MENTAL CAPACITY ACT POLICY

Document Control

A. Confidentiality Notice

This document and the information contained therein is the property of Aspiro Healthcare.

This document contains information that is privileged, confidential or otherwise protected from disclosure. It must not be used by, or its contents reproduced or otherwise copied or disclosed without the prior consent in writing from our organisation

B. Document Details

Author and Role:	Lem Podmore, Transformation Manager
Current Version Number:	V1
Current Document Approved By:	
Date Approved:	

C. Document Revision and Approval History

Version	Date	Version Created By:	Version Approved By:	Comments
V1	10.06.2019	Lem Podmore		

Introduction

The **Mental Capacity Act (MCA)** 2005 became fully effective on 1st October 2007 in England & Wales and provides a framework to empower and protect people who may lack capacity to make some decisions for themselves.

'A person who lacks capacity', means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken.

The lack of this capacity could be due to a mental health condition, a severe learning disability, a brain injury, a stroke or unconsciousness due to an anaesthetic or sudden accident and may be on either a temporary or a permanent basis.

Mental Capacity Act

The MCA makes clear who can take decisions in which situations, and how they should go about this.

Anyone who works with or cares for an adult who lacks capacity must comply with the MCA when making decisions or acting for that person. Within primary care the provisions will apply to GPs, nurses and those to whom a referral may be made

This applies whether decisions are life-changing events or more everyday matters and is relevant to adults of any age, regardless of when they lost capacity.

The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests.

The MCA only applies where the person lacking capacity is 16 years or older. Any decisions for children younger than 16 can be made with the consent of people with parental responsibility. The Court of Protection has the powers to make decisions about the property and affairs of people under the age of 16.

This policy should be used in conjunction with Advance Directives ("Living Wills") Protocol [*] and Power of Attorney Protocol [*].

FIVE CORE PRINCIPLES

1. A person is assumed to have capacity. A lack of capacity has to be clearly demonstrated
2. No one should be treated as unable to make a decision unless all practicable (reasonable) steps to help them have been exhausted and shown not to work

3. A person can make an unwise decision. This does not necessarily mean they lack capacity
4. If it is decided a person lacks capacity then any decisions taken on their behalf must be in their best interests
5. Any decision taken on the behalf of a person who lacks capacity must take into account their rights and freedom of action. Any decision should show that the least restrictive option or intervention is achieved

RECORD KEEPING

In normal consultations there is the assumption of capacity unless there is evidence to suggest that this may be in doubt. This may arise from behaviour or concerns raised by others such as family members.

Clinical staff will, in the normal course of care, make decisions regarding capacity and the patient's ability to consent to the treatment proposed.

All practice clinicians will maintain a record within the clinical system of long-term or significant plans, decisions or considerations made in respect of a patient's capacity.

When making a record relating to capacity the record will include as a minimum:

- What the decision (or the outcome) was;
- Why a particular decision has been made;
- How the decision was made
  - ➢ What information was used in arriving at the decision;
  - ➢ A record or copy of the information used;
  - ➢ Other staff involved, consultations, family involvement, referrals, etc.

Such records and audit trail provide evidence for staff if they face civil or criminal charges or complaints.

ASSESSMENT OF CAPACITY

It is not within the scope of this policy document to provide full clinical guidance on the assessment of capacity. The following general considerations will be applied.

The Official Code of Practice (see Resources) provides for a two-stage question test:

Q Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)

Q If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

This test must be used and the records must record this and the response.

When assessing a person's ability to make a decision, consider:

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?
- Can the person communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?

Where the person is unable to do ***any one*** of the above,
they are unable to make the decision themselves.

When assessing a person's capacity to make more complex or serious decisions consider:

- Is there a need for a more thorough assessment (perhaps by involving a doctor or other professional expert)?

In addition, to help a person make a decision for themselves, the practice will:

- Provide relevant information
  - ➢ Does the person have all the relevant information they need to make a particular decision?
  - ➢ If they have a choice, have they been given information on all the alternatives?
- Communicate in an appropriate way:
  - ➢ Explain or present the information in a way that is easier for the person to understand (for example, by using simple language or visual aids)?
  - ➢ Explore different methods of communication if required, including non-verbal communication?
  - ➢ Ascertain if anyone else can help with communication (for example, a family member, support worker, interpreter, speech and language therapist or advocate)?
- Make the person feel at ease:
  - ➢ Identify if there are particular times of day when the person's understanding is better?
  - ➢ Identify if there are particular locations where the person may feel more at ease?
  - ➢ Ascertain whether the decision could be put off to see whether the person can make the decision at a later time when circumstances are right for them?
- Support the person:
  - ➢ Ascertain if anyone else can help or support the person to make choices or express a view

See **Appendix B** for a checklist.

PRINCIPLES OF BEST INTEREST

The following are common factors that must always be considered when trying to work out someone's best interests:

- Do not base the decision simply on someone's age, appearance, condition or behaviour
- Consider all relevant circumstances
- Make every effort to enable the person who lacks capacity to take part in making the decision
- If there is a chance that the person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent
- Special considerations apply to decisions about life-sustaining treatment
- Take into account the person's past and present wishes and feelings, beliefs and values
- Consider the views of other people who are close to the person who lacks capacity as well as the views of an attorney or deputy
- Take into account any written instructions which exist already (Advance Directives)

Document the assessment processes and reasons. Consider taking the least restrictive alternative.

DEPRIVATION OF LIBERTY SAFEGUARDS

The Deprivation of Liberty Safeguards (DoLS) form part of the Mental Capacity Act, aiming to make sure that people are receiving care in a way that does not inappropriately restrict their freedom, ensuring decisions made on their behalf are in their best interests. They also ensure that arrangements only deprive someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. It applies to vulnerable people aged 18 or over who have a mental health condition and do not have the mental capacity to make decisions about their own care or treatment.

Those planning care should always consider all options, which may or may not involve restricting the person's freedom, and should provide care in the least restrictive way possible. However, if all alternatives have been explored and it is believed necessary to deprive a person of their liberty in order to care for them safely, permission must be obtained by following strict processes. These processes are the Deprivation of Liberty Safeguards, and they have been designed to ensure that a person's loss of liberty is lawful and that they are protected.

The key elements of the safeguards are:

- To provide the person with a representative
- To give the person (or their representative) the right to challenge a deprivation of liberty through the Court of Protection
- To provide a mechanism for deprivation of liberty to be reviewed and monitored regularly

See also: Consent Protocol [*].

ADVANCE DIRECTIVES

These enable an adult with capacity to make provision for a time when they may lose capacity. An Advance Directive properly drawn up is as valid as a current decision.

If an Advance Directive involves the refusal of life-sustaining treatment it must be made in writing and be signed and witnessed; however in other circumstances directives may be verbal and recorded / written down. See also Advance Directives [*].

A Lasting Power of Attorney made after an Advance Directive will overrule it and gives an attorney the right to consent or refuse treatment. An Advance Directive decision will also be withdrawn if the person subsequently did something inconsistent with it.

See also: Powers of Attorney [*].

INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCA)

The role of IMCAs is to support and represent a person who lacks capacity in making a specific decision, and who has no-one (other than paid carers) to support them.

IMCAs are available to individuals who:

- Are aged 16 years old or over
- Lack the capacity to make a specific decision about serious medical treatment or long-term accommodation
- Have no family or friends available and appropriate to support or represent them
- Have not previously named someone who can help with a decision
- Have not made an LPA (or, before October 2007, an EPA).

An IMCA is independent of the person making the decision and:

- Provides support for the person who lacks capacity;
- Represents the person without capacity in discussions about any proposed treatment;
- Provides information to work out what is in a person's best interests;
- Questions or challenges decisions that they believe are not in the best interests of the person lacking capacity;
- Presents individuals' views and interests to the decision-maker.

The IMCA is not the decision-maker but the decision maker has a duty to take into account the information and views expressed by the IMCA.

An IMCA must be instructed and consulted, for people lacking capacity who have no-one else to support them whenever an NHS body is proposing to:

- Provide, withhold or stop serious medical treatment; or
- Move a person into long-term care in hospital for longer than 28 days or a care home for longer than eight weeks; or
- Move the person to a different hospital or care home

Serious medical treatment includes the treatment of both physical and mental conditions; therefore, an IMCA should be instructed if the NHS Body is:

- Giving new treatment, stopping treatment or withholding treatment, in circumstances where there is a fine balance between the likely benefits, burdens and the risks of the single treatment to the patient
- Deciding between treatments where the choice is not clear
- Considering treatment which is likely to have serious consequences for the patient

Serious consequences include where treatment or the decision to treat:

- Causes serious and prolonged pain, distress or side-effects
- Has potentially major consequences, i.e., surgery or life support treatment discontinuation
- Has a serious impact on the patient's future life choices

NHS bodies can also decide to instruct IMCAs in decisions concerning care reviews or in adult protection cases, where it is thought that someone is or has been abused or neglected by another person, or someone is abusing or has abused another person.

In emergency situations, it is likely that there may be insufficient time to instruct an IMCA. Any decisions about the treatment given, and the reasons for them, must be made in the patient's notes. If treatment with serious consequence follows from the emergency treatment, an IMCA should be instructed.

You should always act in the patient's best interests while you are waiting for the IMCA's report.

An IMCA has the right to challenge decisions about the assessment of capacity and about what is in their client's best interests. They may, for example, challenge a decision if they did not feel that enough attention had been paid to their report and any other relevant information.

If the IMCA disagrees with the treatment you have suggested, you should take time to explain and discuss it with them and try to come to an agreement. If an agreement cannot be reached, the IMCA may use the formal complaints system to settle the case or, in more urgent cases, may refer the decision to the Court of Protection.

The IMCA service is available in England (through local authorities, who work in partnership with NHS organisations) and Wales (through Local Health Boards).

Local authorities or NHS organisations are the "responsible bodies" for instructing an IMCA to represent a person who lacks capacity.

For decisions about serious medical treatment, the responsible body will be the NHS organisation providing the person's healthcare or treatment.

For decisions about admission to accommodation in hospital for 28 days or more, the responsible body will be the NHS body that manages the hospital.

Staff in the NHS, (e.g. doctors or consultants) are the "decision makers" and all have a duty, under the Mental Capacity Act, to instruct an IMCA where the eligibility criteria are met.

The "decision-maker" is the person who is proposing to take an action in relation to the care or treatment of an adult who lacks capacity, or who is contemplating making a decision on behalf of that person.

Who the decision maker is will depend on the person's circumstances and the type of decision. For example, the decision-maker may be a care manager or a hospital consultant.

Staff working in statutory organisations, in the local authority or NHS who are involved in making best interests decisions should know when a person has a right to IMCA and when they have a duty to instruct an IMCA. This duty may fall on GPs from time to time.

Practices are recommended to research the local method of referral to IMCA through the Patient Advice and Liaison Service (PALS) operating within their CCG area.

RESOURCES

Mental Capacity Act 2005 Code of Practice

DoH Primary Care Training Pack

IMCA (independent mental capacity advocate) England

Making decisions: the IMC service: Department of Health - Publications and statistics

www.gov.uk/government/collections/mental-capacity-act-making-decisions

Mental Capacity Act 2005 Code of Practice

Advance Directives ("Living Wills") Protocol [*]

Power of Attorney Protocol [*]

BMA online assessment toolkit: https://www.bma.org.uk/advice/employment/ethics/mental-capacity/assessing-mental-capacity

Keeping track of the progress of the amendment to DOLS:
https://services.parliament.uk/bills/2017-19/mentalcapacityamendment.html

APPENDIX A

Criteria for referral to IMCA

Any person who meets the following criteria must be referred to the IMCA service:

- Is a decision being made about serious medical treatment or a change of accommodation; or a care review or adult protection procedures?
- Does the person lack capacity to make this particular decision?
- Is the person over 16 years old?
- Is there nobody (other than paid staff providing care or professionals) whom the decision-maker considers willing and able to be consulted about the decision? (This does not apply to adult protection cases).

Criteria for non-referral to IMCA

IMCAs do not need to be instructed if:

- A person who now lacks capacity has nominated someone to be consulted specifically on the same issue;
- A person has a personal welfare attorney who is authorised specifically to make decisions on the same issue; or
- A personal welfare deputy has been appointed by the court with powers to make decisions on the same issue.

APPENDIX B - ASSESSMENT OF CAPACITY CHECKLIST

A person's capacity may be dependent on many factors. It can vary depending on the subject matter.

Incapacity arises if a person is unable to make a decision because of an impairment of, or a disturbance in the functioning of the mind or brain.

A checklist for assessing Mental Capacity is as follows:

1. CAPACITY TEST		
Is the person able to understand the information relevant to the decision?	**YES**	**NO**
Consider how to improve comprehension: *Checking literacy, simplify language:* *Use of visual aids:* *Controlling noise in the environment:* *Use of translator:* *Giving information slowly – in small chunks:* *Choose time of day when Patient is most alert:*		
Is the person able to retain that information?	**YES**	**NO**
Consider how to improve retention of information: *Use of written or drawn material:* *Multiple repetitions of information:* *Patient rehearsing material in their own words:* *Choose time of day when Patient is most alert:* *Taping verbal material to play back:* *Friend present to lower anxiety:*		
Is the person able to use or weigh that information as part of the process of making a decision?	**YES**	**NO**
Consider how to help evaluation: *Give all options, including non-desirable ones:* *Encourage systematic methods e.g. listing pros & cons:* *Choose time of day when Patient is most alert:* *Use a decision tree:* *Check reasons for choice as these can lead to more options or choices e.g. worries about using a bus might lead to refusing a hospital appointment. Check alternatives.*		
Is the person able to communicate his / her decision?	**YES**	**NO**
Consider how to help communication: *Use of Translator:* *Friend present to lower anxiety:* *Use of appropriate communication support e.g. computer:* *Ask open, rather than closed questions:* *Check on more than one occasion if decision remains stable:* *Is the Patient talking to someone they feel able to tell?*		

If the answer to any of these questions is "No" then the person lacks capacity.		
Therefore based on the above test does the person have Capacity?	**YES**	**NO**

2. WHAT IS THE POSITIVE EVIDENCE UPON WHICH THE DECISION REGARDING THE PERSON'S LACK OF CAPACITY IS BASED?	
3. WHO HAS MADE THE DECISION ABOUT THE PERSON'S CAPACITY?	
Who did that person discuss the matter with?	
Was an additional opinion sought? If so from whom?	

Name: .....

Signed: ..... Date: .....