NHS Lincolnshire

Mental Capacity Act [2005] Policy

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NHS Lincolnshire

Mental Capacity Act [2005] Policy

Version Control Sheet

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
1				
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	Contents page	Amended contents page to comply with new format	July 2009	Maureen Catterson
	Consistency in use of terminology in relation to NHS Lincolnshire and Lincolnshire Community Health Services	Throughout document	April 2009	Maureen Catterson
	Consistency in reference to other sections and appendices to document	Throughout document		
	1.3	Reference to whom policy applies to		
	2.4	Reference to Quality Impact Assessment		
	3.1	Omission of reference to Learning Disabilities		
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	6.5	Amended to read as the person's condition changes'		
	7.2	Amendment to page no.		
	7.4	Timescale omitted		
	8	IMCA written in full		
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	9.5	Correction to contact details		

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
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	13.1	Amended to read Section 5 and change in use of language – cot sides to bed rails		
	13.4	Subsection omitted		
	14	Inclusion of section on Deprivation of Liberty Safeguards. All further sections consequently have section numbers amended		
	15	Title amended to reflect change of name		
	15.1	Link to web site included		
	15.6	Amended to reflect changes to the law		
	15.7	Inclusion of new subsection to reflect changes to the law		
	18.3	Amendment to the legal powers of an attorney		
	18.5	Insertion on guidance on court procedures		
	18.6	New subsection relating to Court of Protection fees and web link to information		
	19.2	Inclusion of web link to Code of Practice		
	19.3	Amended to include related reading material		
	20.2	Amendment to page no ref		
	23.2	Amendment to availability of training provided		
	23.3	Amended to reflect training relationship with DoLS		
	24.2	Inclusion of audit process by LCHS		
	25.2	Inclusion of availability of leaflets in several languages		
	26.1	Inclusion of two further relevant policies		
	27	Inclusion of references		
	Appendix 1	Addition of request for NHS No.	July 2009	Maureen Catterson

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
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	Section 1.3	Omitted: and Lincolnshire Community Health Services		
	Section 4.1	Omitted: and Lincolnshire Community Health Services Amended to read: NHS Lincolnshire		
	Section 5.2	Omitted: and Lincolnshire Community Health Services		
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	Section 22.2	Omitted: and LCHS Omitted: Managing Director Omitted: Director Lead LCHS Omitted: Associate Director, Clinical Governance and Risk. Omitted: Operational Lead LCHS		
	Section 23.1	Omitted: and LCHS		
	Section 24.1	Omitted: and LCHS		
	Section 24.2	Reference LCHS annual audit removed		
	Section 24.3	Amended to 24.2		
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Policy Statement

Background

The Mental Capacity Act 2005 (MCA) aims to clarify a number of legal uncertainties and to reform and update the current law where decisions need to be made on behalf of people who lack mental capacity. This policy should be read in conjunction with the Mental Capacity Act Code of Practice and Deprivation of Liberty Safeguards Code of Practice

Statement

The MCA introduces new statutory responsibilities which apply to everyone who works in health and social care. It includes anyone that is involved in the care, treatment or support of people over the age of 16, living in England or Wales, who are unable to make all or some decisions for themselves.

Responsibilities

Compliance with the policy will be the responsibility of the Chief Executive, Director of Quality and Involvement

Managers are responsible for ensuring staff have access to the policy and attend training.

Training

Training for front-line staff will be provided by Workforce Development and will be accessible via the training Directory on the website

Dissemination

All Directorates via my Mail and NHS Lincolnshire Website

Resource implication

As identified via risk assessments and Incident reports

1. BACKGROUND

1.1 Mental capacity is the ability to make a decision. Capacity can vary over time and by the decision to be made. The inability to make a decision could be caused by a variety of permanent or temporary conditions e.g. dementia, stroke, unconsciousness (due to an illness or treatment for it) or substance misuse.

1.2 In the past clinicians have tested a person's capacity by using a number of subjective tests taken from legal cases (the common law) where capacity has been in dispute.

1.3 The Mental Capacity Act (2005) Policy applies to staff working for both NHS Lincolnshire.

2. INTRODUCTION

2.1 The Mental Capacity Act 2005 (MCA) aims to clarify a number of legal uncertainties and to reform and update the current law where decisions need to be made on behalf of people who lack mental capacity. This policy should be read in conjunction with the Mental Capacity Act Code of Practice available online at: www.dca.gov.uk/legal-policy/mental-capacity/publications.htm and the Deprivation of Liberty Safeguards Code of Practice available online at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAnd Guidance/DH_085476 Deprivation of Liberty Safeguards Policy and Procedure; Advanced Decisions to Refuse Treatment Specialist Guidance (adult) and Safeguarding Adults Policy available on NHS Lincolnshire website

2.2 The MCA introduced new statutory responsibilities and applies to everyone who works in health and social care and is involved in the care, treatment or support of people over the age of 16, living in England or Wales, who are unable to make all or some decisions for themselves.

2.3 The MCA came into force in two stages:

Stage 1 – 1 April 2007
Introduction of new test for capacity for adults where an Independent Mental Capacity Advocate (IMCA) may be invoked
Introduction of best interest checklist for adult lacking capacity
Introduction of IMCA
New criminal offence of neglect/ ill treatment of an adult lacking capacity
Limitations regarding deprivation of liberty and restriction of movement

Stage 2 – 1 October 2007
Lasting Power of Attorney
Office of the Public Guardian
Court of Protection
Legally binding Advance Decision
Decisions which cannot be excluded

2.4 The MCA has been subject to Equality and Diversity Impact Assessment nationally by the Department of Justice which included consultation with groups in Lincolnshire. Equality and diversity is therefore implicit within the policy. An assessment of the equality impact of the Lincolnshire policy will be undertaken jointly by members of the Implementation Network.

3. THE FIVE KEY PRINCIPLES

3.1 The Act works on the basis that capacity is **decision specific** which means capacity should be determined in relation to the decision a person is being asked to make. It is very rare that a person will have no capacity for any decision making.

3.2 The MCA is underpinned by five core or key principles:

1. Presumption of capacity

A person must be assumed to have capacity unless it is established that he or she lacks capacity

2. Maximising decision-making capacity

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

3. Unwise decisions

A person is not to be treated as unable to make a decision because s/he makes an unwise decision

4. Best interests

An act done, or decision made, under the Mental Capacity Act for on behalf of a person who lacks capacity must be done, or made in his/her best interests

5. Least restrictive alternative

Before an act is done, or a decision 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.

4. WHO DOES THIS POLICY REFER TO?

4.1 This policy refers to adults and young people over 16 years old in receipt of services from NHS Lincolnshire who may lack capacity to make decision. Children and young people under 16 would be covered by the Children's Act.

4.2 A separate section which relates specifically to those aged 16-18 can be found later in the policy in section nine.

4.3 A person lacks capacity in relation to a matter if, at the material time, s/he is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

4.4 It does not matter whether the impairment or disturbance is permanent or temporary.

4.5 Lack of capacity cannot be established merely by reference to:

- a person's age or appearance, or
- a condition, or an aspect of their behaviour, which might lead others to make unjustified assumptions about their capacity.

5. WHO SHOULD ASSESS CAPACITY?

5.1 The decision as to who is the best person to assess for capacity is dependent on the decision which needs to be made. For most day-to-day decisions, such as when to get up or what clothes to wear, the carer or individual most directly involved with the person needing the care will be best placed to assess the person's capacity to make the decision at the time it needs to be made.

5.2 For more complex assessments, professionals with specific training and experience in assessing capacity may be involved. The following factors may indicate the need for involvement of a more experienced professional:

- The gravity of the decision or its consequences
- Where the person concerned disputes a finding of incapacity
- Where there is disagreement between family members, carers and/or professionals as to the person's capacity
- Where the person concerned is expressing different views to different people, perhaps through trying to please each or tell them what s/he thinks they want to hear
- Where the person's capacity to make a particular decision may be subject to challenge, either at the time the decision is made or in the future
- Where there may be legal consequences of a finding of capacity
- The person concerned is repeatedly making decisions that put him/her at risk or that result in preventable suffering or damage

In any of the above circumstances it is the policy of NHS Lincolnshire that only those staff who have completed training to assess capacity will make formal assessments.

5.3 Legal matters

In circumstances such as legal matters, e.g. making an Lasting Power of Attorney, the solicitor involved will need to decide whether or not the person has sufficient capacity to make the decision. They may ask for an assessment from a psychiatrist.

5.4 Medical treatment or examination

When consent for medical treatment or examination is required, the doctor *proposing the treatment* should decide whether the patient has the capacity to consent or refuse the treatment. It is not necessary, except in more complex cases, for a referral to be made to a psychiatrist for an assessment of mental capacity.

5.5 Care planning issues

For care planning issues, such as decisions whether or not to move into residential care, assessments can be made by social workers who have specific experience of working with people with mental ill health, and who have been trained in assessing capacity.

If the assessor is in any doubt after assessment it is entirely proper for them to obtain a 'second opinion' from other trained colleagues. Furthermore assessments can be undertaken by teams of staff if this is found to be appropriate. In all circumstances this should be thoroughly documented in the notes.

6. CAPACITY ASSESSMENTS

6.1 A capacity assessment can be triggered in one of many ways following the establishment of a need for the patient to make a specific decision, for example:

a) The person's behaviour suggests they may lack capacity
b) The person's circumstances suggest they may lack capacity
c) Someone else has raised concerns
d) There have been capacity issues previously

6.2 A capacity assessment should begin from a presumption that the person has capacity.

6.3 **The two stage functional test.**

A person will be found to be lacking capacity to make a specific decision if:

1. There is an impairment of or disturbance in the functioning of the person's mind or brain

2. The impairment/ disturbance is sufficient that the person lacks capacity to make a particular decision

Following establishment of the above the following then needs to be considered:

1. Can the person understand information relating to the decision they need to make
2. Can they retain that information long enough to make the decision
3. Can they weigh up/ use the information to make a decision
4. Can they communicate by any means their decision?

To undertake this assessment staff should use the appropriate forms which can be found in Appendix 1 of this document

6.4 Where there may be issues of equality and diversity and the person that it relates to lacks capacity, the assessment process will identify this and all relevant methods of communication and advocacy will be utilised.

6.5 The capacity assessment should be revisited regularly (as the person's condition changes) to ensure it is still relevant and valid.

7. BEST INTEREST - MAKING THE DECISION AND ANY DISPUTES

7.1 Following the capacity assessment if a patient is found to be lacking capacity the decision may be taken on their behalf – provided the decision made is in their best interest.

7.2 Staff need to justify and record this decision formally in the notes by the use of a best interest checklist which should then be inserted into the service user's health and social care information for future reference.

To make a decision on behalf of someone lacking capacity trained staff should use the best interest checklist in Appendix 2 of this document

7.3 Family and friends will not always agree about what is in the best interests of the person. If you are the decision-maker you will need to clearly demonstrate in your

record keeping that you have made a decision based on all available evidence and taken into account all the conflicting views.

7.4 If there is a dispute, the following things might assist you in determining what is in the person's best interests:

- Involve an advocate who is independent of all the parties involved (please note this is not an IMCA – see below for definition)
- Get a second opinion
- Hold a formal or informal case conference
- Go to mediation
- An application could be made to the Court of Protection for a ruling (see section 17).

8. INDEPENDENT MENTAL CAPACITY ADVOCATE

8.1 The Independent Mental Capacity Advocate (IMCA) is a very specialist type of advocate who can only be invoked when certain criteria are met.

8.2 For details on the procedure for invoking an IMCA and the criteria please see the IMCA procedure in Appendix 4

8.3 The duties of an IMCA are as follows:

- support the person who lacks capacity and represent their views and interests to the decision-maker
- obtain and evaluate information
- as far as possible, ascertain the person's wishes and feelings, beliefs and values
- ascertain alternative courses of action
- obtain a further medical opinion, if necessary.

8.4 IMCAs have the right to see medical information on the patient they are representing including health and social care notes.

8.5 However the IMCA cannot be a decision maker.

9. CHILDREN AGED 16 AND 17

9.1 The MCA applies to adults and young people aged 16 or over. For children aged 16 or under the Children Act 1989 (CA) will apply.

9.2 For those aged 16 and 17 years of age an overlap between the CA and MCA may occur and either may apply depending on the circumstances. The same procedures can be invoked e.g. Court of Protection for a person aged 16 or 17 as they would be for an adult.

9.3 However there are a number of provisions in the MCA not available to 16 or 17 year olds. These are:

- Making a Lasting Power of Attorney (see section 15)
- Making an advance decision
- Making a will

9.4 For issues around 16 and 17 year olds and consent please consult the NHS Lincolnshire Consent Policy.

9.5 For complex capacity cases it is recommended that staff contact Head Of Deprivation of Liberty Safeguards at NHS Lincolnshire on 01522 515399 and Head of Risk and Quality or Deputy for LCHS on 01522 574189. If necessary specialist legal opinion can be obtained.

10. CRIMINAL OFFENCE

10.1 Section 44 of the MCA creates a new criminal offence of wilful neglect or ill treatment of an adult lacking capacity by anyone responsible for that person's care, attorneys of Lasting Power of Attorneys or Enduring Power of Attorneys, or deputies appointed by the court.

10.2 The penalties for being found guilty of this offence range from a fine to a maximum of a five year prison sentence.

10.3 Neglect or ill treatment can include a range of circumstances such as physical abuse including assaults, deprivation, for example, of basic necessities such as food and clothing.

10.4 In all cases where there is suspicion of a section 44 offence in the first circumstance members of staff should **alert their line manager or on call manager** immediately and invoke the current **Adult Protection Procedure** which can be found on the NHS Lincolnshire website. A Trust incident form should also be completed and consideration should be given to whether it is necessary to involve the police.

10.5 On instigation of adult protection procedures a resultant investigation by social services and/or the police may follow. In all circumstances staff will be expected to fully co-operate with any internal or external investigation.

11. PART IV MENTAL HEALTH ACT 1983 (as amended by MHA 2007)

11.1 The MCA section 28 provides that the MCA does not apply to any treatment for a medical disorder which is being given in accordance with the rules about compulsory treatment as set out in Part IV of the Mental Health Act 1983 (as amended by Mental Health Act 2007).

11.2 Staff should be aware that the statutory safeguards which the Mental Health Act 1983 (as amended by Mental Health Act 2007) gives in relation to compulsory psychiatric treatment must always be afforded to those patients to whom the Mental Health Act 1983 (as amended by Mental Health Act 2007) applies.

11.3 However the above does not preclude the use of the MCA in relation to a **physical** condition. If a patient has capacity to make decisions regarding their physical welfare or has an Advanced Decision regarding physical treatment this must be upheld.

12. EXCLUDED DECISIONS

12.1 The MCA section 27, 28 and 29 lists certain decisions that can **never** be made on behalf of a person who lacks capacity. There will be no question of an attorney consenting or of the Court of Protection making an order or appointing a deputy to provide the requisite consent.

12.2 The decisions which can never be made on behalf of someone who lacks capacity are:

- Consenting to marriage or civil partnership
- Consenting to sexual relations
- Consenting to a divorce
- Consenting to the dissolution of a civil partnership
- Consenting to a child being placed for adoption
- Consenting to the making of an adoption order
- Discharging parental responsibilities in matters not relating to a child's property
- Giving a consent under the Human Fertilisation and Embryology Act 1990
- Voting at an election for any public office or referendum

13. RESTRICTION OF MOVEMENT

13.1 Section 5 of the Act makes provision for the restraint of a person providing certain criteria are satisfied. Restraint covers a wide range of actions, including the use, or threat, of force to do something that the person concerned resists - for example, by using bed sides.

13.2 If you have undertaken a capacity assessment and found the person is lacking in capacity the restraint must be in the person's best interest.

The MCA identifies two further conditions which must be satisfied in order for protection from liability for restraint to be available:

- You must reasonably believe that it is necessary to undertake an action which involves restraint in order to prevent harm to the person lacking capacity
- Any restraint must be a proportionate response in terms of both the likelihood and seriousness of that harm. Using excessive restraint could leave you liable to a range of civil and criminal penalties

13.3 Physical restraint can be used but only as a last resort. Other methods of restraint which can be used include a verbal warning, the locking of doors and chemical restraint.

14 DEPRIVATION OF LIBERTY SAFEGUARDS

14.1 The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS) came into force on 1 April 2009. The safeguards apply to people in England and Wales.

14.2 They amend a breach of the European Court of Human Rights and provide for the lawful deprivation of liberty of those people who lack capacity to consent to arrangements made for their care or treatment in either hospitals or care homes, but need to be deprived of their liberty in their own best interests, to protect them from harm.

14.3 There are certain criteria that apply to the relevant person – the person who is or who may be deprived of their liberty. A person must:

- be aged 18 or over
- have a mental disorder such as dementia or a learning disability
- lack the capacity to consent to where their treatment and/or care is given
- need to have their liberty taken away in their own best interests to protect them from harm.

14.4 The deprivation of liberty safeguards make it clear that a person may only be deprived of their liberty:

- in their own best interest to protect them from harm
- if it is a proportionate response to the likelihood and seriousness of the harm, and
- if there is no less restrictive alternative.

14.5 Primary Care Trusts (PCTs) and local authorities (designated as 'supervisory bodies' under the legislation) have statutory responsibility for operating and overseeing the MCA DOLS whilst hospitals and care homes (the designated 'managing authorities') have responsibility for applying to the relevant PCT or local authority for a Deprivation of Liberty authorisation.

14.6 The legislation includes a statutory requirement for all care homes and hospitals as well as local authorities and PCTs to keep a clear and comprehensive records for every person deprived of their liberty. This includes records of applications for authorisations, details of assessment process, information about the relevant person's representative and the documentation related to termination of authorisation

14.7 To assist with this record keeping requirement, and to ensure the administration of MCA DOLS system is as straightforward and seamless as possible, The Department of Health has developed a number of standard forms for use by both supervisory bodies and managing authorities. If used in their edited form, these forms ensure compliance with the safeguards and promote a consistent approach to record keeping. Electronic copies of all forms are available from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089772

14.8 Certain conditions must be met before a person can be deprived of their liberty. These conditions are known as 'qualifying requirements' and are undertaken by Mental Health Assessors and Best Interest Assessors. The six qualifying requirements are age requirement; no refusals requirement; mental capacity requirement; mental health requirement; eligibility requirement and best interest requirement.

14.9 The Deprivation of Liberty safeguards will be monitored by the Care Quality Commission (CQC).

14.10 For further information on NHS Lincolnshire Deprivation of Liberty Safeguards consult **NHS Lincolnshire's Deprivation of Liberty Safeguards Policy and Procedures** available from NHS Lincolnshire on their website at www.lpct.nhs.uk .

15. ADVANCE DECISIONS TO REFUSE TREATMENT

15.1 This section is designed to be a brief introductory guide to Advance Decisions to Refuse Treatment (ADRT). For more detailed information please consult the Mid Trent Cancer Network document on **Advance Decisions to Refuse Treatment, specialist guidance.** The guidance is available from www.lpct.nhs.uk

15.2 An Advance Statement is where a patient expresses a preference regarding care and treatment, for example, to be admitted to a single sex ward. It is not legally binding.

15.3 An Advance Decision is where a patient makes a decision about refusing treatment at a future time when they may lack capacity. The MCA gives legal recognition to advance decisions to refuse medical treatment but does not cover treatment when a person is detained under the Mental Health Act 1983 (see section 11).

15.4 If an advance decision relates to life sustaining treatment it must be in writing and witnessed – ideally by a carer or relative or if this is not appropriate an advocate or independent third party - but not by a member of Trust staff unless there are special circumstances.

15.5 A copy of the Advance Decision should be held on the patient's health and social care notes which should indicate on the front cover an Advance Decision is in place.

15.6 In relation to verbal advanced decisions there is no set format under MCA. This is because they will vary depending on a person's wishes and situation. Healthcare professionals will need to consider whether a verbal advanced decision exists and whether it is valid and applicable (see 15.8 below).

15.7 Where possible, healthcare professionals should record a verbal advanced decision to refuse treatment in a person's healthcare record. This written record could prevent confusion about the decision in the future. The record should include:

- a note that the decision should apply if the person lacks capacity to make treatment decisions in the future
- a clear note of the decision, the treatment to be refused and the circumstances in which the decision will apply
- details of someone who was present when the oral advanced decision was recorded and the role in which they were present (for example, healthcare professional or family member), and
- whether they heard the decision, took part in it or are just aware that it exists.

15.8 To be valid the maker of the ADRT fully understood the implications of the ADRT when it was made.

Events that would make an ADRT invalid are:

- the person withdrew the decision while *they* still had capacity to do so
- after making the ADRT the person made a Lasting Power of Attorney (LPA) giving an attorney authority to make treatment decisions that are the same as those covered by the ADRT
- the person has done something which is clearly goes against the ADRT which suggests they have changed their mind.

15.9 An Advance Decision can be overridden if the patient's actions clearly go against what is contained in their Advance Decision. It can also be overridden by an attorney who holds a Lasting Power of Attorney (see section 16) if it confers that authority and was made **after** the Advance Decision. The validity and the dates of the LPA must be scrutinised on the relevant forms if this issue becomes apparent – see section 16 for further information.

15.10 It should be made clear that staff may not be protected from liability if they knowingly act against a valid Advance Decision. This could result in disciplinary and potentially even legal action. However staff may conscientiously object if in the circumstances they feel this is appropriate.

15.11 Advance Decisions to Refuse Treatment cannot be used to demand certain treatments.

16. LASTING POWER OF ATTORNEY/OFFICE OF PUBLIC GUARDIAN

16.1 A Lasting Power of Attorney (LPA) is a formal legal document which confers the attorney (or donee as it sometimes called) the authority to make decisions regarding property, affairs, personal welfare and healthcare decisions.

16.2 An attorney may be entitled to refuse treatment on behalf of a patient but cannot demand treatment or a certain type of treatment on the patient's behalf.

16.3 An attorney can be anyone e.g. family, friend, carer, professional such as solicitor etc. The attorney must be over 18 and cannot be a discharged bankrupt (for property and affairs in the LPA). However **staff members of the Trust cannot become attorneys** for a patient or carer they have a professional duty of care towards – although there may be exceptional circumstances.

16.4 To be valid an LPA must be formally written down, signed and registered with a body known as the Office of the Public Guardian. An LPA can also be verified through this body – and should be verified if a paper copy cannot be presented to staff.

16.5 The contact details for the Office of the Public Guardian are as follows:

Website:	www.guardianship.gov.uk
Telephone number:	0845 330 2900
Email address:	custserv@guardianship.gsi.gov.uk

16.6 Attorneys can only make gifts or donations on behalf of the donor that are reasonable in the circumstances and are relative to the size of the donor estate. If staff have any suspicions regarding improper use of an attorneys power under an LPA they should refer the matter immediately to the Office of the Public Guardian.

16.7 A copy of an LPA can and should be kept in the patient's health and social care notes.

16.8 LPAs have been designed to replace Enduring Powers of Attorney (EPA) which many people may already have. The difference in the two documents is that an EPA can only relate to financial and property affairs. Existing EPAs continued to be valid after 1 October 2007 (when the MCA was introduced) – and should be recognised. However no new EPAs can be made. An EPA created after 1 October 2007 would not be legally valid.

17. RESEARCH

17.1 The MCA sections 30,31,32,33 and 34 lay down clear parameters for research where people without capacity may be the subjects.

17.2 The appropriate authority must be sought prior to launching a research project i.e. the Secretary the State in England.

17.3 For anyone contemplating research involving patients who may lack capacity further information and the advice of the NHS Lincolnshire's Research and Development Manager should be sought.

18. COURT OF PROTECTION

18.1 A specialist Court – the Court of Protection –has jurisdiction relating to the whole of the MCA. It deals with decisions concerning both the property and affairs and the health and welfare of people who lack capacity. It is particularly important in resolving complex or disputed cases, for example, about whether someone lacks capacity or what is in their best interests. In specific situations, the Court of Protection is also able to consider cases relating to children who are under 16, for example when longer term decisions need to be made about their financial affairs. The Court of Protection has the same powers, rights, privileges and authority as the High Court.

18.2 The Court of Protection has the power to:

- make declarations about whether or not a person has capacity to make a particular decision
- make decisions on serious issues about healthcare and treatment
- make decisions about the property and financial affairs of a person who lacks capacity
- appoint deputies to have ongoing authority to make decisions
- make decisions in relation to Lasting Powers of Attorney (and Enduring Powers of Attorney).

18.3 The Court is able to appoint a deputy if necessary, for example because a person has an ongoing lack of capacity. The power given to a deputy will vary from case to case. However, the deputy can only make those decisions that they are authorised to make by the order of the court and must always make decisions in the person's best interest.

18.4 Paid health and social care professionals will not usually be appointed as deputies because of the possible conflict of interests.

18.5 Guidance on the court's procedures, including how to make an application, is given in the **Court of Protection Rules and Practice Directions** issued by the court. Available from http://publicguardian.gov.uk/decisions/decisions.htm

18.6 There is usually a fee for applications to the Court of Protection. Details of the fees charged by the court and the circumstances in which fees may be waived or remitted are available from the Office of the Public Guardian at http://publicguardian.gov.uk/about/fees.htm

Supporting Sections

19. CODE OF PRACTICE

19.1 The MCA is supported by a Code of Practice which details all of parts of the Act and offers working examples of the Act in practice.

19.2 It is expected that all service areas will have access to a copy of the Code of Practice. The Code of Practice is also available to download electronically at http://www.publicguardian.gov.uk/dols/code-of-practice-041007.pdf

19.3 The MCA is also supported by easy read **Making Decision** booklets produced by the Department of Constitutional Affairs. The booklets are as follows:

1. Making decisions about your health, welfare or finance. Who decides when you can't?
2. Making decisions. A guide for family, friends and other unpaid carers
3. Making decisions. A guide for people who work in health and social care
4. Making decisions. A guide for advice workers
5. an easy read version – A guide for patients and service users
6. Making decisions. The Independent Mental capacity Advocate (IMCA) Service

Hard copies can be ordered from the Department of Constitutional Affairs website http://www.dca.gov.uk/legal-policy/mental-capacity/publications.htm

20. RECORD KEEPING

20.1 It will not usually be necessary to document the assessment of a person's capacity to consent to routine and low-risk interventions, such as providing personal care or taking a blood sample.

20.2 When undertaking assessments of capacity to make choices regarding significant actions, it is essential for health and social care professionals to clearly document the process of the assessment and the evidence that the person lacked capacity to take the action in question. This can be achieved by undertaking the two stage capacity test using the form in **Appendix 1**. A referral for an IMCA will not be accepted without this documentation. The capacity assessment should be revisited regularly to ensure it is still relevant and valid.

20.3 Clear reference to any background or circumstances, the decision to which capacity needs to be assessed, the assessment itself and the outcome (and best interest checklist if the outcome determines that someone does not have capacity to make a specific decision) should be written or inserted into the notes. The person undertaking the assessment should be clearly identifiable.

21. CONFIDENTIALITY

21.1 An assessment of capacity may require the sharing of information amongst health and social care professionals. If a person lacks capacity to consent to disclosure staff should consider whether it would in the patient's best interests to disclose the information. Only as much information as necessary should be divulged.

21.2 The Act places a duty on those assessing capacity to consider taking into account the wishes and feelings of others who may be involved with a patient, for example as a carer or family member. Although these individuals may be involved in both the capacity assessment and any subsequent best interest decision making process, only as much information as is needed should be disclosed. In most circumstances very little of the patient's actual medical records should be disclosed.

21.3 Where an attorney under a personal welfare LPA has been appointed they will be entitled to have access to health and social care information and will also determine if information can be disclosed. Staff must normally consult with them before sharing any information.

21.4 Where it is not possible to consult, for example, because urgent treatment is necessary, staff must act in the patient's best interests and advise the attorney of any action taken as soon as practicable.

22. ROLES AND RESPONSIBILITIES

22.1 This policy is based on legislation therefore it will apply to all staff within the NHS Lincolnshire.

22.2 The following table outlines the roles and responsibilities of staff working within the NHS Lincolnshire.

Title	Responsibility
Chief Executive	Accountable Officer
Director of Quality and Involvement	Director Lead
Head of Workforce Development	Training Lead
Trained staff	Capacity assessment/ compliance
Head of Deprivation of Liberty Safeguards	Operational Lead NHS Lincolnshire

23. TRAINING

23.1 The Workforce Development department is responsible for training NHS Lincolnshire staff on the MCA.

23.2 Training is mandatory for all new clinical staff on MCA. Existing staff are expected to update every three years. A shortened version will be available for NHS Lincolnshire staff. Training sessions will be promoted through the training website and booked through the normal training procedures.

23.3 Deprivation of Liberty safeguards training will be delivered in partnership with MCA training. Training dept will feedback attendance to DOLS team for audit purposes.

24 AUDIT AND REVIEW

24.1 It is important to audit usage of the new capacity assessment within NHS Lincolnshire. An audit will indicate:

- assessments of capacity and best interest decisions made under the MCA have been lawfully undertaken;
- are appropriately recorded and that
- the duty on NHS bodies to instruct independent mental capacity advocates (IMCAs) is carried out.

24.2 This policy will be reviewed annually and when there is a change in legislation.

25. FURTHER ADVICE

25.1 For advice regarding policy and procedure regarding MCA please contact Deputy Director Corporate Affairs on 01522 513355 or Associate Director Clinical Governance and Risk, Provider Services 07917 133825
If necessary specialist legal opinion can be obtained.

25.2 A leaflet on capacity for patients has been produced by the Department of Constitutional Affairs. Copies of the leaflet have been distributed throughout inpatient units in the LCHS. The leaflet it produced in several languages to accommodate people who do not speak English as a first language

Further copies can be downloaded or reordered from the DCA website:
http://www.dca.gov.uk/legal-policy/mental-capacity/publications.htm

26. CROSS REFERENCE

26.1 When reading this policy the following Trust policies should also be considered (NB This list may not be exhaustive):

- Consent Policy
- Advance Decision to Refuse Treatment Guidance
- Records Management Policy
- Access to Health Records Policy
- Complaints Policy
- Safeguarding Adults Policy
- Deprivation of Liberty Safeguards Policy

27. REFERENCES

Department of Education and Skills (2004) *The Children Act 2004,* London: The Office of Public Sector Information. Available at http://www.opsi.gov.uk.ACTS/acts2004/en/ukpgaen_20040031_en_1htm

Department of Health (2007) *The Mental health Act 1983 as amended by Mental Health Act 2007,* London: The Office of Public Sector Information. Available at: http://www.opsi.gov.uk/acts/acts2007a.htm

Lincolnshire Partnership NHS Foundation Trust (2008) *Safeguarding Adults Policy.*

Mid Trent Cancer Network (East Midlands Health and Social care Community 2007) *Advanced Decisions to Refuse Treatment: Specialist Guidance (Adult).*

Ministry of Justice (2007) *Mental Capacity Act (2005) Code of Practice,* London: The Office of the Public Guardian. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Ministry of Justice (2008) *Mental Capacity Act (2005) Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental capacity Act 2005 Code of Practice,* London: The Office of the Public Guardian. Available at http://www.dca.gov.uk/legal-policy/mental-capacity/publications.htm

PROCEDURE FOR UNDERTAKING A CAPACITY ASSESSMENT

This procedure should be carried out every time a capacity assessment is required. The assessment begins with the recording of some personal information, then moves on to a two stage test for capacity and concludes with some final general questions.

All parts will need to be completed. The form must be signed at the end. If parts 1, 4, 5 and 12 are incomplete the assessment will not be valid.

1. PERSON'S NAME: _____
2. DATE OF BIRTH: _____
3 NHS Nos. _____
4. NAME OF ASSESSOR: _____
5. JOB TITLE: _____
6. DATE: _____

7. PLEASE SUMMARISE BELOW THE DECISION WHICH NEEDS TO BE MADE:

8. ON WHAT GROUNDS DO YOU SUSPECT THERE MAY BE A REASON TO QUESTION THIS PERSON'S CAPACITY:

The person's behaviour suggests they may lack capacity	☐
The person's circumstances suggest they may lack capacity	☐
Someone else has raised concerns	☐
There have been capacity issues previously	☐
Other (please specify)	☐

_____

9. PART ONE OF THE TWO STAGE TEST

DOES THE PERSON HAVE AN IMPAIRMENT OF OR DISTURBANCE IN THE FUNCTIONING OF THE MIND OR BRAIN?

NO – test ends and no lack of capacity determined	☐
YES – CHOOSE FROM BELOW AND RECORD	☐

Tick applicable

Neurological Disorder	☐
Learning Disability	☐
Mental Disorder	☐
Dementia	☐
Stroke	☐
Head Injury	☐
Delirium, Unconsciousness	☐
Substance Use	☐
Other (please specify)	☐

10. PART TWO OF THE TWO STAGE TEST

IS THE IMPAIRMENT/ DISTURBANCE SUFFICIENT THAT THE PERSON LACKS CAPACITY TO MAKE A PARTICULAR DECISION?

To establish this answer the four questions given below. The first three should be applied together. If, after all appropriate support has been given, the person cannot do any of these three things, they will be treated as unable to make the decision. The fourth question only applies in situations where the person cannot communicate their decision in any way. (Refer to sections 4.14 – 4.25 of the Code of Practice for further guidance).

	YES	NO
Can the person understand information relating to the decision?	☐	☐

The assessor will need to demonstrate they have attempted all forms and methods of communication with the person to aid understanding, for example use of visual aids, different languages, use of family members, tried at different times of the day, person is at ease etc.?

Notes _____

_____

_____

Can the person retain the information long enough to make the decision?	☐	☐

The assessor should take into account that the person only needs to retain the information long enough to make the decisions required.

Notes _____

_____

_____

Can the person weigh up/use the information to make a decision?	☐	☐

The person would need to demonstrate they understand and appreciate the consequences of the decision.

Notes _____

_____

_____

Can the person communicate their decision by any means? *e.g. signing, writing, speaking, gesturing, blinking, squeezing a hand*	☐	☐

Notes _____

_____

_____

11. FURTHER INFORMATION

If the assessment has been undertaken as part of a team or there is any concern over the original assessment it is advisable to seek a second opinion.

Was the assessment made with anyone else? Yes ☐ No ☐

If yes, please record below names and job titles

_____
_____
_____

Have you sought a second opinion? Yes ☐ No ☐

If so, please record who below

NAME: _____
JOB TITLE: _____

If a second opinion is required a full assessment should be undertaken by that person and attached to the original assessment.

In circumstances where there is a dispute or a second opinion is requested, the Practice Manager should be informed and involved if appropriate

Does this person have fluctuating capacity? If yes, please provide date when capacity will be reassessed.

Yes ☐ (see below)
No ☐

Date to reassess _____

12. Completed by:: _____

Job title: _____

Signed: _____

Date: _____

If on the basis of this assessment it is decided that the person lacks capacity to make the decision, a best interest determination should be undertaken using the Best Interests Checklist and the decision recorded in the person's notes.

Appendix 2

BEST INTERST CHECKLIST (Two pages)

If you have undertaken the capacity assessment and determined someone does not have capacity to make the specific decision required then the following best interest guidance should be followed when making the decision.

1. Does this person have an enduring power of attorney/ lasting power of attorney?

YES ☐ (see below paragraph)
NO ☐

If yes, a copy must be obtained. Where the attorney is authorised to decide on matters of healthcare or social care **they must be contacted** before a decision can be made.

The existence, validity and applicability of the LPA **must** be verified through the Office of the Public Guardian.

2. Does this person have an advance decision?

YES ☐ (see below paragraph and q 3)
NO ☐

If yes, a copy must be obtained and checked for validity.

3. Does this advance decision affect the decision needed to be made in this assessment (please document below)?

NO ADVANCE DECISION ☐
ADVANCE DECISION NOT RELEVANT ☐
ADVANCE DECISION RELEVANT ☐

If the advance decision is relevant and makes clear and specific instructions – which do not involve any treatment under part VI of the MHA 1983 you must not contravene the advance decision. **Now consult the Advance Decisions Policy**.

4. Have you considered the principle of equal consideration in that the decision you are making for this person is not based on their physical appearance, age, gender, dress, religion or culture?

YES ☐ NO ☐

5. Have you taken into account all relevant circumstances for this person and the relative advantages and disadvantages of those circumstances to the patient of the decision made? e.g. financial implications

YES ☐ NO ☐

6. Have you considered if this person may regain capacity in the future – and if so is it possible to delay the decision until that time?

YES ☐ NO ☐

7. Can the person's lack of capacity be decreased or mitigated if any way which may help to restore capacity to make the decision required?

YES ☐ NO ☐

8. Have you encouraged as far as is practicably possible the person's involvement in the decision to be taken on their behalf?

YES ☐ NO ☐

9. Have you taken into account any previous wishes, feelings or requests made by this person either written or verbally (such as an advance statement) on the decision to be made on their behalf?

YES ☐ NO ☐

10. Have you ensured the decision can as a far as is practicably possible maintain the privacy and dignity of the person?

YES ☐ NO ☐

11. Have you considered any values and any religious, cultural or spiritual beliefs this person is known to have?

YES ☐ NO ☐

12. Have you made a decision which is in the circumstances the least restrictive and invasive option?

YES ☐ NO ☐

13. Have you considered the value or benefit the decision may add to another person?

YES ☐ NO ☐

14. Have you consulted with and considered the views of the following people?

Anyone named by the person to be consulted? ☐
Anyone engaged in the person's care or treatment as a carer? ☐
Anyone designated an attorney under an existing and valid LPA? ☐
Any deputy appointed by the Court of Protection? ☐

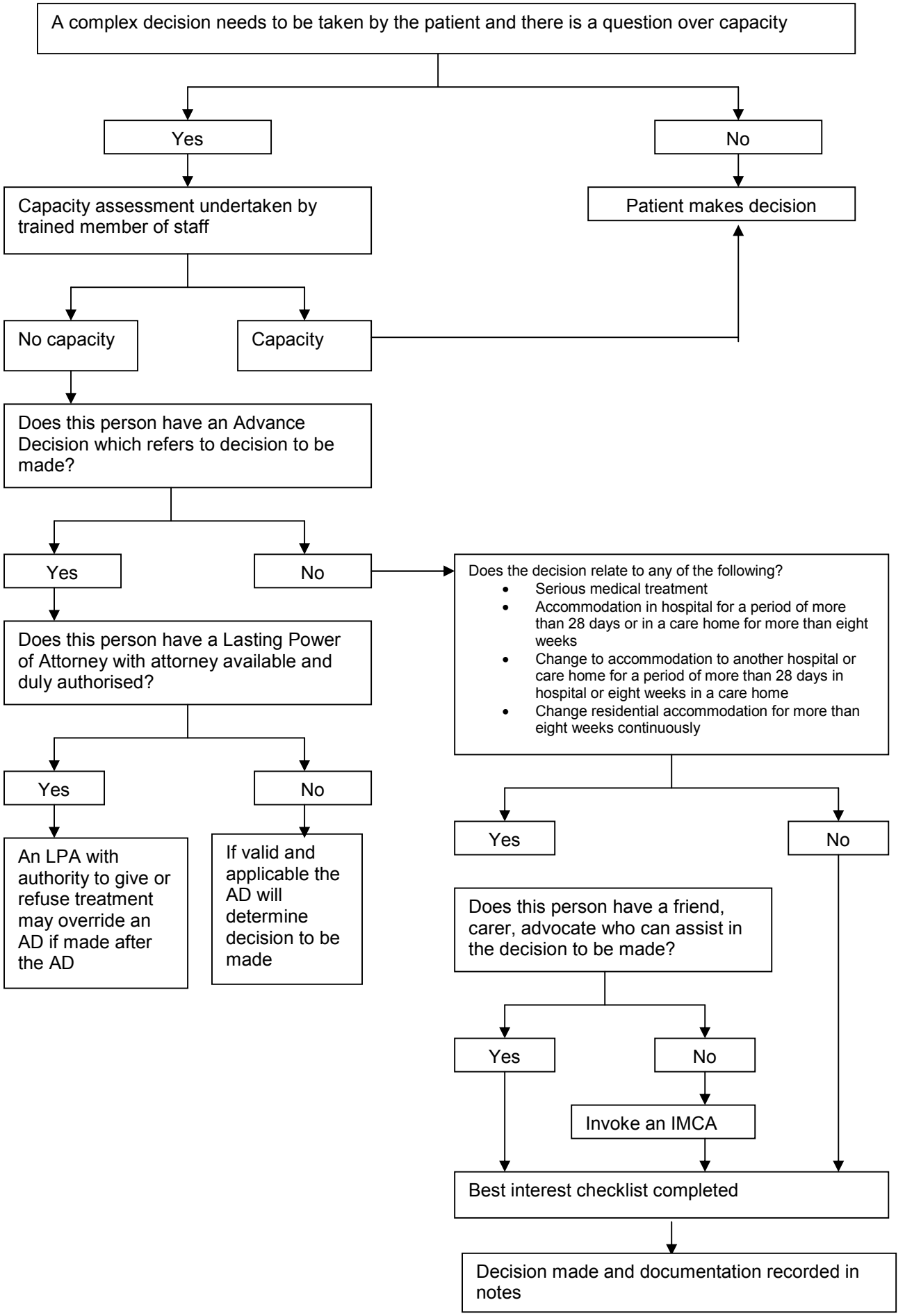
Explanatory notes from any of the above must be made below:

_____
_____
_____
_____
_____
_____

Completed by: _____
Job title: _____
Signed: _____
Date:

Appendix: 3

PROCEDURE FOR UNDERTAKING A CAPACITY ASSESSMENT



Appendix 4

PROCEDURE FOR INVOKING AN INDEPENDENT MENTAL CAPACITY ADVOCATE

An IMCA can only be invoked by the person responsible for the patient's care and treatment.

For example, on a ward this would be the named nurse under supervision from the unit or ward manager. In the community this may be a care co-ordinator. The IMCA service **will not** take referrals from unauthorised or unknown persons. Therefore it is important to ensure that when invoking an IMCA name and job title are quoted.

The criteria are as follows:

1. The person must lack capacity and this must be evidenced through the capacity assessment
2. The person should ordinarily be resident in Lincolnshire, be living in a residential unit or be an inpatient in an NHS hospital in Lincolnshire
3. The person is not currently detained under the Mental Health Act 1983
4. The person is facing one of the scenarios as outlined below

The IMCA must be invoked if all the above criteria are met and the decision to be made relates to any of the following:

- Where an NHS body is proposing 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 eight 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 eight weeks in a care home
- Where a local authority proposes to provide or to change residential accommodation for more than eight weeks continuously.

AND the person has no relative, friend, carer, LPA, EPA, deputy or individual nominated by the person lacking capacity

This list is not exhaustive and there may be other circumstances when an IMCA can be invoked. Optional referrals can include:

1. Care reviews in hospital (for those aged 16 or over, which are not routine and propose a serious decision to be made)
2. Adult protection issues (where current family member, carer is subject of allegation)

The IMCA service in Lincolnshire is operated by the advocacy service 'Speaking Up'.

If the above criteria has been met to invoke an IMCA you will need to telephone the following number **0845 650 0081**.

On receipt of referral the Speaking Up service will require the completion of the three part referral form below (pages 22, 23 and 24) which must be completed and returned by a secure method e.g. fax.

If an **urgent** decision is required an IMCA need not be consulted before a decision can be made.

SpeakingUp
voice | action | change

Appendix 5

IMCA REFERRAL FORM

(This page will be used as case file front sheet when a referral is actioned) **(PAGE 1)**

Date referral received (office use only): ***Case No (office use only):***

PLEASE COMPLETE PAGES 1, 2a and 3a

NAME OF PERSON REFERRED:

DOB: **Sex: M / F** **Ethnicity** ***(see table attached)*****:**

Address:

Tel No:

Decision-maker (on referral issue):

Position: **Organisation:**

Referrer (if different from decision-maker):

Position: **Organisation:**

Contact details: Tel No: **email:**

Hospital & Ward: **Admission date:**
(if applicable)

Involved professionals not listed above and contact details:

Client's language/preferred communication methods:

RISKS TO PERSONAL SAFETY – Detail any information needed to ensure the safety of the advocate and the referred person, including risk management procedures in place:

SpeakingUp
voice | action | change

IMCA REFERRAL FORM

(Please ensure you have completed page 1 of this referral form (page 2a)

NOTE: Pages 2a & 3a should be completed where the person being referred is deemed to lack mental capacity to make an informed decision about the referral issue.

PERSON REFERRED: **DOB:**

Referrer's relationship to referred person:

CAPACITY:

Name & position of the professional who has decided the referred person lacks mental capacity to make a decision on the referral issue:

How was the capacity decision made (eg, has an assessment been carried out)?:

Is referred person: **Aware of the advocacy referral?** **Y / N**

Able to make some decisions without support? **Y / N**

Able to make his/her wishes known on the referral issue? **Y / N**

FAMILY & FRIENDS:

Does the referred person have family? Y / N and/or friends? Y / N

If yes, outline the nature of their involvement:

If the decision-maker does not consider them appropriate to consult with, give reasons why:

SpeakingUp
voice | action | change

IMCA REFERRAL FORM (CONTINUED) **(page 3a)** AR3(a)

Please ensure you have completed 1 and 2 (a) of this form

PERSON REFERRED:

REASON FOR REFERRAL:

See attached guidance on page 21 of policy and detail the decision to be made:

Signature: _____(Referrer)

Date: _____

PLEASE RETURN TO: IMCA, 1a FORTESCUE ROAD, CAMBRIDGE CB4 2JS
IMCA FAX: 0845 650 0081
imca@speakingup.org