jrhsupport

MENTAL CAPACITY POLICY

Adapted from the Nottingham and Nottinghamshire MULTI-AGENCY JOINT POLICY & PROCEDURE ON THE MENTAL CAPACITY ACT (2005) Second Edition: June 2010

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1. INTRODUCTION

The purpose of this guidance is to inform health and social care staff about the local procedural arrangements for working with service users with impaired mental capacity. This policy and procedure applies to all JRH Support involved in the care, treatment and support of people over the age of 16 who are unable to make all or some decisions for themselves – but please note that some sections only apply to those over 18.

The basic principles of the Act are described in this document. It is not intended to replace the Code of Practice**.** For a detailed wider commentary on the practice implications of the Act, staff must consult the Act itself and the Code of Practice, as well as case law commentary as it emerges. Staff are reminded that they must have regard to the Code of Practice and will need to take active responsibility for equipping themselves to practice within the law and they should be able to explain how they have regard to the Act and the Code when acting or making decisions on behalf of people who lack capacity to make decisions for themselves. Background to Legislation

Finance and property-related matters for people lacking capacity to manage their affairs has rested with the Court of Protection since 1959 with Enduring Powers of Attorneys being introduced in 1986 as a means by which individuals could choose who managed their estate should they lose capacity to manage their affairs. All other matters in relation to people who lacked capacity have been covered by the Common Law and the Doctrine of Necessity. However, a succession of cases in recent years showed the need for an over-arching body of law to cover this group of vulnerable people and to protect their rights and freedoms.

1.1 Equality Impact Assessment

The Equality Impact Assessment on the Mental Capacity Act (30th May 2007) states "the aim of the Act is to provide an appropriate balance between an individual's' right to autonomy and self determination with the right to safeguards and protection from harm". In meeting this balance, the impact of the Act is expected to be positive for all groups assessed in the Equality Impact Assessment.

JRH Support will ensure that we meet this aim by using the Code of Practice and our organisation's procedures to support staff in how they implement the Act.

1.2 Defining Lack of Capacity

The Mental Capacity Act provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. The Act defines '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*". The Act contains the following key elements in regard to capacity:-

Time specific - the issue is whether a person can make a decision at a particular time

Decision specific - capacity relates to a specific decision not a general ability to make decisions

Diagnostic threshold - must have permanent or temporary impairment of or disturbance in the functioning of the mind or brain

Not based on appearance and behaviour - i.e. not assuming someone lacks capacity just because they have a learning disability

Balance of probabilities - lack of capacity must be decided on the balance of probabilities of what is more likely than not.

The Act states that a person cannot make a decision if they cannot do any of the following four things:

- Understand information given to them relevant to the decision
- Retain that information long enough to be able to make the decision
- Use or weigh up the information available to make the decision as part of the decision –making process
- Communicate their decision

Lack of capacity can be due to:

- A stroke or brain injury
- A mental health problem
- Dementia
- A learning disability
- Confusion, drowsiness or unconsciousness because of an illness or the treatment of it
- A neurological disorder
- Substance misuse

The law further emphasises that the disturbance in the functioning of the mind or brain can be permanent or temporary. It says that no-one can be labelled 'incapable' by reference simply to a particular diagnosis or mental condition nor by reference to a person's age or appearance or aspect of their behaviour that might lead to an unjustified assumption about their lack of capacity.

1.3 Key Principles of the Act

Staff will need to keep the following Five Key Principles in mind when working with people who may lack capacity to make decisions and statutory organisations need to demonstrate that they are working to these principles:

- **Presumption of Capacity**

  A person must be assumed to have capacity unless it is established that she/he lacks capacity to make a decision.

- **Maximising decision-making**

  A person is not to be treated as unable to make a decision unless all practical efforts to help them have been made without success.

- **Unwise decisions**

  A person is not to be treated as unable to make a decision because he/she makes an unwise decision. The Code of Practice distinguishes between unwise decisions where a person has capacity to make them and repeated unwise decisions that cause concern and unwise decisions that require investigation

- **Best interests**

  An act done or decision made under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in his/her best interests. (See Section 4 - **Best Interests Checklist**).

- **Least restrictive option**

  Before an act is done or a decision is made on behalf of a person lacking capacity it should be considered whether these purposes can be achieved in a way that is less restrictive of that person's rights and freedom of action.

2. ASSESSMENT OF CAPACITY

The Act sets out a two stage test of diagnostic and functional elements for assessing whether a person lacks capacity to take a particular decision at the relevant time, based on the principles outlined above. If, for example, a person has a diagnosis of "dementia" or "learning disability" this does not imply or determine that they lack capacity. The Act simplifies assessment of capacity and encourages this to be undertaken by a wide range of health and social care staff on a regular basis.

There should be evidence of a capacity assessment - where capacity is in doubt - when the particular support plan has been developed. This means that it is not then always necessary for support staff to assess capacity if this has been assessed as part of the support plan - for example where a support worker helps a person to get dressed. The support plan should take account of the possibility that capacity can fluctuate and even though the assessment in the support plan indicates that the person lacks capacity, that person may actually have capacity at the time the decision needs to be made. Likewise where the situation is urgent such as when a person runs into the road and may need restraint in order to protect them from harm there is no expectation that a detailed capacity assessment has taken place. Reasonable belief that the person lacks capacity to make the decision will be enough.

Decision makers must be prepared to justify their decision. A more detailed capacity assessment should be carried out if a more serious decision has to be made and capacity is in doubt

2.1 Who makes assessments under the Act?

All health and social care staff are likely to have to assess capacity at some stage. Who assesses capacity depends on the nature of the decision that needs to be made. For day-to-day domestic decisions a carer can make decisions about capacity and take decisions on behalf of the person cared for, provided that they reasonably believe that the person lacks capacity to make the decisions and then act in the person's best interests. However, more experienced decision makers will become involved in assessing capacity when:-

- When a decision needs to be made that is serious or has serious consequences
- There is a dispute about capacity by the person or by carers or other decision makers
- A person is expressing different views to different people, perhaps in an attempt to tell them what they think they want to hear
- A challenge to a person's capacity to make a decision is likely
- There are legal consequences to a finding of capacity
- A person is repeatedly making decisions that put them or others at risk of harm
- Capacity is at issue in a case of adult safeguarding

The Act requires a nominated decision maker for a decision on behalf of a person lacking capacity to decide for him or herself. The Act does not specify who should undertake the assessment of capacity but gives guidance in Paragraph 4.38 – 4.43 of the Code of Practice. Primarily it is the person who is to undertake an act in connection with care or treatment who is responsible for the assessment.
Carers and all levels of health and social care staff will make day-to-day assessments based on best interests and the principles of the Act on a regular basis for the more minor decisions on behalf of people who lack capacity. More serious decisions will require more senior/ appropriately qualified decision makers/practitioners. The Code of Practice discusses decision making in more detail.

2.2 The test of Capacity

Firstly, the person must have an impairment of or disturbance in functioning of the mind or brain. A lack of capacity must not be established merely by reference to a person's age or appearance or a condition that they might have or aspect of their behaviour which might lead another to an unjustified assumption about that person's capacity. Capacity is to be assessed in relation to a particular decision at the relevant time that the decision needs to be made.

If a person does not have an impairment of or disturbance in functioning of the mind or brain, then they cannot lack capacity.

Secondly, the impairment or disturbance must mean that they cannot understand, retain weigh up or communicate their decision in any way.

This guidance offers documentation for recording the **Two Stage Test for Capacity (Appendix 1 and 2)**

2.3 Guidelines for completion of the Two Stage Test (MCA Code Chapter 4)

Stage 1: The diagnostic threshold

The Act and Code of Practice acknowledge that if there is an established diagnosis of mental illness, learning disability or some other condition then this is sufficient to confirm "impairment of or disturbance in functioning of the mind or brain". However, some may not have a formal diagnosis of this kind, but assessors need to take all reasonable steps to satisfy themselves that there is a temporary or permanent impairment or disturbance in the functioning of the mind or brain. The diagnostic descriptor "Other" is to be used for conditions/diagnoses that do not readily fit the main categories mentioned above.

Nature of decision
Assessors should record the nature of the decision facing their service user

Stage 2: The functional threshold a) Understanding the information

This test requires the assessor to help the person understand the information relevant to the decision. The Code of Practice provides examples (MCA Code 4.18). Information should be presented in a clear and simple way or with the use of visual aids. Cultural/linguistic considerations should be included and family, friends and carers of the person being assessed should be used to assist the process. In order to demonstrate "understanding" a person needs to understand the nature of the decision, the reason why it is needed and to have an element of foresight about the likely effects of making or not making the decision.

b) Retain the information

Information need only be held in the mind of the person long enough to make the decision. The Code of Practice gives examples of how to help people retain information for longer (MCA Code 4.20).

c) Use or weigh the information

Some people can retain and understand the information but an impairment or disturbance in functioning - such as psychosis - stops them from using it. The inability to use the information has to be the result of the disorder not a lack of agreement with or trust in the decision makers. The person must be able to consider and balance the arguments for and against a proposed action and weigh up the likely consequences before making a decision.

d) Communicate the decision in any way

The Code of Practice gives examples of how people should be helped to communicate "in any way" (MCA Code 4.24). Assessors should consider using specialist workers to assist in communication i.e. for people with sensory impairment.

General Notes

- The answer NO to any of the questions in part 2 of the test indicates that the person lacks capacity in relation to that decision.
- The Act requires “reasonable belief” of the assessor that a person lacks capacity in relation to a decision.
- Decision makers/practitioners need to be able to identify objective reasons why a person lacks capacity based on the above test.
- Decision makers/practitioners should take care to sign and date the assessment and record the time by the 24 hour clock.

3. BEST INTERESTS

Once a person is assessed as lacking capacity to make a decision the Act requires the decision maker to make a “best interests decision” on their behalf. The decision maker is the person who would undertake the act in connection with care or treatment. This could be a different person in relation to each decision (see MCA Code 5.8 – 5.12). The Act provides detailed rules on determining Best Interests and there is commentary in the Code of Practice (Chapter 5). This Policy and Procedure provides specimen Best Interests checklists for use by “decision makers”, to guide them through the key statutory criteria and to act as a record that employees are reasonably acting in the best interests of vulnerable people.

3.1 Best Interests Check List

See **Appendix 3 and 4** for specimen checklists. A checklist should be used as a guide to the statutory best interests indicators. It should be used to guide best interests discussions and evidence of those discussions should be recorded in patient/ service user notes. As a minimum there should be evidence of the following:

How the decision was reached.

What the reasons for that decision were.

Who was consulted in relation to the decision?

4. REFERRAL TO IMCA (INDEPENDENT MENTAL CAPACITY ADVOCATE) SERVICE

The Act places a legal duty on local authorities and the NHS to refer a person to an Independent Mental Capacity Advocate Service in certain circumstances in order to support vulnerable people who lack capacity to make important decisions. IMCAS must be involved when a person has been evidenced as lacking capacity in relation to important decisions about treatment and about longer periods of accommodation in a hospital or care home. IMCAs may also be involved in some other cases where decisions with serious implications need to be made and when they have no family, friends or carers.

4.1 Referral Criteria for Nottingham City & Nottinghamshire IMCAs

- Referral to be made only by relevant "decision maker" i.e. a qualified member of local authority-employed health and social care staff or by qualified staff employed by an NHS body.
- The person must lack capacity for the required decision as evidenced by use of the Two Stage Capacity Test.
- The Person should be ordinarily resident in Nottingham City or Nottinghamshire County or be living in a residential unit or be an in-patient in an NHS hospital situated in that area.
- The proposed serious decision about treatment is not psychiatric treatment for a person currently detained under The Mental Health Act (1983) or accommodation arranged under the MHA Section 7
- An IMCA should be involved in a decision about ECT in a non – detained patient who may lack capacity and is where there is no one appropriate to consult.
- That person has no relative, friend or carer (someone not paid to care), Lasting Power of Attorney (Section 40 of the MCA allows for an IMCA to be involved in decisions about any matters that may not be covered by LPAs with specific remits), Enduring Power of Attorney, Deputy or individual nominated by the person lacking capacity who is appropriate to consult in determining the person's best interests. (note relatives and carers considered by decision makers as not appropriate to consult might include: relatives permanently living abroad and cases where adult protection issues have been raised. If family and friends disagree with the decision maker, that does not automatically mean they are "not appropriate to consult". Decision maker judgement is the arbiter of "appropriateness".
- The person must be facing one of the decisions described in 4.2 below.

4.2 Decisions where a Person <u>must</u> be referred to an IMCA

- Where an NHS body is proposing serious medical treatment or proposing stopping or withholding serious medical treatment.
- Where an NHS body proposes to provide accommodation in hospital for a period of more than 28 days or in a care home for more than 8 weeks.
- Where an NHS body proposes to change a person's accommodation to another hospital or care home for a period of more than 28 days in hospital or 8 weeks in a care home.
- Where a local authority proposes to provide or to change residential accommodation for more than 8 weeks continuously.

4.3 Optional Decisions where the Local Authority and the NHS have powers to involve an IMCA which should be considered on a case by case basis.

In the Local Authority, a person at team manager level would authorise these referrals. Staff at ward manager/community team manager level would authorise these referrals in the health sector. Decision makers would consider individual cases.

4.4 Safeguarding (Adults who lack capacity)

Eligibility:

Person alleged to be at risk of abuse or neglect must formally lack capacity in relation to serious decisions about their own well-being and safety; OR The potential/alleged perpetrator of abuse or neglect lacks capacity in relation to serious decisions about their behaviour, and where serious harm has been alleged.

Where formal safeguarding measures are being put in place in relation to the protection of vulnerable adults from abuse.

Where there is a serious exposure to risk

Risk of death
Risk of serious injury or illness
Risk of serious deterioration in physical and mental health
Risk of serious emotional distress

In addition the individual lacking capacity must be over 18. Safeguarding situations are the only circumstances where an IMCA may be involved even if the individual has family and friends representing his/her interests. If there is an LPA in place and there is a reasonable belief that the LPA is not acting in the best interests of the person then an application to the Court of Protection should be made for a best interests decision or for displacement of the LPA before an IMCA is instructed.

4.4.1 At what point should an IMCA become involved In Safeguarding Adults Decisions?

Where the early indications of the case point to life-changing implications or serious exposure of risk and where consultation with family is compromised by the reasonable belief that they would not have the person's best interest at heart.

Where there is a challenge to the protection plan or conflict of interest between the responsible authority and the person or conflict of interest or views between the decision makers about the best interests of the person.

Consideration should be given as to the most appropriate time to instruct an IMCA. In some cases it would be appropriate to involve them at the strategy/discussion/meeting stage. This would need to happen for cases when the individual's wishes would have a significant impact on the investigative process or where immediate actions needed to be taken to safeguard the individual. In other cases it may be more appropriate for an IMCA to become involved at The Adults Safeguarding Meetings and subsequent reviews so that they can input into the

safeguarding plan. Involvement of an IMCA should be reviewed once the specific decisions that prompted their original referral have been resolved.

There is a serious review process available through the Adult Safeguarding Boards for cases that require oversight.

4.5 Access to Records

All Health and Social Care staff need to be aware that IMCAs have statutory right of access to and copying of records that the record holder believes to be relevant to the decision. Decision makers and practitioners should be prepared to give access to files and notes but only to relevant information to the decision. Those responsible for service user records should ensure that third party information and other sensitive information not relevant to the decision at hand remains confidential.

Following referral and IMCA involvement and IMCA report, the referrer (both NHS and Local authority), will be expected to communicate the outcome of the case to the IMCA service.

4.6 IMCAs and the Deprivation of Liberty Safeguards (Mental Capacity Act 2005)

There is a separate role for IMCAs in regard to the Deprivation of Liberty Safeguards. Refer to the Nottinghamshire Multi – Agency Policy & Procedure on the Deprivation of Liberty Safeguards for details.

5. CONFIDENTIALITY, DISCLOSURE AND CONSULTATION

Health and social care staff are expected to work within the five principles of the Act to maximise people's ability to consent to disclose information.

Health and social care staff may only disclose information about somebody who lacks capacity to consent to disclose when it is in their best interests to do so (MCA Code 5.56 and Chapter 16) or when there are other lawful reasons to do so. The Data Protection Act 1998 and the common law duty of confidentiality principles are relevant. Each agency must abide by their confidentiality policies and procedures.

LPAs and court deputies can ask to see information concerning the person so long as the information applies to the decisions for which the attorney or deputy has legal authority. The Code gives guidance about requests for limited information not requiring formal processes but they must also respect confidentiality. Any more detailed requests should be in writing (paragraphs 16.9 -16.18).

The Public Guardian or Court of Protection visitor is allowed to examine and take copies of all relevant health, local authority social care, or care records.

IMCAs are allowed to examine and take copies of health, local authority social service or care records that the record holder thinks may be relevant to the IMCAs involvement – and the specific decision.

People who lack capacity for certain decisions may have the capacity to agree to someone seeing their own personal information or indeed see their own information. Even if they do lack capacity to give such consent, a deputy or attorney could see their personal information if it is in their best interests and relates to their legal authority.

6. LIABILITY, CONVEYANCE, AND STAFF PROTECTION FOR ACTS DONE UNDER SECTION 5 MCA

6.1 Liability

Section 5 of the Act (Acts in Connection with Care and Treatment) indicates that decision makers i.e. staff and carers must:

Act within the Five Principles of the Mental Capacity Act (see 1.4 above).

Take “reasonable steps” to ascertain whether a person lacks capacity to consent to the act.

Have a reasonable belief that the person lacks capacity to make the specific decision.
Ensure that the proposed act does not contravene the authority of a registered LPA or deputy who has the appropriate decision making authority, or a valid and applicable advance decision to refuse treatment.
Act in the best interests of that person.

This protection is for undertaking acts without the consent of a person who lacks capacity in relation to that act and does not protect against the consequences of civil liability for loss or damage or negligence - either in carrying out a particular act or by failing to act where necessary.

Most decisions or acts will not require extensive paperwork to be completed – so long as carers and decision makers:-

a) can give clear, objective reasons why they had a reasonable belief that someone may lack capacity and

b) how they considered all the relevant circumstances that led them to have reasonable grounds to believe they acted in the person’s Best Interests.
Care plans should provide evidence of use of the two stage test and best interests checklist in order to allow other staff to carry out day to day acts of care or treatment under reasonable belief that the person lacks capacity. The Care Plans should include running records that are up to date. This is to evidence an audit trail of decision making.

6.2 Change of Residence

Chapter 6 of the Code of Practice (6.8 – 6.14), gives detailed guidance. Health and Social Care staff must follow the Act’s principles, complete the Two Stage Capacity Test and Best Interests checklist, and record these according to their agency

requirements. A referral to an IMCA must take place if the referral criteria are satisfied.

The Mental Capacity Act (Section 6) provides clear limits to the use of force or restraint, for example when helping someone move. If the process of transportation to a care home or hospital may amount to deprivation of liberty, further authorisation may be required (Refer to Multi – Agency Deprivation of Liberty Policy and Procedure for guidance).

If there is a serious disagreement in a complex situation and all avenues such as an IMCA referral and case meetings have been tried, a referral to the Court of Protection for a Best Interests decision may be necessary.

6.3 Restraint

The Act defines restraint as a situation when a person "uses, or threatens to use, force to do an act which the person resists "or when a person "restricts the liberty of movement of someone who lacks capacity whether or not the person resists". Restraint could take the form of:

Physical intervention: one or more members of staff holding or moving someone, or blocking their movement to stop them from leaving.

Physical restraint: stopping an individual's movements by the use of equipment (e.g. bed rails, belts and tables).

Denial of practical or staff resources to manage daily living: such as not taking people to the toilet, removing or not answering the call bell.

Environmental restraint: managing the environment to restrict free movement, e.g. by locks or complicated keypads.

Chemical restraint: the use of medication to restrain; this could be regularly prescribed medication, medication prescribed to be used 'as required', over-the-counter medication, or illegal drugs.

Electronic surveillance: close circuit television, electronic tagging, pressure pads and door alarms may be used to monitor and subsequently control people's behaviour.

Medical restraint: fixing medical interventions, such as drips, so that the individual cannot remove them.

Forced care: restraining a resident so that personal care may be carried out, forced feeding or making people take medications.

Taken from: CSCI Report: 'Rights, risks and restraints: an exploration into the use of restraint in the care of older people'. http://www.csci.org.uk/PDF/restraint.pdf

Section 6 (1) of the Act does not permit restraint unless there is reasonable belief that it is necessary to prevent harm and that the restraint used is proportionate to the likelihood and seriousness of harm *to the person who lacks capacity.* The Code of

Practice (6.11, 6.39 -6.48), gives examples and further guidance. The emphasis of the guidance falls on the person carrying out the restraint (or authorising it) to identify the reasons to justify it, i.e. if the person would suffer harm unless they were restrained in some way. The Act does not authorise restraint to prevent harm coming to other people who might be injured by the person without capacity, but staff may still have a duty of care to these others. Restraint under the common law may be justified in these circumstances.

Appropriate use of restraint falls short of deprivation of liberty**.** However, where the restriction or restraint is ***frequent, cumulative and ongoing,*** then care providers should consider whether this has gone beyond permissible restraint. Restriction of liberty even though it has been agreed to be in the person's best interests may still amount to deprivation of liberty. If this is unavoidable, further authorisation must be obtained.

Deprivation of Liberty under the Mental Capacity Act can only occur if:

The Court of Protection authorises it (s 16) *or*

Authorisation has been granted by a Supervisory Body under the Deprivation of Liberty Safeguards procedures (or urgent self authorisation granted by the managing authority pending assessment by the Supervisory Body) (Schedule A1) *or*

The deprivation of liberty is necessary to provide *emergency* medical treatment AND an order is being sought from the Court of Protection (s 4B).

Refer to the Deprivation of Liberty Safeguards Code of Practice and the Multi – Agency Deprivation of Liberty Policy and Procedure for detailed guidance.

6.4 Transport

Informal Carers can convey a person as long as they have taken reasonable steps to ascertain that the person lacks capacity to agree to be conveyed and that it is in their best interests to be conveyed.

Health and social care decision makers, police and ambulance personnel need to have evidenced that they have taken reasonable steps to ascertain capacity to consent to conveyance and best interests to do so unless in cases of urgent necessity. In general there is no impediment in law to conveying people who lack capacity as long as it is done to prevent harm and that it is proportionate to the seriousness of harm.

People cannot be transported for treatment if they have made a valid and applicable advance decision to refuse that treatment.

Health and safety considerations, lone working, insurance provision and appropriate risk assessments continue to have primacy when transporting vulnerable people.

The following considerations should be included:-

In general an incompliant person not capable of consenting to be conveyed should not be moved in a workers own car without a strong rationale to do so, and not without an accompanying robust risk management plan. Other workers may also need to travel in the car to provide additional safeguards. This especially applies to moving vulnerable people into care homes or hospitals. Moving someone to view a care facility or visit a day centre for example may require a less stringent series of safeguards as the implications of the decision are less serious.

Local Authority and NHS transport providers should request evidence of a capacity assessment and best interests checklist as part of their referral information for conveying vulnerable people, especially between residential homes and between hospitals for example.

Police or ambulance staff moving a person lacking capacity to consent may do so if they have a "reasonable belief" that the person lacks capacity and should be moved in their best interests.

Guidance on authority to convey the person to the place at which they are authorised to be deprived of their liberty can be found in the Multi Agency DOLS Policy.

6.5 Urgency

In the case of urgent medical treatment, decision makers should act in the person's best interests unless they are aware of clear reasons why the treatment or care should not be given in those circumstances (such as a valid and applicable advance decision to refuse treatment see MCA Code 6.35, 6.37). If there is doubt as to whether a valid and applicable advance decision exists, treatment may be given whilst awaiting a ruling from the Court.

7. ADVANCE PLANNING

7.1 Advance Decision to Refuse Treatment (ADRT) (MCA Code Chapter 9)

A person who is over 18 years of age and who has capacity to make the decision can specify what medical treatments they would refuse in the future should they lack capacity. The person must specify the treatment that is to be refused and the circumstances of that refusal.

Advance Decisions relate to refusal of medical treatment rather than social care. They are not demands for treatment nor can they be used to refuse 'basic care' such as being kept clean or free from pressure sores.

There are distinctions between advance decisions to refuse treatment (which could be made verbally) and advance decisions to refuse *life-sustaining* treatment (which are subject to strict requirements).

If the advance decision is in relation to *life sustaining* treatment:

It must be in writing - it must be signed by the maker (or another in the maker's presence and that signature witnessed).

It must be witnessed.

It must contain a statement confirming that the decision is to apply to that treatment 'even if life is at risk'.

There is no statutory format for an advance decision – it is the *content* that is vital – not the appearance – but Nottinghamshire health and social care staff can access a blank ADRT form on www.adrtnhs.co.uk

Advance decisions to refuse treatment must be recorded in Health and Social Care records when they are received by health and social care decision makers. An advance decision can be withdrawn or altered at any time whilst the person has capacity.

A valid and applicable advance decision to refuse treatment will be binding on decision makers and treatment cannot be given (Note: exceptions when the treatment is for a mental disorder and the patient is detained under the Mental Health Act 1983 – see below).

The East Midlands Ambulance Service has agreed a 'Registration of End of Life Care Decision 'protocol with an accompanying 'Clinical Guidance Bulletin'. See their website www.emas.nhs.uk for more details.

7.2 Statements of wishes & feelings (MCA Code 5.40 – 5.45)

The Act requires decisions to be taken in a person's best interests. This includes taking into account any relevant written statement that the person may have made when they had capacity.

These can cover a wide range of preferred treatments or ways in which people would prefer to be cared for if they lose capacity. They enable views and preferences on a range of healthcare, treatment, social care and personal issues to be recorded and taken into account when subsequent decisions are being made on behalf of that person should they lose capacity to make these decisions for themselves.

Staff should consider adding a "planning ahead" element to user/patient reviews e.g. Care Programme Approach reviews. A person's capacity at the time to make the decision must be supported and aided as much as possible.

Evidence of statements of wishes and feelings (verbal or written) must be recorded in Health and Social Care records when they are made by the service user.

Although these general wishes must be taken into account by those providing care and treatment in the future when working out best interests, they are not legally binding. If a person has made a written statement and the decision maker has not been able to follow it, the decision maker must record the reasons why (MCA Code 5.43).

7.3 Lasting Power of Attorney (MCA Code Chapter 7)

An individual over 18 years old who has capacity (the donor), can appoint someone else (the donee) to make decisions on their behalf.

A Personal Welfare Lasting Power of Attorney enables decisions to be made regarding health and welfare such as personal care and medical care.

A Property and Affairs Lasting Power of Attorney enables decisions to be made regarding finance and property.

A donor can appoint one or more person to have Lasting Power of Attorney,

The donee of the LPA must be consulted by decision makers as part of best interests decision making (MCA Code 7.25). *Nevertheless, it is very important to recognise that the donee may have the decision making power in relation to the issue. Personal Welfare Attorneys may only make decisions when the donor lacks capacity to make the decision.* The donee of a Personal Welfare LPA may have authority to refuse life sustaining treatment if that has been specified explicitly within the LPA document. All Lasting Powers of Attorney MUST be registered with the Office of the Public Guardian in order for the donee to have any authority to act on behalf of the person. It is important to have sight of the original document (copies are not acceptable) or to confirm with the Office of the Public Guardian to establish the extent of the donee's decision making ability.

JRH Support will make reasonable efforts to ascertain whether an LPA is in place for patient/users to whom they are offering a service and whether a statement of wishes & feelings or valid and applicable ADRT is in place. The Office of the Public Guardian can be contacted on 0300 456 0300 by decision makers who need to check that an LPA is registered. The individual organisation's safeguarding lead or equivalent should also be contacted in the event that decision makers have legitimate concerns about the conduct of (*not* merely disagreement with) the person acting as the LPA.

8. DISPUTES

The Code of Practice (Chapter 15) gives general guidance on how to resolve disputes and conflicts about issues of capacity. The Court of Protection is the final arbiter on matters of capacity but Local Authority and NHS staff should seek local resolution of disputes/concerns/challenges rather than risking expensive legal processes. In the first instance the relevant line-manager should provide an overview and support to resolve disputes. If this is unsuccessful then the relevant Local Authority or NHS Service Head/Service Manager will convene a case review and reconciliation process with help from the respective legal section. Differing agencies should have regard to their own dispute and reconciliation procedures.

8.1 Notification

Disputes and challenges about IMCAs will go first to the relevant advocacy organisation internal reconciliation process then if unresolved to the individual agencies complaints and legal processes. The Nottinghamshire IMCA steering group should be notified of any such disputes. For Nottingham City residents this would be the Commissioning Officer, Nottingham City Council (Older Persons). For Nottinghamshire County residents, the Service Manager Mental Health, County Hall.

9. FINANCE

9.1 Appointees

The Department for Work and Pensions (DWP) can appoint someone (an appointee) to claim and spend benefits on a person's behalf if that person:

- Gets social security benefits or pensions
- Lacks the capacity to act for themselves
- Has not made a property and affairs LPA or an EPA, and
- The court has not appointed a property and affairs deputy.

The DWP checks that an appointee is trustworthy. It also investigates any allegations that an appointee is not acting appropriately or in the person's interests. It can remove an appointee who abuses their position. Concerns about appointees should be raised with the relevant DWP agency. (MCA Code 14.36)**.**

9.2 Personal Budgets and Direct Payments

Self Directed Support/Personalised Plans and people who lack capacity

Both Self Directed Support and Person Centred Planning have values that link closely with the MCA, around communication, enabling decision making and promoting choice. The person centred thinking tools can be helpful in ensuring that the person is as involved as possible with decisions surrounding personal budgets and self directed support, particularly when the person does not have capacity to make decisions in specific areas.

The Mental Capacity Act states that involvement should continue even if the person does not have the capacity to make the decision. This means that although they may not be able to make the overall decision, they may be able to make smaller decisions that are part of the overall decision. For instance, someone may not have capacity to make a decision about what support provider they want but they may be able to tell you (through their words or behaviour) that they prefer female staff to male staff. This information must *always* be taken into account when supporting someone to develop their support plan and arrange support. Tools such as **Good Day Bad Day** and **Important to and for** can be used to gather more information. It is important also that any statement that the person has made should be used to support best interest's decision making where a person lacks capacity.

The Self Directed Support/Personal Budget process for people who lack capacity:
Initial assessment should identify at an early stage where capacity is in doubt and this should be further explored as part of the Self Assessment Questionnaire (SAQ). The SDSA includes a section which identifies how capacity issues were managed during the assessment, for example what steps were taken to try to enable the service user to make decisions. It also identifies the sections of the assessment where" best interest" decisions have been taken on behalf of the service user who lacks capacity.

The above information should be explored as part of the Self Assessment Questionnaire and recorded in the outcomes boxes and the support plan should evidence how we are taking into account the views of the person when they lack capacity.

If a person has fluctuating capacity, a **Decision Making Profile** may enable us to explore how best to support the person in decision making. This information should then be used to inform when and how we support the person with the SAQ and support plan.

It is particularly important for people who lack capacity that we continue to learn about what is important to them on an ongoing basis after the implementation of support services. This information can then be used to inform reviews and update support plans. **Learning Logs** are a useful tool to promote ongoing learning and may be a useful tool to complete when supporting someone who has a personal budget.

Direct Payments:

Someone who has eligible needs but who lacks capacity to consent to direct payments can still receive them. An assessment of capacity should be undertaken to establish this. Local Authorities can then make direct payments to a person who lacks capacity but via an appropriate and willing 'suitable person' who can receive it on their behalf.
Further advice and Guidance is available in the Department of Health Document "Guidance on direct payments - For community care, services for carers and children's services". Published in September 2009 or go to:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_104840

9.3 Paying for goods and services:

Paid care staff and other carers may have to make decisions about the person's money in some circumstances e.g. pay for a hairdresser or house repairs. This kind of payment for necessary goods and services on behalf of a person who lacks capacity is permissible under sections 5 and 8 of the Mental Capacity Act.

Decisions that need to be made about financial issues need to follow the best interests principle.

It is important to consider what are 'necessary' goods and services to the person; suitable for the person and their requirements (6.58)

The carer must take reasonable steps to check whether the person can make the payment themselves or has capacity to consent to the carer to doing it for them (6.61)

Bills, receipts and proof of payments should be kept. This is particularly true for those who are in care homes or who receive domiciliary care.

However, this does not give access to a person's income, assets or allow the sale of property. This is only possible through **formal legal authority**; a court order, a Lasting Power of Attorney responsible for the person financial affairs or a deputy appointed by the Court of Protection (MCA Code 6.56 – 6.66).

9.4 Access to a person's assets

9.4.1. Property and Affairs LPAs (MCA Code Chapter 7)

Once an LPA is registered with the Office of the Public Guardian, the Attorney may make any decisions authorised in the instrument about the person's financial affairs even where the person still has capacity but has agreed for this to happen. This is different to the Personal Welfare LPA where the LPA can only make a decision on behalf of a person who lacks capacity and where they have that decision making ability.

Following registration the attorney can then manage the donor's financial affairs in line with the powers given in the LPA. There may be restrictions or conditions on the way the LPA can manage an account as attorney.

9.4.2. Enduring Power of Attorney (EPA)

An EPA will have been created prior to October 2007 but is similar to an LPA in that the Attorney may make any agreed decision about the person's financial affairs even where the person still has capacity but has agreed for this to happen. When the person" is or is becoming incapable of managing […] their affairs" the Attorney must register it with the Office of the Public Guardian (MCA Code 7.5). There are different rules that apply to LPAs and EPAs. Whilst existing EPAs are still valid, only LPAs can be made following the introduction of the Mental Capacity Act.

9.4. 3. Property and Affairs Deputies

The Court may appoint a deputy to manage a person's financial affairs if the person lacks capacity to make decisions about their property or finances and they have not made an EPA or LPA.

Applications to the Court are necessary for this to happen (see below).If appropriate, an applicant may be nominated by the Local Authority Corporate Director (Court Deputy) or NHS equivalent to be appointed by the Court of Protection as a Deputy (MCA Code 8.35 – 8.37).

10. THE COURT OF PROTECTION and OFFICE OF THE PUBLIC GUARDIAN (MCA Code Chapter 8)

10.1

The Court of Protection is based in London but may hear cases in regional courts. The Court may appoint Deputies who will make decisions on finance matters for persons lacking capacity. In exceptional cases they may appoint deputies for health and welfare matters to make decisions about ongoing complex care decisions. These would usually be family members or could be Local Authority employees or the existing Deputy.

The Court of Protection has a dedicated customer enquiry service. For any queries relating to applications to the Court of Protection or to request Court of Protection forms, call 0300 456 4600 or email courtofprotectionenquiries@hmcourts-service.gsi.gov.uk

10.2

The Office of the Public Guardian regulates Deputies and Lasting Powers of Attorney.

The OPG can be contacted on 0300 456 0300 or email at:
customerservices@publicguardian.gsi.gov.uk

11 CHILDREN (MCA Code Chapter 12)

Note: The term “children” is used for people under the age of 16, and “young people” for those aged 16 and 17.

11.1 The MCA and children under 16

In most situations the care and welfare of children under 16 continues to be dealt with under the Children Act 1989.

There are two parts of the MCA that apply to children under 16:-

. The Court of Protection’s powers to make decisions concerning the property and affairs of a child under the age of 16. The Court can make these decisions where it considers it likely that the child will lack capacity to make decisions about their property and affairs even when they are 18. This could be useful as it means there will be no need for new proceedings once the young person reaches adulthood: the arrangements made for them as a child can continue smoothly past the age of 18.

. The criminal offence of ill treatment or neglect also applies to children under 16 who lack capacity because of any impairment or disturbance in functioning in the mind or brain as no lower age limit is specified for the victim. It remains to be seen whether there will be any advantages in prosecuting someone under this law rather than under existing laws used to protect children.

Care and treatment of children under 16 is governed by common law principles (known as *Gillick* competence or Fraser Guidelines), the Children Act 1989, and where appropriate, the Mental Health Act 1983 (as amended).

11.2 The MCA and young people of 16 and 17

Most of the provisions of the MCA apply to young people once they are 16.

There are exceptions and the following parts of the MCA **do not apply to 16 and 17 year olds**, but only to people who are 18 and over:-

Making a Lasting Power of Attorney

Making an advance decision to refuse treatment

Making a will. The law generally does not allow people under 18 to make a will and the MCA confirms that the Court of Protection has no power to make a will on behalf of anyone under 18.

The Deprivation of Liberty Safeguards procedures apply only to those over 18.

The Code of Practice provides guidance on acts of care and treatment for young people who lack capacity to consent as well as background guidance about care and treatment for competent young people.

11.3 Young People who will need an Independent Mental Capacity Advocate (IMCA)

Young people aged 16 and 16 must be referred to the IMCA service if they:

- Lack capacity in a relation to a decision
- Are facing major or life changing decisions as defined in the IMCA guidance in this policy and
- Have no family member, friend or existing advocate who can support them in making a decision in their best interests
-

11.4 Young people who already use an Advocacy Service

Some young people, who lack capacity, and who have no family or friends able to support them appropriately, will often already be using an advocacy service. Many of these young people either will be Children in Need or will be Looked After.

Local Authorities have a duty to provide an advocacy service for all children and young people looked after, in need and in receipt of After Care (Adoption Act 2002 amendment to Children Act 1989). In addition, all children looked after who do not have regular contact with their parents will have an independent visitor. It will remain within the judgement of the decision maker, to decide on a case by case basis, whether the connection with these advocates is sufficiently robust to constitute an appropriate support or an otherwise unsupported young person facing the sort of decisions that might require an IMCA.

Should an IMCA be required then the IMCA will be provided by the local authority approved IMCA service.

11.5 Transitions

Transitions staff should act with regard to the five principles of the Act and Chapter Twelve of the Code of Practice when helping young people to prepare for transition into adult services and plan for their future.

11.6 Working with parents who may lack capacity

Health and social care staff working with children and young people whose parents may lack capacity in relation to important decisions will need to be aware of the principles of the Act and the Code of Practice. They may consider that the parents will need additional help to make decisions or have decisions made for them in their best interests.

12. INTERFACE WITH THE MENTAL HEALTH ACT 1983 (as amended).

12.1 General

In general, treatment of detained people under Part 4 of the Mental Health Act 1983 takes precedence over the Mental Capacity Act. However if a person is subject to the Mental Health Act, there should be no assumption that they lack capacity and those who do lack capacity do not stop being under the protection of the Mental Capacity Act. An example would be that if the person required treatment for a physical condition not related to their mental health such as diabetes, then the principles, sections and guidance of the Mental Capacity Act should be followed.

12.2 Guardianship

If a person lacks capacity to make a decision, in general a decision maker can use the Mental Capacity Act and in particular the protection from liability provided by section 5 so long as all relevant safeguards are followed. In some circumstances the person may respond to the authority of the Guardian under the Mental Health Act and therefore be more willing to comply with any necessary care or treatment or Guardianship may confer greater safeguards of independent review for the person.

Generally, decisions about residential care where the person lacks capacity can be also carried out on the basis of section 5, or the decision of an attorney or deputy. Guardianship may be more appropriate where:-

It is thought necessary in the interests of the welfare of the patient or for the protection of others to reside in a named place.

And particularly when decisions are best placed in the hands of one person or authority.

If the decision is very complex and there are different and closely balanced views, a best interests decision from the Court of Protection may be preferable.

Note – Guardianship does not confer any power to deprive a person of their liberty. If Deprivation of Liberty is an issue for a person who lacks capacity and is subject to Guardianship, then appropriate authorisation must be obtained using the Deprivation of Liberty Safeguards procedures.

12.3 Detained Persons

- The treatment provisions of Part 4 of the Mental Health Act take precedence over the MCA in relation to treatment for mental disorder. (This applies where the patient is detained under the longer term sections such as s 2 and s 3). Part 4 does not apply to the short term sections (or to s.35). The Mental Capacity Act could be used to treat a person who lacks capacity in their best interests who is detained under the shorter term sections of the MHA (Section 4, 5(2), 5(4), s7, s 135, and s 136) or s.35.

- Advance Decisions to Refuse Treatment that are applicable & valid still apply unless they relate to medical treatment for *mental disorder* following detention under the MHA when the MHA takes precedence. Note that the Mental Health

Act has been amended to enable refusal of Electro Convulsive Therapy by a detained patient who has capacity. A patient who now lacks capacity may have made a valid and applicable advance decision when they did have capacity to refuse ECT. The provisions of Section 58A of the Mental Health Act are applicable.

- Second Opinion Appointed Doctor provisions apply under the MHA. A SOAD will consider the validity and applicability of any advance decision to refuse treatment relating to ECT.

- For detailed guidance on all of the treatment provisions relating to mental health patients see the Mental Health Act Code of Practice Chapters 23 and 24

- An IMCA is not required for formal admissions to hospital under the MHA or to a care home under Guardianship or Section 17 leave including Community Treatment Orders. An IMCA can be instructed in relation to a detained patient if that detained patient lacks capacity and the decision is in relation to serious medical treatment for a physical condition or a change of accommodation in relation to s117 aftercare.

- 'Nearest Relative' powers remain and are distinct from LPA or Deputy authority.

- A person who is a Personal Welfare Attorney may apply to a manager's panel or tribunal on behalf of a detained patient, and may refuse Electro Convulsive therapy on that patient's behalf.

12.4 Non-detained people in mental health hospital wards

- The MCA applies to the care of a patient who lacks capacity in this setting. Care cannot conflict with the valid authority of an appropriately authorised LPA or Deputy or a valid and applicable ADRT.

- IMCA provision may apply.

- A person lacking capacity who is not objecting and who is or may be deprived of their liberty can only be deprived of their liberty without recourse to the Mental Health Act if prior authorisation from the Court of Protection is received, in an emergency to give life sustaining treatment while awaiting a ruling from the Court of Protection, or by using the Deprivation of Liberty Safeguards procedures. This may require either urgent self authorisation by the Managing Authority together with a request to the relevant Supervisory Body for authorisation.

The MCA cannot be used as an alternative mode of admission where the criteria for the MHA apply i.e. when the patient objects or where, from knowledge of the patient, it is likely that the person would object if they had capacity.

12.5 Persons under a Community Treatment Order:

- A person who is subject to a Community Treatment Order who is recalled to hospital comes under the provisions of Part 4 of the Mental Health Act (as above).

- A person who has not been recalled but lacks capacity to consent to treatment may be treated under part 4A of the Mental Health Act. This is the case unless treatment would conflict with an advance decision made by the patient, or the views of an Attorney with appropriate authority, Deputy, or the Court of Protection.

- For detailed guidance on all of the treatment provisions relating to mental health patients see the Mental Health Act Code of Practice Chapters 23 and 24.

13. DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

13.1

The DOL Safeguards, which relate to people who lack capacity and who are being or may be deprived of their liberty came into effect in April 2009. There is a DOL Safeguards Code of Practice which covers this complex area. There is also a separate Nottinghamshire Multi – Agency Policy & Procedure relating to the Deprivation of Liberty Safeguards which should be read in conjunction with this Policy and Procedure.

14. RECORDING

14.1

When staff undertake an assessment of capacity, the outcome and evidence should be recorded. Any staff who need to make a decision in a person's best interests should consult the best interests checklist and record as a minimum:

- How the decision was reached
- What the reasons for reaching the decision were
- Who was consulted
- What particular factors were taken into account

(MCA Code 4.61, 5.13, 3.15)

14.2

General statements of wishes and feelings must be recorded in the person's records and practice notes during all decision maker contacts with people across all fields in health and social care.

Where it is known that an individual has made an advance decision to refuse treatment, this must be recorded in the person's notes together with evidence of a clear and up to date care plan of action relating to that advance decision

Consultation with LPA and deputies must be recorded.

Consultations and efforts to engage people in decisions should be adequately documented.

IMCAS and those authorised by the Court of Protection must have access to all relevant documents.

15. Criminal Offence

The Act contains measures creating the criminal offences of wilful neglect or ill treatment of a person lacking capacity (section 44) which apply to anyone responsible for a person's care, donees of LPAs or EPAs, or deputies appointed by the Court who are caring for a person who lacks capacity. On conviction the offender is liable to imprisonment (maximum sentence 5 years) and/or fine. Concerns relating to these offences should be referred under the local Safeguarding policy.

www.safeguardingadultsnotts.org