Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

MENTAL CAPACITY ACT (MCA) POLICY

POLICY

Reference	CPG-TW-SG-MCA
Approving Body	Safeguarding Steering Group
Date Approved	22nd February 2023
Issue Date	31st March 2023
Version	v6.0
Summary of Changes from Previous Version	• Complete rewrite
Supersedes	v5.0, Issued 13th September 2019 to Review Date February 2023 (ext2)
Document Category	• Clinical
Consultation Undertaken	The following consultation was undertaken. It was circulated to the Medical Director, Chief Nurse Executive, and Divisional Nursing Leads plus all members of the Safeguarding Steering group where it was agreed.
Date of Completion of Equality Impact Assessment	February 2023
Date of Environmental Impact Assessment (if applicable)	N/A
Legal and/or Accreditation Implications	The Trust must comply with the legislative requirements of the Mental Capacity Act and provide assurance within its contractual and regulatory responsibilities to external bodies
Target Audience	All Trust staff
Review Date	February 2026
Sponsor (Position)	Chief Nurse
Author (Position & Name)	Martin Watson - MCA / DoLS / LPS Lead Practitioner (supported by Richard Idle - Named Lead Nurse for Safeguarding Adults)
Lead Division/ Directorate	Corporate
Lead Specialty/ Service/ Department	Nursing/ Safeguarding Team
Position of Person able to provide Further Guidance/Information	Safeguarding Team

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
• MCA Form 1 (for Nurses/AHPs) • MCA Form 2 (for Doctors) • MCA Form 3 Best Interest Assessment	• Available to order via Clinical Illustration – Ref SG0001 • Forms 2 & 3 can be printed via the Safeguarding intranet site
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

The Mental Capacity Act 2005 (MCA) and the Code of Practice 2007 protects the rights of people aged 16 and over to make their own decisions. The MCA also provides a statutory framework to make decisions on behalf of people who lack mental capacity, because of an impairment or disturbance in the functioning of their mind or brain, to make certain decisions, in their best interests. The MCA contains provisions for people aged 18 and over and who have capacity at the time, to plan in advance for a time when they may lack capacity in the future.

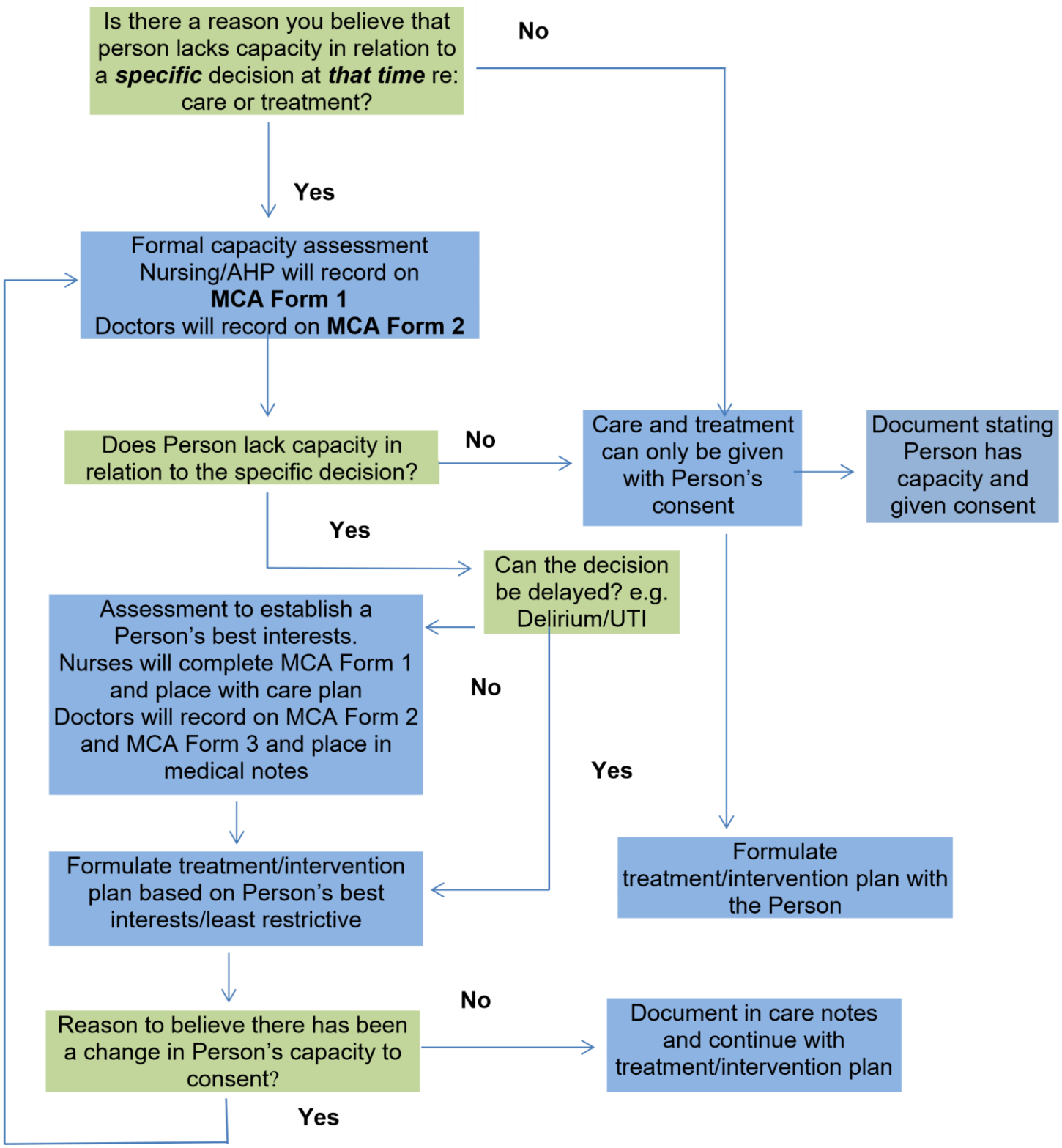
The MCA and related statutes are reflected in the broader understanding, promotion and protection of human rights in this country.

The MCA is underpinned by five statutory principles that protect people's rights to make their own decisions; requires healthcare staff to empower people to make their own decisions, wherever possible; and guides and inform decision-making in respect of people who may lack capacity to make certain decisions in some aspects of their life, including their healthcare.

The MCA 2005 Key Principles

• Presumption of capacity – Every adult 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
• Least restrictive option – Anything done for or on behalf of people without capacity should be the least restrictive option of their rights and freedoms
• Unwise decision – People have the right to make what others might regard as an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. A person shouldn't be treated as lacking capacity because they make a decision other people consider unwise.
• Maximise capacity - Support individuals to make their own decisions. People must be given all appropriate help to make a decision for themselves before it can be claimed that they lack capacity to make the decision.
• Best interest – Any act or decision made on behalf of someone who lacks capacity must be in their best interests.

1.1 Overview of the MCA process



1.2 Children and Young people

Children – aged under 16

The Act does not generally apply to people under the age of 16. There are 2 exceptions:

The Court of Protection can make decisions about a child's property or finances (or appoint a deputy to make these decisions) if:

- the child lacks capacity to make such decisions; and
- is still likely to lack capacity to make financial decisions when they reach the age of 18.

Offences of ill treatment or wilful neglect of a person who lacks capacity can also apply to victims younger than 16.

1.3 Care and treatment of young people aged 16 or 17

- The Family Reform Act 1969 presumes that young people have the legal capacity to agree to surgical, medical or dental treatment. This also applies to any associated procedure i.e., investigations, anaesthesia or nursing care.
- As with adults, decision-makers should assess the young person's capacity to consent to the proposed treatment or care.
- If the young person lacks capacity to consent because of an impairment or disturbance in the functioning of their mind or brain, then the MCA will apply in the same way as it does to a person 18 and over.
- If they lack capacity for any other reason for example because they are overwhelmed by the implications of the decision, the Act will not apply to them, and the legality of any treatment should be assessed under common law principles.
- The presumption of capacity does not apply to some rarer types of procedure (for example organ donation or other procedures which are not therapeutic for the young person) or research. In these cases, anyone under 18 is presumed to lack legal capacity, subject to the test of 'Gillick competence'
- If a young person has capacity to agree to treatment, their decision to consent must be respected. Difficult issues can arise if a young person has legal and mental capacity and refuses consent - especially if a person with parental responsibility wishes to give consent on the young person behalf. The Family Division of the High Court can hear cases where there is disagreement – the Court of Protection has no power to settle a dispute about a young person who is said to have the mental capacity to make the specific decision.
- Under common law a person with parental responsibility for a young person (aged 16-17) is generally able to consent to the young person receiving care or medical treatment where they lack capacity as defined in the Act. However, if a young person lacks the mental capacity to make a specific care or treatment decision as defined by the Act, health care staff providing the treatment can carry out treatment decision as defined by the Act, healthcare staff providing the treatment can carry out treatment and care with protection from liability whether or not a person with parental responsibility consents. The Act's principles must be followed, and actions carried out must be in the young person's best interests

1.4 Parts of the Act that do not apply to young people aged 16-17 years

Most of the Act applies to young people aged 16 years and over. There may be an overlap with The Children's Act 1989. There are 3 exceptions:

- Only people aged 18 and over can make a Lasting Power of Attorney.
- Only people aged 18 and over can make an advance decision to refuse medical treatment.
- The Court of Protection may only make a statutory Will for a person aged 18 and over.

2.0 POLICY STATEMENT

2.1 The legal framework provided by the MCA is supported by a Code of Practice ('The Code'), which provides guidance and information about how the MCA works in practice. **Section 42 of the Act requires that those who make decisions in relation to persons who lack capacity must have regards to the code.** This duty to have regard to the Code applies to those acting in 'a professional capacity' and 'receiving remuneration' and therefore will apply to all employees of The Trust. For further information please refer to: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

2.2 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 set out Fundamental Standards. Of particular relevance to this policy are Standard 8 (General), Standard 9 (Person Centred Care), Standard 10 (Dignity and Respect), Standard 11 (Need for Consent) Standard 12 (Safe Care and Treatment), Standard 13 (Safeguarding) and Standard 17 (Good Governance). The Trust is required to adhere to these standards.

2.3 It is the Trust policy to ensure compliance with the Act and the Codes of Practice (including the Deprivation of Liberty Safeguards Code). All patients to whom the MCA applies should expect to receive appropriate care underpinned by the legal framework.

Following this policy will help the Trust to meet its obligations to:

- Guide staff in providing care to patients who lack capacity to make specific decisions for themselves
- Ensure the Mental Capacity Act is used lawfully

3.0 DEFINITIONS/ ABBREVIATIONS

'The Trust'	Means the Sherwood Forest Hospitals NHS Foundation Trust
'Staff'	Means all employees of the Trust including those managed by a third-party organisation on behalf of the Trust
Code of Practice	Written to support the understanding and application of how the Mental Capacity Act 2005 works in practice.
Consent	The legal basis for undertaking any intervention with a patient is either the patient's valid consent, or a lawful basis for acting in the absence of a patient's valid consent.
Capacity	Capacity is the ability to make a specific decision at the time the decision needs to be made. Ability to make a decision is informed by, for example, a person's ability to understand the decision and why it needs to be made.
Lack of Capacity	The Mental Capacity Act (MCA) defines a 'lack of capacity' as an inability to make a particular decision at a particular time due to "an impairment of or disturbance in the functioning of the mind or brain".
Decision Maker	The **'Decision Maker'** is the person who is most appropriate to make a particular decision or who has the specific authority to make the decision. The 'Decision Maker' is the person responsible for an act in connection with care or treatment. That decision maker makes a decision where, on the balance of probabilities, they believe that a person lacks capacity to make a decision for themselves. Any member of staff who comes into contact with patients (particularly those who provide hands on care and treatment) may be 'decision makers' under the Act. A decision maker might be a nurse, and occupational therapist, physiotherapist, healthcare assistant, or a doctor/clinician
Two Stage Test	The 'two stage' test of capacity as set out in the Mental Capacity Act Code at 4.11 is the template for the assessment of capacity where it is in doubt and reflects the provisions in section 2(1) and 3(1) of the Act.
Best Interests	Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for them. The person making the decision is referred to as the 'decision maker'. It is the decision maker's responsibility to work out what would be in the best interests of the person who lacks capacity. The Act does not define the term "best interest"; however, Section 4 of the Act (supported by the Code) sets down how to decide what is in the best interests of a person who lacks capacity in any particular situation.
Wilful Neglect	The meaning varies depending on the circumstances. Usually it means that a person has deliberately failed to carry out an act they knew they had a duty to do.

Lasting Power of Attorney (LPA)	An adult with capacity can nominate an Attorney(s), who has legal authority to make decisions on their behalf, if they lack capacity to make those decisions for themselves at point in the future. There are two types of Lasting Power of Attorney, health and welfare, including the authority to make decisions regarding the person's care and treatment; and, property and affairs.
Donor	A person who makes a Lasting Power of Attorney.
Court Appointed Deputies	A deputy is appointed by the Court of Protection to make decisions for someone who is unable to do so on their own. They are responsible for making these decisions until either the person they're looking after dies or is able to make decisions on their own again. This replaces the previous system of receivership.
Restrictions, Restraint and Deprivation of Liberty	Section 6 of The Mental Capacity Act defines restraint as the use or threat of force where an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person or others, and if restraint is used is proportionate to the likelihood and seriousness of the harm. There is no single definition of deprivation of liberty. The starting point is the persons care plan, and takes into consideration the "Acid Test" the type, the duration, effect, and the manner of implementation of the restriction/restraint measures in question.
Advance Decisions to Refuse Treatment	Adults with capacity may make a decision in advance to refuse treatment if they should lose capacity in the future. An Advance Decision will have no application to any treatment which a Doctor considers necessary to sustain life, unless strict formalities have been complied with.
Independent Mental Capacity Advocate (IMCA)	The statutory Independent Mental Capacity Advocacy service is to help particularly vulnerable people who lack capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about these decisions.

4.0 ROLES AND RESPONSIBILITIES

Title	Organisational Role	Key Responsibilities
Trust Board	Strategic	-Strategic overview and final responsibility for setting the direction of this policy - Ensure that it fulfils its statutory responsibilities
Chief Nurse	Executive Lead	The Chief Nurse is responsible for the Trust strategic direction for this policy - Agree action plans to address issues relating to this policy - Update the Trust Board regularly on issues relating to Mental Capacity Act Policy
Executive Medical Director	Executive Lead	The Executive Medical Director is responsible for ensuring that there is an up-to-date-policy that meets both legal and best practice guidance and that professional conduct relating to consent is maintained.
All Trust Staff	Adherence	All staff involved in obtaining consent or providing treatment are accountable both legally and professionally for their actions. - Familiarise themselves with the 5 statutory principles - Recognise the importance of how issues of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation may impact on assessment of adults and families and subsequent responses - Attend appropriate mandatory Mental Capacity Act training - Undertake capacity assessments as appropriate - Act as the decision maker when appropriate - Refer for advocacy where required - Ensure care planning processes reflect whether a person has the capacity to consent to the services which are to be provided and whether their actions are likely to result in a deprivation of liberty - Ensure any decisions taken in a Person's "best interest" is reflected in the Best interest checklist and referred to in the Multi-Disciplinary Team (MDT) and clearly documents a best interest decision plan - Progress agreed adult safeguarding action plans, for which they are responsible, within agreed timescales - Ensure they communicate effectively with other professionals and members of multi-agency groups to promote adult safeguarding Maintain good record keeping standards and work according to the Trust Health Record Keeping policy

Title	Organisational Role	Key Responsibilities
Sister Charge Nurse Matrons	Operational	Ensure copies of the Code of Practice and other relevant guidance are available to staff: - Ensure staff are appropriately trained regarding mental capacity/DoLS and promote best practice in this area - Ensure that policies and procedures are followed and understood as appropriate to each staff member's role and function; and to appropriately act on and report non-compliance with policy. - Ensure that all decisions regarding best interest are monitored and have had the required capacity assessment/ best interest decision making paper work completed within the health record and evidence within MDT meetings. - Act as/ or delegate the Managing Authority duties and responsibilities for completion of DoLS forms and liaison with the Supervisory Body. - Ensure compliance with conditions attached to DoLS authorisation. - Ensure any dispute regarding best interest decisions are dealt with locally/informally and then following the necessary pathway when a resolution cannot be agreed.
Divisional General Managers Heads of Nursing Matrons	Implementation	Have overall responsibility for standards of clinical practice within their area of responsibility, ensuring that both legal and best practice standards are achieved. Provide advice and support to staff on MCA/DoLS issues/concerns raised within their service areas - Ensure staff receive appropriate education and training - Investigate adult MCA/safeguarding concerns raised within the Trust and co-operate with any related investigations
Divisional Clinical Chairs	Implementation	Have overall responsibility for standards of clinical practice within their area of responsibility, ensuring that both legal and best practice standards are achieved. They will be responsible for the activities of medical staff within that area of responsibility and work with the medical director in maintaining their standards of practice in this regard -Provide advice and support to staff on MCA issues/concerns raised within their service areas - Ensure staff receive appropriate education and training - Investigate adult MCA/safeguarding concerns raised within the Trust and to co-operate with any related investigations

Title	Organisational Role	Key Responsibilities
Head of Safeguarding Named Nurse Safeguarding Adults Named Doctor for Safeguarding Adults	Implementation	-Ensure clear and robust procedures are in place for staff to obtain guidance and clarity with regard to the Mental Capacity Act - Support other staff in identification of and appropriate reporting (form completion) of cases that may constitute a DoLS - Support other staff to follow local and national guidance in assessment of capacity and in making choices on behalf of people lacking capacity - Assist with embedding the principles of the MCA within the Trust - Provide feedback where appropriate on use of MCA and DoLS, specific issues and concerns, and training to Service Managers - Maintain a record of safeguarding and MCA cases for monitoring and recording purposes - Provide Trust staff with support and advice for complex safeguarding / MCA and Deprivation of Liberty Safeguards (DoLS) concerns - Support the investigation of safeguarding/MCA concerns raised within the Trust
Head of Safeguarding Named Nurse Lead for Adult Safeguarding Named Doctor for Safeguarding Adults	Leadership	-Provide clinical leadership and strategic direction on all aspects of Safeguarding Adults to ensure that health services contributions are co-ordinated and integrated across the Trust - Provide expert knowledge and advice to Trust staff in accordance with national and local requirements arising from relevant legislation and guidance, including the National Framework for Safeguarding Adults
Safeguarding Steering Group	Assurance	The Safeguarding Steering Group will review the audit undertaken by Divisions

5.0 APPROVAL

Following consultation, this policy (v6.0) has been approved by the Trust's Safeguarding Group.

6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

6.1 Consent

The legal basis for undertaking any care and treatment with a person is either the person's valid consent, or a lawful basis for acting in the absence of a person's valid consent.

Valid consent requires 3 elements to be present: the person has been provided with appropriate information about the care and treatment and any potential options or choices in a format they can understand; the decision is made without duress/undue influence; the decision maker has capacity to make and communicate the decision at that time.

It should be acknowledged that doubt, vacillation and avoidance can be normal responses to being faced with a difficult decision and are not indicative that a person lacks capacity to make the decision for themselves.

Valid informed consent cannot be taken when the patient lacks the mental capacity for that decision at that time, or if one or both of the other elements are missing. The Mental Capacity Act provides a framework for the decision-making process and a lawful basis for acting where because of a lack of capacity, there is no valid consent. For further information refer to Trust Policy: Consent to Examination, Treatment and Care (available on the Trust intranet) http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=19264

Capacity is *time* and *decision specific*. A person may have capacity for one decision but not another or many decisions, but there may be doubt about a particular decision.

The 5 statutory principles in Section 1 of the Mental Capacity Act guide the decision-making process when applying to decisions and actions relating to care and treatment under the Act:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

6.2 Statutory Principle 1: Presumption of Capacity

A person must be assumed to have capacity unless it is established that they lack capacity.

The law says that all persons over the age of 16 years must be assumed to have capacity unless it there is evidence that they lack capacity to make the specific decision, at the time it needs to be made. This principle protects the rights of people, who have capacity to make their own decisions.

This principle also states that if anyone believes a person lacks capacity, they must provide proof. Paragraph 6.2.3 explains the standard of proof required and how a person's capacity should be assessed and how this should be recorded. It is not up to a person to prove that they have capacity, the burden of proof rests with the person who claims that the person lacks capacity.

There is therefore no requirement to routinely assess capacity where it is not in doubt. Consent should be sought for any intervention. A valid consent consists of information, capacity to make the decision and that the decision is given without duress/undue influence. For further information refer to Trust Policy: Consent to Examination, Treatment and Care (available on the Trust intranet) http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=19264

6.2.1 Statutory Principle 2: Help for the Person to Make the Decision

A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

A decision maker must give the person all practicable help to make the specific decision/decisions for themselves. This might include using a different form of communication, providing information in a more accessible format or treating any medical condition which may be affecting the persons capacity.

It is not necessary for the person to understand every detail of the issue nor is it always necessary for a person to understand all the peripheral detail. Being able to understand and weigh up the key details relevant to the decision to be made will be sufficient. Different individuals may give different weight to different factors. What is reasonably practicable in one circumstance will be much less so in an emergency. If the decision can be put off until the person has capacity to make it for themselves, it should wait unless it is an emergency.

6.2.2 Statutory Principle 3: Unwise Decision Making

A person is not to be treated as unable to make a decision merely because they make an unwise decision.

An ***eccentric or unwise decision*** does not *necessarily* indicate a lack of capacity. A person with capacity can make decisions that others might not agree with. Repeated decisions that put the person at risk of harm might indicate the need for a capacity assessment. Members of staff have a duty of care to investigate carefully where it appears that capacity for a decision may be in doubt.

6.2.3 Assessment of Capacity

The MCA defines the lack of capacity as: *'If at the material time, the person is unable to make a decision for themselves, because of an impairment or a disturbance in the functioning of the mind or brain.'*

Having mental capacity means a person is able to make their own decisions. A person can lack capacity for the purposes of the MCA even if the loss is partial or temporary or if capacity fluctuates over time.

A person may lack capacity to make one decision but not others.

If there is a belief that a person lacks the capacity to make a specific decision, then it must be demonstrated that on the balance of probabilities, it is more likely than not, that the person lacks the necessary capacity to make the decision at the time it needs to be made.

Where there is doubt about a person's capacity to make a specific decision, consideration should be given to:

- Does the decision need to be made immediately?
- If not, is it possible to delay the decision until the person has capacity to make the decision themselves?
- Has everything been done to help and support the person making the decision?

In supporting people to make decisions consideration should be given to the following questions:

- Has the person had all the relevant information needed to make the decision in question?
- Could the information be explained or presented in a way that is easier for the person to understand?
- Are there particular times of the day when the person's understanding is better or particular locations where they feel more at ease?
- Can the decision be put off until the circumstances are right for the person concerned?
- Can anyone else help or support the person to make choices or express a view, such as an independent advocate or someone to assist communication:

The MCA code sets out a '2 stage test' which guides the prospective decision maker (e.g. nurse/doctor/allied health professional) in order to help them reach a conclusion as to whether the person does or does not have capacity to make a specific decision of their care and treatment plan/s.

A 2-stage test must be completed by a nurse/doctor/allied health professional and placed in the nursing/medical records to support the care and/or treatment decision

The 2 stage test. (MCA Form 1 for Nurses/AHPs, MCA Form 2 for Doctors). Forms are available via the Trust safeguarding intranet page.

If the decision relates to investigations or a procedure, the assessment of the patient's capacity can be recorded on Consent Form 4: Form for adults who are unable to consent to investigations or treatment.

1.**The 'diagnostic test'**

Does the person have an impairment of or a disturbance in the functioning of their mind or brain?

There will be an assessment as to whether there is an impairment of, or disturbance of the functioning of, the person's mind or brain, examples of which may include:

Conditions commonly associated with a positive answer to the diagnostic test can include but not exclusively:

- Dementia
- Stroke
- 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 a brain injury, and
- The symptoms of alcohol or drug use.

An impairment of or disturbance in functioning of the mind or brain may be temporary or permanent. There does not need to be always a specific medical disease to impair capacity for example, a person might be severely intoxicated or under the influence of drugs rendering them unable to make a decision at that time.

If there is no impairment of, or disturbance in the functioning of, their mind or brain, the person cannot lack capacity for the purposes of the MCA.

2. The 'functional test'

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

If stage 1 of the test of capacity is met there will be an assessment as to whether the impairment or disturbance affects their ability to make a specific decision when they need to.

A person is unable to make a decision if one or more of the following is evident and they are unable to:

- Understand information about the decision to be made (relevant information);

- Retain the information in their mind long enough to be able to make the decision;
- Use or weigh that information as part of the decision making process;
- Communicate their decision – this could be talking, using sign language or even simple muscle movements such as blinking an eye.

6.2.4 Who should assess capacity?

The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made.

In general terms, the person who is proposing to take a particular action in connection with the care or treatment of an individual will be responsible for assessing the individual's capacity to consent to that particular action.

This means within the Trust different people e.g. nurses, doctors, allied health professionals will be involved in assessing someone's capacity to make different decisions at different times. An assessment may also be conducted using a collaborative approach by the multidisciplinary team

6.2.5 Recording Assessments of Capacity

Although the starting point must always be a presumption of capacity, health professionals should always make an assessment of an individual's capacity to make particular treatment or care related decisions and record the findings in the relevant professional records.
An assessment of the individual's capacity to consent or agree to the provision of care and treatment will be part of the care planning processes for health and social care needs and should be recorded in the relevant nursing and medical documentation.

Within the Trust, any professional proposing care and treatment should carry out an assessment of the individual's capacity to consent (with a multi-disciplinary team, if appropriate), clearly documenting the steps taken. This should be filed in the appropriate record with the appropriate plan of care e.g. nursing care plan, medical treatment plan.

Where there are concerns around whether the individual has the capacity to consent or refuse to consent to the treatment or act, or to make a specific decision, a formal assessment of mental capacity must be carried out and recorded by the decision maker.

For Nurses /AHP this will need to be completed on MCA form 1. For medical staff on MCA Form 2. Both forms are available on the Trust intranet. If the decision relates to investigations or a procedure, the assessment of the patient's capacity can be recorded on Consent Form 4: Form for adults who are unable to consent to investigations or treatment.

In the event that an individual is judged to lack capacity to make a decision, it is essential that all professional staff involved in that individual care and treatment keep an accurate record of all the decisions and discussions concerning their mental capacity, for example:

- What specific decision needed to be made and by when
- The evidence indicating the individual lacks capacity for that specific decision
- What steps were taken to support the individual to make their own decision
- What decision(s) were taken in the best interest of the individual and who was involved in this process
- The multi-disciplinary meeting notes should clearly indicate all of the above and be written in a clear and concise format, including the best interest decision checklist
- This information should be stored in the patient medical and nursing notes, to ensure that all involved in care are aware of the best interest decision

 This information is an essential element of clinical practice. It provides evidence to support those staff involved within the decision making in the event that they are called to account for their actions

Capacity Assessment in the Care Planning Process

It is identified within the MCA (2005) that an assessment of the person's capacity to consent or agree to the provision of service will be part of the care planning process for their health and social care needs and must be in the relevant documentation. This may include:

- The individual's nursing care plan/nursing process
- Care programme approach within Mental Health services
- Individuals who are subject to the single assessment process

This means we can only ask the individual to sign their care plan if they have the capacity to consent to the care plan (see regulation 9: person centred care).

When a person lacks capacity to consent to a care plan, the care plan is written in their best interests, until such time that the individual regains their capacity – at this point the care plan can be reviewed.

 The care plan must be regularly reviewed demonstrating that capacity was being assessed as an ongoing process in the care planning for such individual. This must be evidenced within the relevant documentation e.g. nursing, medical care and treatment plans.

6.2.6 Statutory Principle 4: Best Interests

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

If a person has been assessed as lacking capacity for a specific decision, then any act done for, or decision made on behalf of the person lacking capacity must be done or made in that person's best interests.

Under the MCA, many different people e.g. nurse, doctor, allied health professional may be required to make decisions or act on behalf of someone who lacks capacity to make a particular decision for themselves.

The person making the decision is referred to as the **'decision-maker'**. Once it appears on the balance of probabilities that the person lacks capacity, the decision maker is required to act in the best interests of the person who lacks capacity.

The MCA does not specify what is in a person's best interests, nor does it define best interests. Section 4 of the MCA sets out appropriate factors to be taken into account where they are relevant to any given situation. These are framed into the Best Interests Checklist

Case law (*Aintree NHS Trust v James*) has stated that the purpose of the best interests test is to consider matters from the person who lacks capacity's point of view, though it is not a substituted judgement test.

Guidance on the best interest's checklist can be found in Appendix A

Because every case – and every decision – is different, the law cannot set out all the factors that will need to be taken into account in working out someone's best interests. Section 4 of the Act sets out common factors that must always be considered when trying to work out someone's best interests. These factors are summarised in the checklist here:

• Working out what is in someone's best interests cannot be based simply on someone's age appearance, condition or behaviour. Paragraphs 5.16-5.17 MCA Code of Practice.
• All relevant circumstances should be considered when working out someone's best interests. This is to try and identify the factors that the person who lacks capacity would take into account if they were making the decision or acting for themselves. Paragraphs 5.18-5.20 MCA Code of Practice.
• Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision. Paragraphs 5.21-5.24 MCA Code of Practice.
• If there is a chance that a 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. Paragraphs 5.29-5.36 MCA Code of Practice
• Special considerations apply to decisions about life-sustaining treatment. Paragraphs 5.29-5.36 MCA Code of Practice.
• The person's past and present wishes and feelings, beliefs and values should be taken into account. Paragraphs 5.37-5.48 MCA Code of Practice.
• Avoid restricting the person's rights – see if there are other options that may be less restrictive of the person's rights and freedoms. Paragraphs 5.37-5.48 MCA Code of Practice.

When making a best interest decision staff must consider:

- Regaining capacity – it may be appropriate to delay the decision to allow further time for additional steps to be taken to restore the person's capacity or to provide support and assistance which would enable the person to make the decision themselves.
- Encouraging participation – the person must be permitted and encouraged to participate as fully as possible in any act done for him/her and any decision affecting him/her. Time must be taken to try to seek their views. A trusted relative or friend, or an Independent Mental Capacity Advocate, may be able to help the person to express wishes or aspirations or to indicate a choice between different options.
- The person's feelings and wishes – the person making the decision must consider so far as is reasonably ascertainable, the person's past and present wishes and feelings; the beliefs and values that would be likely to influence his/her decision if he/she had capacity; and the other factors that he/she would be likely to consider if he/she were able to do so. This also includes specific views may have been set out in an Advance Directive, communicated informally to relatives and carers or formally in the Lasting Power of Attorney.
- The views of other people – the person making the decision must take into account, if it is practicable and appropriate to consult with them, the views of anyone named by the person as someone to be consulted on the matter in question or on matters of that kind; anyone engaged in caring for the person or interested in their welfare; any donee of a Lasting Power of Attorney. You may also need to consult with other professionals involved in the person's care. This may include the need to involve an Independent Mental Capacity Advocate (IMCA) if the person meets the criteria – see Paragraph 6.7 of the policy for more details.
- Do not make assumptions – the person making the decision must not make any assumptions about the person based on age, condition, appearance or behaviour.

 In all circumstances any person acting as a decision maker is required to follow the recommended "Best interest decision making checklist" (available on Trust intranet)

Best interests decisions must be documented appropriately using MCA Form 3 Best Interest Determination. MCA Form 3 is available on the safeguarding intranet page

If the decision relates to investigations or a procedure, the best interest decision making process can be recorded on Consent Form 4: Form for adults who are unable to consent to investigations or treatment.

Best Interest Meetings

Best Interest meetings can be a helpful forum for discussing best interests decisions, when a person lacks capacity and are considered best practice in complex or more serious decisions. If a best interest meeting has taken place, this should be documented using the MCA Form 3 best interest determination form available on the Trust intranet.

If the decision relates to investigations or a procedure, the best interest meeting and outcome can be recorded on Consent Form 4: Form for adults who are unable to consent to investigations or treatment.

Whether a best interests meeting has been held or not, all staff are required to follow the guidance in the MCA Code of Practice, apply the statutory principles and the best interests checklist.

Urgent Decisions
There are occasions when an urgent decision is required.

In the absence of a valid and applicable advance decisions regarding refusal of treatment (ADRT), nothing should prevent immediate actions to preserve life, prevent homelessness or protect from serious harm.

In specific situations there is a compulsion on doctors and other health care staff to make very rapid decision in emergency situations where there is no time to consult (in the absence of any pre-existing or anticipatory treatment decision or ADRT). Cardiopulmonary Resuscitation is one such treatment, this is covered by the Recommended Summary Plan for Emergency Care and Treatment Policy.

Urgent decisions will have to be made and immediate action taken in the person's best interests. In these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions, or to consult with any known attorneys or deputies. However, even with urgent decisions, healthcare staff should try to communicate with the person and keep them informed of what is happening.

Life-sustaining treatment
The MCA Code of Practice highlights a special factor in the checklist which applies to treatment that is considered life-sustaining. All reasonable steps, which are in the person's best interests should be taken to prolong their life. There may be a limited number of cases where treatment is futile, overly burdensome to the patient, or where there is no realistic prospect of recovery. In those circumstances it may be that it would be in the person's best interests to withdraw or withhold life-sustaining treatment, even if this results in the person's death.

The decision-maker must not be motivated by a desire to bring about the person's death for whatever reason, even if this is from a sense of compassion. However, this does not mean that healthcare staff are obliged to provide, or to continue to provide life-sustaining treatment that is not in the person's best interests.

Designated Decision Makers
The Act identifies two types of designated decision makers who have designated authority to make decisions. These are Lasting power of Attorney (LPAs) and Court of Protection Appointed Deputies.


Within the Trust all staff must ensure that all patients are routinely asked if they have an LPA or deputy. The original document must be seen and a copy taken and placed in the medical health record behind the red safeguarding divider and in the nursing care record. Further guidance can be found on the LPA flowchart on the Trust safeguarding intranet page

Exceptions to the best interest principle

1. When a person has previously made a valid and applicable advance decision to refuse medical treatment, their decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests. See paragraph 6.8 for more information on advance decisions to refuse treatment.
2. Concerns the involvement in research, in certain circumstances, of someone lacking capacity to consent. For further guidance please see the NHS Health Research Authority guidance.
https://www.hra.nhs.uk/planning-and-improving-research/policies-standardslegislation/mental-capacity-act/

6.2.7 Statutory Principle 5: Less Restrictive Intervention

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

A decision maker must consider whether it is possible to decide or act in a way that is minimally restrictive where that is possible to do so. The decision maker may also consider whether it is necessary to act at all.

Restraint

Restraint is not just about 'hands on' interventions. Locking a door, telling a person that they cannot do something or go somewhere, giving medication to affect behaviour might have the effect of restraining a person. This applies even if they are not resisting.

The MCA defines restraint as the use or threat of force to make someone do something they are resisting or to restrict a person's freedom of movement whether they are resisting or not. Staff will only attract protection from liability when carrying out an action intended to restrain a person who lacks capacity if the following conditions are met:


To be lawful under the Act, any restraint must be:

- Reasonable, necessary and proportionate to the harm that would come to the person who lacks capacity if the person were not subject to restraint.
- It must always be for the minimum necessary time, be clearly documented and subject to review.
- It must always be in the best interests of the person who lacks capacity and be less restrictive of the person's rights and freedoms.

For further guidance please refer to Trust Policy: Restrictive Practices available on the Trust intranet: http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?contentid=41090

Appropriate use of restraint does not in itself amount to a deprivation of a person's liberty.

6.3 Deprivation of Liberty

Article 5 of the European Convention on Human Rights states:

- *5 (1) Everyone has the right to liberty & security of person. No one shall be deprived of his liberty save in the following cases [e – persons of unsound mind] and in accordance with a procedure prescribed by law.*
- *5(4) Everyone who is deprived of their liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.*

Therefore where:

- The person does not validly consent to their care arrangements (a person who lacks capacity to consent cannot validly consent)
- The State is responsible for the situation (As an NHS body, the Trust is part of 'the State')
- The person is under both 'continuous supervision and control AND is not free to leave'. (the 'Acid Test' or the 'Cheshire West' test);

 The person is 'deprived of their liberty'.

In order to comply with Article 5, a deprivation of liberty may occur lawfully by:

- Detention under the Mental Health Act 1983
- A Court Order (High Court or Court of Protection)
- The Mental Capacity Act Deprivation of Liberty Safeguards (DOLS). **Patients over the age of 18 only**.

 **Any inpatient in the care of the Trust who is deprived of their liberty must have one of the above legal frameworks in place.**

The MCA on its own cannot authorise a deprivation of liberty.

 **A deprivation of liberty that is not authorised is unlawful**

For detailed guidance on the DOLS process please refer to Trust Policy: Deprivation of Liberty Safeguards Policy (available on the Trust intranet)
http://sfhnet.nnotts.nhs.uk/content/showcontent.aspx?ContentId=21927

 **A DoLS application form must be placed in the medical health care record behind the red safeguarding divider**

6.4 Limitations of Protection from Liability

Professionals will be protected from liability under Section 5 if they can demonstrate that they have taken appropriate steps to assess capacity, reasonably believe that the person lacks capacity and can demonstrate that they have carried out a best interest assessment and reasonably believe that the Act is in best interests.

-  **Section 5 does not provide a defence in cases of negligence – either in carrying out a particular act or by failing to act where necessary**
-  **Acts may not be protected from liability where there is inappropriate use of restraint**
-  **Acts may not be protected from liability where a person who lacks capacity is deprived of their liberty without authorisation**

6.5 Capacity to consent to admission/remaining in hospital

For the care or treatment to amount to a deprivation of liberty, the person must be unable to give their consent (because they lack capacity to give their informed consent) to the accommodation arrangements made for their care or treatment.

6.6 Excluded Decisions

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 themselves. There are certain decisions which can never be made on behalf of a person who lacks capacity to make them, this is because they are so personal to the individual or governed by other legislation.

 **Nothing in the Act permits a decision to be made on someone else's behalf on the following matters:**

- Consenting to marriage or a civil partnership
- Consenting to have sexual relations
- Consenting to a decree of divorce on the basis of two years separation
- Consenting to the dissolution of a civil partnership
- Consenting to a child being placed for adoption or the making of an adoption order
- Discharging parental responsibility for a child in matters not relating to the child's property
- Giving consent under the Human Fertilisation and Embryology Act 1990
- Voting

Where a person who lacks capacity to consent is currently detained and being treated under Part IV of the MHA, nothing in the MCA authorises anyone to:

- **Give the person treatment for mental disorder**
- **Consent to the person being given treatment for mental disorder**

6.7 Independent Mental Capacity Advocates (IMCAs)

6.7.1 Purpose of the IMCA service

The purpose of the IMCA service is to provide independent safeguards and to help people who lack capacity to make certain important decisions about serious medical treatment and changes of accommodation, and who have no family or friends (other than paid carers) that it would be appropriate to consult about those decisions. Whether a person is appropriate to consult relates, for example, to whether they are able to be contacted, whether they are willing and able to be consulted or to represent the person.

An IMCA is not the decision-maker, but the decision-maker has a duty to take into account the information given by the IMCA

6.7.2 When an IMCA MUST be instructed

Where a person lacks capacity to make a particular decision and is "un-befriended" as described above, decision makers in local authorities and NHS Trusts have a duty to instruct an IMCA where:

- The decision is about serious medical treatment provided by or proposed by the NHS (but excludes treatment regulated under Part IV of the Mental Health Act 1983);
- It is proposed by the NHS or Local Authority that the person be moved to long-term care of more than 28 days in a hospital or 8 weeks in a care home (where that accommodation or move is not a requirement of the Mental Health Act 1983);
- A long-term move (8 weeks or more) to different accommodation is being proposed by the NHS or Local Authority, for example a move to a different hospital or care home (where that accommodation or move is not a requirement of the Mental Health Act 1983).

The 2006 IMCA Regulations define 'serious medical treatment' as:

Treatment which involves giving new treatment, stopping treatment that has already started or withholding treatment that could be offered in circumstances where:

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

 **Where the decision concerns 'serious medical treatment' and there is no-one other than paid staff who are appropriate to consult about the person's best interests, an Independent Mental Capacity Advocate (IMCA) referral is mandatory. Within the Trust the decision maker who is in charge of the treatment, will be responsible for the referral (referral forms are available on the Trust safeguarding intranet page)**

Serious medical treatment does not cover treatment for a mental disorder where the patient is detained under the Mental Health Act.

Where treatment is urgent, the need to instruct an IMCA should not delay the treatment, but an IMCA should be instructed with minimal delay after the treatment has begun.

An IMCA may also be instructed on behalf of a person lacking capacity for:

- Care reviews, where no-one else is available to be consulted
- Safeguarding adult cases, whether or not family or friends are involved

6.7.3 Role of the IMCA

An IMCA must decide how best to represent and support the person who lacks capacity that they are helping.

The Trust must ensure IMCAs are given all reasonably practicable assistance to carry out their function. This includes access to notes that the decision maker considers relevant to the decision.

6.7.4 IMCA Referrals

 When a decision maker makes a referral to the IMCA Service, the referral should be to the IMCA Service in the Nottinghamshire Local Authority area where the incapacitated person currently is.
Who to refer to is not based on ordinary residence but instead on the location of the person at the time the decision needs to be made/ treatment provided.
Advocacy services are independent of the Trust, and service provision is subject to periodic tender. The IMCA provider may therefore be subject to change during the currency of this policy. Check the Trust intranet for the identity of the current provider and appropriate referral forms **(referral form are available on the Trust safeguarding intranet page)**

6.8 Advanced Decisions

An advance decision enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.

If an advance decision to refuse treatment is valid and applicable it has the same effect as a decision made by someone with capacity.

 An advance decision to refuse treatment must exist (in the prescribed form) be valid and applicable to current circumstances. For support, please contact safeguarding team/legal team or Duty Nurse Manager (out of hours)

If an ADRT exists, is valid and applicable, it has the same effect as a decision that is made by a person with capacity: healthcare professionals must follow this legally binding decision.

There are no particular formalities about the format of an advance decision. It can be verbal or written, unless it concerns life-sustaining treatment

If an advance decision refuses life-sustaining treatment it must be:

- be in writing (it can be written by someone else or recorded in healthcare notes)
- be signed and witnessed, and
- state clearly that the decision applies even if life is at risk.

To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:

- has done anything that clearly goes against their advance decision
- has withdrawn their decision
- has subsequently conferred the power to make that decision on attorney, or
- would have changed their decision if they had known more about the current circumstances.

6.9 Lasting Power of Attorney

The Act replaces the Enduring Power of Attorney (EPA) with the Lasting Power of Attorney (LPA).

A Power of Attorney is a legal document that allows one person (the donor) to give another person (the donee or attorney) authority to make decisions on their behalf which are as valid as if made by the person themselves.

LPAs can cover personal welfare (including healthcare and consent to medical treatment) and property and affairs (including financial matters) for people who lack capacity to make such decisions for themselves.

A personal welfare LPA can only be used at a time when the patient (donor) lacks capacity to make a specific welfare decision.

A personal welfare LPA allows attorneys to make decisions to accept or refuse healthcare or treatment unless the donor has stated clearly in the LPA that they do not want the attorney to make these decisions.

Even where the LPA includes healthcare decisions, attorneys do not have the right to consent to or refuse treatment in situations where:

- **The donor has capacity to make the particular healthcare decision (section 11(7)(a))**
  - An attorney has no decision making power if the donor can make their own treatment decisions
- **The donor has made an advance decision to refuse the proposed treatment (section 11(7)(b))**
  - An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment. But if the donor made an LPA after the advance decision, and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the advance decision.
- **A decision relates to life-sustaining treatment (section 11(7)(c))**
  - An attorney has no power to consent to or refuse life-sustaining treatment, unless the LPA document expressly authorises this.
- **The donor is detained under the Mental Health Act (section 28)**
  - An attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983.

Confirming the Existence and Validity of an LPA

If a patient has appointed an attorney under an LPA, it is essential that any member of staff wishing to make a decision or carry out an act can satisfy themselves that the attorney has the necessary authority to make decisions on behalf of the person lacking capacity, or that they must be consulted.

For an LPA to be valid and binding, it must be registered with the Office of the Public Guardian (OPG). Any staff member wanting to confirm that an LPA is valid, i.e. registered, not revoked and the attorney has not been removed, should contact the OPG. The safeguarding team can be contacted for support in this process. The OPG is only contactable in office hours, i.e. Monday – Friday 9-5.

- The original LPA document for health and welfare must be seen and a copy taken and placed in the medical health record behind the red safeguarding divider

6.10 Court of Protection

An issue is likely to go to the Court of Protection if, for example there is a dispute between healthcare professionals and others about best interests of the person which cannot be resolved by collaborative dialogue between the parties. This and other complex cases that may need to go to the Court of Protection will require access to professional legal advice.

Decision that must come before the Court of Potection

Care and treatment involving any of the following decisions should be brought before a court:

- Cases involving organ or bone marrow donation by a person who lacks capacity to consent
- Cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
- All other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests.


If a decision is required that may need to involve the Court of Protection, advice and guidance should be sought from the Trust Legal Team in the first instance.

6.11 Information Sharing

Much of the information required to assist and inform the decision-making process under the Act is sensitive or confidential. It is regulated by:

- The Data Protection Act 1998
- GDPR
- The common law duty of confidentiality
- Professional codes of conduct on confidentiality
- Information sharing protocols, and
- The Human Rights Act 1998 and European Convention on Human Rights

An attorney acting under a valid LPA or EPA (and sometimes a deputy) can ask to see information concerning the person they are representing, as long as the information applies to decisions the attorney has the legal right to make. Attorneys and deputies should only ask for information that will help them make a decision they need to make on behalf of the person who lacks capacity. The person who releases information must make sure that an attorney or deputy has official authority (they may ask for proof of identity and appointment).


Staff should discuss any concerns with information governance, safeguarding team, legal team, for support and guidance

6.12 Interface with the ReSPECT Process

The "ReSPECT Process" refers to the policy to support the move to a more shared decision making model for "Recommended Summary Plans for Emergency Care and Treatment". This process can be at its most basic a process to capture and communicate decisions to attempt cardio pulmonary resuscitation or not. The anticipated use is much more inclusive and considers the priorities for the patient, the context of the decision, the risks or harms the person is willing to take. This process is much more proactive and can be part of advance care planning and end of life care. The Trust has a specific policy to support the use of the process. The policy complies with the MCA, its Code of Practice and the other statutory and common laws of England and Wales. The ReSPECT process is a national tool accredited and supported by the CQC. For more information refer to the Trust Intranet http://sfhnet.nnotts.nhs.uk/admin/webpages/default.aspx?recid=1533

6.13 Interface with the Mental Health Act (1983)

Paragraph 13.11 of the Mental Health Act Code (2015):
"…The MCA should be central to the approach professionals take to patients who lack capacity in all health and care settings (including psychiatric and general hospitals).The starting point should always be that the MCA should be applied wherever possible to individuals who lack capacity and are detained under the Act…"

If the issue concerns treatment for the mental disorder or one of its symptoms/manifestations, the Mental Capacity Act framework will be used to assess capacity. The legal basis for actually undertaking the treatment remains the Mental Health Act.

The Mental Capacity Act will be the legal framework for undertaking treatment for a physical condition which is unrelated to the mental disorder - even if the person who lacks capacity is a MHA detained patient.

An Advance Decision to Refuse Treatment (ADRT) which refuses treatment for a mental disorder may be (but does not have to be) overridden if the patient is MHA detained and the responsible clinician considers that there is no alternative.

Treatment of a patient who is subject to sections 4, 5, 135 and 136 of the Mental Health Act 1983 cannot be given contrary to the patient's capacitous objection. Where the patient lacks the capacity, it is possible to treat under the provisions of the Mental Capacity Act.

Professionals may need to think about using the MHA to detain and treat somebody who lacks capacity to consent to treatment (rather than use the MCA), 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
• The person needs treatment that cannot be given under the MCA (for example, because the person has made a valid and applicable advance decision to refuse an essential part of treatment)
• The person may need to be restrained in a way that is not allowed under the MCA

- It is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might then refuse to give consent)
- The person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so, or
- There is some other reason why the person might not get treatment, and they or somebody else might suffer harm as a result.

Before making an application under the MHA, decision-makers should consider whether they could achieve their aims safely and effectively by using the MCA instead. Compulsory treatment under the MHA is not an option if:

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

The MCA applies to people subject to the MHA in the same way as it applies to anyone else, with four exceptions:

- If someone is detained under the MHA, decision-makers cannot normally rely on the MCA to give treatment for mental disorder or make decisions about that treatment on that person's behalf
- If somebody can be treated for their mental disorder without their consent because they are detained under the MHA, healthcare staff can treat them even if it goes against an advance decision to refuse that treatment
- If a person is subject to guardianship, the guardian has the exclusive right to take certain decisions, including where the person is to live, and
- Independent Mental Capacity Advocates do not have to be involved in decisions about serious medical treatment or accommodation, if those decisions are made under the MHA.

6.14 Offences

The MCA introduced two new criminal offences: ill treatment and wilful neglect of a person who lacks capacity to make relevant decisions (section 44 MCA). The offences may apply to:

- Anyone caring for a person who lacks capacity – this includes family carers, healthcare and social care staff in hospital or care homes and those providing care in a person's home,
- An attorney appointed under a Lasting Power of Attorney or an Enduring Power of Attorney, or
- A deputy appointed for the person by the court.

These people may be guilty of an offence if they ill-treat or wilfully neglect the person they care for or represent. Penalties will range from a fine to a sentence of imprisonment of up to five years – or both.

Ill treatment and neglect are separate offences. For a person to be found guilty of ill treatment, they must either:

- Have deliberately ill-treated the person, or
- Been reckless as to whether they were ill-treating the person or not.

It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

The meaning of 'wilful neglect' varies depending on the circumstances.
It usually means that a person has deliberately failed to carry out an act they knew they had a duty to do

Where a concern is known safeguarding procedures will need to be followed. Please contact the safeguarding team, or the duty nurse manager (out of hours)

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
The application of the MCA and MCA/DoLS will be audited as part of a regular audit programme	Divisional Heads of Nursing	Nursing Matrix Perfect Ward Ward Assurance	Monthly Quarterly	Monthly highlight report to Nursing and Midwifery Board Quarterly reporting to Safeguarding Steering Group
	Clinical chairs	Clinical governance	Monthly	Divisional governance meeting
	Safeguarding Team	Dip testing	Quarterly	Quarterly reporting to Safeguarding Steering Group Exception reporting to Patient Quality Safety Group
	Named Doctor Safeguarding Adults	Dip testing	Yearly	Annual reporting to Safeguarding Steering Group Exception reporting to Patient Quality Safety Group

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Training compliance and assurance all staff have the required competency as set out in: NICE guideline decision making and mental capacity (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)	All Staff Sisters/charge nurses/matrons	SFHT training policy Ward training matrix Staff induction, mandatory and update training records Staff attendance records on restrictive practices training Preceptorship training records MCA competency standards Medical appraisal process	In accordance with SFHT training policy matrix Quarterly Monthly Annually	Ward Assurance reporting matrix Monthly and Quarterly Divisional highlight report Safeguarding Quarterly reporting to safeguarding steering group Divisional governance meetings OLM Ward assurance, Appraisals Yearly Appraisal

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Able to demonstrate legal compliance with Mental Capacity Act 2005	All staff	Audit , Policies and procedures, CQC rating Nursing and medical documentation , Complaint process		• Copies of MCA policies. • Evidence an MCA lead. • Written evidence of MCAcompliant capacity assessments and best interest's decision-making documentation and procedures. • Evidence that rights of patients and compliance with the Act are being recognised and actioned within care planning policies, guidance and training. • Evidence that the MCA is linked into the SFHT's systems and processes relating to improving service users' experience and the quality of their care and treatment.
	Division/ Governance team	Incident reporting/ Trust Management of serious incident framework	As occur/ divisional governance	Monitoring of Datix incident reporting relating to MCA/ DoLS and restraint /restriction within monthly divisional governance meetings,

8.0 TRAINING AND IMPLEMENTATION

Mental Capacity Act training and Deprivation of Liberty Safeguards training is provided both face to face and on eLearning.

TRAINING MATRIX
MCA training requirements by staff group (proposal August 2019, draft)

LEVEL	TIME REQUIREMENT	STAFF GROUP	REFERESSHER	AWARENESS LEVEL
Level 1 e.g. admin, volunteers, medirest staff	Pre-employment e-learning	All staff to undertake this as part of preemployment training requirement	Mandatory workbook for those staff not in level 2 or level 3	All staff to understand basic principles around consent and the need to seek consent. All staff to have basic knowledge of the notion of capacity and that there is a requirement to assess this. Understand how to access support within the organisation regarding issues of consent and capacity. Understand the importance of information sharing display confidence in engaging individuals in discussing their needs
Level 2	2 hours (induction) Face to face	Unqualified clinical staff (all non-registered staff working in a clinical capacity e.g. healthcare support workers, therapy assistants e.g. physiotherapy, occupational therapy)	Annual as part of mandatory training requirements	As above To understand the principles of protecting individuals from interventions which are not consented. To be able to advocate for individuals using different communication skills regarding the principles of consent, mental capacity and best interests

	2 hours (induction) Face to face	All qualified clinical staff (all registered clinical staff e.g. Nurses, Allied Health Professionals	None	See below
Level 3 e.g. Nurses, Allied Health Professionals)	3-4 hrs (e-learning plus competency)	All qualified clinical staff (all registered clinical staff e.g. Nurses,Allied Health Professionals)	3 yearly (revisit eLearning)	As above. Use professional knowledge and judgement to assess capacity to consent. Be proactive in supporting patient need understand legislative frameworks underpinning mental capacity. Be able to evidence effective record keeping. Understand how to access appropriate support and meet legislative demands
Level 3	3-4 hrs (e-learning plus competency)	All medical staff	3 yearly (e learning) Refresher sessions covering documentation /legality at medicine and surgical governance	As above. Use professional knowledge and judgement to assess capacity to consent. Be proactive in supporting patient need understand legislative frameworks underpinning mental capacity. Be able to evidence effective record keeping. Understand how to access appropriate support and meet legislative demands

9.0 IMPACT ASSESSMENTS

This document has been subject to an Equality Impact Assessment, see completed form at Appendix C. The assessment concluded that the policy would have no adverse impact on, or result in the positive discrimination of, any other diverse group detailed. These include the stands of disability, ethnicity, gender, identity, sexual orientation, religion/belief, social inclusion and community cohesion. This document is not subject to an Environmental Impact Assessment.

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Mental Capacity Act 2005
- Mental Capacity Act 2005 Deprivation of Liberty Safeguards, TSO, 2008
- Human Rights Act 1998
- Mental Health Act 1983
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- NICE Guidelines 2018 Decision Making and Mental Capacity
- Disability Discrimination Acts (DDA) 1995 and 2005
- Equality Act 2010
- Care Act 2014
- Adult Safeguarding: Roles and responsibilities for Health Care Staff 2018
- CQC Regulation 9: Person-Centred Care
- CQC Regulation 10: Respect and Dignity
- CQC Regulation 11: Need for Consent
- Data Protection Act
- GDPR
- *Aintree University Hospitals Foundation Trust v James [2013] UKSC 67*
- *R (Ferreira) v HM Senior Coroner for Inner South London [2017] EWCA Civ 31*
- *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents), P and Q (by their litigation friend, the Official Solicitor) (Appellants) v Surrey County Council (Respondent) [2014] UKSC 19*
- *PC, NC & City of York [2013] EWCA Civ 478*
- *Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250*

Related SFHFT Documents:

- Deprivation of Liberty Safeguards (DOLS) Policy
- Enhanced Patient Observation Guideline (for Adult in-patients)
- Policy for Consent to Examination, Treatment and Care
- Learning Disability (LD) policy
- Mental Health Act Policy
- ReSPECT Policy

11.0 KEYWORDS

2005; two stage test; best interests; interest; IMCA; advanced decision to refuse treatment; ADRT; personal welfare; lasting power of attorney; LPA; court appointed deputy deputies; court of protection; deprivation of liberty; DOL;

12.0 APPENDICES

Appendix A Best Interest Checklist

Appendix B Lasting Power of Attorney (LPA) Flowchart

Appendix C Equality Impact Assessment

APPENDIX A – BEST INTEREST CHECKLIST

 Weigh up all of the factors below in order to work out what is in a person's best interests

Best Interests Checklist

A person trying to work out the best interests of a person who lacks capacity to make a particular decision (lacks capacity) should:

If the decision concerns life-sustaining treatment.

- Not to be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life.

Assess whether the person might regain capacity

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

Avoid restricting the person's rights

- See if there are other options that may be less restrictive of the person's rights

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.

Identify all relevant circumstances

- Try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.

Find out the person's views

Try to find out the views of the person who lacks capacity, including:

- The person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.

- Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.

- Any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

Avoid discrimination

- Not make assumptions about someone's best interests simply on the basis of a person's age, appearance, condition or behaviour.

Consult others

- If it is practical and appropriate to do so, consult other people for their views about the person's best interests and see if they have any information about the person's wishes and feelings, beliefs and values. In particular, try to consult:

a. Anyone previously named by the person as someone to be consulted on either the decision in question or similar issues.

b. Anyone engaged in caring for the person.

c. Close relatives, friends or others who take an interest in the person's welfare.

d. Any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person.

e. Any deputy appointed by the Court of Protection to make decisions for the person.

- For the decisions about major medical treatment or where the person should live and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted.

- When consulting, remember that the person who lacks the capacity to make the decision or act for themselves still has a right to keep their affairs private – so it would not be right to share every piece of information with everyone.

Please consider does the patient or carer require any reasonable adjustments
(Equality Act 2010, accessible information standards)

Exceptions to the best interest's principle

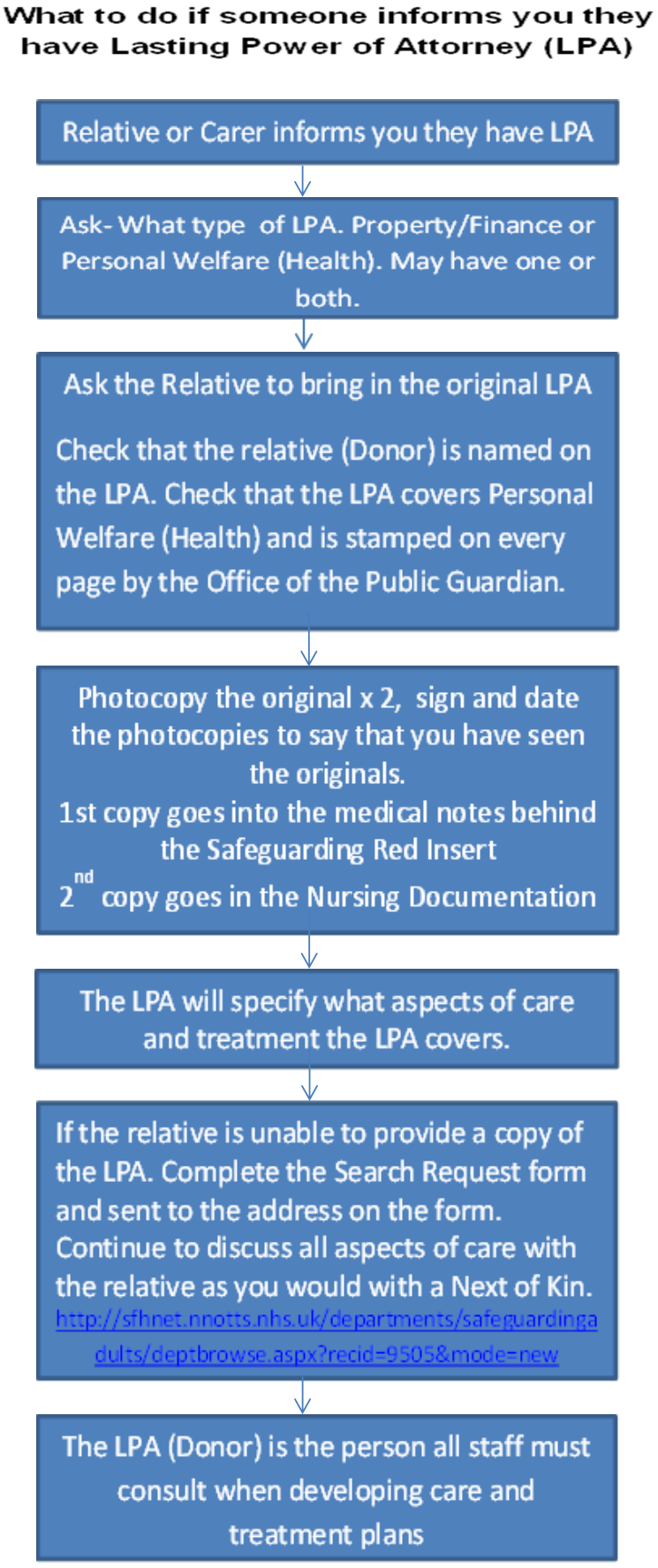
There are two circumstances when a best interest's principle will not apply.

1. Where someone has previously made an advance decision to refuse treatment while they had capacity to do so. Their advance decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests.

2. Involvement in research, in certain circumstances, of someone lacking capacity to consent.

For further information please consult:
Mental Capacity Act 2005
Code of Practice
Issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the Act

APPENDIX B – LASTING POWER OF ATTORNEY (LPA) FLOWCHART



APPENDIX C – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Mental Capacity Act (MCA) Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: February 2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	This policy aims to have a positive impact on any member of the wider community. Consequently the Trust as a public authority must, in the exercise of its functions, have due regard to the need to a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010 in regard to the nine protected characteristics in the Equality Act 2010 (age, disability gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation). The policy must be read in the context of the statement of guiding principles found in Chapter 1 of the Mental Health Act Code of Practice	N/A	N/A
Gender	As Race	N/A	N/A

Age	As Race	N/A	N/A
Religion	As Race	N/A	N/A
Disability	As Race. However, as mental health is classified as a disability under the Disability Discrimination Act this policy promotes consistency of mental health	N/A	N/A
Sexuality	As Race	N/A	N/A
Pregnancy and Maternity	As Race	N/A	N/A
Gender Reassignment	As Race	N/A	N/A
Marriage and Civil Partnership	As Race	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	As Race	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out?

- N/A

What data or information did you use in support of this EqIA?

- The Human Rights Act 1998 prevents discrimination in the enjoyment of a set of fundamental human rights

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- N/A

Level of impact From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact: High Level of Impact/Medium Level of Impact/Low Level of Impact *(Delete as appropriate)* For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.
Name of Responsible Person undertaking this assessment: Martin Watson
Signature:
Date: February 2023