NHS
Bedfordshire, Luton and Milton Keynes
Integrated Care Board

Mental Capacity Act Policy

Document Status:

This is a controlled document. Any printed or downloaded copies are not controlled. The version of this document published on the Bedfordshire, Luton & Milton Keynes Integrated Care Board website is the controlled copy
www.befordshirelutonandmiltonkeynes.icb.nhs.uk

Sustainable Development - Environmental

Do you really need to print this document?

Please consider the environment before you print this document and where possible copies should be printed double-sided. Please also consider setting the page range in the print properties, when relevant to do so, to avoid printing the document in its entirety.

Document Control	
Document Owner:	Chief Nursing Director
Document Author(s):	Mental Capacity Act and Liberty Protection Safeguards Lead
Directorate:	Nursing and Quality
Approved By:	The Board of the Integrated Care Board
Date of Approval:	01-07-2022
Date of Next Review:	01-07-2024 (see statement on page 6)
Effective Date:	01-07-2022

Version Control			
Version	**Date**	**Reviewer(s)**	**Revision Description**
Final v1.0	01-07-2022	The Board of the Integrated Care Board	Adopted approved policy

Implementation Plan

Development and Consultation:	The following individuals were consulted and involved in the development of this document: ▪ Mental Capacity Act and Liberty Protection Safeguards Lead ▪ Safeguarding Adults Leads ▪ Continuing Health Care Development Practitioners
Dissemination:	Staff can access this document via the website and will be notified of new and revised versions via the staff briefing. This document will be included in the organisation's Publication Scheme in compliance with the Freedom of Information Act 2000.
Training:	The following training will be provided to make sure compliance with this document is understood: ▪ Mental Capacity Act (MCA): An Overview ▪ Assessing Mental Capacity: Talk through of a Mental Capacity Assessment ▪ Deprivation of Liberty Safeguards (DoLS) ▪ Court of Protection Deprivation of Liberty (COPDOL) Processes and Procedures The training required to comply with this policy are: ▪ Mental capacity Act Policy awareness sessions ▪ Mandatory training programme ▪ E-learning ▪ Multi-Agency training may be available from the Local Authority ▪ Bespoke training may also be available from the Safeguarding Adults Team and/or MCA/DoLS Lead for the ICB
Monitoring:	Monitoring and compliance of this document will be carried out via: ▪ Verification of COPDOL Applications ▪ Auditing of Mental Capacity documentation ▪ Checking its accuracy in applying it in working practice ▪ Listening to feedback from staff who use the Policy
Review:	The Document Owner will ensure this document is reviewed in accordance with the review date on page 2.
Equality, Diversity and Privacy:	Appendix 1 - Equality Impact Assessment Appendix 2 - Data Protection Impact Assessment
Associated Documents:	The following documents must be read in conjunction with this document: • Safeguarding Adults Policy • Covert Administration of Medication Policy/Guidance

References:	The following articles were accessed and used to inform the development of this document and included are some useful resources: ▪ https://www.mentalcapacitylawandpolicy.org.uk/mca-codes-of-practice-update/ ▪ https://www.mentalcapacitylawandpolicy.org.uk/ ▪ https://capacityguide.org.uk/ ▪ The Mental Capacity Act 2005 http://www.legislation.gov.uk/ukpga/2005/9/contents ▪ Social Care Institute for Excellence (SCIE). This site provides information on the basics in terms of introductory knowledge and key messages, and builds up through stages, with links to guidance targeted at specific audiences, such as health and social care professionals and independent mental capacity advocates (IMCA's). https://www.scie.org.uk/mca ▪ Assistance in completion of MCA assessments for practitioners and patients: www.assessright.co.uk ▪ MCA law cases: http://www.39essex.com/cop_cases/ ▪ Deprivation of Liberty: A Practical Guide. (April 2015) The Law Society https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/ **Legislation and statutory requirements** ▪ Cabinet Office (1998) Human Rights Act 1998. London. HMSO. ▪ Cabinet Office (2000) Freedom of Information Act 2000. London. HMSO. ▪ Cabinet Office (2005) Mental Capacity Act 2005. London. HMSO. ▪ Cabinet Office (2007) Mental Health Act 2007. London. HMSO. ▪ Cabinet Office (2010) Equality Act 2010. London. HMSO. ▪ Cabinet Office (2014) Care Act 2014. London. HMSO. ▪ Griffiths, Rachel and Leighton, John (November 2012) Adults' Service SCIE Report 62. Managing the transfer of responsibilities under the Deprivation of Liberty Safeguards: a resource for local authorities and healthcare Commissioners. London: Social Care Institute for Excellence. ▪ Health and Safety Executive (1974) Health and Safety at Work etc. Act 1974. London. HMSO. ▪ House of Lords (March 2014) Select Committee on the Mental Capacity Act 2005: Post-legislative scrutiny. London: The Stationery Office **Best practice recommendations** ▪ Department of Health. (2006) Records Management: NHS Code of Practice. London: DH. ▪ NHS Litigation Authority. (2008) Risk Management Standard for Primary Care Trusts. London: NHSLA. ▪ NHS England (London) (April 2014) Mental Capacity Act 2005: A guide for Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance. London: NHS England ▪ NHS England (London) (July 2015) Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework; London NHS England

	▪ HM Government (June 2014) Valuing Every Voice, respecting every right: Making the Case for the Mental Capacity Act. The Government's response to the House of Lords Select Committee report on the Mental Capacity Act 2005. ▪ Lord Chancellor and Secretary of State for Justice and Secretary of State for Health ▪ Independent Safeguarding Authority http://www.isa-gov.org.uk/ ▪ Ruck Keene, Alex and Dobson, Catherine (April 2014) Mental Capacity Law: Guidance Note. Deprivation of Liberty in the Hospital Setting. London: 39 Essex Street ▪ Social Care, Local Government and Care partnership (2014). Positive and Proactive Care: Reducing the need for restrictive interventions. London: Department of Health ▪ Social Care Institute for Excellence (August 2014) Adult Services: Report, ▪ Deprivation of Liberty Safeguards: putting them into practice. London: www.scie.org.uk ▪ Deprivation of Liberty: A Practical Guide. (April 2015) The Law Society https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Mental Capacity Act and Deprivation of Liberty – Holding Statement for Policies to be updated.

February 2022.

The Mental Capacity Act Policy and the Deprivation of Liberty Safeguards Policy are both due for renewal, however we are postponing reviewing these until we have a date for implementation, in anticipation of the Mental Capacity (Amendment) Act 2019 coming into force which has now been delayed twice. Whilst we are awaiting the new code of practice to be published for consultation, the statutory law and guidance should be followed in conjunction with the information on case law which can be found on the link below.

There are currently two separate Codes of Practice to the Mental Capacity Act 2005, one for the main body of the Act, and one for the Deprivation of Liberty Safeguards. They are statutory Codes: they have been approved by Parliament, and the MCA 2005 requires certain people to have regard to them. Those people include anyone acting in a professional capacity.

Neither Code of Practice has ever been updated since they were published, the main Code in 2007, and the DoLS Code in 2009. They are both out of date in significant ways.

As part of the coming into force of the Mental Capacity (Amendment) Act 2019, it was anticipated that there would be a new Code published which would (in one place) update the main MCA Code and give guidance as to the operation of the Liberty Protection Safeguards. (LPS) However, the LPS have been delayed and, whilst we anticipate that there will be a consultation on the draft Code in 2022 (hopefully relatively early in 2022), it appears likely that professionals will be operating using two out of date Codes for some time.

Alex Ruck Keene (a specialist barrister at 39 Essex Chambers in The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) has created a guidance note with his colleagues in Chambers which indicates where the current Code of Practice is out of date.

Whilst professionals must have regard to the Codes, they should depart from them where they have been superseded by case-law which makes clear what is in the Act itself, the source of the law.

Alex Ruck Keene et al has prepared this guide to those parts of the two Codes which are most out of date.

See link below.
https://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2022/02/Mental-Capacity-Guidance-Note-Codes-of-Practice-Update-February-2022.pdf

We would expect that all professionals adhere to the Act, it's code, guidance and any caselaw that supersedes and amend any working practice to ensure compliance with the law.

The MCA & DoLS Policies will be reviewed once the Code of Practice is finalised and published and will at that time be amalgamated into one Policy.

Table of Contents

1.0 Introduction

1.1 NHS Bedfordshire, Luton and Milton Keynes Integrated Care Board (the ICB) aims to ensure robust governance through its formal written procedural documents, such as this document, which communicate standard organisational ways of working. These documents help clarify operational requirements and consistency within day-to-day practice. They can improve the quality of work, increase the successful achievement of objectives and support patient safety, quality and experience. The ICB aims to ensure its procedural documents are user friendly, up-to-date and easily accessible.

1.2 The ICB must design and implement procedural documents that meet the diverse needs of our service and workforce, ensuring that none is placed at a disadvantage over others, in accordance with the Equality Act 2010. The Equality Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to the individual protected characteristics is incorporated at Appendix 1.

1.3 A Data Protection Impact Assessment is a process which helps assess privacy risks to individuals in the collection, use and disclosure of personal information. The Data Protection Impact Assessment initial screening, which was used to determine the potential impact this policy might have with respect to an individual's privacy is incorporated at Appendix 2.

1.4 This policy covers the areas outlined in the Mental Capacity Act 2005 (MCA), and the MCA Code of Practice (2007); see appendix 3 for MCA process flow chart, appendix 4 for MCA Assessment Forms and MCA referral form and appendix 5 for information and guidance.

1.5 The policy makes reference to the use of restraint under the Act and the interface with Article 5 (Right to liberty and security) and 8 (Right to respect for private and family life) of the Human Rights Act. This will then ensure a person's rights are respected and upheld, and ICB staff are aware of the process that needs to be followed where best interest decisions are likely to engage a person's human rights.

1.6 The preparation of this document has included an assessment of risk covering clinical, financial, business and operational risks arising specifically from the implementation of the procedures described herein.

2.0 Scope

2.1 This policy applies to all ICB staff members, including Ordinary Members of the Board of the ICB, involved in policy-making processes, whether permanent, temporary or contracted-in under a contract for service (either as an individual or through a third-party supplier).

2.2 The purpose of this policy is to:

- Outline the responsibilities of the ICB in applying the Mental Capacity Act (2005) and the Code of Practice (2007), with regard to ensuring that as Commissioners of health services, these responsibilities are adopted and embedded by those we commission services from.
- Assist ICB Staff in determining whether an adult lacks capacity, including:
  - How to establish this
  - What action to take once identified
  - How to make decisions when a person lacks capacity
  - When to instruct an Independent Mental Capacity Advocate (IMCA)
- Outline steps staff should take to demonstrate they have taken appropriate action when making 'best interests' decisions for various levels of decision-making.

3.0 Definitions

3.1 The following terms and abbreviations are used within this document:

Reference	Abbreviated Term
ADRT	Advance Decision to Refuse Treatment
CoP	Court of Protection
DoLS	Deprivation of Liberty Safeguards
EPA	Enduring Power of Attorney
GP	General Practitioner
IMCA	Independent Mental Capacity Advocate
LPA	Lasting Power of Attorney
MCA	Mental Capacity Act
MHA	Mental Health Act
OPG	Office of the Public Guardian
SMT	Serious Medical Treatment (Can be anything considered invasive to the body) See full definition at 3.3 below

3.2 Definition of Mental Capacity

3.2.1 Mental Capacity is the ability to make decisions for ourselves. It should be assumed that an adult (aged 16 or over) has full legal capacity to make decisions for themselves unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made.

3.2.2 A person is deemed to lack capacity at a certain time if they are unable to make a decision for themselves in relation to a matter because of an impairment, or a disturbance in the functioning of the mind or brain.

3.2.3 An impairment or disturbance in the brain could be as a result of:

- A stroke or brain injury

- A mental health problem
- Dementia
- A significant learning disability
- Confusion, drowsiness or unconsciousness or because of an illness or treatment for it
- The effects of drugs and/or alcohol
- Delirium

(This list is not exhaustive)

3.2.4 Mental Capacity is our decision making ability; when capacity is assessed it is for one decision at a time, and is time and issue specific. It is the assessor's responsibility to find and document evidence that the person lacks the capacity to make that specific decision at that time. The person being assessed does not have to prove they have capacity, as they have capacity until proven and evidenced otherwise. (Principle 1: A person is to be assumed as having capacity).

3.2.5 Lacking capacity is about a particular decision at a certain time, not a number or range of decisions. If someone cannot make a complex decision it does not mean they lack capacity for all decisions.

3.2.6 It does not matter if the impairment or disturbance is permanent or temporary but if the person is likely to regain capacity in time for the decision to be made, the decision should be delayed and the person empowered to make their own decision. Therefore capacity assessments may be required at various periods or different times of the day and a review of the decision is necessary.

3.2.7 Capacity cannot be established merely by reference to a person's age, appearance or condition, or any aspect of their behaviour, which might lead others to make an assumption about their capacity. (E.g. just because someone has a diagnosis of a dementia or a learning disability does not mean that they lack capacity; a person has capacity until it is evidenced otherwise). The person does not have to prove they have capacity, it is the responsibility of the assessor/decision maker to find and record the evidence that the person lacks the capacity for that particular decision at that time. Assumptions should not be made about a person's quality of life. It is essential to fully involve the individual in the assessment and give weight to their views, preferences and wishes.

3.2.8 Individuals are entitled to make decisions which others may deem as unwise, providing there is no objective evidence that they lack the capacity to do so. Lack of Capacity must be established and evidenced following the processes outlined in appendix 3. If someone is making an unwise decision this should be respected; however, it is good practice to offer support and monitoring should there be consequences for the person based on their decision.

3.3 **Serious Medical Treatment (SMT)**

3.3.1 Serious Medical Treatment (SMT) is defined in the Mental Capacity Act 2005 (Independent Mental Capacity Advocates; IMCA) (General) Regulations 2006 as treatment which involves providing, withdrawing or withholding treatment in circumstances where one or more of the following apply:

- In a case where a single treatment is being proposed, there is a fine balance between its benefits to the person and the burdens and risks it is likely to entail for them
- In a case where there is a choice of treatments, a decision as to which one to use is finely balanced
- What is proposed would be likely to involve serious consequences for the person.

3.3.2 The MCA Code of Practice says that 'serious consequences' may include treatment options which:

- Cause serious and prolonged pain, distress or side effects
- Have potentially major consequences for the person (for example, major surgery or stopping life-sustaining treatment)
- Have a serious impact on the person's future life choices.

3.3.3 The MCA Code of Practice lists the following examples of possible Serious Medical Treatment:

- Chemotherapy
- Electro-convulsive therapy
- Therapeutic sterilisation
- Major surgery (such as open-heart surgery or brain/neurosurgery)
- Major amputations (for example, loss of an arm or leg)
- Treatments that will result in permanent loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration
- Termination of pregnancy.

3.3.4 Any decision not to offer the above treatments would similarly require the involvement of an IMCA.

4.0 Policy Statement

4.1 The Board and Chief Executive Officer of the ICB are committed to the development of a just and fair "no blame" culture, and this document supports that ethos.

4.2 The ICB aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the ICB will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

4.3 The ICB has a duty to ensure provider services are delivered in accordance with the Mental Capacity Act 2005 (MCA) and that the rights of those who use services are promoted and protected. The ICB has responsibility for commissioning high quality care and treatment. The ICB must ensure providers understand the Mental Capacity Act 2005, apply it to practice and monitor compliance and ensure that all staff are trained and competent in applying it to their working practice.

4.4 Fundamentally the ICB will want to ensure:

- The MCA is given a high profile and priority within the ICB
- Compliance and how this will be achieved is a key part of the tendering process

5.0 Roles and Responsibilities

5.1 Chief Executive Officer

The Chief Executive Officer has overall responsibility for the strategic direction and operational management, including ensuring that ICB process documents comply with all legal, statutory and good practice guidance requirements.

5.2 MCA & DoLS Lead

The Mental Capacity Act & Deprivation of Liberty Safeguards Lead is responsible for:

- Maintaining and reviewing this policy document.
- Updating this policy when required
- Monitoring the implementation of this policy document
- Delivering training in relation to this policy

5.3 All Managers

All managers are responsible for ensuring that relevant staff within the ICB have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

5.4 All Staff

- All staff, are responsible for:
- Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken.
- Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities.
- Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly.
- Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager.
- Attending training/awareness sessions when provided.

6.0 Processes and Procedures

6.1 Mental Capacity Act:

6.1.1 Legal Protection

6.1.1.1 The MCA provides legal protection from liability for carrying out certain actions in connection with care and treatment of people provided that:

- You have observed the principles of the MCA
- You have carried out, or been party to, an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in question and;
- You reasonably believe the action you have taken is in the best interests of the person and;
- You reasonably believe it is a proportionate response to the risk identified.

6.1.2 Examples of treatments/Interventions:

6.1.2.1 Provided you have complied with the MCA in assessing capacity and acting in the person's best interests, you will be able to treat patients who do not have the capacity to give their consent. For example:

- Diagnostic examinations and tests
- Assessments
- Medical and dental treatment
- Surgical procedures
- Admission to hospital for assessment or treatment (except for people detained under the Mental Health Act 2007 (MHA)
- Nursing care
- Emergency procedures – in emergencies it will often be in a person's best interests for you to provide urgent treatment without delay under the common law doctrine of necessity/emergency.
- Permanent placements in residential/nursing care (although must try least restrictive option first where viable and applicable.(i.e. care package at home first)

(This list is not exhaustive)

6.1.3 The five key principles

6.1.3.1 There are five key principles underpinning the Mental Capacity Act (2005) as follows:

1. A presumption of capacity - every adult (above the age of 16 yrs. under the MCA) has the right to make his or her own decisions and must be assumed to have capacity unless it is proved otherwise.
2. Supporting Individuals to make their own decisions – a person must be given all practicable help to empower and support the individual to make their own decisions.

3. Unwise decisions - just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
4. Best interest – anything done for or on behalf of a person without capacity must be done in their best interests. (This is not what another individual believes to be the person's best interests, but what that person being assessed would want if they were able to make this decision for themselves).
5. Least restrictive – anything done for or on behalf of a person without capacity should be the least restrictive of their basic rights and freedoms. Before the act or decision is made, ensure it can be achieved in the least restrictive manner.

6.1.4 Introducing other bodies

6.1.4.1 The Mental Capacity Act applies to all people in England and Wales over the age of 16, with the exception of making a Lasting Power of Attorney (LPA); making an Advance Decision to Refuse Treatment and making a will. In these situations, a person must be aged 18 or over.

6.1.4.2 The Act also introduces other bodies and regulations that staff must be aware of including:

- The Independent Mental Capacity Advocate (IMCA) involve this person when no family/friends to consult
- The Office of the Public Guardian (OPG)
- The Court of Protection (CoP)
- Advance Decisions to Refuse Treatment (ADRT)
- Lasting Powers of Attorneys (LPA's) & Deputies

6.1.5 The Independent Mental Capacity Advocate (IMCA)

6.1.5.1 The IMCA provision:
Independent Mental Capacity Advocacy Providers in Bedfordshire, Luton & Milton Keynes:

Bedford Borough & Central Bedfordshire	**Luton**	**Milton Keynes**
VoiceAbility 0300 303 1660 option 2 helpline@voiceability.org www.voiceability.org	Pohwer Advocacy: 0300 456 2370 pohwer@pohwer.net www.pohwer.net/luton	The Advocacy People 0330 440 9000 info@theadvocacypeople.org.uk www.theadvocacypeople.org.uk

6.1.5.2 Advocacy is taking action to help people:

- Express their views
- Secure their rights

- Have their interests represented
- Access information and services
- Explore choices and options

Advocacy promotes equality, social justice and social inclusion. The IMCA does not assess the person's capacity and is not a decision maker for a person who is deemed as lacking the capacity for that particular decision at that time. The IMCA will support the person who lacks capacity and represent their views and interests to the decision maker, who must take these into account, when making a decision in the person's best interests. The decision maker must inform the IMCA of the final decision made in the best interests of the individual and justify the reasoning behind the decision.

6.1.5.3 An IMCA referral MUST be made when a person has been deemed to lack the capacity for a particular decision at that time and the person has no family or friends to support them and:

- There needs to be a decision made relating to Serious Medical Treatment or
- Changes in long-term care (more than 28 days in a hospital or 8 weeks in a care home) or
- A long-term move to different accommodation is being considered for a period of over 8 weeks

6.1.5.4 An IMCA referral MAY be considered for a person who has been deemed to lack the capacity for a particular decision at that time and the person has no family or friends to support them when:

- Care Reviews take place, if the IMCA would provide a particular benefit e.g. continuous care reviews about accommodation or changes to accommodation and also if the IMCA has been involved previously.
- Safeguarding adult investigations take place - even if the person is befriended, but family/friends have been deemed inappropriate to consult.

6.1.5.5 If a decision is to be made in relation to any of the above statutory areas (apart from emergency situations) an IMCA **MUST** be instructed **PRIOR** to the decision being made. If it is urgent then the decision can be taken without an IMCA but they must be instructed afterwards.

6.1.5.6 If, after consultation with your line manager, you consider the appointment of an IMCA would be of particular benefit to an individual then a referral must be made as outlined within Appendix 3.

6.1.5.7 It is important to remember that an IMCA is not a decision maker for a person who lacks capacity, but instructed to support the person who lacks capacity and represent their views and interests to the decision maker; equally, they are not mediators between parties in any dispute.

6.1.5.8 The IMCA will prepare a report for the person who instructed them and if they disagree with the decision made they can also challenge the decision maker.

6.2 The Office of the Public Guardian (OPG)

6.2.1 The OPG exists to help protect people who lack capacity by setting up a register of Lasting Powers of Attorney; Court appointed Deputies; receiving reports from Attorneys acting under LPAs and from Deputies; and providing reports to the COP, as requested.

6.2.2 The OPG can be contacted to find out if someone has an LPA or Deputy acting for them: Apply to search the Office of the Public Guardian registers to see if someone has another person acting on their behalf.

6.2.3 This can be an attorney under a lasting power of attorney, an attorney under an Enduring Power of Attorney or a court appointed Deputy. You need to complete form 'OPG 100' to search the register. This is a free service.

6.2.4 Send your completed form to: Office of the Public Guardian
customerservices@publicguardian.gsi.gov.uk
Fax: 0870 729 5780

6.2.5 Further information regarding the Office of the Public Guardian can be found by the following link:
https://www.gov.uk/government/organisations/office-of-the-public-guardian

6.3 The Court of Protection (CoP)

6.3.1 This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so.

6.3.2 When the MCA came fully into force in October 2007 it set up a Court of Protection to make decisions in relation to the property and affairs, and also health and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges and authority in relation to mental capacity matters as the High Court. It is a superior court of record and is able to set precedents (examples to be followed in future cases).

6.3.3 The Court of Protection has the powers to:

- Decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions;
- Appoint Deputies to make decisions for people lacking capacity to make those decisions;
- Decide whether an LPA or EPA is valid; and remove Deputies or Attorneys who fail to carry out their duties,
- Hear cases concerning any objections to register an LPA.

6.3.4 Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are available from https://www.gov.uk/search?q=court+of+protection+fees

6.3.5 Further information regarding the Court of Protection can be accessed via the website and the following link: https://www.gov.uk/courts-tribunals/court-of-protection

6.3.6 It must be stressed that any reference to the Court of Protection must be discussed with The Mental Capacity Act and Deprivation of Liberty Safeguards Lead in the first instance. The ICB must ensure that all informal and formal internal mechanisms be exhausted before making any application to the Court of Protection. Refer also to Clinical Intervention. (See guidance Appendix 5).

6.4 Advance Decisions to Refuse Treatment (ADRT)

6.4.1 A person may have expressed verbally or documented an advance decision to refuse specific treatments, which may relate to medical decisions and treatment; these should be recorded in the persons file where there is knowledge of them. These may also be logged with the person's GP. ADRT's are legally binding if made in accordance with the Act.

6.4.2 Making an Advance Decision to Refuse Treatment over the age of 18 years allows particular types of treatment a person would never want, to be honoured in the event of them losing capacity – this is legally binding and all professionals must respect the person's wishes providing the ADRT is valid and applicable (see below).

6.4.3 You must make all reasonable effort to establish if an Advance Decision to Refuse Treatment exists and that it is valid and applicable to the particular treatment in question.

6.4.4 The Act introduces a number of guidelines that must be followed. Therefore a person should check that their current Advance Decision to Refuse Treatment meets the criteria below (6.4.5 to 6.4.7) if it is to take effect.

6.4.5 An Advance Decision to Refuse Treatment does not need be in writing although it is more helpful. ADRT's about life sustaining treatment must be in writing (treatment needed to keep a person alive and without it, they may die).

6.4.6 Advance Decisions to Refuse Treatment regarding life sustaining treatment **must**:

- Be in writing
- Contain a specific statement, which says "*this decision applies even though my life may be at risk"*
- Signed by the person or nominated appointee and in front of a witness
- Signed by the witness in front of the person

6.4.7 The person signing and/or witnessing should not be someone who is likely to benefit from the person's death.

6.4.8 This does not change the law on euthanasia or assisted suicide. A person cannot ask for an ADRT to end their life or request treatment in the future.

6.4.9 The validity of an ADRT may be challenged on the following grounds;

- If the ADRT is not applicable to this treatment decision
- If it is treatment for a mental disorder, treatment could be given under the Mental Health Act if the criteria for admission are met
- If the relevant person changes their mind
- If they do a subsequent act that contradicts the ADRT
- They have appointed a Lasting Power of Attorney (LPA) for Personal Welfare **after** the date of the ADRT. This means that the LPA can make this decision in the person's best interests only if the person has been deemed as lacking the capacity to make that decision at that time.

6.5 Lasting Powers of Attorney (LPA)

6.5.1 This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. This has far reaching effects for healthcare workers because the Mental Capacity Act extends to the way people using services can plan ahead for a time when they may lack capacity. These are Lasting Powers of Attorney (LPAs), Advance Decisions to Refuse Treatment (ADRT's) and written statement of wishes and feelings. LPAs can be friends, relatives or a professional for:

- Property and Affairs LPA regarding financial and property matters.
- Personal Welfare LPA regarding decisions about health and welfare.
- This must be recorded in the person's file where there is knowledge of it. It only comes into effect after the person loses capacity and must be registered with the Office of the Public Guardian. An LPA can only act within the remit of their authority.

6.5.2 Important facts about Lasting Powers of Attorneys (LPA's) and Enduring Powers of Attorney (EPA's)

- Enduring Powers of Attorney (EPAs) will continue whether registered or not, although must be registered if the person loses capacity.
- EPA's will only cover decisions for Property and Affairs and does NOT cover Personal Welfare or health decisions.
- Only EPAs made and signed before October 1, 2007 can still be used. After that date donors will make a Lasting Power of Attorney (LPA) instead.
- When a person makes an LPA they must have the capacity to understand the importance of the document and the authority and powers they are giving to the LPA.

- Before an LPA can be used it must be registered with the Office of the Public Guardian.
- An LPA for property and affairs can be used when the person still has capacity unless the donor specifies otherwise.
- A personal welfare LPA will have no power to consent to, or refuse treatment whilst the person has the capacity to decide for themselves.
- If a person deemed as lacking the capacity for their care and treatment is in your care and has an LPA for personal welfare acting in their best interests, the LPA will be the decision maker on all matters relating to the person's care and treatment. The LPA has a duty to provide the documentation to evidence that they have this decision making authority. You must take a copy of the LPA document and the registered document and place it on the persons file. If this evidence is not provided and copies are not in the person's file, you as the professional will remain the decision maker until the documentation is produced.
- If the decision is about life sustaining treatment the LPA will only have the authority to make the decision if the LPA documentation specifies this. Otherwise, this decision is made by the person proposing that care or treatment.
- If you are directly involved in the care or treatment of a person, you should not agree to act as a Lasting Power of Attorney for that person.
- It is important to read in full, the LPA documentation to understand the extent of the attorney's power. (Some or all decisions may be stipulated).
- An LPA cannot demand a particular treatment, they will be able to make decisions as stipulated in the LPA documentation.

6.6 Excluded Decisions

6.6.1 Decisions that are not covered by the MCA should be taken to The Court of Protection include:

- Making a will
- Making a gift (unless the person has a finance LPA)
- Entering into a contract
- Entering into litigation
- Entering into marriage
- Consenting to Sexual Relationships
- Divorce
- Adoption
- Voting or standing for office
- Proposed withholding or withdrawal of artificial nutrition and hydration from a person in a permanent vegetative state or a minimally conscious state.
- Cases involving organ or bone marrow donation by a person who lacks capacity to consent.
- Cases involving non-therapeutic sterilisation of a person who lacks capacity to consent.

6.6.2 There must always be an assumption of capacity; however procedural guidance (appendix 5) advises staff what to do if it is suspected that a person has a disturbance in the function of the mind or brain and may lack the capacity to make a decision at the particular time it needs to be made. The test, often referred to as the Functional Test, supports assessors to determine whether or not the person can make the decision or lacks the mental capacity to do so.

6.6.3 It is recognised that a number of different professionals are involved with persons who may lack capacity and in certain circumstances may be required to make decisions on their behalf, as long as the decisions they make are within their job remit and they know and understand the implications of making that particular decision at that time.

6.6.4 The extent to which expert input is required, and the degree to which detailed recording is necessary, depends on the nature of the decisions being made. Some decisions will be day to day, such as what to wear, and other decisions many have more lasting or serious consequences such as a change of accommodation, serious medical treatment or restraint.

6.6.5 Staff have to show that they have:

- Followed the five key principles which must inform all actions carried out when providing care or treatment for a person who lacks capacity
- Enabled the person, so far as is possible, to make their own decisions
- Taken reasonable steps to establish lack of capacity and documented this
- Reasonable belief that the person lacks capacity for that decision at that time
- Demonstrated their action will be in the person's best interests.

6.6.6 Section 5 of the Act offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity, provided they have followed due process and can evidence this through documentation.

6.7 Restraint

6.7.1 Section 6(4) of 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 resisting, or
- Restrict a person’s freedom of movement, whether they are resisting or not.

6.7.2 Any action intended to restrain a person who lacks capacity will not have protection from liability unless the following two conditions are met:

1. The person taking action must reasonably believe that restraint is necessary to **prevent harm** to the person who lacks capacity, and
2. 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.

6.7.3 Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. Professionals or carers must not use restraint just so that they can do something more easily.

6.7.4 If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible and consideration should be given as to whether the restraint used could be classed as a deprivation of the persons liberty. A legal authorisation will be required if The Deprivation of Liberty Safeguards 2009 apply.

6.7.5 Staff should consider less restrictive options before using restraint. Where possible, they should ask other people involved in the person's care what action they think is necessary to protect the person from harm. For example, it may be appropriate to get an advocate to work with the person to see if they can avoid or minimise the need for restraint to be used.

6.8 Archiving

6.8.1 Archived copies of superseded policy documents will be retained in accordance with Records Management: NHS Code of Practice 2009.

6.9 Equality Impact Analysis Statement

6.9.1 The ICB is committed to promoting equality in all its responsibilities – as commissioner of services, as a provider of services, as a partner in the local economy and as an employer. This policy will contribute to ensuring that all users and potential users of services and employees are treated fairly and respectfully with regard to the protected characteristics of age, disability, gender, reassignment, marriage or civil partnership, pregnancy and maternity, race, religion, sex and sexual orientation.

6.9.2 This is a substantial and, within its area of work, wide ranging policy.

6.9.3 The purpose of this policy is:

- To outline the responsibilities of the ICB in applying the Mental Capacity Act Code of Practice, with regard to ensuring that as Commissioners of services, these responsibilities are also adopted by those that we commission services from.
- To assist ICB staff in determining whether an adult lacks capacity, how to establish this, what action to take, how to make decisions when a person lacks capacity and when to instruct an Independent Mental Capacity Advocate (IMCA)
- To outline the responsibilities of ICB Commissioning staff who will be expected to monitor provider services to demonstrate that they have taken proper action when taking 'best interest' decisions for various levels of decision-making and are applying the Mental Capacity Act (2005) in everyday working practice.

6.9.4 It is comprehensively based on statutory requirements and NHS and other specialist policies and practices, which are, where appropriate, subject to equality impact assessments in their own right, and does not introduce working that is unique to the ICB.

6.9.5 An Equality Impact Assessment of the Mental Capacity Act 2005 was undertaken at the time of the Act and this can be found at http://webarchive.nationalarchives.gov.uk/20071204130111/http:/www.justice.gov.uk/docs/mc-equality-impact.pdf

6.9.6 This policy does not create actions that could have a differential impact on Bedfordshire Luton and Milton Keynes residents because of a protected characteristic. It will be more relevant to people with some protected characteristics than others, but if the procedures are implemented in a non-discriminatory way, they will not produce a differential impact because of the protected characteristic.

6.9.7 When looking at opportunities to promote equality the policy includes practical advice from the Code of Practice which would promote equality, such as providing Interpreters to support communication.

6.9.8 Considering all these factors it is my opinion that a separate equality impact assessment for this policy is not required.

Endorsed by
Equality Lead Luton CCG
April 2017

Appendix 1 - Equality Impact Assessment Initial Screening

Please answer the questions against each of the protected characteristic and inclusion health groups. If there are significant impacts and issues identified a full Equality / Quality Impact Assessment (EQIA) must be undertaken. It is against the law to discriminate against someone because of these protected characteristics. For support and advice on undertaking EQIAs please contact: agcsu.equalities@nhs.net

Name of Policy:	Mental Capacity Act and Deprivation of Liberty Safeguarding Policies
Date of assessment:	08/06/2022
Screening undertaken by:	Mental Capacity Act and Liberty Protection Safeguards Lead

Protected characteristic and inclusion health groups. Find out more about the Equality Act 2010, which provides the legal framework to tackle disadvantage and discrimination: https://www.equalityhumanrights.com/en/equality-act/protected-characteristics	Could the policy create a disadvantage for some groups in application or access? **There is reference to all of the protected characteristics however no disadvantage, application or access to any.**	If Yes - are there any mechanisms already in place to mitigate the potential adverse impacts identified? If not, please detail additional actions that could help. If this is not possible, please explain why
Age A person belonging to a particular age (for example 32 year olds) or range of ages (for example 18 to 30 year olds).	The Policy will positively impact on vulnerable adults age 16+. It sets out the procedures which staff are required to adhere to empower and support individuals to make their own decisions.	
Disability A person has a disability if she or he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.	The Mental Capacity Act is in place to uphold individual's rights and freedoms and linked to The Human Rights Act 1998. This policy sets out to address any discrimination relating to disability in line with legislation. The policy allows for scrutiny of care packages where restrictions may be in place that may amount to a deprivation. If so, an authorisation to make lawful that care package will be put in place and will further protect the individual.	
Gender reassignment The process of transitioning from one gender to another.	The policy sets out to address any discrimination relating to Gender reassignment in line with current legislation.	
Marriage and civil partnership Marriage is a union between a man and a woman or between a same-sex couple. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'.	This policy sets out to address any discrimination relating to marriage and civil partnership in line with current legislation.	
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a	This policy sets out to address any discrimination relating to Pregnancy and Maternity in line with current legislation	

baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.		
Race Refers to the protected characteristic of race. It refers to a group of people defined by their race, colour and nationality (including citizenship) ethnic or national origins.	This policy sets out to address any discrimination relating to race in line with current legislation.	
Religion or belief Religion refers to any religion, including a lack of religion. Belief refers to any religious or philosophical belief and includes a lack of belief. Generally, a belief should affect your life choices or the way you live for it to be included in the definition.	This policy sets out to address any discrimination relating to Religion or belief in line with current legislation.	
Sex A man or a woman.	This policy sets out to address any discrimination relating to sex in line with current legislation.	
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex, to both sexes or none.	This policy sets out to address any discrimination relating to sexual orientation in line with current legislation.	
Carers Individuals within the ICB which may have carer responsibilities.	This policy does not impact on any working arrangements. Carers are consulted as part of any mental capacity process, to establish the views of the actual individual concerned. (Not the views of the carer)	
Please summarise the improvements which this policy offers compared to the previous version or position.		
Rebranding required and updates to new Advocacy Providers across Bedfordshire, Luton & Milton Keynes and incorporated new case law and resources for contacting local authority colleagues.		
Has potential disadvantage for some groups been identified which require mitigation?		
No – The Mental Capacity Act 2005 and The Mental Capacity (Amendment) Act 2019 is in place to empower individuals and uphold their rights and freedoms. The Government have their own EQIA completed for the legislation also. The overall aim is to ensure individuals are supported to make informed decisions where possible and if unable to, evidence is documented, and decisions made in the persons best interests using a checklist that evidences that the persons wishes and feelings are given primacy and where their wishes are not followed full justification in the documentation is		

essential.

Appendix 2 - Data Protection Impact Assessment Initial Screening

Data protection is the fair and proper use of information about people. Before completing this form, please refer to the Data Protection Impact Assessment (DPIA) Guidance in the Information Governance (IG) section on the staff Intranet or contact the Data Protection Officer for support via blmkicb.ig@nhs.net

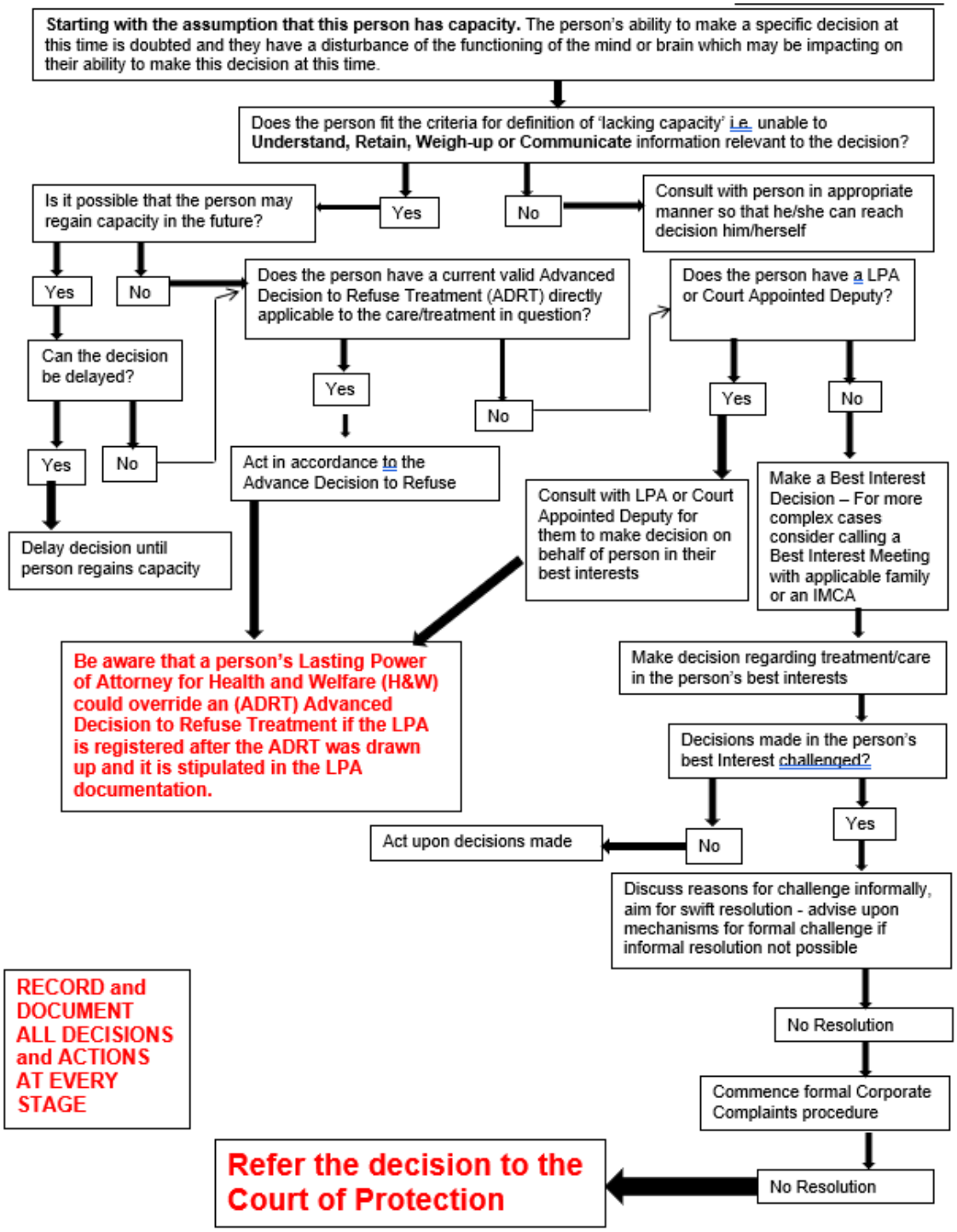
A DPIA is a process to help you identify and minimise the data protection risks. You must do a DPIA for processing that is likely to result in a high risk to individuals. You can use our screening checklist below to help you decide when to do one. If you have answered 'Yes' to any of the 10 screening questions, you must then carry out a full DPIA using the Stage 2 form, which is also available on the Intranet in the IG section.

Name of Policy:	Mental Capacity Act Policy and Deprivation of Liberty Policy
Date of assessment:	08/6/2022
Screening undertaken by:	Mental Capacity Act and Liberty Protection Safeguards Lead

Stage 1 – DPIA form **please answer 'Yes' or 'No'**

1. Will the policy result in the processing of personal identifiable information / data? This includes information about living or deceased individuals, including their name, address postcode, email address, telephone number, payroll number etc.	Yes
2. Will the policy result in the processing of sensitive information / data? This includes for living or deceased individuals, including their physical health, mental health, sexuality, sexual orientation, religious belief, National Insurance No., political interest etc.	Yes
3. Will the policy involve the sharing of identifiers which are unique to an individual or household? e.g., Hospital Number, NHS Number, National Insurance Number, Payroll Number etc.	Yes
4. Will the policy result in the processing of pseudonymised information by organisations who have the key / ability to reidentify the information? **Pseudonymised data -** where all identifiers have been removed and replaced with alternative identifiers that do not identify any individual. Re-identification can only be achieved with knowledge of the re-identification key. **Anonymised data -** data where all identifiers have been removed and data left does not identify any patients. Re-identification is remotely possible, but very unlikely.	No
5. Will the policy result in organisations or people having access to information they do not currently have access to?	No
6. Will the policy result in an organisation using information it already holds or has access to, but for a different purpose?	No
7. Does the policy result in the use of technology which might be perceived as being privacy intruding? e.g., biometrics, facial recognition, CCTV, audio recording etc.	No
8. Will the policy result in decisions being made or action being taken against individuals in ways which could have a significant impact on them? Including profiling and automated decision making. (This is automated processing of personal data to evaluate certain things about an individual i.e., diagnosis and then making a decision solely by automated means - without any human involvement)	No
9. Will the policy result in the collection of additional information about individuals in addition to what is already collected / held?	No
10. Will the policy require individuals to be contacted in ways which they may not be aware of and may find intrusive? e.g., personal email, text message etc.	No

Appendix 3 - Policy Flowchart



Appendix 4 - Mental Capacity Assessment Forms

Mental Capacity Assessment for LESS Complex Decisions (June 2022) V2

Every adult should be assumed to have the capacity to make a decision unless it is proven that they lack capacity for that decision. An assumption about a person's capacity cannot be made on the basis of a person's age, appearance, diagnosis or aspect of their behaviour.

1	**Name & Address of Relevant Person**	If in hospital Stick hospital label here						
2	**Preferred Name of Relevant Person**							
3	**Date of Birth**							
4	**NHS Number**							
5	**I am starting this assessment on (insert date and time) …… Although I presume capacity, I doubt the person is able to make this particular decision at this time.**							
6	**What is the decision that needs to be made?**							
7	**Can the decision be delayed because the person is likely to regain capacity in the near future? Give Reasons below:**	Yes		Not likely		Not appropriate to delay		
8	**Assessment:**							
a. Person has ability to <u>understand</u> information related to the decision to be made?						Yes		No
Details:								
b. Person has ability to <u>retain</u> information long enough for the decision to be made?						Yes		No
Details:								
c. Person has the ability to <u>use or weigh up</u> the information in considering the decision?						Yes		No
Details:								
d. Person has ability to <u>communicate</u> their decision by any means?						Yes		No
Details: (State what steps have been taken to achieve communication)								
9	**Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?**					Yes		No
9a	**Details of Impairment:** (For example: symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with me illness, a dementia, significant learning disability, brain damage, confusion, drowsiness, or loss of consciousness due to a physical or medical cond							
If you have answered YES to all of the questions 8a – 8d above, then on the balance of probability, the person is likely to have capacity to make this particular decision at this time. If you have answered **NO** to one or more of those questions then on the balance of probability the person is not likely to have capacity for this decision and you will be required to proceed.								

Details of any Advance Decisions to Refuse Treatment (ADRT): (Does any ADRT relate to this particular decision. Reference and attach any relevant documents)					
Conclusion:					
10	**Person HAS the capacity to make this informed decision at this time?**	Yes		No	
Document and detail your evidence and give reasons for your conclusion:					
11	**What is the person's Preferences/Wishes?** NB. If person has the capacity for this decision you must respect their preferences and wishes, document these here and sign and date below the completion of this capacity decision. If they DO NOT have capacity for this decision you must still respect the rights, will and preferences of the individual and give weight to their views when making a decision in their best interests.				
Signed:		**Date of Completion:**			
If person is found to lack the capacity to make this decision for themselves please continue					
12	**Are there any known relatives or friends to consult with?** If they have Lasting Power of Attorney that covers this decision, i.e. Person Welfare to cover Health decisions) they may be able to make this decision in the best interests of the person, photocopy LPA docs and keep on person's file.	Yes		No	
Names of relatives/friends you have consulted		Contact/Email/ Telephone			
13	Where there are NO relatives/friends to consult with, an Independent Mental Capacity Advocate (IMCA) **MUST be instructed** (by the decision maker, i.e. person completing this form) if the decision is about **Serious Medical Treatment, a permanent accommodation move** or you have identified that you are likely to be depriving the relevant person of their liberty; **Deprivation of Liberty Safeguards** (DoLS). **For details of Independent Mental Capacity Advocacy Providers in BLMK please refer to page 3**				
Name of IMCA allocated	**Referral sent (date)**	**Tel/Email of IMCA**			
14	**Detail any disputes or disagreements and who is disputing:** (Include details of what steps were taken to resolve the disputes) Attach other sheets if required.				
15	**State final decision made in the person's best interests:** (please refer to Section 4 of the MCA or Chapter 5 of the MCA Code of Practice)				

Declarations:

I confirm that the following decision has been made without assumption as to the age, appearance, condition or behaviour of the person.

I confirm that where the decision relates to life sustaining treatment, I am satisfied that the decision made has not been motivated in any way, by a desire to bring about the person's death.

I confirm that I have considered all relevant factors. I have taken reasonable steps to establish whether the person lacks capacity in this matter. I reasonably believe that the person does lack capacity (because of the impairment or disturbance in the functioning of their mind or brain), in relation to this matter and that it will be in the person's best interests' for the decision to be made or act to be done.

I confirm that where the decision or act is intended to restrain, I believe that the restraint used is necessary in order to prevent harm to the person and that it is a proportionate response to the likelihood and seriousness of that harm.

Name of Assessor/Decision maker/person completing this form:	

Role/Job Title of the above:	
Signature:	
Date of completion:	
Date when decision will be reviewed:	

Independent Mental Capacity Advocacy Providers in BLMK:

Bedford Borough & Central Bedfordshire	Luton	Milton Keynes
Voice Ability 0300 303 1660 option 2 helpline@voiceability.org www.voiceability.org	*Pohwer Advocacy:* 0300 456 2370 pohwer@pohwer.net www.pohwer.net/luton	*The Advocacy People* 0330 440 9000 info@theadvocacypeople.org.uk www.theadvocacypeople.org.uk

Mental Capacity Assessment - MCA 02 For more complex decisions

ASSESSMENT of CAPACITY

BLMK Integrated Care Board (ICB)
MCA 02 For more complex decisions
Documentation for: The MENTAL CAPACITY ACT 2005

To be completed by: The person proposing the particular care or treatment and only when you doubt the person's ability to make a particular decision at the time it needs to be made.

Please Note: If more than one decision needs to be made a separate assessment form should be completed for each decision.

SERVICE USER/RELEVANT PERSON DETAILS		
Formal NAME of the Relevant Person		
Preferred NAME of the Relevant Person		
DATE OF BIRTH		
NHS ID Number		
ADDRESS of the Relevant Person		
MAIN CARER or NEXT OF KIN		
NAME OF DECISION MAKER/ASSESSOR **(Person completing this form)**		
POSITION HELD & Employer		
TEAM **Contact details** **Tel** **Email**		
NAMES, ROLES AND DETAILS OF OTHER PROFESSIONALS involved: (Include Advocates or Independent Visitors)		
DO ANY OF THE FOLLOWING APPLY?		**DETAILS:** including the date the document was drawn up, and when it was registered with the office of the public guardian (Both doc's need to be seen: e.g. LPA &Registration)

ENDURING POWER OF ATTORNEY (for property and affairs ONLY - created prior to the Mental Capacity Act, but still valid)	Yes/No	
LASTING POWER OF ATTORNEY (for property and affairs or personal welfare-replaced Enduring Power of Attorney following the implementation of the Mental Capacity Act)	Yes/No	
DEPUTY (someone appointed by the Court of Protection to make decisions on behalf of someone who lacks capacity to make the specific decision**.** Can be in relation to property and affairs, or personal welfare or both, must be stated on documentation.	Yes/No	
ADVANCE DECISION TO REFUSE TREATMENT (ADRT) Details specific treatments that the person wishes to refuse – must be valid and applicable to the situation	Yes/No	
DATE ASSESSMENT STARTED:		

1. Decision

Every adult should be assumed to have the capacity to make an informed decision; unless it is proved that they lack capacity. An assumption about someone's capacity cannot be made on the basis of a person's age, appearance, condition, or aspect of their behaviour.

1.1 What is the specific decision requiring an assessment of capacity?

Decision:
Note. If more than one decision needs to be made, you must use a new assessment form for each separate decision, only if you doubt that person's ability to make that particular decision

2. Assessment

2.1 What is the extent of the person's impairment? (Please tick or place a cross as appropriate)

Permanent		**Temporary**		**Fluctuation**	

2.2 Please complete the following questions in order to form an opinion as to whether the impairment is sufficient to suggest that the person lacks the capacity to make the particular decision at this moment in time.

Assessment of Capacity		**Factual: Evidence/observations/comments/source/dates/times**
1. Do you consider the person is able to understand the information relevant to the decision? And that this information has been provided in a way that the person is most likely able to understand?	Yes/No	
2. Do you consider the person is able to retain the information for long enough to be able to make the decision?	Yes/No	
3. Do you consider the person is able to use or weigh that information as part of the process of making the decision?	Yes/No	
4. Do you consider the person is able to communicate their decision?	Yes/No	

If you have answered YES to the questions above, then on the balance of probability, the person is likely to have capacity to make this particular decision at this time. **Conversely, if you have answered NO to any of the questions above then on the balance of probability the person is likely NOT to have capacity and you will be required to proceed.**

2.3 Is there an Impairment of or disturbance in the functioning of the person's mind or brain?
(For example symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with mental illness, dementia, significant learning disability, brain damage, confusion, drowsiness, or loss of consciousness due to a physical or medical condition)

Response				**Evidence/Comments and Source**
Yes		**No**		

If you have answered NO to 2.3 above, the person is considered to have Mental Capacity and can make their own decision, within the meaning of the Mental Capacity Act. You must respect their decision.
You do not need to proceed any further.

Please sign and date to conclude and save this MCA assessment on the person's file.

Date Assessment Completed:	
Signature:	

Appendix 5 - Information and Guidance

The completion of Mental Capacity Assessments

When a person is in your care and needs to make a decision, you must assume that person has capacity and make every effort to support and encourage the person to make the decision themselves. Remember that people can make unwise or eccentric decisions, but this does not mean they lack capacity.

This could include:

- Does the person have all relevant information?
- Could the information be explained or shown more easily?
- Are there particular times of the day when a person's understanding is better?
- Can anyone else help to support the person?

Every effort must be made to encourage and support a person to make a decision for themselves. If this is difficult, an Independent Mental Capacity Advocate (IMCA) is a service offering a specific type of advocate that will only be involved if there is no-one else appropriate and in specific situations such as:

- Decisions about Serious Medical Treatment (SMT) (See 2.3 in main Policy for definition)
- Decisions about moving into long term care or moving home e.g. Where the stay is likely to be 8 weeks or more. (Permanent accommodation moves not temporary Respite)
- The Deprivation of Liberty Safeguards

The IMCA should also be considered for:
Some Safeguarding processes (when the person's family or friends have been deemed as inappropriate to consult.
Care reviews; Where the IMCA was involved previously, it is good practice to involve them at the review stage of that decision.

The IMCA will:

- Obtain and evaluate relevant information
- Discuss the proposed decision with professionals and others involved
- Find out as far as possible the person's wishes and feelings
- Consider alternative courses of action
- Get a further medical opinion where necessary
- Provide a report with submissions for the person making the decision

When there is reason to believe a person lacks the capacity at this time, consider:

- Has everything been done to help and support the person? Do they wear glasses or a hearing aid, have the batteries been checked? Do they wear dentures? Are they wearing them? Do they feel comfortable and at ease?
- Does the decision need to be made without delay or can the decision wait if the person is likely to regain capacity?

The aim is to support and empower the person to make their own decision where possible.

If the person's ability to make a particular decision when it needs to be made is doubted then you will need to assess their capacity to make that particular decision at that time.

Decision Making

The person responsible for undertaking the capacity assessment is usually the Decision Maker (the person proposing the care or treatment) though they should consult everyone involved in the decision. The Decision Maker will be the person who will carry out the act/treatment proposed or who will delegate the act to a colleague. For example, a GP asks a District Nurse to administer insulin. If in doing so, the District Nurse feels the person's blood sugars are low then they should use their own professional judgement and report back to the GP. The Decision Maker should be the most appropriate person in relation to the type of decision involved and their professional remit. Therefore different people will be involved in assessing a person's capacity at different times.

However, if a person has a Lasting Power of Attorney or Court appointed Deputy then that person would act as the decision maker within the remit of their legal powers. For example finance and property, or health and welfare or both if stated. Note: If Enduring Power of Attorney (EPA) this will cover decisions relating to property and affairs only and not personal welfare decisions.

Important to consider the following:

- What is the Decision that needs to be made? (Only one decision per assessment)
- Who will be involved generally? (family/friends/carers/professionals)
- Who needs to be consulted? (family/friends/carers/professionals)
- Who is the decision maker? (Usually the person proposing the care or treatment, providing they know the implications of having or not having that treatment and that they must follow the guidance in the Mental Capacity Act and its Code of Practice).
- How should the decision be made?

Consider the following prior to any assessment:

- The environment is appropriate where it is quiet, uninterrupted and no distractions.
- If the person wears a hearing aid; that it is in place and working, if they wear dentures; ensure they are wearing them and they are comfortable, if they wear glasses; that they are wearing them if they need; all to aid with focussing on the subject matter and enhancing communication with the person to empower them in making the decision for themselves where possible.
- The person has the relevant information and in a format that they can understand? Do not burden the person with more detail than is necessary.
- Could the information be explained in an easier way and do you need help from other people, for example a Speech and Language Therapist or an Interpreter to help with any issue of communication? Do not rely on family to interpret for you, it is best practice to get an interpreter in to remain unbiased.
- Is this the right moment or place to discuss this decision, does the person seem comfortable discussing this issue now?
- Can anyone else assist? Consult with family and other people who know the person well.
- Does the decision have to be made now? Try to choose the best time for the person e.g. try to get the person when they are at their best, if they are a morning person, a capacity assessment should be completed in the morning.
- Ensure that the effects of any medication or treatment are considered, e.g. complete the capacity assessment before their medication if it makes them drowsy?

- Can this decision wait until the person has capacity if the loss is temporary? Remember, the aim is to support and empower the individual to make their own decisions, where possible.
- Be aware of cultural factors which may have a bearing on the individual. Consider whether an advocate is required to support them and ensure that the person has a voice.
- Make one decision at a time. Do not rush the person, take time to listen and be with the person to fully understand their wishes.

You must always follow the five key principles of the MCA in any decision-making and assess at a person's best level of functioning for the decision to be taken.

The MCA states that "assessment of capacity to take day to day decisions or consent to care requires no formal assessment procedures". However although day-to-day assessments of capacity may be informal, they should still be written down by staff. Therefore if an employee's decision is challenged, they must be able to describe why they had a reasonable belief of a lack of capacity. Therefore recording and documentation should always be written and evidenced within a patient's case notes or care plan.

In relation to less complex decisions it is still essential that there is evidence of a formal, clear and recorded process. In order to achieve this a Mental Capacity Act Assessment Form (MCA01) 2 page assessment must be completed.

In relation to more complex decisions involving perhaps a life changing decision it is essential that there is evidence of a formal, clear and recorded process. In order to achieve this a Mental Capacity Act Assessment Form (MCA02) full assessment form for more complex decisions must be completed.

How to determine if someone lacks mental capacity:

The starting point and foundation is the assumption that the person can make the decision for themselves. If you have reason to doubt this, then follow the guidance below:

- The assessment of capacity must be date, time and issue specific; complex decisions may involve a series of smaller decisions
- If someone cannot make a complex decision, don't assume they cannot make a simple decision
- You cannot decide someone lacks capacity based on his or her appearance, age, condition or behaviour alone.
- Can the decision wait until the person regains capacity and is it safe to delay the decision?

1. Understand the information relevant to the decision including the likely consequences of making or not making the decision.
2. Retain the information long enough to make the decision.
3. Use or Weigh up the information as part of the decision making process
4. Communicate their decision by any means

In order to decide if a person has the mental capacity to make a decision you must decide whether there is an impairment or disturbance in the functioning of the person's brain – whether permanent or temporary.

If so, does the impairment/disturbance make the person unable to make that particular decision at the time it needs to be made?

An assessment must be made on the balance of probabilities, if they cannot do one or more of the above 1-4 you are likely to deem that person as lacking capacity for that decision at that time.

The person will be deemed unable to make a particular decision if after all appropriate help and support to make the decision has been given to them and ***because*** of their impairment or disturbance in their mind or brain they cannot make that decision.

Sometimes your assessment may be challenged by another person acting for the individual such as a family member or advocate. Seek resolution in the following ways:

- Raise the matter with the person who made the assessment and check records.
- Another capacity assessment might be considered at different times of the day to allow for fluctuating capacity.
- A second opinion may be useful.
- Involve an advocate but not an IMCA.
- Case conference
- Local complaints procedure.
- Mediation
- Ruling by Court of Protection (last resort)

Recording best interests decisions

If a person has been assessed as lacking capacity to make that decision then the decision made for, or on behalf of, that person, must be made in his or her best interests. A best interest's decision must be objective; it is about what is in the person's best interests and not the best interests of others. Best interest is wider than what is medical best practice. It is about what the person would have wanted if they had capacity today; for example, if they have always been a cautious person, the decision maker would make a more cautious decision for them in their best interests and vice versa if they had always been a risk taker.

The decision maker must weigh up all the factors involved, consider the advantages and disadvantages of the proposals and determine which course of action is the least restrictive for the person involved. This includes consideration of restrictions and/or Deprivation of Liberty.

By best interests we mean:

- The decision maker has considered all relevant circumstances, including any written statements made while the person had capacity, which must also be taken into account and any other information relevant to this decision
- Equal consideration and non-discrimination – consider the view of all involved not just those who agree with your preferred option
- Do not to make an assumption that a decision is made merely on the basis of a person's age or condition
- The decision maker has considered whether the person is likely to regain capacity – can the decision be put off until then and is there any advantage in doing so?
- Permitting and encouraging participation - the person has been involved as fully as possible in the decision, with the appropriate means of communication or using other people to help the person participate in the decision making

process. Healthcare professionals are therefore required to make enquiries of relatives, carers and friends of the person. Consideration must be given as far as reasonably ascertainable to the person's past and present wishes and feelings, and the beliefs, values and any other factors that would be likely to be taken into account if the person had capacity, and to take into account, if practicable and appropriate the views of people who have formally or informally been involved with, or named by, the incapacitated person.

- Special considerations for life sustaining treatment - the decision maker is NOT motivated by a desire to bring about the person's death.
- Taking into account the views of anyone involved in caring for the person, any IMCA, any Attorney appointed by the person or any Deputy appointed by the Court of Protection.
- Consider whether there is a less restrictive alternative or intervention that is in the person's best interests.

When determining someone's best interests you must be able to demonstrate:
That you have carefully assessed any conflicting evidence and provided clear, objective reasons as to why you are acting in the person's best interests.

As far as possible try to ascertain:
Has the person set out their views in a document, appointed a person to act on their behalf, or do they have friends or family involved in their care?

If practicable and appropriate you must consult with, and take in to account, the views of the following:
- A Nominated Person
- Lasting Power of Attorney appointed
- Enduring Power of Attorney appointed
- Court Appointed Deputy
- Other persons engaged in caring for, or interested in, the person

For significant decisions, a Best Interest Meeting may need to be arranged with all relevant parties. Therefore, in order to evidence a Best Interests decision you must document this on the Mental Capacity Assessment form (MCA 01 or 02).

Challenging the Result of an Assessment of Capacity or Best Interests Decision.
Your assessment of capacity may be challenged. It is important that everything you do is carefully documented.

It may be challenged in the following ways:
- Raised directly with you
- Request for a second opinion
- Involving an advocate – not an IMCA
- Complaints procedure
- Court of Protection
- However every effort should be made to resolve disagreements as informally as possible. Consider the importance of the following:
- How robust is the risk assessment?
- Has everything been factually recorded?
- Degree of 'contentiousness' of best interests decision between those involved in the person's care, i.e. the level of disagreement by family or IMCA as to proposed course of action?

- Is there a possibility of conflict of interest between family members and person, e.g. over finances?
- The urgency with which decision needs to be made?
- Degree to which the decision or intervention can be reversed (undone)? The more irreversible, the higher the level of consultation required. Potential risks to the person and implications if a decision is made, not made or not reversed, including where other dependents are involved (e.g. children)

The Code of Practice makes it clear that any dispute about the interests of a person who lacks capacity should be resolved in a quick and cost effective manner.

Where significant persons are involved in the person's life every effort should be made to consult with and involve them and arrive at an agreed decision provided that it is in the person's best interests and meets their assessed social and/or medical needs.

Where agreement cannot be reached, seek assistance from your line manager or a senior manager in this process, further meetings may be necessary including seeking legal advice.

If no agreement can be reached, the family or carers have recourse to the ICB complaints procedures.

Recourse to the Court of Protection should be the last resort if no agreement can be reached.

Decisions that must be taken to The Court of Protection when a person has been deemed as lacking the capacity to make that decision for themselves, these decisions cannot be made in a person's best interests:

- Cases involving organ or bone marrow donation by a person who lacks capacity to consent.
- Cases involving non-therapeutic sterilisation of a person who lacks capacity to consent.
- If there is a dispute about where a person should stay, an authorisation does not resolve the dispute. The Code of Practice of the Mental Capacity Act states that unresolved disputes about residence, including the person themselves disagreeing, should be referred to the Court of Protection (8.28 MCA Code of Practice).

NB. This guidance should supplement the guidance available in Chapter 5 of the Mental Capacity Act Code of Practice.

Tip: Write the decision in one clear sentence. Avoid using jargon and phrase the question in language the person will understand.

Q&A's

1. Does the person have an impairment of, or disturbance in the functioning of mind or brain?

The Mental Capacity Act covers permanent, transient and temporary impairments of the brain. Permanent and transient conditions may include dementias, acquired brain injuries, learning disabilities or mental health problems. Temporary

conditions may include deliriums and being under the influence of drugs or alcohol, or side effects of medication such as sedatives.
You do not need to have a formal diagnosis from a doctor, though that helps. Think about how you might gather such information? You could access information from paper and electronic files, such as assessments, care plans or letter from a consultant/GP. The type of medication someone is prescribed could provide a clue. Where the person is could give a clue, for example, a resident is living in a dementia care unit. You can gain information from the person, their family or care staff who know them well. Also, your own experience of working with service users may well help you spot the sign that a person may be suffering from some form of mental disorder. Remember, you only need to have a reasonable belief that is that it is more likely than not the person has an impairment of, or disturbance in the functioning of their mind or brain.

2. Why do you feel this does/doesn't affect the person's ability to make this decision at the time it needs to be made?
Give a brief explanation of why you 'reasonably believe' the person's impairment or disturbance in the functioning of their brain is affecting their ability to make this decision. An example may well be that the person is behaving in an unusual manner and making decisions that would conflict with their usual decision making patterns etc. Be descriptive, examples can illustrate your assessment. Be careful not to make assumptions based purely on a person's age, diagnosis or behaviour. It may well be that you do not feel the person's disturbance or impairment is affecting their ability to make this decision at this time. If that is the case, record your reasons. You must then conclude the resident has the mental capacity to make this decision. You do not need to complete the rest of the form. Remember that you can't overrule the decision the person makes just because you feel the choice they have made is an unwise choice.

3. Does the person understand the information relevant to this decision?
Ask yourself what information the person needs to be able to make this decision. This should include all viable options and not just the option others feel is best for them. Some information about probable advantages and disadvantages of each option will also be invaluable.
Explain what efforts you have made to help the person understand the information, such as using different media or rewording information? Be careful not to provide too much information. Avoid jargon and use the person's preferred method of communication. Consider if there is anyone the person trusts and would like to be present. Carefully consider the appropriate venue and timing of your assessment.

4. Is the person able to retain the information long enough to make the decision?
How do you know if the person has remembered the information? Firstly asking them to repeat it back to you can work but you need to be careful they are not just repeating it 'Parrot fashion'. You can ask them to summarise or paraphrase information. One handy hint is to ask the person to explain what you have told them to someone else in your presence. You can then get a clear picture of how much information they have retained and how well they have understood it. Remember that the person only needs to be able to retain information for long enough to be able to weigh it up and communicate their decision.

5. Is the person able to weigh-up the information relevant to the decision?

Can they tell you the advantages and disadvantages of the options under consideration? This should include the option of doing nothing. Can they explain the consequences of their preferred option? Remember the person does not have to give a rationale that you agree with, they need only demonstrate they can weigh-up the information.

6. Can the person communicate their decision by any means?

What is the person's preferred method of communication? The person does not have to be able to articulate only indicate their preference. It may be as simple as pointing or indicating preference with a thumbs up or thumbs down. Be creative, and don't be afraid to ask obvious questions to ensure you have fully understood the choice the person has made.

7. Best Interests decision making guidance

A best interest decision must follow all of the elements in Section 4 of the Mental Capacity Act 2005.

8. What is the decision you need to make on the persons behalf?

Before making a decision on behalf of a person, you must believe that on the balance of probabilities, the person does not have the capacity to make the decision themselves. You should also record that on the mental capacity assessment form. You should ask yourself if the decision needs to be made now or can it be postponed until the person regains capacity, for example, a person suffering from a Urinary Tract Infection may regain capacity with the appropriate treatment. Otherwise continue to make the decision now if delay is likely to result in harm or significant loss to the person.

Be clear what the decision is you are trying to make. You may need to re-word the original question to read from your perspective, not that of the person.

Ask yourself if you are the appropriate person to take on the role of decision-maker. The decision-maker should be the person who is proposing the task/outcome of the decision. For example, medical decisions should only be made by staff with the appropriate knowledge about the care and/or treatment proposed and should follow the guidance in the Mental Capacity Act and Code of Practice.

Do not take on the role if the decision is outside your usual job remit. Similarly you do not have to carry out a task that you believe will cause harm to the person. An example would be you would not continue to give a prescribed laxative if the person is suffering from diarrhoea, you would seek appropriate medical advice.

9. Are there any delegated decision-makers? (EPA, LPA, or Deputy)

Before taking on the role of decision-maker you must ensure that the person has not foreseen such events and appointed someone to make such decisions on their behalf. Enduring Power of Attorney [EPA] was replaced with Lasting Power of Attorney [LPA] by the Mental Capacity Act 2005 {implemented in 2007}. However, any EPA's registered before then will still be valid. A further note of caution is to remember that EPA and LPA (for Property and Affairs) only give the Donee powers to make decisions regarding the person's money and property. It does not grant them authority to make health and welfare decisions. Only an LPA (for Personal Welfare) would allow the Donee to make healthcare and welfare related decisions. Before accepting that a relative or friend has power of attorney, ask to see a copy of the Registration Document and check the LPA

documentation carefully to make sure this particular decision is covered in the documentation.
If the Donee has a valid EPA or LPA then it is their decision to make and you can't override them. Similar rules apply to anyone who has gained the powers of a Deputy by applying to the Court of Protection. If you feel any delegated decision maker (EPA, LPA or Deputy) is not acting in the best interests of the person you should report this as a Safeguarding Adults alert and/or also to the Office of the Public Guardian.

10. How to Report a Concern to the Office of the Public Guardian:
If you have concerns about an attorney or a deputy, e.g. the misuse of money or decisions that aren't in the best interests of the person they're responsible for. Or you may question the authenticity of LPA documentation.

Office of the Public Guardian
Email: opg.safeguardingunit@publicguardian.gsi.gov.uk
Telephone: 0300 456 0300
Text phone: 0115 934 2778
Monday to Friday, 9am-5pm except Wednesday, 10am-5pm

Call 999 if someone is in immediate danger or your local police if you think someone has committed a criminal offence.

11. Advance Decisions to Refuse Medical Treatment (ADRT)
These are only valid if made whilst the person had capacity. They are legally binding, though it is worth noting that only refusals of treatment are binding. Anything else are considered to be the wishes and feelings of the person. Please remember that these are still very significant and the decision-maker must have regard to them when making any decision on the person's behalf. ADRT's can be invalidated if you have evidence that they were made whilst the person lacked capacity or were made under duress. The Mental Health Act 1983 would also allow you to override a person's refusal of treatment for a mental disorder but not a physical disorder unrelated to their mental health diagnosis. ADRT's can also be invalidated if the person has made a subsequent inconsistent decision and changed their views without updating the ADRT. If the refusal of treatment would bring about the death of the person then further criteria are needed. It must be written down, contain a precise statement of what they are refusing, a written acknowledgement that such a refusal may bring about their death, be dated, signed and witnessed.

12. Record the names of all of those people you have consulted with in making this best interest decision.
State clearly, their professional role or relationship to the person. Ensure you have contact details should you need to clarify points at a later date or send out copies of the assessment and best interest's decision. When seeking the most appropriate people to consult, you should consider who knows the person best or is best able to communicate with the person. This is not always the most qualified person and may be the care worker who provides care on a regular basis. Further guidance can be obtained by following the Best Interest Checklist in Section 4 of the Mental Capacity Act. Do not select only the people you feel will agree with your preferred outcome. It is healthy to record conflicting views as this can make us challenge our own assumptions, values and prejudices.

13. Always strive to seek the views of family members, again being careful not to only ask those who will agree.

Where the person does not have any family or friends with whom you can consult then you should consider the criteria for instructing an Independent Mental Capacity Advocate (IMCA). It is a legal duty to do so if making decisions about a change of accommodation for more than 6 weeks in a care home or 28 days in a hospital. An example might be moving a person from one care home to another. It is also a duty when the decision relates to Serious Medical Treatment, however it would usually be a doctor who would be the decision maker in these circumstances. There is a power to instruct an IMCA if you are reviewing the person's accommodation or if you are concerned family may not be able or willing to represent the best interests of the person. Always record your reasons for either instructing or not instructing an IMCA.

14. What are the views of the person/any similar decisions?

Record carefully any views expressed by the person regarding the decision in question, even if you feel they lack capacity to make an informed choice. It may be possible to draw inferences from previous decisions the person made when they had capacity. For example, if the person regularly went to their GP for a 'Flu jab' then it would be a reasonable assumption they would have consented if they had capacity. It is worth bearing in mind, however that you are not duty bound to follow previous decisions only to have regard to them in coming to your own conclusion about what is in their best interests.

If the person themselves is disputing the best interests decision or action taken then the decision maker should follow the flow chart in Appendix 3 for resolving disputes, this may be a decision that you must take to the Court of Protection if all avenues have been explored and exhausted in resolving the dispute. All options explored will need to be evidenced and documented in the application to the Court of Protection.

15. What are the views of others?

You should record the views of carers/family and friends and those of relevant professionals in coming to the conclusion you reach. These views do not have to all be in agreement. Differences of opinion are healthy and stimulate debate. Record a summary of their views relevant to the question being discussed. Ensure all parties have the necessary information to help them participate fully but be careful that you do not breach confidentiality unnecessarily. When taking account of the views of the person, ensure you have taken into consideration all of the factors they would have seen as relevant to the decision, for example, caring commitment, religious beliefs, values and attitudes. Include any written information around their previous wishes and feelings.

16. Explain why the person will not regain mental capacity or why delaying could cause additional harm?

Explain why you feel the person will, or won't regain the mental capacity to make this decision. For example, you may say the person never had mental capacity around this decision due to a developmental delay or learning disability or that they have lost mental capacity due to a dementia or traumatic brain injury. If the person will regain mental capacity to make this treatment decision then you must justify any decision not to wait. For example, the person is suffering from a delirium which, with treatment would mean the person will regain capacity but in the mean time they are bleeding and need treatment to prevent further blood loss.

17. Explain how you have supported the person to be involved in the process and avoided discriminating against them:

What steps have you taken to allow the person to be involved in the treatment decision as much as is possible? For example, have you presented information in a different format, have you ensured they are in a quiet place away from distractions and that they have someone with them with whom they are comfortable. Be careful to evidence how you have ensured you have not made assumptions based on their age, disability or behaviours.

18. Is this decision about life-sustaining treatment?

If you are making a decision about withholding or withdrawing life-sustaining treatment you must evidence how you are not motivated by a desire to bring about the person's death. That does not mean you have to provide treatment which you believe to be futile or overly burdensome on the person and provides no chance of recovery. Where there is disagreement about the withholding or withdrawal of life-sustaining treatment then take legal advice and consider an application to the Court of Protection for a declaration of best interests.

19. Areas of Agreement/Areas of Disagreement

Wherever there are disputes, it is always worth starting with the areas upon which all parties can agree. For example, you may all agree that you want what is best for the person. The following section covers those areas in which you can't all agree should be recorded. Be careful to record these fully and clearly state who it is that is in disagreement about what. You do not need universal agreement to reach a conclusion though every effort should be made to reach agreement to reduce the risk of legal challenges.

20. State clearly the outcome of the decision you have made?

Once you have reached a conclusion, you should state clearly and precisely what is the decision you have made and how it will be carried out. Include any transitional arrangement that may be necessary. Where possible, seek agreement about how things will proceed and who will do what, by when.

21. Explain the rationale for your decision

Detail why you have made the choice you have made from the realistic options available. It is often easier to explain why you have made one choice over another by making comparisons between the two most viable alternatives. For example, you may state that a choice between two care homes of equal quality is made because one is closer to the person's family or friends. It is not always possible to make the best choice, e.g., resources may impact negatively upon your decision, often the best you can do is choose the least harmful choice.

22. What is your contingency plan?

Should your preferred choice not work out as planned, what is your back up plan. This should hopefully reduce the likelihood of having to go 'back to the drawing board' should something unexpected prevent your primary choice from being available or a change in circumstances renders your first choice as no longer being in the person's best interests.

23. Dates and Signatures

Always record the date and time upon which you made your final decision. If this decision was made over several contacts then it may be worth noting the dates and times of consultations which deals with the views of those consulted. The MCA assessment form should always be signed by the decision-maker and

clearly print their name for clarity. It is also useful to put the date when this decision will be reviewed, if this is foreseeable, to ensure it remains in the best interests of the person.
It will not always be necessary to complete a new mental capacity assessment if all circumstances remain the same. Complete a new mental capacity assessment if there are significant changes.

24. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)

DNACPR notices should only ever be made by a doctor involved in the person's care. Guidance states they should only be put in place if the person's medical condition means that such an event is reasonably foreseeable and such attempts to prolong life would have little or no benefit to the person. Such decisions should be made in consultation with the family and should be reviewed regularly. A list of all parties consulted in making this decision should be recorded. The latest updated guidance can be found: https://www.resus.org.uk/dnacpr/decisions-relating-to-cpr/

25. Using restraint

Section 6(4) of 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 resisting, or
Restrict a person's freedom of movement, whether they are resisting or not.

Any action intended to restrain a person who lacks capacity will not have protection from liability unless the following two conditions are met:

1. The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
2. 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.

Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. Professionals or carers must not use restraint just so that they can do something more easily.
If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible and consideration should be given as to whether the restraint used could be classed as a deprivation of the persons liberty. See Deprivation of Liberty Safeguards Policy for further guidance.
Staff should consider less restrictive options before using restraint. Where possible, they should ask other people involved in the person's care what action they think is necessary to protect the person from harm. For example, it may be appropriate to get an advocate to work with the person to see if they can avoid or minimise the need for restraint to be used.

Disclaimer

The guidance above should be read in conjunction with the Mental Capacity Act and also as secondary guidance; The Mental Capacity Act Code of Practice and check whether it has been superseded by case law.

Legal advice should be sought to ensure compliance with the act and subsequent case law.

If the organisation has a Mental Capacity Act and Deprivation of Liberty Safeguards Lead, consult them in the first instance or the Safeguarding Adults Lead.

Alternatively, the Local Authority in your area have their own Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) lead and can also be contacted for further advice, but the ultimate decision made or action taken would remain with the decision maker concerned and they should be able to justify their actions or decisions made when adhering to the Mental Capacity Act (2005) and The Deprivation of Liberty Safeguards (2009).

Useful Contacts:

Independent Mental Capacity Advocacy Providers in BLMK:

Bedford Borough & Central Bedfordshire:
VoiceAbility
t: 0300 303 1660 option 2
e: helpline@voiceability.org
w: voiceability.org

Luton Council:
Pohwer Advocacy:
t: 0300 456 2370
e: pohwer@pohwer.net
w: www.pohwer.net/luton

Milton Keynes Council:
The Advocacy People
t: 0330 440 9000
e: info@theadvocacypeople.org.uk
w: theadvocacypeople.org.uk/

Local Authority Leads: MCA/DoLS/LPS

Bedford: dols@bedford.gov.uk
Central Beds: dols@centralbedfordshire.gov.uk
Luton: dols@luton.gov.uk
Milton Keynes: dols@milton-keynes.gov.uk

BLMK HCP Mental Capacity Act and Liberty Protection Safeguards Lead:
Karen McCulloch - Karen.mcculloch2@nhs.net