Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 6843

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10 August 2021

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to vulnerable people with disabilities in emergency settings.

You asked:
1. Is there a separate waiting area for vulnerable adults with learning difficulties?
2. Are responsible adults allowed to accompany vulnerable adults with learning difficulties when they are seen by clinical staff in ED?
3. Are carers welcome to provide care if needed?
4. Does your Trust have policies in place to assess capacity to consent to investigations and treatment for adults with learning disabilities? If so, could you supply me with a copy of these policies?
5. Do you have policies relating to the administration of treatment/pain relief when an adult with learning disability is unable to consent? If so, please could I request a copy of these policies?

Trust response:
1. Whilst there are no designated separate waiting facilities for people with learning disabilities, should the need arise a separate room can be sourced for a person with a learning disability to wait upon request.
2. Yes, people who are in a carer role are permitted to support the person in ED. If a person has been risk assessed to require 2:1 or 3:1 staffing the same level of staffing should be permitted to support them in ED, evidence of community risk assessment highlighting this need must be provided. People with learning disabilities are also able to be accompanied by a Chaperone.
3. Yes (see answer above).
4. Please see the following Mental Capacity Act Policy & Procedure – this covers all adults who may lack capacity including those with learning disabilities.

5. Mental Capacity Act Policy & Procedure and reasonable adjustment guidance.

Mental Capacity Act Policy and Procedure

Target audience:	All Trust clinical staff
Author:	Lead Nurse Dementia Care **Contact details:** Ext. 33738
Other contributors:	n/a
Executive lead:	Chief Nurse
Directorate:	Corporate Nursing
Specialty:	Nursing
Supersedes:	Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure (Version 4.0: June 2015) Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure (Version 4.1: August 2015) Mental Capacity and Consent, Guidance for Staff (January 2007)
Approved by:	Safeguarding Adults Committee, 25th February 2019
Ratified by:	Policy Ratification Committee, 21st March 2019
Review date:	March 2023

Document history

Requirement for document:	The Mental Capacity Act 2005 is an important piece of legislation. It is a statutory framework for people who lack capacity to make decisions for themselves, and sets out who can take decisions in which situations and how. The Code of Practice provides guidance to anyone who is working with and / or caring for anyone over the age of 16 who lack capacity to make particular decisions. Certain categories of people are legally required to 'have regard to' relevant guidance in the Code of Practice including anyone who is: • Acting in a professional capacity for, or in relation to, a person who lacks capacity. People acting in a professional capacity may include: • A variety of healthcare staff (doctors, dentists, nurses, therapists, radiologists, paramedics etc.) • Social care staff (social workers, care managers etc.)
Cross references (external):	1. Mental Capacity Act 2005. Code of Practice. Office of the Public Guardian. 2. NICE Guideline: Decision-making and mental capacity (NG108) October 2018. 3. The Mental Capacity Act 2005. Guidance for providers. Care Quality Commission. December 2011.
Associated documents (internal):	• Care of the Dying Patient Policy and Procedure [RWF-OPPPCSS-C-CAN2] • Dementia Operational Policy and Procedure [RWF-OPPPCS-C-NUR10] • Delirium Policy and Procedure [RWF-NUR-NUR-POL-2] • End of Life Care Strategy [RWF-ONC-PAL-STR-1] • Operational Discharge Policy and Procedure [RWF-OPPPES-C-AEM6] • Policy and procedure for consent to examination or treatment [RWF-OPPPES-C-SM5] • Restraint Policy and Procedure [RWF-OPPPCS-C-NUR4] • Safeguarding Adults at Risk Policy and Procedure [RWF-OPPPCS-C-NUR5] • Safeguarding Children Policy and Procedure [RWF-OPPPCS-C-NUR6]

Keywords:	Mental capacity	Assessment of capacity	Best Interest Decisions.
	Best Interest Meetings	Lasting Power of Attorney	Advance decisions.
	Test of capacity	Fluctuating capacity	Decision maker
	Court of Protection	Independent Mental Capacity Advocate (IMCA)	MCA

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	Mental capacity and Consent, Guidance for Staff	January 2007
2.0	Reformatted and reviewed	March 2010
2.1	Appendix 11 under review	October 2010
3.0	Complete overhaul of previous policy	October 2013
4.0	Updated Policy and Procedure in relation to deprivation of Liberty Safeguard	June 2015
4.1	Archived old DOLS form 1 and updated DOLS form 4.	August 2015
5.0	Complete overhaul of previous policy and appendices and separation of Mental Capacity Act Policy and Procedure from Deprivation of Liberty Safeguards Policy	March 2019

Summary for

Mental Capacity Act Policy

This policy and procedure acknowledges the importance that the Mental Capacity Act 2005 (MCA) has in ensuring that patients are empowered, as far as is possible, to make their own decisions.

The Act was developed to ensure a person-centred process occurs when staff are faced with assessing and enabling a patient to make their own decisions or are having to make Best Interest Decisions on their behalf.

All people who care for someone who has any level of mental incapacity are required to work within the meaning of the Act. However, professionals who care for people with mental incapacity have a formal duty to have regard to the Act and the Code of Practice.

Trust staff are required to follow this policy and procedure to ensure they are working within the meaning of the law and are upholding patients' rights to autonomy to make their own decisions.

Contents

1.0 Introduction, purpose and scope

This document is intended to ensure that staff are working effectively with patients who have impaired mental capacity and within the Mental Capacity Act 2005 (the Act), and associated Code of Practice. It gives guidance on how to help people to make decisions, assess for mental capacity and if they are unable to make a particular decision, what principles staff should follow to act in another person's best interests.

2.0 Definitions/glossary

Term	Definition
Advance decision (or directive).	An advance decision to refuse treatment (sometimes referred to as a living will) is a decision an individual can make when they have capacity to refuse a specific type of treatment, to apply at some time in the future when they have lost capacity. It means that families and health professionals will know the person's decisions about refusing treatment if they are unable to make or communicate decisions themselves.
Artificial nutrition and hydration	Has been recognised as a form of medical treatment. It involves using tubes to provide nutrition and fluids to someone who cannot take them by mouth. It bypasses the natural mechanisms that control hunger and thirst and requires clinical monitoring.
Best interests	Any decision made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out someone's best interests (see Section 6)
Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made.
Child / young person	Anyone who has not yet reached their 18th birthday.
Consent	The voluntary and continuing permission of the person to receive particular treatment or care and support, based on an adequate knowledge of the purpose, nature, likely effects and risks including the likelihood of success, any alternatives to it and what will happen if the treatment does not go ahead. Permission given under any unfair or undue pressure is not consent. A person who lacks capacity to consent cannot consent to treatment or care and support, even if they cooperate with the treatment or actively seek it.

Term	Definition
Court Appointed Deputy	A person appointed by the Court of protection who is authorised to make decisions (relating to the person's health, welfare, property or financial affairs) on behalf of someone who lacks mental capacity and who cannot make a decision for themselves at the time it needs to be made.
Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions.
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.
Enduring Power of Attorney (EPA)	A Power of Attorney created under the Enduring Powers of Attorney Act 1985 appointing an attorney to deal with property and financial affairs. Existing EPAs continue to operate under Schedule 4 of the Act.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them.
Lasting Power of Attorney (LPA)	A Power of Attorney created under the Act appointing an attorney (or attorneys) to make decisions about the person's personal welfare (including healthcare) and/or deal with the person's property and affairs.
Life-sustaining treatment	Treatment that in the view of the person providing healthcare, is necessary to keep a person alive.
Mental capacity	See capacity
Mental Capacity Act 2005 (MCA)	A law that applies to people aged 16 and over in England and Wales and provides a framework for decision-making for people unable to make some or all decisions for themselves.
Mental Health Act 1983 (MHA)	A law mainly about the compulsory care and treatment of patients with mental health problems. In particular, it covers detention in hospital for mental health treatment.
Office of the Public Guardian (OPG)	The Public Guardian will be supported by the Office of the Public Guardian, which will supervise deputies, keep a register of deputies, Lasting Powers of Attorney and Enduring Powers of Attorney, check on

Term	Definition
	what attorneys are doing, and investigate any complaints about attorneys or deputies.
Personal welfare decisions	Any decisions about person's healthcare, where they live, what clothes they wear, what they eat and anything needed for their general care and well-being. Attorneys and deputies can be appointed to make decisions about personal welfare on behalf of a person who lacks capacity.
Property and affairs	Any possessions owned by a person (such as a house or flat, jewellery or other possessions), the money they have in income, savings or investments and any expenditure. Attorneys and deputies can be appointed to make decisions about property and affairs on behalf of a person who lacks capacity.
Restraint	The use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.
SALT	Speech and Language Therapy.
Statutory principles	Are designed to emphasise the fundamental concepts and core values of the Act and to provide a benchmark to guide decision-makers, professionals and carers acting under the Act's provisions.

3.0 Duties

Person/Group	Duties
Medical Director	• The Medical Director must ensure that all medical staff are conversant with the Mental Capacity Act and are complying with the five Statutory Principles of the Act. (see 5.2)
Chief Nurse	• The Chief Nurse must ensure that all nurses are conversant with the Mental Capacity Act and are complying with the five Statutory Principles of the Act.(see 5.2)
Clinical Director, Therapies	• The Head of Allied Health must ensure that all Allied Health professionals working in the Acute Trust are conversant with the Mental Capacity Act and are complying with the Five Statutory Principles of the Act.(see 5.2)
Divisional Directors of Nursing and Quality (DDNQs)	• It is the duty of the DDNQs to identify and release key staff with the correct grade and skills to undertake the Mental Capacity Act training that is offered to equip staff with the requisite skills and knowledge.

Person/Group	Duties
Matron Safeguarding Adults	• It is the duty of the Matron for Safeguarding Adults to advise in complex cases with regard to Mental Capacity Assessments and Best Interest Decision Making processes. • It is their duty to ensure there is a training programme for Mental Capacity Assessments to reach all appropriate clinical staff and audit compliance.
Matrons	• It is the duty of the Matrons to have an overarching responsibility for safeguarding in their areas and support and provide advice to staff accordingly. They should ensure that they and their staff have received appropriate training and have the requisite skills and knowledge to perform their duties. For complex cases they should seek advice and support from the Matron Safeguarding Adults.
All clinical staff	• It is the duty of all staff to adhere to the five Statutory principles of the Mental Capacity Act 2005. • It is the duty of all staff to assess capacity in relation to each decision to be made and at the time this decision needs to be made, whether this is a simple or complex decision. • It is the duty of all staff assessing mental capacity to clearly evidence and document their findings and decisions and act in the person's best interests.

4.0 Training/competency requirements

- Mental Capacity Act (MCA) training is mandatory for all clinical staff.
- All staff that assess Mental Capacity for patients with regard to simple or complex decisions will require appropriate training.
    - Level 1 MCA Basic Awareness or Level 2 e-learning for Safeguarding Adults or Level 2 Safeguarding Adults Clinical Update.
- Advice and guidance is available from the Matron Safeguarding Adults and the Named Nurse Safeguarding Children (where a 16 or 17 year old is concerned).

5.0 Mental Capacity Act (MCA)

"A person must be assumed to have capacity unless it is established that he lacks capacity" (Principle 1, section 1 (2), Mental Capacity Act 2005).

Some people may require help to be able to make a decision or to communicate their decision. However, this does not necessarily mean that they cannot make that decision – unless there is proof that they do lack capacity to do so. **Anyone who believes that a person lacks capacity should be able to prove their case**.

"A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success" (Principle 2, section 1 (3), Mental Capacity Act 2005).

The support people might need to help them varies. It depends on personal circumstances, the kind of decision that has to be made and the time available to make the decision. It might include:

- Using a different form of communication.
- Providing information in a more accessible form.
- Treating a medical condition which may be affecting a person's capacity.
- Having a structured programme to improve a person's capacity to make particular decisions.

"Under the Mental Capacity Act 2005, capacity is decision-specific, and an individual is assumed to have capacity unless, on the balance of probabilities, proven otherwise. The concept of capacity under the Mental Capacity Act 2005 is relevant to many decisions including care, support and treatment, financial matters and day-to-day living". (NICE Guideline: Decision-making and mental capacity (NG108). October 2018).

The Mental Capacity Act 2005 **does not** generally apply to people under the age of 16. Most of the Act applies for young people aged between 16 and 17 years, who may lack capacity within section 2(1) to make specific decisions. There are three exceptions:

1. Only people aged 18 and over can make a Lasting Power of Attorney (LPA)
2. Only people aged 18 and over can make an advance decision to refuse medical treatment
3. The Court of Protection may only make a statutory will for a person aged 18 and over.

An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not on their ability to make decisions in general.

Section 2(2) of the Act states that the impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

- The loss of capacity is partial
- The loss of capacity is temporary
- Their capacity changes over time

A person may also lack the capacity to make a decision about one issue but not about others.

An assessment that a person lacks capacity to make a decision must never be based simply on:

- Their age
- Their appearance
- Assumptions about their condition
- Any aspect of their behaviour

"Appearance", covers all aspects of the way people look i.e. physical characteristics of certain conditions (e.g. scars, features linked to Down's

syndrome or cerebral palsy) as well as aspects of appearance such as skin colour, tattoos and body piercings, or the way people dress.

"Condition" includes physical disabilities, learning difficulties and disabilities, illness related to age, temporary conditions (e.g. drunkenness or unconsciousness).

Aspects of behaviour might include extrovert (shouting or gesticulating) and withdrawn behaviour (talking to yourself or avoiding eye contact).

Anybody who claims that an individual lacks capacity should be able to provide proof. They need to be able to show, *on the balance of probabilities,* that the individual lacks capacity to make a particular decision, at the time it needs to be made (section 2(4)). This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question.

The test of capacity

The Code of practice includes an important **'two-stage test of capacity':**

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

If the person does not have such an impairment or disturbance, they will **not** lack capacity under the Act.

Examples of an impairment or disturbance include:

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning disabilities
- The long-term effects of brain damage
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury
- The symptoms of alcohol or drug use

Stage 2. 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?

People must be given all practicable and appropriate support to help them make the decision for themselves. Stage 2 can only apply if all support has failed.

A person lacks capacity to make a particular decision if they cannot either:

- **Understand** information relevant to the decision (Relevant information includes: the nature of the decision; the reason why the decision is needed and the likely effects of deciding one way or another, or making no decision at all), or
- **Retain** that information in their mind long enough to make the decision (People who can only retain information for a short while must not automatically be assumed to lack the capacity to

decide – it depends on what is necessary for the decision in question), or

- **Weigh up** that information as part of the decision-making process (Sometimes people can understand information but an impairment or disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given), or
- **Communicate** their decision – by using verbal or non-verbal means. Refer to SALT if full assessment or assistive devices required.
  (Sometimes there is no way for a person to communicate, before deciding that someone falls into this category, it is important to make all practical and appropriate efforts to help them communicate. This might include involvement of speech and language therapists, specialists in non-verbal communication or other professionals. Communication by simple muscle movements can show that somebody can communicate and may have capacity to make a decision.)

People with fluctuating or temporary capacity

- Some people have fluctuating capacity, some factors which may indicate that person may regain or develop capacity in the future are:
  - The cause of the lack of capacity can be treated, either by medication or some other form of treatment or therapy.
  - The lack of capacity is likely to decrease in time (e.g. when it is caused by the effects of medication or alcohol, or following a sudden shock.)
  - A person with learning disabilities may learn new skills or be subject to new experiences which increase their understanding and ability to make certain decisions.
  - The person may have a condition which causes capacity to come and go at various times, so it may be possible to arrange for the decision to be made during a time when they do have capacity.
  - A person previously unable to communicate may learn a new form of communication.
- As in any other situation, an assessment must only examine a person's capacity to make a particular decision when it needs to be made. It may be possible to put off the decision until the person has the capacity to make it.

Conducting an assessment of capacity

The Code of practice does not require care services and workers to undertake formal, recorded assessments for minor day-to-day decisions about giving routine care.

Normal assessment and planning arrangements for care, treatment and support should already be providing staff with full information on a person's capacities, needs and abilities.

All assessments relating to capacity, whether formal or informal, must be undertaken under the five principles of 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 them 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 their 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.**

Assessors should have sufficient knowledge of the person being assessed (except in emergencies or where services have had no previous contact with the person) to be able to:

- Recognise the best time to make the decision.
- Provide tailored information, including information about the consequences of making the decision or of not making the decision.
- Know whether the person would be likely to attach particular importance to any key considerations relating to the decision.

The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved is assessing someone's capacity to make different decisions at different times.

If a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity to consent.

5.2.1 Preparing for an assessment

In preparing for an assessment, the assessor should be clear about:

- The decision to be made.
- Whether any ability to make a decision is caused by any impairment of or disturbance in the functioning of the mind or brain in that person.
- The options available to the person in relation to the decision.
- What information the person needs in order to be able to explore their options and make a decision, and in a format which is accessible for them.
- What the person needs in order to understand, retain, weigh up and use relevant information in relation to this decision, including the use of communication aids.

- How to allow enough time for the assessment, giving people with communication needs more time if needed.
- How to introduce the assessment and conduct it in a way that is respectful, collaborative, and non-judgemental and preserves the person's dignity.
- How to make reasonable adjustments including, for example, delaying the assessment until a time when the person feels less anxious or distressed and more able to make the decision.
- How to ensure that the assessment takes place at a location and in an environment and through a means of communication with which the person is comfortable.
- How to identify the steps a person is unable to carry out even with all practicable support.
- Whether involving people with whom the person has a trusted relationship would help the assessment.

Where consent has been provided, health and social care practitioners should identify people who could be spoken with in order to inform the capacity assessment. For example, this may include the individual's family or friends.

Health and social care practitioners should take a structured, person-centred, empowering and proportionate approach to assessing a person's capacity to make decisions, including everyday decisions.

Use of single tools (such as the Mini-Mental State Examination) that are not designed to assess capacity may yield information that is relevant to the assessment, but practitioners should be aware that these **should not be used as the basis for assessing capacity.**

If a person refuses to engage in some or all aspects of the capacity assessment, the assessor should try to establish the reasons for this and identify what can be done to help them participate fully.

Practitioners should understand that the person has to retain the information only for the purposes of making the specific decision in question, and for the period of time necessary to make the decision and for it to be put into effect.

Practitioners should be aware that a person may have decision-making capacity even if they are described as lacking 'insight' into their condition. Capacity and insight are two distinct concepts. If a practitioner believes a person's insight/lack of insight is relevant to their assessment of the person's capacity, they must clearly record what they mean and how they believe it affects/does not affect the person's capacity.

5.2.2 Recording the assessment

If, following the assessment of capacity, the practitioner finds no evidence to displace the assumption of capacity; this should be documented in the healthcare records.

If the outcome of the assessment is that the person lacks capacity, the practitioner should clearly document the reasons for this in the patient's healthcare record **(Appendix 4).**

Records of assessment and decisions must show:

- Details of the two-stage assessments of capacity.
- What impairment/disturbance of the mind or brain has been identified, the reasons why the person is unable to make the decisions and the fact that the person's inability to make the decision is a direct consequence of the impairment or disturbance identified.
- The practicable steps that have been taken to help the person make the relevant decision for themselves and any steps taken by other parties involved.
- How much the person is able to understand information that is relevant to the decision.
- Whether the person can remember relevant information long enough to make the decision.
- How well the person can weigh up relevant pros and cons when making the decision.
- How the person can let other people know what their decisions are, and how well they can do this.
- If the person is assessed as lacking capacity, why the practitioner considers this to be an incapacitous decision as opposed to an unwise decision.
- All assessments of mental capacity must be recorded at an appropriate level to the complexity of the specific decision being made at a particular time.

5.2.3 When to be involved

Health and social care practitioners and/or other relevant professionals and experts must be involved when an assessment and/or decision has particularly significant consequences. These include when:

- There are disagreements with the person, their family or others about their capacity to make a decision.
- The person's capacity may be challenged by someone.
- The decision is about life sustaining or other particularly significant medical treatment.
- Where a decision not to resuscitate someone is being considered.
- Reporting abuse or crime.
- Other people may be at risk.
- Considering whether the person should move to new accommodation or receive care, treatment or support at home.
- The decision has legal complications or consequences, such as for liability.
- There are significant financial or property issues.

5.2.4 Challenging a finding of lack of capacity

There are likely to be occasions when someone may wish to challenge the results of an assessment of capacity. The first step is to raise the matter with the person who carried out the assessment. Ask the assessor to:

- Give reasons why they believe the person lacks capacity to make the decision, and
- Provide objective evidence to support their belief.

The assessor must show they have applied the principles of the Mental Capacity Act.

Where there is disagreement about the initial capacity assessment a second opinion should be sought from an independent practitioner or another expert in assessing capacity.

If a disagreement cannot be resolved, the person who is challenging the assessment may be able to apply to the Court of Protection. The Court of Protection can rule on whether a person has capacity to make the decision covered by the assessment.

6.0 Best Interest decision making

One of the principles of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's *best interests.*

There are exceptions to this, including circumstances where a person has made an advance directive to refuse treatment.

This principle covers all aspects of financial, personal welfare and health care decision-making actions. It applies to anyone making decisions or acting under the provisions of the Act, including:

- Family carers, other carers and care workers
- Healthcare and social care staff
- Attorneys appointed under a Lasting Power of Attorney or registered Enduring Power of Attorney
- Deputies appointed by the court to make decisions on behalf of someone who lacks capacity, and
- The Court of Protection

When working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity.

6.1 Who can be a decision maker?

Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. It is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.

- For most day-to-day actions or decisions, the decision-maker will be the carer most directly involved with the person at the time.
- Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for

carrying out the particular treatment or procedure is the decision-maker.
- Where nursing or paid care is provided, the nurse or paid carer is the decision-maker.
- If a Lasting Power of Attorney (or Enduring Power of Attorney) has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision maker, for decisions within the scope of their authority.

In some cases, the same person may make different types of decision for someone who lacks capacity.

There are also times when a joint decision might be made by a number of people.

6.2 What must be taken into account?

Because every case – and every decision – is different, the law cannot set out all the factors that will need to be taken into account. Some common factors that must always be considered include:

- Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition or behaviour.
  ("Appearance", covers all aspects of the way people look, i.e. physical characteristics of certain conditions (e.g. scars, features linked to Down's syndrome or cerebral palsy) as well as aspects of appearance such as skin colour, tattoos and body piercings, or the way people dress.
  "Condition" includes physical disabilities, learning difficulties and disabilities, illness related to age, temporary conditions (e.g. drunkenness or unconsciousness).
  Aspects of behaviour might include extrovert (shouting or gesticulating) and withdrawn behaviour (talking to yourself or avoiding eye contact).
- All relevant circumstances should be considered.
- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision.
- If there is a chance that the person will regain 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.
- The person's past and present wishes and feelings, beliefs and values should be taken into account.
- The views of other people who are close to the person who lacks capacity should be considered, as well as the views of an attorney or deputy.

What is in the person's best interests may change over time. This means that even when similar actions need to be taken repeatedly in connection with the person's care and treatment, the person's best interests should be regularly reviewed.

Any staff involved in the care of a person who lacks capacity should make sure a record is kept of the process of working out the best interests for each relevant decision, setting out:

- How the decision about the person's best interests was reached
- What the reasons for reaching the decision were
- Who was consulted to help work out best interests, and
- What particular factors were taken into account

6.2.1 Other factors to consider

Section 4(6) (c) of the Act requires decision-makers to consider any other factors the person who lacks capacity would consider if they were able to do so. This might include the effect of the decision on other people, obligations to dependents or the duties of a responsible citizen.

The Act allows actions that benefit other people, as long as they are in the best interests of the person who lacks capacity to make the decision. 'Best interests' goes beyond the person's medical interests. If it is likely that the person who lacks capacity would have considered these factors themselves, they can be seen as part of the person's best interests.

6.3 How should the person who lacks capacity be involved?

Wherever possible, the person who lacks capacity should be involved in the decision-making process. Even if they lack capacity to make the decision, they may have views on matters affecting the decision, and on what outcome would be preferred.

Consulting the person who lacks capacity will involve taking time to explain what is happening and why a decision needs to be made.

A number of practical steps to assist and enable decision-making include:

- Using simple language and/or illustrations or photographs to help the person understand the options.
- Asking them about the decision at a time and location where the person feels most relaxed and at ease.
- Breaking the information down into easy-to-understand points.
- Using specialist interpreters or signers to communicate with the person. (refer to SALT for formal assessment).

6.3.1 Who should be consulted?

The Act places a duty on the decision-maker to consult other people close to a person, where practical and appropriate. The decision maker has a duty to take into account the views of the following people:

- Anyone the person has previously named as someone they want to be consulted.
- Anyone involved in caring for the person.
- Anyone interested in their welfare.
- An attorney appointed by the person under a Lasting Power of Attorney, and

- A deputy appointed for that person by the Court of Protection.

If there is no-one to speak to about the person's best interests, the person may qualify for an Independent Mental Capacity Advocate (IMCA).

6.4 Recording a Best Interest decision

This should include:

- A clear explanation of the decision to be made.
- The steps that have been taken to help the person make the decision themselves.
- A current assessment concluding that the person lacks the capacity to make this decision, evidencing each element of the assessment.
- A clear record of the person's wishes, feelings, cultural preferences, values and beliefs, including any advance decision.
- The choices that have been put to the person.
- The details the person needs to understand.
- The best interest's decision made, with reasons.

When making best interest decisions, staff should explore whether there are less restrictive options that will meet the person's needs. This should take into account:

- What the person would prefer, including their past and present wishes and feelings, based on past conversations, actions, choices, values or known beliefs.
- What decision the person who lacks capacity would have made if they were able to do so.
- All the different options. The restrictions and freedoms associated with each option.
- The likely risks associated with each option.

Appendix 5 should be used to record the Best Interest Meeting.

6.5 How should someone's best interests be worked out when making decisions about life-sustaining treatment?

The fundamental rule is that anyone who is deciding whether or not life-sustaining treatment is in the best interests of someone who lacks capacity to consent to or refuse treatment must not be motivated by a desire to bring about the person's death.

Whether a treatment is 'life-sustaining' depends not only on the type of treatment, but also on the particular circumstances in which it may be prescribed. It is up to the doctor or healthcare professional providing treatment to assess whether the treatment is life-sustaining in each particular situation.

As with all decisions, before deciding to withdraw or withhold life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in the person's best interests. All factors should be considered, and in particular, the decision-maker should consider any statements that

the person has previously made about their wishes and feelings about life-sustaining treatment.

Doctors are not under an obligation to provide, or to continue to provide, life-sustaining treatment where that treatment is not in the best interests of the person, even where the person's death is foreseen. Doctors must apply the best interest's principles and use their professional skills.

If the doctor's assessment is disputed, and there is no other way of resolving the dispute, ultimately the Court of Protection may be asked to decide.

Where a person has made a written statement in advance that requests particular medical treatments, these requests should be taken into account by the treating doctor. Like anyone else involved in making this decision, the doctor must weigh written statements alongside all relevant factors to decide whether it is in the best interests of the patient to provide or continue life-sustaining treatment.

If someone has made an advance decision to refuse life-sustaining treatment, specific rules apply (see section 10)

Where there is any doubt about the patient's best interests an application should be made to the Court of Protection for a decision (in such circumstances, staff should contact Legal Services and the Safeguarding Matron).

7.0 Using restraint

Section 6 (4) of the Act states that someone is using restraint if they:

- Use force – or threaten to use force – to make someone do something that they are resisting, or
- Restrict a person's freedom of movement, whether they are resisting or not.

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

- The person taking action must reasonably believe that restraint is *necessary* to prevent *harm* to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts must be a *proportionate response* to the likelihood and seriousness of harm.

In addition to the requirements of the Act, the common law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in a way which may cause harm to others, staff may, under common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

Anyone considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used.

A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible.

Carers and healthcare and social care staff should consider less restrictive options before using restraint. Please refer to the MTW Restraint Policy and Procedure for further guidance. (RWF-OPPPCS-C-NUR4)

8.0 Lasting Power of Attorney (LPA)

Only adults aged 18 or over can make an LPA, and they can only make an LPA if they have capacity to do so.

Section 10 (4) of the Act allows the donor to appoint two or more attorneys and to specify whether they should act 'jointly', 'jointly and severally', or 'jointly in respect of some matters and jointly and severally in respect of others'.

- Joint attorneys must always act together. All attorneys must agree decisions and sign relevant documents.
- Joint and several attorneys can act together but may also act independently if they wish. Any action taken by an attorney alone is as valid as if they were the only attorney.

If a donor who has appointed two or more attorneys does not specify how they should act, they must always act jointly.

An LPA must be registered with the Office of the Public Guardian (OPG) before it can be used. An unregistered LPA will not give the attorney any legal powers to make a decision for the donor.

If an LPA is unregistered, attorneys must register it before making any decisions under the LPA.

Healthcare staff must ask to see the LPA to ensure that it has been registered and can be used. A copy of this should be placed in the healthcare records.

8.1 Personal Welfare LPAs

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 that particular healthcare decision.**
  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.**
  An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment.
  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.**
  An attorney has no power to consent 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 or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983.

Attorneys must always follow the Mental Capacity Act's principles and make decisions in the donor's best interests. If healthcare staff disagree with the attorney's assessment of best interests, they should discuss the case with other medical experts and /or get a formal second opinion. Then discuss the matter further with the attorney. If they cannot settle the disagreement, they can apply to the Court of Protection.

9.0 What is the role of the Court of Protection and court-appointed deputies?

The Court of Protection has powers to:

- Decide whether a person has capacity to make a particular decision for themselves.
- Make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions.
- Appoint deputies to make decisions for people lacking capacity to make those decisions.
- Decide whether an LPA is valid, and
- Remove deputies or attorneys who fail to carry out their duties.

10.0 Advance decisions

It is a general principle of law and medical practice that people have a right to consent or refuse treatment. The courts have recognised that adults have the right to say in advance that they want to refuse treatment if they lose capacity in the future – even if this results in their death. This has been a fundamental principle of the common law for many years and it is now set out in the Act when a person can make an advance decision to refuse treatment. This applies if:

- The person is 18 or older, and

- They have the capacity to make an advance decision about treatment.

A valid and applicable advance decision to refuse treatment is as effective as a refusal made when a person has capacity. Therefore, an advance decision overrules:

- The decision of any personal welfare LPA made before the advance decision was made.
- The decision of any court-appointed deputy.
- The provisions of section 5 of the Act, which would otherwise allow healthcare professionals to give treatment that they believe is in a person's best interests.

Healthcare professionals must follow an advance decision if it is valid and applies to the particular circumstances. Where an advance decision is being followed, the best interest's principle does not apply. Healthcare professionals must follow a valid and applicable advance decision, even if they think it goes against a person's best interests.

People can only make advance decisions to *refuse* treatment. Nobody has the legal right to demand specific treatment, either at the time or in advance. But people can make a request or state their wishes and preferences in advance. Healthcare professionals should then consider the request when deciding what is in a patient's best interests if they lack capacity.

The Court of Protection may make declarations as to the existence, validity and applicability of an advance decision, but it has no power to overrule a valid and applicable advance decision to refuse treatment.

10.1 What should be included in an advance decision?

There are no particular formalities about the format of an advance decision. It can be written or verbal, unless it deals with life-sustaining treatment, in which case it must be written and specific rules apply.

An advance decision to refuse treatment:

- Must state precisely what treatment is to be refused – a statement giving a general desire not to be treated is not enough.
- May set out the circumstances when the refusal should apply.
- Will only apply at a time when a person lacks capacity to consent or refuse the specific treatment.

Specific rules apply to life-sustaining treatment:

- It must be in writing.
- Be signed by the person.
- Be signed in the presence of a witness, the witness must then sign the document in the presence of the person making the advance decision.

- Include a clear, specific written statement from the person making the advance decision that the advance decision is to apply to the specific treatment even if life is at risk.

An advance decision cannot refuse actions that are needed to keep a person comfortable (sometimes called basic or essential care). Examples include warmth, shelter, actions to keep a person clean and the offer of food and water by mouth. Section 5 of the Act allows healthcare professionals to carry out these actions in the best interests of a person who lacks capacity to consent. An advance decision **can refuse artificial nutrition and hydration.**

10.2 Changes to an advance decision

Section 24 (3) allows people to cancel or alter an advance decision at any time while they have the capacity to do so. There are no formal processes to follow. People can cancel their decision verbally or in writing, and they can destroy any original written document.

Healthcare professionals should record a verbal cancellation in healthcare records. This then forms a written record for future reference.

People can make changes to an advance decision verbally or in writing whether or not an advance decision was made in writing, but if a person wants to change an advance decision to include a refusal of life-sustaining treatment, they must follow the procedure above.

10.3 Deciding if an advance decision is invalid or not applicable.

Events that would make an advance decision invalid include those where:

- The person withdrew the decision while they still had capacity to do so.
- After making the advance decision, the person made an LPA giving an attorney authority to make treatment decisions that are the same as those covered by the advance decision.
- The person has done something that clearly goes against the advance decision which suggests that they have changed their mind.

The advance decision is not applicable to the treatment in question if:

- The proposed treatment is not the treatment specified in the advance decision.
- The circumstances are different from those that may have been set out in the advance decision, or
- There are reasonable grounds for believing that there have been changes in circumstance, which would have affected the decision if the person had known about them at the time they made the advance decision.

11.0 Independent Mental Capacity Advocate (IMCA)

The aim of the IMCA service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no-one else (other than paid staff) to support or represent them or be consulted.
The IMCA service provides safeguards for people who:

- Lack capacity to make a specified decision at the time it needs to be made.
- Are facing a decision on a long-term move or about serious medical treatment and
- Have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests.

If a person who lacks capacity has nobody to represent them or no-one that it is appropriate to consult, an IMCA must be instructed in prescribed circumstances. The prescribed circumstances are:

- Providing, withholding or stopping serious medical treatment.
- Moving a person into long-term care in hospital (for more than 28 days) or a care home (for more than eight weeks), or
- Moving the person to a different hospital or care home.

The IMCA will:

- Be independent of the person making the decision.
- Provide support for the person who lacks capacity.
- Represent the person without capacity in discussions to work out whether the proposed decision is in the person's best interests.
- Provide information to help work out what is in the person's best interests, and
- Raise questions or challenge decisions which appear not to be in the best interests of the person.

IMCAs have a different role from many other advocates. They:

- Provide statutory advocacy.
- Are instructed to support and represent people who lack capacity to make decisions on specific issues.
- Have a right to meet in private the person they are supporting.
- Are allowed access to relevant healthcare records and social care records.
- Provide support and representation specifically while the decision is being made, and
- Act quickly so their report can form part of decision-making.

If an IMCA is required it is important that they are involved as soon as possible. Delay can hold up medical treatment, discharge from hospital or placement in a care home. See **Appendix 6** IMCA referral form. Please note that you will need to add the word "[secure]" in the subject line of a message (with the inclusion of the square brackets).

12.0 What is the relationship between the Mental Capacity Act and the Mental Health Act 1983?

Professionals may need to think about using the Mental Health Act (MHA) to detain and treat somebody who lacks capacity to consent to treatment (rather than use of 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 patient's mental disorder does not justify detention in hospital, or
- The patient 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
- IMCAs do not have to be involved in decisions about serious medical treatment or accommodation, if those decisions are made under the MHA.

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy/procedural document to the Corporate Governance

Assistant (CGA) who will upload it to the Trust policy database on the intranet, under "Policies & guidelines".

- A monthly publications table is produced by the CGA which is published on the Trust intranet under "Policies & guidelines". Notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

2.0 Monitoring compliance with this document

- Annual audit of compliance with Mental Capacity Assessments and Best Interest Decision making processes will be undertaken, to monitor the frequency and quality of formal recording of steps taken to support decision-making. Findings of the audit will be reported to the Safeguarding Adults Committee with any appropriate action plans, by the Matron for Safeguarding Adults.
- A quarterly report in relation to IMCA referrals with their outcomes will be reported to the Safeguarding Adults Committee by the Matron for Safeguarding Adults.
- Quarterly training updates will be presented to the Safeguarding Adults Committee by Learning and Development, to identify areas of compliance and where improvements are required.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 4 years or sooner if changes in legislation or practice occur.

4.0 Archiving

The Trust approved document management database on the intranet, under '"Policies & guidelines", retains all superseded files in an archive directory in order to maintain document history.

APPENDIX 2

CONSULTATION ON: Mental Capacity Act Policy and Procedure

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Lead Nurse Dementia Care

By date: 31st December 2018

Job title:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff must be included in all consultations:				
Corporate Governance Assistant	11/12/18	20/12/18	Y	Y
Counter Fraud Specialist Manager (tiaa)	11/12/18	11/12/18	N	N
Energy and Sustainability Manager	11/12/18			

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Chief Pharmacist and Formulary Pharmacist	11/12/18			
Formulary Pharmacist	11/12/18			
Staff-Side Chair	11/12/18			
Complaints & PALS Manager	11/12/18			
Emergency Planning Team	11/12/18	13/12/18	N	N
Head of Staff Engagement and Equality	11/12/18			
Head of Clinical Information Systems and Healthcare Records Services	11/12/18	24/12/18	Y	Y
All individuals listed on the front page				
The relevant lead for the local Q-Pulse database				
All members of the approving committee (Safeguarding Adults Committee).	11/12/18	12/12/18	Y	Y
Other individuals the author believes should be consulted				
Ethics Committee	11/12/18			
Chief Nurse / Medical Director	11/12/18			
ADNSs	11/12/18			
Matrons	11/12/18			
Corporate Nursing Team	11/12/18	2/1/19	N	N
Dementia Strategy Group	11/12/18			
SALT	11/12/18	2/1/19	Y	Y
The following staff have given consent for their names to be included in this policy and its appendices:				

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of document	Mental Capacity Act Policy and Procedure
What are the aims of the policy?	To ensure all staff adhere to the principles of the Mental Capacity Act 2005.

Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Gender identity	No
People of different ages	Yes by law only applies to those aged 16 and over – refer to Safeguarding Children's Policy and Procedure.
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	Yes – if mental capacity is affected, refer to policy.
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	Yes
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document

FURTHER APPENDICES

The following appendices are published as related links to the main policy/procedure on the Trust approved document management database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Mental Capacity Assessment	RWF-OWP-APP65	This policy

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
5	Best Interest Decision Making Meeting	RWF-OWP-APP67	This policy
6	IMCA Referral	RWF-OWP-APP68	This policy