresolved legal advice should be sought in order that the matter can be referred to the Court of Protection

**9. Do all relatives and carers agree with the proposed management and the wishes of the Donee?**

Yes ☐ No ☐

If Yes, proceed as planned.

If No, then this presents a potential risk and further advice should be sought.

I confirm I have understood and reviewed this checklist in respect of the above named service user:

Name of Health Professional: _____

Signature of Health Professional: _____

Designation of Health Professional: _____

Date: _____

**This checklist is only intended to provide guidance and a framework when considering a LPA. Where there are any doubts considering the validity and applicability of the LPA, further medical and or legal advice should be sought.**

**Body Map Assessment Tool**

Birmingham Community Healthcare NHS
NHS Trust

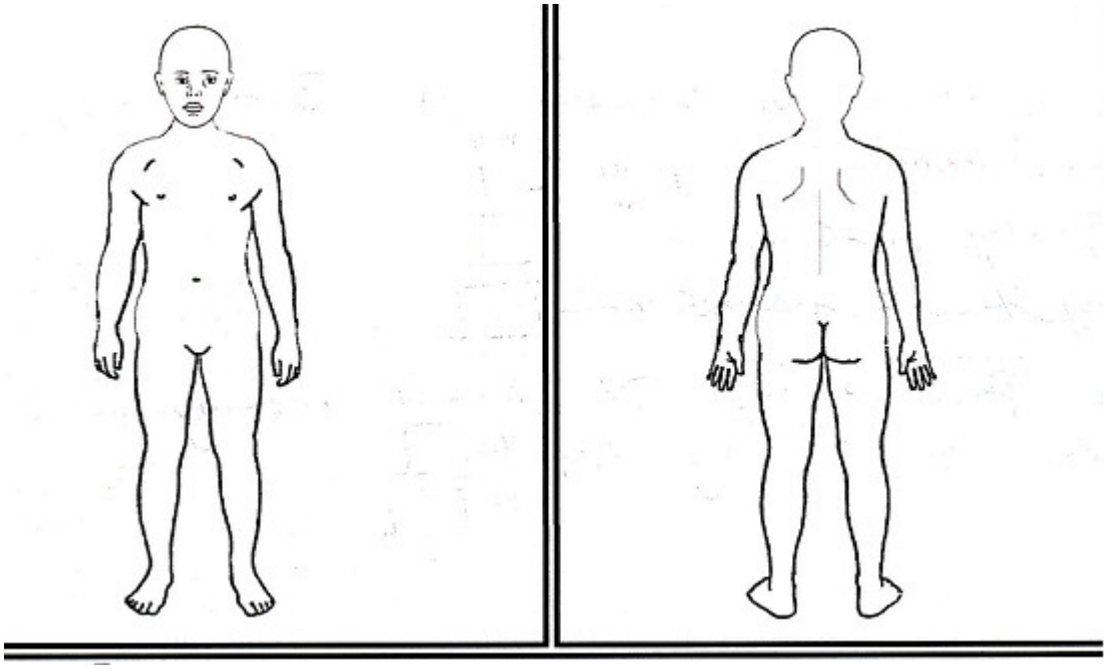
## Body Map Assessment

| | |
|---|---|
| a) | Service user's name:<br><br>Service user's location: |
| b) | What is the purpose of undertaking the body map?<br><br>Unknown/unexplained injury ☐<br><br>Safeguarding concern ☐ |
| c) | Does the person have the mental capacity to consent to the body map?<br><br>Yes ☐ No ☐ |
| d) | Is it considered in the person's best interests to undertake the body map?<br><br>Yes ☐ (proceed under the Mental Capacity Act)<br><br>No ☐ (state reason) |

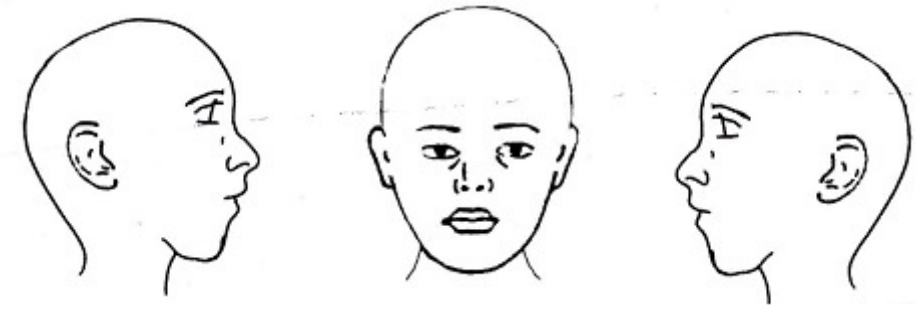
**These diagrams are designed for the recording of any observable bodily injuries that may appear on the person. Where bruises, burns, cuts or other injuries occur,**

**shade and label them clearly on the diagram. Label any internal injuries that have been identified through medical examination. Visible injuries apparent in soft tissue parts of the body, including the neck, underarms, stomach, genitals or inner thighs, are unlikely to manifest as a result of a fall or other accidents of this nature.**

**Front** **Back**



**Face**



| |
|---|
| Name of person completing this assessment: |
| Signature: |
| Date: |

**Appendix 8**

## Definitions

The table below is not a full index or glossary. Instead, it is a list of key terms used in the Code or the Act and the main references to them.

| Term | Definition |
|---|---|
| Acts in connection with care or treatment | Tasks carried out by carers, healthcare or social care staff which involve the personal care, healthcare or medical treatment of people who lack capacity to consent to them |
| Advance Decision to refuse treatment | A decision to refuse specified treatment made in advance by a person who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to or refuse the specified treatment. Specific rules apply to Advance Decisions to refuse life sustaining treatment |
| Best interests | Any decisions made or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out someone's best interests |
| Capacity | The ability to make a decision about a particular matter at the time the decision needs to be made |
| Court of Protection (CoP) | The specialist Court for all issues relating to people who lack capacity to make specific decisions |
| Decision-maker | Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout the Code as the 'decision-maker' and it is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity |
| Deprivation of Liberty Safeguards (DoLS) | The Deprivation of Liberty Safeguards apply to people in hospital, nursing and residential homes who lack capacity to consent to the arrangements made for their care and treatment but for whom are receiving care and treatment that amount to a deprivation of liberty |
| Deputy | Someone appointed by the Court of Protection with ongoing legal authority as prescribed by the Court to make decisions on behalf of a person who lacks capacity to make particular decisions |
| Enduring Power of Attorney (EPA) | A Power of Attorney created under the Enduring Powers of Attorney Act (1985) appointing an Attorney to deal with the Donor's property and financial affairs. Existing Enduring Powers of Attorney will continue to operate |
| Ill-treatment | Section 44 of the Act introduces a new offence of ill-treatment of a person who lacks capacity by someone who is caring for them or acting as a Deputy or Attorney for them. That person can be guilty of ill-treatment if they have deliberately ill-treated a person who lacks capacity or been reckless as to whether they were ill- |

| | |
|---|---|
| | treating the person or not. It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health |
| Independent Mental Capacity Advocate (IMCA) | Someone who provides support and representation for a person who lacks capacity to make specific decisions where the person has no-one else to support them. It is not the same as an ordinary advocacy service |
| Lasting Power of Attorney (LPA) | A Power of Attorney created under the Act appointing an Attorney (or Attorneys) to make decisions about the Donor's personal welfare (including healthcare) and/or deal with the Donor's property and affairs |
| Life Sustaining Treatment | Treatment that, in the view of the person providing healthcare, is necessary to keep a person alive |
| Office of the Public Guardian (OPG) | The Public Guardian is an officer established under Section 57 of the Act. The Public Guardian will be supported by the Office of the Public Guardian, which will supervise Deputies, keep a register of Deputies, Lasting Powers of Attorney and Enduring Powers of Attorney, check on what Attorneys are doing and investigate any complaints about Attorneys or Deputies |
| Protection from liability | Legal protection, granted to anyone who has acted or made decisions in line with the Act's principles |
| Personal welfare | Personal welfare decisions are any decisions about a person's healthcare, where they live, what clothes they wear, what they eat and anything needed for their general care and well-being. Attorneys and Deputies can be appointed to make decisions about personal welfare on behalf of a person who lacks capacity. Many acts of care are to do with personal welfare |
| Property and affairs | Any possessions owned by a person (such as a house or flat, jewellery or other possessions), the money they have in income, savings or investments and any expenditure. Attorneys and Deputies can be appointed to make decisions about property and affairs on behalf of a person who lacks capacity |
| Restraint | The use or threat of force to help do an act which the person resists or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm |
| Statutory principles | The five key principles are set out in Section 1 of the Act. They are designed to emphasise the fundamental concepts and core values of the Act and to provide a benchmark to guide decision-makers, professionals and carers acting under the Act's provisions. The principles generally apply to all actions and decisions taken under the Act |

| | |
|---|---|
| Two-stage test of capacity | To assess whether or not a person has capacity to make a decision for themselves at that time |
| Wilful neglect | An intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks (or whom the person reasonably believes lacks) capacity to care for themselves. Section 44 introduces a new offence of wilful neglect of a person who lacks capacity |

**Appendix 9**

## Training Flowchart

**All NHS clinical professional and clinical support staff who work directly with the specified age groups**

**All clinical staff who have any contact or work with young people aged 16 to 17 years and adults from aged 18 years and clinical support staff predominantly working with adult patients and young people with possible mental capacity issues.**

**Level 1a MCA Awareness**

Induction or SA Raising Awareness e-learning.

**Then** three yearly via completion of a screening assessment required to examine level of knowledge and competence. Successful completion will be classed as competent at Level 1 Raising Awareness, Level 1a MCA Awareness, Level 1b DoLS Awareness and Prevent. If unsuccessful Induction or e-learning to be completed.

**Relevant to Role**
**Mandatory for all qualified professional staff who work predominantly with young people aged 16 to 17 years and adults from aged 18 years required to obtain consent and complete more formal assessments of capacity with patients and clinical support staff predominantly working with adult patients and young people with possible mental capacity issues.**

**Level 2a MCA in Practice**

E-learning (competence for Level 1a should have been acquired).

**Then** three yearly refresher via e-learning. Update/additional bespoke training may be required as identified by PDR plus CPD, workshops, inter or single agency training, related academic study or evidence of reflective practice if required.

**MCA Managers Update**

**Operational and Divisional managers with SA or Safeguarding Children responsibilities of services of predominantly young people aged 16 to 17 years and adults aged 18 years and over (competence of Level 2a MCA in Practice should have been acquired according to role/ responsibilities).**

As required via Trust intranet/bespoke sessions.

**MCA Specialist and Advanced Practice**

**If providing specialist and advanced advice/guidance/supervision where there are SA, MCA and DoLS concerns (where additional knowledge is required around restraint practices, the impact/relevance of clinical diagnoses on mental capacity, complex mental capacity assessments, clinical supervision, Court of Protection and relevant healthcare law and practice)**

**Updates** via workshops and conference attendance, CPD events, inter or single agency training, related academic study or evidence of reflective practice.
Frequency: as required

**Experts, Designated Professionals and Board level staff**
**For SA experts and Designated Professionals with competences 23 and 24 specific to Board level staff.**

Annual update for Board members.
Experts/Leads/Directors via PDR, opportunities via networking, political awareness, leadership, strategy and national and international conferences as required.