Assessing a Patient’s Mental Capacity

Guidance for Staff on the Mental Capacity Act

CG 14

Additionally refer to: Adult Protection Policy and Procedure
Advanced Decisions
Cardiopulmonary Resuscitation Policy
Deprivation of Liberty Safeguards
Restraint of Adults and Children receiving care in the Trust

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1 Document Statement
This guidance sets out for staff the process to be followed in assessing a patient’s capacity to make decisions and what to do if a patient is assessed as being unable to make a decision.

This document reflects the legal framework provided by the Mental Capacity Act 2005 and reflects the Mental Capacity Act 2005 Code of Practice (the Code) which provides guidance and information about how the Mental Capacity Act works in practice.

The Code is legislated by law, which means that certain categories of people have a legal duty to comply with it when working with or caring for adults who may lack capacity to make decisions. This includes clinical staff that have a legal duty to assess mental capacity when proposing to provide, or withhold, medical treatment.

This document contains specific details about:

- Assessing the mental capacity of patients to make decisions.
- Determining the ‘best interests’ of patients who lack capacity.
- Recording assessment of capacity, best interest decisions and how to recognise an advance decision, use of a Lasting Power of Attorney or appointment of a Deputy.
- Instructing Independent Mental Capacity Advocates (IMCAs) to represent people without capacity who have no-one to speak for them when decisions need to be made about serious medical treatment or a change in care home or hospital accommodation.
- Resolving disputes regarding any of the above.
- Referring matters to the Court of Protection for a declaration.
- Legal requirements when undertaking research on patients who lack capacity to consent to it.

2 Overview
The Mental Capacity Act 2005 came into force in 2007 and provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions.

The Act enshrines in statute current best practice, and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. The Act also enables people to plan ahead for a time when they may lose capacity. It replaces current statutory schemes for Enduring Powers of Attorney and Court of Protection receivers with reformed and updated schemes.

The Act introduces two new criminal offences of ill treatment or wilful neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

3 Duties and responsibilities

3.1 Chief Executive
The Chief Executive has overall responsibility for ensuring that the Trust is compliant with the Mental Capacity Act 2005.

3.2 Director of Nursing & Quality
The Director for Nursing & Quality has overall responsibility for ensuring overall implementation of the policy through the Trust and its use.

3.3 Medical Director
The Medical Director is responsible for ensuring that the Medical Staff are aware of the requirements of the Act and comply with these.
3.4 **Deputy Director of Nursing & Quality**
The Deputy Director has delegated responsibility for the day to day implementation of the policy and ensuring its compliance.

3.5 **Adult Safeguarding Lead**
The Adult Safeguarding Lead has overall responsibility, as the link member of staff on the policy, to provide advice and oversee training on the Mental Capacity Act 2005 and the policy.

3.6 **All clinical staff**
Staff are responsible for familiarising themselves with the policy, knowing where to access the policy and working within the Mental Capacity Act 2005.

4 **The Legal Starting Point - Five Key Principles of the Mental Capacity Act 2005**
The legal requirements of the Act are underpinned by five statutory principles. These are:

(i) **A Presumption of Capacity**  
Every adult (aged 16 or over) has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.

(ii) **Individuals being supported to make their own decisions**  
Every person must be given all practicable help to make their own decision before being considered to lack the capacity to do so.

(iii) **Unwise Decisions**  
Just because a person makes what might seem to others as an eccentric or unwise decision, they should not, for that reason alone, be considered as lacking capacity to make that decision.

(iv) **Best Interests**  
An act done or decision made under the Act for or on behalf of a person who lacks capacity, must be done in their best interests.

(v) **Least Restrictive Option**  
When deciding on what is in their best interests, anything done for, or on behalf of a person who lacks capacity, should be the least restrictive way of achieving the required outcome, whilst respecting their basic rights and freedoms, including privacy.

4.1 **Definition of Mental Capacity**  
The Trust has adopted the definition set out in Section 2(1) of the Mental Capacity Act 2005:

“For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of impairment of, or a disturbance in the functioning of, the mind or brain”.

**Assessment of Capacity**
The law states that a person is unable to make a particular decision if, due to an impairment of or disturbance in the functioning of their mind or brain, they are unable to do any of the following four things:-

- Understand relevant information given to them
- Retain information long enough to be able to make a decision
- Be able to weigh up the information available in order to make a decision
- Communicate their decision (whether verbally or otherwise)
Capacity is decision-specific. A person might lack the capacity to deal with their finances but have capacity to decide whether to consent to a particular treatment. An assessment of a person’s capacity must therefore be based on their ability to make a specific decision. This assessment needs to be made at the time the decision needs to be made. The Trust recognises that many patients have the potential to lack capacity at some time during their lives. Loss of capacity can be temporary or permanent due to a physical or medical condition. e.g. brain injury, mental illness, being under the influence of alcohol or drugs.

4.2 Who is affected by the Mental Capacity Act?
The Mental Capacity Act 2005 primarily affects people aged 16 and above, although certain elements of the Act apply to children under the age of 16.

4.3 Decisions covered by the Act
The Act covers a wide range of decisions made, or actions taken, on behalf of people who may lack capacity to make specific decisions for them. These include:

- Day to day decisions – such as what to wear
- Routine care or treatment decisions – washing, dressing, routine blood tests etc
- Major life changing decisions – such as whether the person should move into a care home or undergo serious medical treatment (see section 3.6)

4.4 Decisions excluded from the Act
There are certain decisions that can never be made on behalf of a person who lacks capacity to make these decisions, or are governed by other legislation. These are summarised as

- Decisions concerning Family Relations e.g. marriage / civil partnership; sexual relationships; divorce / dissolution
- Decisions about parental responsibility for a child; adoption; consent to fertility treatment
- Mental Health Act Matters Decisions to give treatment for mental disorder to people who are compulsorily detained for assessment/treatment under the Mental Health Act 1983.
- Decisions on voting

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

Although the Mental Capacity Act does not allow anyone to make these decisions on behalf of someone who lacks capacity, the Mental Capacity Act 2005 does not prevent action being taken to protect a vulnerable person from abuse or exploitation.

4.5 Implications for Trust Staff
The Mental Capacity Act 2005 applies to everyone involved in the treatment, care, or support of someone who lacks capacity (including carers and family carers). In particular the following Trust staff have an obligation to comply with the Mental Capacity Act 2005 and associated Code of Practice:

- Anyone acting in a professional capacity for, or in relation to, a person who lacks capacity e.g. doctors, nurses, Healthcare Assistants.
- Anyone carrying out research approved in accordance with the Act.

4.6 Emergency Situations
In an emergency situation, urgent treatment decisions may have to be made and immediate action taken in a person’s best interests. In these situations, it may not be practical or appropriate to delay treatment while trying to help the person make their own decision, or consult with others. However, even in emergency situations, healthcare staff should try and communicate with the person and keep them informed of what is happening.
Once the emergency situation has passed, the patient’s mental capacity must be assessed in accordance with the provisions of the Act.

4.7 When should capacity be assessed?
It is important to carry out an assessment when a person’s capacity is in doubt. It is also important that the person who does the assessment can justify the conclusions. There are a number of reasons why people may question a person’s capacity to make a decision, for example:

- The person’s behaviour or circumstances cause doubt as to whether they have capacity to make a decision.
- Somebody else says they are concerned about the person’s capacity.
- The person has previously been diagnosed with an impairment that affects the way their mind or brain works.

5 Assessing Capacity

5.1 Responsibility for Assessing Capacity
Under the Act, many different people may be required to assess capacity and make best interests decisions on behalf of someone who lacks capacity. The person who makes the decision in a given situation is known as the “decision maker”.

Where the decision involves the provision of medical treatment, the doctor or other member of the healthcare staff responsible for carrying out the particular treatment or procedure is the decision maker. While a decision may involve the multidisciplinary team it is ultimately the professional responsible for the person’s treatment that must ensure capacity has been assessed appropriately.

Where a Lasting Power of Attorney has been registered or a Deputy has been appointed under a Court Order, the Attorney or Deputy will be the decision maker for decisions within the scope of their authority. This may include decisions about treatment and care (see section 7.3).

Where a valid and applicable advance decision exists, then this must be followed (see section 5.4).

In any legal case, the burden of proof will be on the decision maker. They will need to be able to demonstrate on the balance of probabilities (i.e. more likely than not) that an individual lacks capacity to make a particular decision at the time it needs to be made.

For acts of care or treatment the assessor must have a ‘reasonable belief’ that the person lacks capacity to agree to the action or decision to be taken. To have ‘reasonable belief’ the professional must take ‘reasonable steps’ to establish the person lacks capacity to make a relevant decision. The steps that are considered ‘reasonable’ will depend on individual circumstances and the urgency of the decision.

It is therefore essential that the outcome of all assessments is recorded in the patient’s health care records.

More complex decisions are likely to need a formal assessment and a professional opinion, for example, from a Consultant colleague or a Psychiatrist, might be necessary. Examples of these types of decision might include:

- A decision is complicated or has serious consequences.
- The assessor concludes that the person lacks capacity and the person challenges the findings.
- Family members, carers and/or professionals disagree about the person’s capacity.
• The person being assessed is expressing different views to different people.
• Somebody had been accused of abusing a vulnerable adult who may lack capacity to make decisions that protect them.
• A person repeatedly makes decisions that put them at risk or could result in suffering or damage

However, the final decision about a person’s capacity must be made by the decision maker; not the professional who is there to advise.

5.2 The Test of Capacity
An assessment that a person lacks capacity to make a decision must never be simply based on:
• Their age. (the Act generally applies to people who are 16 and over. The Code of Practice provides more information on how the Act affects children and young people)
• Their appearance
• Assumptions about their condition
• Any aspect of their behaviour

An assessment of mental capacity must only examine a person's capacity to make a particular decision when it needs to be made. It may be possible to postpone a decision until a person has capacity to make it.

The Mental Capacity Act sets out a two stage test of capacity. See Appendix 1 for a proforma checklist.

Stage One
Does the person have impairment, or a disturbance in functioning of their mind or brain?

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

Note: Stage One requires proof that the person has an impairment of the mind or brain, or some sort of disturbance that effects the way their mind or brain works. If a person does not have such an impairment or disturbance “of the mind or brain”, they will not lack capacity under the Act and the functional test cannot be carried out.

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

For a person to lack capacity to make a decision, the Act states that their impairment or disturbance must affect their ability to make a decision when they need to. People must be given all practical and appropriate support to help them make a decision for themselves before concluding that they lack capacity.
Inability to make a decision

A person is unable to make a decision if they cannot:

i  **Understand the information about the decision to be made (the Act calls this “relevant information”).**

Relevant information includes:
- The nature of the decision.
- The reason why the decision is needed, and
- The likely affects of deciding one way or another, or making no decision at all.

ii  **Retain that information in their mind long enough to use it to make an effective decision.**

People who can only retain information for a short period of time must not automatically be assumed to lack capacity to decide.

iii  **Use or weigh that information as part of the decision making process.**

Sometimes people can understand information but an impairment or disturbance stops them using it. The impairment or disturbance leads to a person making a decision without understanding or using the information given.

iv  **Communicate their decision (by talking, using sign language or any other means).**

Sometimes there is no way for a person to communicate. Examples will include people who are unconscious and those who are conscious but cannot speak or move at all.

**Note:** If a person is unable to satisfy any one of these four requirements then they lack capacity for the decision in question.

5.3  **Fluctuating or temporary capacity**
Some people have fluctuating capacity – they have a problem or condition that gets worse occasionally and affects their ability to make a decision (e.g. a manic depressive or a person with a psychiatric illness).

Temporary factors may also affect someone’s ability to make a decision. Examples will include acute illness, severe pain and the effect of medication or distress after the death of a loved one. Being under the influence of alcohol or drugs may also lead to temporary incapacity to make a decision.

Capacity is decision specific - a person may lack capacity to make a decision about one issue but not about others.

5.4  **Helping People to make their own Decisions**
Before deciding that someone lacks capacity to make a particular decision, there is a duty for decision makers to take all practicable steps to enable the person to make the decision for themselves. This includes:

i  **Providing relevant information.**

- Does the person have all the relevant information they need to make a decision?
- If they have a choice, have they been given information on all of the options?
ii Communicating in an appropriate way.

- Could the information be explained or presented in a way that is easier for the person to understand? (e.g. simple language, visual aids).
- Have different methods of communication been explored? (e.g. non-verbal).
- Could anyone else help with the communication? (e.g. family member, interpreter, speech and language therapist, advocate).

iii Making the person feel at ease.

- Are there particular times of day when the person's understanding is better?
- Are there particular locations where they feel more comfortable e.g. their own home?
- Could the decision be postponed to see whether the person can make the decision at a later time? (e.g. their condition improves).

iv Supporting the person.

- Can anyone else help or support the person to make choices or express a view? (e.g. family member or carer, an advocate or someone to help with communication).

5.5 “Best Interests” - Implications for Healthcare and Treatment Decisions

One of the key principles of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person’s best interests. (See Section 1(5) of the Mental Capacity Act).

The term ‘best interests’ is not defined in the Act, although there is a statutory checklist in Section 4, which must be followed by the decision-maker in order to evidence that a decision is in the persons best interests. It is important to note that this process can only be applied after an assessment of the person’s capacity to make the particular decision for themselves. Provided the steps taken or decisions made by the decision-maker are in the best interests of the person who lacks capacity to make the decision, then the decision maker will be protected from legal liability.

There are exceptions to this – including where a person has made an advance decision to refuse treatment, and the involvement of a person who lacks capacity in research. Unless there is a valid and applicable advance decision to refuse treatment (see section 5.6 below), or a relevant Power of Attorney, (see section 7.3 below) which relates to the particular decision to be made, healthcare staff must carefully establish what is in the patient’s best interests.

In certain cases, where there is no one else available to consult about the person’s best interests, an Independent Mental Capacity Advocate (IMCA) must be appointed to support and represent the person.(see section 6.0 below).

5.6 Making a decision in a person’s ‘best interests’

A decision maker trying to establish the best interests of a person who lacks capacity to make a decision should follow the best interests checklist of the MCA. The main points are:-

i Encourage participation.

Do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision. The person’s views are still relevant even if they lack capacity to make the decision themselves.
ii  **Identify all relevant circumstances.**
Section 4(11) of the Act defines relevant circumstances as those circumstances:

- of which the person making the decision is aware; and
- which it would be reasonable to regard as relevant

In relation to medical treatment the doctor/health professional who is the decision-maker would need to consider the clinical needs of the patient, the potential benefits and burdens of the treatment on the person’s health, and any other factors relevant to making a professional judgement. These would include considering the effect of other treatment options and their pros and cons and the effect of no treatment whatsoever.

iii  **Find out the Person’s Views**
Section 4(6) of the Act requires the decision maker to consider, as far as they are ‘reasonably ascertainable’

- The person’s past and present wishes and feelings (and in particular, any relevant written statements made by him when he had capacity).
- The beliefs and values that would be likely to influence his decision if he had capacity (such as cultural background, religious beliefs, political convictions or past behavioural habits), and;
- The other factors that he would be likely to consider if he were able to do so.

The aim is to try to identify all the things that a person who lacks capacity would take into account if they were making the decision for themselves.

‘Reasonably Ascertained’ means considering all possible information in the time available. What is available in an emergency will be different to what is available in a non emergency.

iv  **Avoid discrimination**
The principle of equal consideration and non-discrimination applies when making a decision on a person’s best interests. Do not make assumptions about someone’s best interests simply on the basis of the person’s age, appearance, condition or behaviour.

v  **Assess whether the person might regain capacity**
Consider whether the person is likely to regain mental capacity (e.g. after receiving medical treatment) if so, can a decision wait until then?

vi  **If the decision concerns life sustaining treatment**
A decision should not be motivated in any way by a desire to bring about a person’s death. No assumptions should be made about the person’s quality of life. However, where a person is nearing the end of their life, e.g. in the end stages of a terminal illness, it will be lawful, in some cases, to withdraw life-sustaining treatment, when the benefits of treatment are clearly outweighed by the burdens.

vii  **Consult Others**
The Act places a duty on the decision maker to consult other people close to the person who lacks capacity, unless it is not practicable and appropriate, when making decisions about what treatment or care might be in the person’s best interests.

Under Section 4(7) of the Act the decision maker has a duty to take into account the views of the following people, only if “practicable and appropriate” to do so:

- Anyone the person has previously named as someone they want to be consulted.
- Anyone involved in caring for the person (on a voluntary/unpaid basis).
• Anyone interested in their welfare (e.g. family carers, other close relatives or an advocate already working with the person).
• Any Attorney appointed under a Lasting Power of Attorney, and
• A Deputy appointed by the Court of Protection to make decisions for the person.

In certain cases, where there is no one whom it is practical or appropriate to consult, and the decision is about “serious medical treatment” or long-term accommodation, there is a duty for the decision-maker to consult an Independent Mental Capacity Advocate (IMCA) must be appointed to support and represent the person.

viii Avoid restricting the person’s rights
Is there an alternative option or options for treatment that will achieve the same result but may be less restrictive of this person’s rights? If so, consider carefully which option is in the person’s best interests.

ix Take all of this into account
Weigh up all of the above factors in order to establish what is in the person’s best interests. See the best interest checklist at Appendix 2

5.7 What happens when there are conflicting concerns?
A decision maker may be faced with people who disagree about a person’s best interests. Family members, partners and carers may disagree between themselves, or they might have different memories about what views the person expressed in the past. Carers and family members might disagree with a professional’s view about the person’s care and treatment needs.

The decision maker will need to find a way of balancing these concerns or deciding between them. It may be possible to reach an agreement at a meeting to air everyone’s concerns. However, an agreement in itself might not be in the person's best interests.

A multidisciplinary meeting or a best interests meeting with an agenda is recommended as a good way to reach decisions/resolve issues about what is in a person's best interests. However, the final responsibility for deciding what is in the person's best interests lies with the member of the healthcare staff responsible for the person’s treatment. It is essential that any meeting is documented in the medical notes.

Recommendations for complex decisions/disputes

• Every attempt is to be made in resolving the dispute at a local level.
• Best interest meeting to be held with all relevant staff/family or carers.
• For a medical decision that is in dispute, gain a second opinion of a Consultant colleague.
• Inform the legal team of on-going or unresolved disputes regarding serious medical treatments or decisions.
• Final responsibility for healthcare decisions in the patient’s best interests will be with the Consultant responsible for the patient.
• Please record all meetings or discussions held in the medical notes.

Major healthcare and treatment decisions – (e.g. major surgery or a decision not to attempt resuscitation) will need special consideration.

If someone wants to challenge a decision maker’s conclusions, it may also be helpful to obtain ‘a second opinion’ from a Consultant colleague or attempt some form of mediation. The Trust may obtain a second opinion, where capacity/best interests are controversial, or family members disagree, in order to assist in reaching a consensus. Families can also be encouraged to pursue a complaint.
through the Trust’s Complaints Procedure. In some limited situations it may be necessary to approach the Courts for direction. In the event that further advice is required please speak with the legal department in the first instance.

NB If a family member/someone close to the patient is strongly opposed to a particular decision, involving serious medical treatment, consider seeking legal advice before proceeding.

5.8 Recording the Decision
It is this Trust's policy to accurately and carefully record details of decisions made regarding the assessment of mental capacity, and the determination of best interests in accordance with standard reporting procedures. Information must be recorded within patient’s healthcare record files. Please see the Appendices to this policy for the appropriate forms to be used.

In the event of legal challenge, even for day to day decisions the professional giving medical or nursing treatment must be able to demonstrate they had a "reasonable belief" that the individual lacked capacity to make the decision in question, and it was in their best interests to take the action they took. If healthcare and social care staff are involved, their skills will affect what is classed as reasonable. For example a doctor assessing someone's capacity to consent to treatment must demonstrate more skill than someone without medical training.

6 Restrictions and Limitations of Best Interests Policy

6.1 Legal Liability
Section 5 of the Act provides protection from liability in the care or treatment of someone reasonably believed to lack capacity.

The Mental Capacity Act 2005 states that an act done or decision made for or on behalf of a person, who lacks capacity, must be in that person’s best interest and may be carried out without formal procedures or court intervention, but with clear restrictions and limitations.

By providing protection, the Act allows necessary caring acts or treatment to take place as if a patient who lacks capacity to consent had consented to them.

6.2 Exceptions to the protection from liability
There is no protection from liability where:

- The care or treatment conflicts with a decision of an Attorney under an LPA.
- The care or treatment conflicts with a decision of a Court Deputy.
- There is a known valid applicable Advance Decision refusing treatment.
- There is an act of negligence.

6.3 Acts in connection with Care or Treatment
The Act does not define ‘care’ and ‘treatment’ and they should be given their normal meaning. However, Section 64(i) makes clear that the treatment includes diagnostic or other procedures. Actions that might be covered by Section 5 of the Act include:

- Carrying out diagnostic examinations and tests.
- Providing medical or dental treatment.
- Giving medication.
- Providing nursing care.
- Carrying out necessary medical procedures or therapies.
- Providing emergency care.
These actions only receive protection from liability if the person is reasonably believed to lack capacity to give permission for the action. The action must also be in the person’s best interests.

6.4 Restraint
Restraint is permitted under the MCA in order to provide care and treatment for those who lack capacity subject to careful assessment and recording. Anybody considering using restraint must have objective reasons to justify that restraint is necessary. Under Section 6 of the Act, restraint is defined as:-

The use or threat of use of force where the incapacitated person resists, or
restricting the person’s liberty of movement, whether or not that person resists.

If a healthcare professional is proposing any action which would amount to restraint they must ensure that:

- They reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity
- The amount and type of restraint used and the amount of time it lasts will be a proportionate response to the likelihood of serious harm.

This must be recorded. A member of staff must not use restraint just so that they can do something more easily. It must be noted that the cumulative effect of a variety of restraint or restrictions on a person’s liberty can result in a deprivation of liberty even if one act alone does not.

Other legal forms of restraint
Restraint is authorised in relation to the care and treatment of those lacking capacity, as set out above. In addition, there are other legal powers to restrain people, where necessary, for the protection of others/protection of property. The common law imposes a duty of care on healthcare staff in respect of all people to whom they provide services. Therefore, if a person who lacks capacity to consent presents challenging behaviour, or is in the acute stages of illness causing them to act in a way which may cause harm to others, staff may, under common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else. Equally, whether or not the person lacks capacity if they are behaving aggressively or in a way that puts others at risk, reasonable restraint can be used. Staff also have the right to use restraint to defend themselves, where they are at risk of harm.

Note: Within this context, the common law does not provide grounds for an action that would have the effect of depriving someone of their liberty (as defined by Article 5(1) of the European Convention on Human Rights).

Sometimes there is no alternative way to provide care and treatment other than depriving a person of their liberty. In this situation a patient may be detained in hospital under the Mental Health Act 1983 – but this only applies to people who require hospital treatment for a mental disorder or they may be detained in hospital using the MCA Deprivation of Liberty Safeguards. For more information, please see Chapter 13 of the Mental Capacity Act Code of Practice.

6.5 Deprivation of Liberty
An important decision by the European Court of Human Rights (ECHR) in the Bournewood case prompted the introduction of these safeguards. In that case, the European court found that this individual, who was an informal patient (incapable of consenting to his care) receiving treatment for his mental disorder in a private hospital, was being deprived of his liberty. There was no legal mechanism under UK law which allowed him to challenge the hospital managers, which amounted to a breach of his human rights. In the judgment, deprivation of liberty was described in the following terms:-
“The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance”. “…the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors…such as the type, duration, effects and manner of implementation of the measure in question”.

6.5.1 Supreme Court Judgment (March 2014)
The judgement is significant in the determination of whether arrangements made for the care and or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty. The test of deprivation of liberty has now been revised into a so-called “acid test” by the Supreme Court and is as follows:

The person is under continuous supervision and control AND is not free to leave

Every element of this must be satisfied i.e.

- Continuous
- Supervision
- Control
- Not free to leave

This would need to be on-going for a period of time (usually 7 days but some restrictions can be so severe that advice will be needed) it is no longer relevant whether the person is compliant or whether there is a lack of objection. The focus is not on the person’s ability to express a desire to leave, but on what those with control over their care arrangements would do if they sought to leave, other forms of restraint which would be deemed as continuous supervision and control could include: sedation, side rails, locked doors and alarms.

A Deprivation of Liberty does not apply if supervision and control is short term e.g. due to a possible delirium which is treatable and therefore the person has a temporary cognitive impairment. Similarly in ED where a patient has been assessed and suitable for discharge home. For short term supervision ensure:

- Risk assessment completed and documented if EPS in use
- Complete assessment of capacity and best interest decision for the use of EPS.

6.5.2 Eligibility Criteria
DOLS apply to patients in hospitals and care homes that need to be deprived of their liberty in order to receive care and or treatment. The eligibility criteria is as follows, the person must be:-

- 18 or over and present in England or Wales
- Suffering from a mental disorder (MHA definition)
- Lacking capacity to consent to arrangements made for their care or treatment
- The Deprivation of Liberty is in their “best interests” to receive the care/treatment and to protect them from harm
- It is not appropriate to detain them under the Mental Health Act
- There is no valid refusal of any part of the treatment under an Advance Decision/Lasting Power of Attorney

6.5.3 Procedure
The hospital must seek “authorisation” from the relevant supervisory body (i.e. the relevant local authority) when it appears likely that either now or in the next 28 days a person may be accommodated and it may amount to a deprivation of liberty.

Where the need for admission to hospital is unexpected, urgent authorisation can be issued by the hospital which must be in writing, and standard authorisation must be obtained before the expiry of the urgent authorisation within 7 days.
Once an application for authorisation has been received, the supervisory body must complete an assessment process. The six assessments are:

- Age assessment
- No refusals assessment
- Mental capacity assessment
- Mental health assessment
- Eligibility assessment
- Best interests assessment

6.5.4 Staff information
For further information regarding the procedure and for making a DoLS referral please refer to the hospital intranet, services and departments, safeguarding, safeguarding adults to access:

- Deprivation of Liberty Safeguards Pathway flowchart.
- Referral forms including examples.

6.6 Mental Health Act 1983
The Mental Health Act 1983 sets out when:

- People with mental disorders can be detained in hospital for assessment or treatment
- People who are detained can be given treatment for their mental disorder without their consent
- People with mental disorders can be made subject to guardianship or aftercare under supervision to protect them or other people.

Trust employees have a duty to consider using the Mental Health Act to detain and treat someone who lacks capacity to consent to treatment if:

- It is not possible to give the person the care or treatment they need without doing something that might deprive them of their liberty and DOLS cannot be used.
- The person needs treatment that cannot be given under the Mental Capacity Act
- The person may need to be restrained in a way that is not allowed under the Mental Capacity Act.
- It is not possible to assess or treat the person safely or effectively without treatment being compulsory
- The person lacks capacity to decide on some elements of the treatment but has the capacity to refuse a vital part of it
- There is some other reason why the person might not get treatment, and they or somebody else might suffer harm as a result

Many people covered by the Mental Health Act 1983 have the capacity to make decisions themselves. Some however, will lack capacity and thus decision makers have a duty to decide whether to use the Mental Health Act or the Mental Capacity Act, or both, to meet the needs of people with mental health problems who lack capacity to make decisions about their own treatment. Trust staff have a duty to uphold the principles of the MCA even if the patient is subject to the Mental Health Act with the following exceptions:

- If the patient is liable to be detained under the MHA, decision makers cannot normally rely on the MCA to give mental health treatment or make decisions about that treatment on the service user’s behalf
- If the patient can be given mental health treatment without their consent because they are liable to be detained under the MHA, they can also be given mental health treatment that goes
against an advance decision to refuse treatment, except an advance decision to refuse electro-convulsive therapy (ECT), which will be binding

- If a patient is subject to guardianship, the guardian has the exclusive right to make certain decisions, including where the service user is to live

IMCAs do not have to be involved in decisions about serious medical treatment or accommodation, if those decisions are made under the MHA

Section 5 of the Mental Capacity Act provides legal protection for people who care for or treat someone who lacks capacity, providing they follow the Act's principles and only if action taken is in the person’s best interests – see section 5.2 above. There are however limitations in terms of restraint and no protection for actions that deprive a person of liberty, or the giving of treatment that goes against an advance decision to refuse treatment. These limitations and restrictions do not apply to the Mental Health Act, but staff should be mindful that others do.

6.7 Advance Decisions
If a patient lacks capacity, but has previously made a valid advance decision to refuse treatment, the advance decision must be followed, if it is found to be applicable to the current situation.(see the Trust's policy on Advance Decisions).

In order to be valid and applicable, an advance decision must:-

- Be made by someone aged 18 or over who has the capacity to make the decision
- Say what treatment they want to refuse, and in what circumstances.

NB: When the advance decision is potentially relevant, the decision maker must consider carefully whether it is “applicable” to the current decision to be made. Is there any evidence to suggest that the person has changed their mind since they made their advance decision, or would have changed their mind, if they still had capacity to do so?

A person can cancel their advance decision (or part of it) at any time, simply by making that wish known.

The Act recognises that adults have the right to say in advance that they want to refuse treatment if they lose capacity in the future – even if this results in their death.

Healthcare professionals must follow an advance decision if it is valid and applies to the particular circumstances. Any health professional that provides treatment which has been validly refused under an advance decision could be guilty of civil or criminal assault.

The MCA imposes particular legal requirements and safeguards on the making of advance decisions to refuse life sustaining treatment. From 01.10.07, the advance decision must, in order to be valid, be in writing, be signed and witnessed and state clearly that the decision to refuse the treatment applies even if life is at risk.

Advance decisions to refuse treatment for mental disorder may not be apply if the person who made the advance decision is or is liable to be detained under the Mental Health Act 1983.

People can only make advance decisions to refuse treatment. Nobody has a legal right to demand specific treatment. However, people can make a request or state their wishes and preferences in advance. Healthcare professionals should then consider the request when deciding what is in the patient’s best interests.
For more information regarding advance decisions please see:

- Chapter 9 of the Mental Capacity Act Code of Practice.
- Trust Policy – Advance Decisions to Refuse Treatment.

### 6.8 Research involving people who lack capacity

The Mental Capacity Act sets out a clear legal framework for many types of research involving people who lack capacity to consent to taking part in such research. The Act excludes Clinical Trials of Medicines as this is covered within the Medicines for Human Use (Clinical Trials) Regulations 2004.

It is important that research is able to involve people who lack capacity, to provide knowledge about the causes of incapacity and about the diagnosis, treatment, care and needs of people who lack capacity.

The Act introduces a number of safeguards to protect people taking part in such research such as:

- Family members or unpaid carers must be consulted about any proposal and agree that the person can be part of the research. If such a person cannot be identified, then the researcher must identify a person who is independent of the research project to provide advice on the participation of the person who lacks capacity in the research.
- If the person without capacity shows any sign that they are unhappy to be involved in the research then the research must not be allowed to continue.

Proposals will only be considered for the approval of research, by the relevant Ethics Committee, involving patients that lack capacity, if the research is linked to:

- An impairing condition that affects the person who lacks capacity, or the treatment of that condition and
- There are reasonable grounds for believing that the research would be less effective if only people with capacity are involved and
- The research project has made arrangements to consult carers and to follow the other requirements of the Act.

The research must also meet one of two additional requirements prior to consideration:

- The research must have some chance of benefiting the person who lacks capacity. The benefit must be in proportion to any burden by taking part, or
- The aim of the research must be to provide knowledge about the cause of, or treatment or care of people with, the same impairing condition or a similar condition.

In relation to the second additional requirement, the risk to the person who lacks capacity must be negligible, there must be no significant interference with the freedom of action or privacy of the person who lacks capacity and nothing must be done or in relation to the person who lacks capacity which is unduly invasive or restrictive.

### 7 Independent Mental Capacity Advocate (IMCA)

An Independent Mental Capacity Advocate (IMCA) is someone instructed to support and represent a person who lacks capacity to make certain serious decisions.

The purpose of the IMCA is to ensure that important decisions about particularly vulnerable people who lack the capacity to make those decisions are carefully considered. The IMCA service becomes involved where the person has no family or friends (other than professionals or paid workers) with whom it would be practical or appropriate to consult, about those decisions. The person may have family or friends, but the decision-maker has decided, it is not appropriate to consult with them, in the particular circumstances.
Each IMCA undergoes specific training, commissioned by the Local Authority to undertake their role, which is to gather information, provide support to the person concerned and make representations about that person’s wishes, feelings, beliefs and values. They provide a report to the decision-maker, bringing to their attention all factors that are relevant to the decision. Any information given by or submissions made by an IMCA must be taken into account when considering serious medical treatment. However, the decision rests with the relevant health professional as to what is in the person’s best interests.

Having said that, the IMCA will be able to challenge the decision maker, where they consider that to be necessary. They can utilise the complaints process/other mechanisms to challenge decisions, including an application to the Court of Protection.

An IMCA must be instructed by the NHS where:

- There is a decision to be made regarding “serious medical treatment” (see 6.1 below) or change of accommodation AND
- The person has no close family or friends, who can be consulted to represent their views AND
- The person has no appointed Attorney or Court Deputy AND
- The person has been deemed by the Decision Maker not to have capacity to make that decision in accordance with the Act.

IMCAs may also be instructed in issues of safeguarding vulnerable adult procedures and care reviews. (Please see the Trust’s IMCA policy for more information).

There is no duty to instruct an IMCA for decisions about serious medical treatment which is to be given under part 4 of the Mental Health Act 1983, nor is there a duty to do so in respect of a move/change of accommodation, if the service user is required to move/change accommodation under the Mental Health Act.

There is no requirement to involve an IMCA where serious medical treatment/a long-term move is urgently required. However, it is good practice to make a referral as soon as it is clear one is appropriate. If it is then not possible to await IMCA input, treatment can be given under the “urgency” exception.

7.1 Definition of Serious Medical Treatment
The Act defines this as being where an NHS body proposes to provide, or secure the provision of, treatment, including providing, withdrawing or withholding treatment. Examples may include:

- A case where a single treatment is being proposed and there is a fine balance between the benefits to the patient and the burdens and risks it is likely to entail for him / her
- A case where there is a choice of treatments and a decision as to which one to use is finely balanced
- A case where the proposed treatment would involve serious consequences for the patient

For contact details see Appendix 3

7.2 Accommodation
There is a duty on an NHS body to instruct an IMCA if a person is to be placed in a hospital (or moved to another hospital) for a time period exceeding 28 days

An IMCA must be instructed as soon as it is realised the placement will, or is likely to exceed that period. However, this can be dispensed with if the placement or move is a matter of urgency.
If a person is to be placed in a care home, for a period of 8 weeks or more, it is the responsibility of the funding body (whether the PCT or the Local Authority) to instruct an IMCA to be involved in that decision.

7.3 Other circumstances
An IMCA may (not must) be instructed by an NHS body;

- There are qualifying arrangements and review is proposed or in progress (i.e., 12 weeks or more in a care home, hospital or residential accommodation or under Section 117 of the MHA 1983)
- As part of protective measures following allegations of abuse or neglect of the patient. An IMCA may therefore be appointed even though there is someone else appropriate to consult.

7.4 Powers/Function of an IMCA
An IMCA has the power to interview the relevant person in private and may examine and take copies of a health records, social services records or care home records, if relevant to their investigation. In addition, an IMCA has the power to obtain further medical opinion if they wish.

An IMCA also has the ability to consult with professionals providing care/treatment, and other persons in a position to comment.

8 The Court of Protection
Some treatment decisions are so serious, that the Court has to make them (see 7.1 below) – unless the person has previously made a Lasting Power of Attorney appointing an Attorney to make healthcare decisions for them, or they have made a valid advance decision to refuse the proposed treatment.

The Mental Capacity Act 2005 created a specialist court, known as the Court of Protection, with jurisdiction to deal with decision making for adults who lack capacity. The Court can also make decisions about property and affairs and personal welfare (welfare and healthcare) matters.

The Court of Protection has the powers to:
- Decide whether a person has the capacity to make a particular decision for themselves
- Make declarations about “best interests”, decisions or orders on matters affecting people who lack capacity to make such decision
- Appoint Deputies to make decisions for people lacking capacity to make those decisions (usually on financial matters only)
- Decide whether a Lasting Power of Attorney, Enduring Power of Attorney or advance decision is valid, and
- Remove Deputies or Attorneys who fail to carry out their duties.

8.1 The Court of Protection and Serious Medical Treatment
The Court of Protection must be asked to make decisions relating to:

- The proposed withdrawal of artificial nutrition and hydration from a patient in a permanent vegetative state.
- Cases where it is proposed that a person who lacks capacity to consent should donate an organ or bone marrow to another person.
- The proposed non-therapeutic sterilisation of a person who lacks capacity to consent (e.g., for contraception purposes).
• Cases where there is a dispute about whether a particular treatment will be in a person’s best interests.

This last category may include cases that introduce ethical dilemmas concerning untested or innovative treatments (e.g. new treatments for variant Creutzfeldt – Jakob Disease, where it is not known that the treatment will be effective) or certain cases involving termination of pregnancy. It may also include cases where there is conflict between professionals or between professionals and family members which cannot be resolved in any other way.

In the first instance please refer to Chapter 8 of the Mental Capacity Act 2005 Code of Practice and speak with the Director of Corporate Affairs.

8.2 Court of Protection and the Appointment of Deputies

If a patient has not appointed or is unable to appoint an Attorney (EPA/LPA) (see 7.3) and they need certain decisions made on their behalf, which cannot be taken other than by bringing the matter to court, then an application will be made to the Court of Protection. In most cases, the application will be made by the patient’s family or carers, but occasionally by the Trust, where no other appropriate person can be identified. The Trust must ensure that all other options have been explored prior to seeking permission to apply to the Court of Protection.

Any application directly to the Court of Protection must be agreed in advance with the Director of Corporate Affairs who will consult the Trust Solicitor for advice and support.

The Court of Protection can appoint a Deputy to make decisions on behalf of the patient. There are specific restrictions on a Deputy’s powers. A Court Appointed Deputy has no authority to make decisions or take actions in the following respects:

• Where the action is intended to restrain the person who lacks capacity
• If they think that the person concerned has capacity to make a particular decision for themselves
• If their decision goes against a decision made by an Attorney acting under a Lasting Power of Attorney granted by the person before they lost capacity,
• To refuse the provision or continuation of life sustaining treatment for a person who lacks capacity to consent
• Deputies will not be able to give consent on a patient’s behalf for treatment under Part 4 of the Mental Health Act 1983, where the patient is liable to be detained under the Mental Health Act.
• Deputies will also not be able to take decisions about where a person subject to guardianship should live, or take decisions that conflict with decisions that a guardian has a legal right to make

The Office of the Public Guardian is responsible for the supervision and support of Deputies and if it is felt that possible abuse or exploitation has taken or is taking place, by any Deputy appointed by the Court of Protection, SATH have a duty to inform the OPG promptly. Any such concerns should be reported urgently to the Director of Corporate Affairs.

8.3 Lasting Power of Attorney (LPA)

A person who is over 18, with capacity, may wish to plan for a future situation where they may have lost capacity and therefore be unable to make certain decisions for themselves.

A Power of Attorney is a legal document which enables a person to give another person the authority to make decisions on their behalf. Under a Power of Attorney, the chosen person (the Attorney or Donee) can make decisions that are as valid as one made by the person making the Power (the Donor) if they had the capacity to do so.
The Mental Capacity Act replaced the Enduring Power of Attorney (EPA) (which covers property and affairs only) with a Lasting Power of Attorney (LPA) which introduced new safeguards against abuse and exploitation.

An Enduring Power of Attorney made prior to the Act continues to have legal force; however, there are different laws and procedures for EPAs and LPAs.

There are two types of LPA - one which authorises decisions in relation to property and financial affairs (property and affairs LPA) or a personal welfare LPA (which includes decisions relating to healthcare and consent to medical treatment).

The LPA must be executed in a prescribed form and it must be registered with the Public Guardian before it can be used. An LPA can only be made if the person has capacity to do so. The two types of LPA apply in slightly different ways:

- Property and affairs LPAs can be used both before and after the donor loses capacity, according to the donor’s wishes.
- Personal Welfare LPAs can only be used when the donor lacks capacity to make a decision in this respect.

When a patient or their representative makes known the existence of an LPA/EPA, Trust staff must check the LPA/EPA for validity and appropriateness and maintain a copy on the patient records. Advice can be obtained from the Legal Services Manager or Head of Patient Services.

An Attorney is a personal choice of the patient. It is Trust policy **not** to allow employees to act as an Attorney during the course of their work.

A personal welfare LPA allows Attorneys to make decisions to accept or refuse healthcare or treatment unless the donor has clearly stated in the LPA that they do not want the Attorney to make these decisions, with the following exceptions:

- Where the donor has capacity to make the particular healthcare decision.
- Where the donor has made an advance decision to refuse the proposed treatment.
- Where a decision relates to life sustaining treatment. An Attorney has no power to consent or refuse life sustaining treatment unless the LPA document expressly authorises this.
- Where the donor is detained under the Mental Health Act, compulsory treatment under that Act can be given without the Attorney’s consent.

In addition, LPAs do not give Attorneys the power to demand specific forms of medical treatment that healthcare staff do not believe are necessary or appropriate for the donor’s particular condition.

The Attorney must act in the donor’s best interests when making decisions about such treatment. This will involve applying the best interest checklist (see 4.6) and consulting with carers, family members and others interested in the donor’s welfare.

The Attorney must not be motivated in any way by the desire to bring about the donor’s death. Should a member of staff doubt that an Attorney is acting in the donor’s best interests; a referral to the OPG should be considered, via the Director of Corporate Affairs.

### 8.4 If Healthcare Staff disagree with an Attorney’s Decision

Attorneys must always follow the Act’s Principles and make decisions in the donor’s best interests. If healthcare staff disagree with the Attorney’s assessment or best interests, they should discuss the case with other medical colleagues and/or obtain a formal second opinion.
The matter should then be discussed further with the Attorney. If it is not possible to reach agreement, the Trust may consider it appropriate to apply to the Court of Protection. While the Court is coming to a decision, healthcare staff can give treatment to prolong the donor’s life or stop their condition getting worse.

For more information please refer to Chapter 7 of the Mental Capacity Act 2005 Code of Practice and the Trust’s policy on Lasting Powers of Attorney.

8.5 Checking the Validity of an EPA and LPA

**EPAs**
- The EPA must be made on the relevant form.
- The EPA must be registered with the Public Guardian when the donor can no longer manage their own affairs.
- The EPA will only cover property and affairs.

**LPAs**
- The LPA may cover property and affairs or personal welfare. It is important to check exactly what it covers.
- The LPA must be a written document set out in the statutory form.
- The document must include prescribed information about the nature and effect of the LPA.
- The LPA must be registered with the Office of the Public Guardian before it can be used. The LPA will be sealed by Office of the Public Guardian on each and every page of the LPA to show it has been registered.
- An unregistered LPA will not give the Attorney any powers to make a decision for the donor.

For more information please refer to Chapter 7 of the Mental Capacity Act 2005 Code of Practice

8.6 The functions of the Public Guardian

The Mental Capacity Act 2005 introduced a new statutory office, the Office of the Public Guardian. The functions of the Public Guardian include establishing and maintaining registers for Lasting Power of Attorney and dealing with Court of Protection orders appointing deputies.

9 Protection from Abuse

The word abuse covers a wide range of actions. In some cases abuse is clearly deliberate and intentionally unkind. But sometimes abuse happens because somebody does not know how to act correctly or they do not have appropriate help and support. Abuse is anything that undermines a person’s human and civil rights. This includes sexual, physical, verbal, financial and emotional abuse. Some abuse will be a criminal offence. If somebody is being abused, it is important to investigate the abuse and take steps to stop it happening. Trust staff should refer to the Vulnerable Adult Policy when they suspect abuse has taken or is taking place.

10 Confidentiality and Record Keeping

People making decisions on behalf of those who lack capacity will often need to share personal information relating to the person lacking capacity, so that they can determine, and act in, that persons best interests. Decision makers must balance the duty to consult other people with the right to confidentiality of the person who lacks capacity. If confidential information is to be discussed, the decision maker should only seek the views of people who it is appropriate to consult, where their views are relevant to the decisions made and the particular circumstances

Trust employees will be required to act upon requests for information, in this context, in accordance with the law. Disclosure of, and access to, such information is regulated by the Data Protection Act 1998; The common law of duty of confidentiality; professional codes of conduct on confidentiality and
information sharing protocols; The Human Rights Act 1998 and European Convention on Human Rights. Any requests for information should be dealt with via the Information Governance Department, to ensure that correct procedures are followed.

The Public Guardian has the authority to examine and take copies of any health record and any record held by a person registered under Part 2 of the Care Standards Act 2000. The Trust will comply with all reasonable and relevant requests when required to do so and will ensure that an appropriate record is maintained of requests to disclose information.

Apart from routine day to day decisions, it is this Trust’s policy to accurately and carefully record details of decisions made regarding the assessment of mental capacity, and the determination of best interests in accordance with standard reporting procedures. Information must be recorded within patient’s healthcare record files. Please see the Appendices to this policy for the appropriate forms to be used.

11 Resolving disagreements and disputes
Disagreements and disputes should be settled as quickly and effectively as possible. There are different options available for the settling of disagreements in relation to:

- a person’s capacity to make a decision
- a decision or an action someone is taking on their behalf, believed to be in their “best interests”

Some disagreements about healthcare, social or other welfare services are so serious that they can only be resolved by the Court of Protection, others can be resolved by either formal or informal procedures.

The Trust will work with the relevant parties to select the most suitable option(s) to attempt to resolve the dispute or disagreement as quickly and fairly as possible. The options available are:

- Involve an advocate to act on behalf of the person who lacks capacity to make the decision
- Obtain a second opinion
- Hold a formal or informal ‘best interests’ case conference
- Mediation
- Pursue the complaint through SATH Complaint Procedures
- Referral to the Office of the Public Guardian for disputes regarding the finances of a person who lacks capacity
- Application to the specialist Court of Protection for a decision maker to be appointed in cases where there is no other way of resolving the matter

12 Training Needs
Training required to fulfil this guidance will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trust's Risk Management Training Policy. These can be accessed via the Learning zone pages on the Trust intranet.

13 Reviewing and Monitoring of this policy
This document will be reviewed in 3 years of approval date, or sooner if required. In order that this document remains current, any of the appendices to the policy can be amended and approved during the lifetime of the policy without the document having to return to the ratifying committee.
An audit of DNAR and best interest checklists will be carried out by the clinical audit department at least annually and reported to the Resuscitation Committee and Clinical Governance Executive.

14 Equality Impact Assessment
This document has been subject to an Equality Impact Assessment and is anticipated to have a positive impact on patients who lack capacity.

15 References
The Mental Capacity Act applies in conjunction with other legislation affecting people who may lack capacity in relation to specific matters. SATH employees acting under the Act should also be aware of their obligations under other legislation, including (but not limited to):

- Care Standards Act 2000
- Data Protection Act 1998
- Disability Discrimination Act 1995
- Human Rights Act 1998
- Mental Health Act 1983
- National Health Service and Community Care Act 1990
- Human Tissue Act 2004

Office of Public Sector Information

The Mental Capacity Act 2005 (Appropriate Body) (England)
www.opsi.gov.uk/si/si2006/20063474.htm

The Mental Capacity Act 2005 (Commencement No.1) (Amendment) Order


Public Guardianship Office
http://www.guardianship.gov.uk/partnership/mca.htm

Department of Health

16 Associated Trust Policies
Do Not Attempt Resuscitation Policy
Consent Policy
Vulnerable Adults Policy and Guidance
Advance Decisions to Refuse Treatment
Complaints Procedure
Deprivation of Liberty Safeguards
Appendix 1  Assessment for Mental Capacity

The following checklist provides a structured approach to assessing whether or not someone has the mental capacity to make a particular decision. Anyone assessing someone’s capacity to make a decision should use the two-stage test of capacity outlined in the Mental Capacity Act (MCA).

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<th>ASSESSMENT OF CAPACITY</th>
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</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Patient Name:</td>
</tr>
<tr>
<td>Patient Hospital No.</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Ward / Department:</td>
</tr>
<tr>
<td>Details of Decision Maker(s):</td>
</tr>
<tr>
<td>Details of Decision to be made:</td>
</tr>
</tbody>
</table>

Assessing mental capacity is always decision-specific and therefore capacity has to be assessed for each decision or type of decision at the time the decision has to be made.

It is important to record clearly why you are making a particular decision or judgement. Please record clearly in the person’s healthcare records your reason for answering “yes” or “no” to the questions below.
**ASSESSMENT OF CAPACITY – Stage 1**

Does the person have an impairment or disturbance in the functioning of their mind or brain. (It does not matter whether the impairment or disturbance is temporary or permanent) e.g. learning disability, dementia, acquired brain injury, drug or alcohol misuse mental illness or other cognitive impairment.

<table>
<thead>
<tr>
<th>YES ☐</th>
<th>NO ☐</th>
</tr>
</thead>
</table>

If ‘YES’ record what the impairment is and what information you used to support this judgement then go to Stage 2. If ‘NO’ the provisions of the MCA do not apply.

---

**ASSESSMENT OF CAPACITY – Stage 2**

To be answered if ‘yes’ at stage 1

**Is the patient able to:**

Understand the information relevant to the decision?

<table>
<thead>
<tr>
<th>YES ☐</th>
<th>NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details:</td>
<td></td>
</tr>
</tbody>
</table>

And

Retain that information in their mind long enough to make an effective decision?

<table>
<thead>
<tr>
<th>YES ☐</th>
<th>NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details:</td>
<td></td>
</tr>
</tbody>
</table>

And

Use or weigh that information as part of the process of making the decision?

<table>
<thead>
<tr>
<th>YES ☐</th>
<th>NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details:</td>
<td></td>
</tr>
</tbody>
</table>

And

Is the patient unable to communicate their decision, whether by talking, using sign language or any other means?

<table>
<thead>
<tr>
<th>YES ☐</th>
<th>NO ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please provide details:</td>
<td></td>
</tr>
</tbody>
</table>
NOTE: the first three points should be applied together. If the person is unable to do any of these three things, they lack capacity to make the decision. The fourth point only applies in situations where people cannot communicate their decision in any way.

If the answer is ‘no’ to any of these questions, this is an indication that the person lacks capacity to make the decision.

Before making this judgement you should ensure that every effort has been made to encourage and support the person to make the decision themselves i.e.

1. Does the person have all the relevant information to make a decision?
2. If they are making a decision which means choosing between alternatives, do they have information on the different options?
3. Would the person have a better understanding if the information was explained or presented in a different way?
4. Are there times of the day when the person’s understanding is better?
5. Are there locations where they may feel more at ease?
6. Can the decision be put off until the circumstances are different and the person concerned may be able to make a decision?
7. Can anyone else help the person to make a choice or express a view? (e.g. family members or carer, an advocate or someone to help with communication)

You should record in the space below that you have considered these issues and the actions you have taken.

If your judgement is that the person lacks capacity and you are the decision-maker then you need to make a “best interests” decision. You must consider the best interests checklist before deciding what is in the patient’s best interests. You must complete the form at Appendix 2.

(If the patient has made a Lasting Power of Attorney or Advance Decision that is applicable to this decision refer to the Trust’s policy or seek advice before proceeding)

Record the outcome of your assessment in the patient’s healthcare records (along with a copy of this form) and sign and date your entry.

I consider the patient has / does not have* capacity to make this decision.

* delete as appropriate

<table>
<thead>
<tr>
<th>SIGNED</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME IN CAPITALS</td>
<td></td>
</tr>
<tr>
<td>JOB TITLE</td>
<td></td>
</tr>
<tr>
<td>DATE</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2:  Best Interests Assessment
Before making a decision as to what is in a person’s best interests you must have first assessed that the individual lacks the mental capacity to make the particular decision that is at issue, at the particular time that the decision needs to be made. (See “Assessing Mental Capacity Checklist” at Appendix 1).

When deciding what is in a person’s best interests the decision-maker must not make that judgement merely on the basis of the individual’s age, appearance, impairment, diagnosed condition or any aspect of their behaviour, which may lead others to make unjustified assumptions about what may be in that person’s best interests.

It is important to record clearly why you are making a particular decision or judgement. Please record clearly in the person’s healthcare records your reason for answering “yes” or “no” to any of the questions below.

<table>
<thead>
<tr>
<th>BEST INTERESTS ASSESSMENT (please tick ☒ when task completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the Question / Issue being considered?</td>
</tr>
<tr>
<td>I have encouraged and assisted the patient to participate in the decision</td>
</tr>
<tr>
<td>I have considered all factors relevant to the decision</td>
</tr>
<tr>
<td>I have attempted to find out the views of the patient, including their past and present wishes and feelings, and taken these into account</td>
</tr>
<tr>
<td>I have not based my assessment solely on the patient’s age, appearance, condition or behaviour</td>
</tr>
<tr>
<td>I have considered whether the patient might regain capacity and if so whether the decision can be delayed</td>
</tr>
<tr>
<td>Please provide details of how you have applied factors a) to e)</td>
</tr>
</tbody>
</table>

I have consulted the following relevant individuals in coming to my decision:
Their views were as follows:

| It was not practicable / appropriate to * consult ………………………………… for the following reasons: * delete as appropriate |
| Independent Mental Capacity Advocate Service |
| A referral to the IMCA service is not necessary as I have been able to consult relevant individuals under the best interests checklist / the decision needs to be taken on an urgent basis* [reason for urgency – please give details below] |
| A referral has been made to the IMCA service and I have taken the IMCA’s view into account* * delete where appropriate |
| Life sustaining Treatment |
| My decision is not motivated in way by a desire to bring about the patient’s death. |
| DETAILS OF DECISION MADE |
| DETAILS OF INDIVIDUALS TO BE INFORMED |

Signed: 

Name in CAPITALS: 

Job Title: 

Date:
Appendix 3: Guidelines for decision making

The following questions provide a structured approach to determining what is in a person’s best interests.

1. Does the person have the mental capacity to make the decision themselves; OR
   Is there a Lasting Power of Attorney; (LPA) in place OR
   Is there a valid Advance Decision in place that relates to this issue: YES/NO

   If ‘YES’ then the person can make the decision themselves; OR
   The decision of the LPA must be accepted; OR
   The Advance Decision must be respected.

   If ‘NO’ proceed to question 2.

2(a) Is it likely that the person will at some time have mental capacity in relation to the matter in question?

   If ‘YES’ go to 2(b). If ‘NO’ proceed to Questions 3 and 4.

2(b) If ‘YES’ will waiting make it likely that irreversible mental or physical harm may arise?

   If ‘YES’ then proceed to questions 3 and 4.

   If ‘NO’ and it is reasonable to wait for this without seriously compromising the person’s safety or best interests then you must wait until they have mental capacity.

3. Has the person been supported, helped and encouraged (so far as reasonably practicable) to participate in the decision-making or to improve their ability to participate as fully as possible in this particular decision: YES/NO

   If ‘YES’ then proceed to question 4.
   If ‘NO’ those actions must be taken.

4. Have each of the following criteria been considered in deciding what is in the best interests of the person? YES/NO

   So far as is reasonably ascertainable:
   • The person’s past and present wishes and feelings, in particular any relevant statement made when they had capacity.
   • The person’s beliefs and values that are likely to influence their decision-making if they had capacity.
   • Other factors the person is likely to have considered if able to do so.

   Unless it is not practicable and/or appropriate, you must consult with the following people and their views must be taken into account when ascertaining the above issues.
   • Any person named as someone to be consulted on the matter in question or matters of that kind.
   • Anyone engaged in caring for the person or otherwise interested in their welfare.
   • Any Donee of a Lasting Power of Attorney granted by the person.
   • Any Deputy appointed for the person by the Court of Protection.
If consultation has taken place, record the outcome and your views as to that information.

If consultation has not taken place, this must happen or if it is not practical or appropriate to do so, the reasons must be carefully recorded.

NB If the decision to be made relates to serious medical treatment (see 6.1) or a long-term accommodation move (see 6.2) and there is no one appropriate or practicable to consult (other than paid carers) then an IMCA must be appointed before the decision is finalised.

The decision-maker must ensure that the action being proposed is the least restrictive alternative and where any restriction on the person’s liberty is being considered that the restriction is proportionate to the risk and for the shortest possible time?

As a result of this assessment record what alternative options have been considered, what decision has been made or proposed as being in the person’s best interests and why it is considered to be the least restrictive alternative.

Record the outcome of your assessment in the patient’s healthcare records and sign and date your entry.
Appendix 4: IMCA Referral flowchart: Should I refer my client to an Independent Mental Capacity Advocate (IMCA)?

Is there an issue of:
- a) Proposed Change of Accommodation
- or
- b) Serious Medical Treatment?

No

Does the client lack capacity to make a decision on the issue in question at this time?

No

You are not required to refer to an IMCA*

Yes

You may be required to refer to an IMCA, please see our website for further details.

Is there an:  
- a) Safeguarding Vulnerable Adults Procedure or  
- b) Care Review?

No

Does the client have anyone else whom it is practical/appropriate to consult?

No

You are not required to refer to an IMCA*

Yes

Must consult them/no need for IMCA

You MUST refer to an IMCA.  
Contact: Shropshire Patients POhWER  
IMCA Team 0300 456 2370 or  
IMCA@pohwer.net Referral forms on  
website: www.pohwer.net  
POWYS Patients via Montgomery Community Health Council 01686 627632.

The IMCA service in Shropshire (both for Shropshire County and Telford and Wrekin) is provided by the advocacy service POhWER. Offices are open 9am – 5 pm Monday to Friday and calls will be taken by a duty IMCA.

*This may not be an IMCA issue, but it may be suitable for another type of independent advocacy.
Appendix 5: IMCA Referral Form – Telford, Wrexham and Shropshire

### IMCA Referral Form Telford & Wrexham and Shropshire

<table>
<thead>
<tr>
<th>Client Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>NHS Number:</td>
<td></td>
</tr>
<tr>
<td>Home Address, postcode, tel</td>
<td></td>
</tr>
<tr>
<td>Location, postcode, tel</td>
<td></td>
</tr>
<tr>
<td>Date referral made:</td>
<td></td>
</tr>
<tr>
<td>Telford &amp; Wrexham</td>
<td>Shropshire</td>
</tr>
</tbody>
</table>

**Reason for Referral (please tick)**

- [ ] Serious Medical Treatment
- [ ] Move to accommodation (NHS body)
- [ ] Move to accommodation (Local Authority)
- [ ] Safeguarding Vulnerable Adults Procedure (LA)
- [ ] Care Review (NHS or LA)

**State Specific Decision (Proposed Options)**

<table>
<thead>
<tr>
<th>Significant dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>When does the decision need to be made by?</td>
</tr>
<tr>
<td>Please give details of any impending meetings or deadlines</td>
</tr>
</tbody>
</table>

**Referrer and Decision Maker’s Contact Details:**

<table>
<thead>
<tr>
<th>Referrer</th>
<th>Decision Maker (If not referrer)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Job Title and Team:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Postcode:</td>
<td></td>
</tr>
</tbody>
</table>
Assessing a Patient’s Mental Capacity Guidance for Staff on the Mental Capacity Act

Tel/Mobile: 
Email: 

Contact person for access to records

Specific Cultural and Communication Needs

<table>
<thead>
<tr>
<th>Language</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Religion</td>
</tr>
<tr>
<td>Sexuality</td>
<td>Disability</td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

**Decision Maker’s Confirmation**
The decision maker is the individual within either the Local authority or the NHS body who has the responsibility for making the decisions on issues of change of accommodation or serious medical treatment on behalf of the client who has been assessed as lacking capacity on either issue. Therefore only the decision maker is able to confirm the following. *

* I confirm that for the above issue I am the Decision Maker on behalf of *(insert NHS body or local authority) ……………………* for decisions regarding *(insert client name)……………………………*

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Please give details of any family or friends and the reasons why you have deemed them inappropriate to consult:

<table>
<thead>
<tr>
<th>Name/relationship</th>
<th>Reason for not consulting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* I also confirm that I deem *(insert client name) ……………………. to have no-one appropriate to consult regarding this issue (excepting safeguarding adults referrals).*

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

* I also confirm that *(insert client name) ……………………… has been deemed to lack capacity to make a decision regarding the above issue. The person making the decision with regard to the client’s lack of capacity in this issue is *(insert name) ……………………..*
Their relationship to the client is ............................................

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please return this form to the IMCA team by fax to 0300 456 2365, by email to IMCA@pohwer.net or by post to POhWER IMCA, PO BoX 14043, Birmingham, B6 9BL. If you have any queries please contact the IMCA duty team by phone on 0300 456 2370. Thank you.