The Newcastle upon Tyne Hospitals NHS Foundation Trust

Application of Mental Capacity Act (2005) policy and procedure

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1. Introduction

The Mental Capacity Act 2005 (MCA) came into effect on the 1st April 2007 and was amended in 2009 to include the Deprivation of Liberty Safeguards (DoLS).

The Act provides a statutory framework to empower and protect any adult and young people over the age of 16 in England and Wales who may not be able to make their own decisions. It sets out roles and responsibilities of carers, both professional and informal.

The MCA and Safeguarding have a significant overlap in order to ensure that the rights, as set out in the **Human Rights Act 1998**, and the safety of adults and young people at risk of harm are protected. The MCA aims to empower and also protect individuals. The MCA empowers by ensuring the fundamental right to make decisions is not inappropriately taken away from the individual. The MCA protects by ensuring where an individual lacks capacity in relation to a specific decisions, actions taken by others are made through best interests decisions.

The MCA also enables people to plan ahead for a time when they may lose capacity by enabling them to make Advance Decisions to Refuse Treatment (ADRT) and Lasting Powers of Attorney (LPA).

Everyone working with and/or caring for an individual aged 16 or over who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person. When the person lacks the capacity to make a particular decision for themselves, the same rules apply whether the decisions are life-changing events or everyday matters.

2. Scope

Guidance on the Act is provided in a Code of Practice to which all Health and Social Care Professionals working with people who lack capacity have a legal duty to have regard. The Code of Practice is available on the Trust intranet.

3. Aims

The aim of this policy is to give staff working within the Trust an overview of the MCA and their roles and responsibilities stemming from the Act in relation to their day to day duties.

The Trust has developed a Quick Reference Guide to the main points of the MCA which staff can use as and when required (Appendix 1)

The Trust has also developed the MCA1 & 2 documents (Appendix 2), which provide practitioners with a tool to assess capacity and to make best interests decisions:

MCA 1 and 2 double sided - with info page.doc

4. Duties (Roles and responsibilities)

Clinical Directors are responsible for the implementation and adherence to the MCA within their areas of responsibility.

All consultants must act as decision makers for clinical decisions and provide guidance to staff within their teams.

Clinical Directors, Directorate Managers and Matrons are responsible for providing support and advice to other staff on the implementation of the policy within their directorate.

The Adult Safeguarding team via the MCA/DoL lead are responsible for providing guidance, advice, support and training to staff within the Trust.

Ward and Departmental Managers are responsible for the local implementation of this policy and for advising nursing and other staff on the processes to be followed.

All Trust staff must ensure compliance with this policy at all times and ensure that they follow the 5 statutory principles of the MCA, as set out in the Code of Practice

5. Definitions

5.1 Advance Decision to Refuse Treatment (ADRT)

A decision made in advance by a person who has capacity to do so to refuse specified treatment. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment.

Specific rules apply to advance decisions to refuse life-sustaining treatment (see page 9).

5.2 Attorney

A person appointed under either a Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA), who has the legal right to make decisions within the scope of their authority on behalf of the person (the donor) who made the Power of Attorney (see page 10).

5.3 Best Interests & Best Interests Decisions

Any decisions made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out what are someone's best interests

(see page 8).

5.4 Best Interests Assessment/Best Interests Assessor

An assessment, for the purpose of the deprivation of liberty safeguards, as to whether deprivation of liberty is in a detained person's best interests, is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm. These assessments are carried out by a specially qualified Best Interests Assessor

5.5 Capacity

This is a short form for "Mental Capacity". The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005, and the statutory test **must** be followed in order to determine whether a person does or does not have "capacity"

5.6 Care Act

The MCA and the Care Act work together to promote the empowerment, safety and wellbeing of adults with care and support needs. Both pieces of legislation should enable individuals to maintain their independence and exercise as much control as possible over their lives and any care and support they receive. https://www.gov.uk/government/publications/the-care-bill-factsheets

5.7 Consent

Agreeing to a course of action – specifically such as referred to in this document, to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.

5.8 Court of Protection

The specialist court which has jurisdiction to decide upon all issues relating to people who lack capacity to make specific decisions. The Court can make decisions where there are particular decisions, disagreements that cannot be resolved in any other way and situations where ongoing decisions may need to be made about the personal welfare of a person who lacks capacity to make decisions for themselves.

5.9 Decision Maker

Under the Act, various people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout the Code, as the 'decision-maker', and it is the decision-makers responsibility to work out what would be in the best interests of the person who lacks capacity.

5.10 Deprivation of Liberty (DoL)
Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice has been defined through case law, see Deprivation of Liberty Policy.

5.11 Deprivation of Liberty Safeguards (DoLS)
The framework of safeguards were developed in 2007 (active from 2009) as a supplement to the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to these arrangements; see Deprivation of Liberty Policy.

5.12 Deputy
Someone appointed by the Court of Protection with ongoing legal authority, as prescribed by the Court, to make certain decisions on behalf of a person who lacks capacity to make particular decisions.

5.13 Enduring Power of Attorney (EPA)
A Power of Attorney created under the Enduring Powers of Attorney Act 1985 appointing an attorney to deal with the donor's property and financial affairs. Existing EPAs continue to operate under Schedule 4 of the Act, which replaces the EPA Act 1985, but no new Enduring Powers of Attorney can be made since the coming into effect of the MCA. Lasting Power of Attorney replaced the EPA function.

5.14 European Convention on Human Rights (ECHR)
A convention drawn up within the Council of Europe setting out a number of civil and political rights and freedoms, and setting up a mechanism for the enforcement of the obligations entered into by contracting states. These are incorporated into English Law by the Human Rights Act, 1998.

5.15 Guardianship
Arrangements, made under the Mental Health Act 1983, for a guardian to be appointed for a person with mental disorder to help ensure that the person gets the care they need in the community.

5.16 Ill treatment
Section 44 of the MCA introduced an offence of ill treatment of a person who lacks capacity by someone who is caring for them, or acting as a deputy or attorney for them. That individual can be guilty of ill treatment if they have deliberately ill-treated a person who lacks capacity, or been reckless as to whether they were ill-treating the person or not. It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

5.17 Independent Mental Capacity Advocate (IMCA)
Someone who provides support and representation for a person who lacks capacity to make specific decisions, when the person has no-one else to

support them. The IMCA service was established by the Mental Capacity Act 2005 and is not the same as an ordinary advocacy service (see page11)

5.18 Lasting Power of Attorney (LPA)
A Power of Attorney created under the MCA (see Section 9(1)) appointing an attorney (or attorneys) to make decisions about the donor's personal welfare (including healthcare) and/or deal with the donor's property and affairs, see Lasting Power of Attorney Policy

5.19 Life Sustaining Treatment
Treatment that, in the view of the person providing healthcare, is necessary to keep a person alive

5.20 Mental Disorder
Any disorder or disability of the mind within the meaning of the Mental Health Act (1983). For example, this can include all learning disabilities and dementia.

5.21 Office of the Public Guardian (OPG)
The Public Guardian is an officer established under Section 57 of the MCA. The Public Guardian will be supported by the Office of the Public Guardian, which will supervise deputies, keep a register of deputies, Lasting Powers of Attorney and Enduring Powers of Attorney check on what attorneys are doing, and investigate any complaints about attorneys or deputies. The OPG replaced the Public Guardianship Office (PGO). The OPG has detailed information about the principles of the Act and links to useful resources for practitioners and clients Office of the Public Guardian

5.22 Personal welfare
Personal welfare decisions are any decisions about a person's healthcare, where they live, what clothes they wear, what they eat and anything needed for their general care and well-being. Attorneys under LPAs and deputies can be appointed to make decisions about personal welfare on behalf of a person who lacks capacity. Many acts of care are to do with personal welfare.

5.23 Property and affairs
Any possessions owned by a person (such as a house or flat, jewellery or other possessions), the money they have in income, savings or investments and any expenditure. Attorneys under LPAs and deputies can be appointed to make decisions about property and affairs on behalf of a person who lacks capacity.

5.24 Restraint
The use or threat of force, chemically and/or physically, to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm, see Restraint Policy.

5.25 Safeguarding

Section 44 of the MCA prioritises people's safety by making willful neglect or mistreatment by anybody towards a person aged 16 or over who lacks capacity to make decisions a criminal offence. The Care Act 2014 has also made it compulsory for Local Authorities to carry out or cause a safeguarding enquiry to be carried out (Link to Care Act Guidance/Link to Children Act 1989) where there are concerns in relation to harm, abuse or neglect.

There are times when an individual makes what might be regarded as an "unwise" decision. It is vital to understand the individual's mental capacity in relation to their safety. There can be occasions when there could be an overriding need for action to be taken by the safeguarding teams in the interests of public safety:

Making "unwise" Choices

Mrs Smith was an 83 year old woman who died following repeated admissions to hospital to treat dehydration and low potassium levels. Through the course of this period there were 17 "Adult Concerns" submitted by the agencies due to concerns about the state of Mrs Smith's property and her personal care needs not being met. On three separate occasions, safeguarding adult's procedures were instigated beyond the referral stage. This included strategy meetings being held just prior to and following her death.

Mrs Smith had been known to services for a number of years and had a history of not engaging. Mrs Smith's capacity was repeatedly assessed and on every occasion, she was assessed as having capacity in relation to decisions such as: self-discharging from hospital against medical advice; refusing care and domestic tasks that were included within her care plan.

Agencies felt that Mrs Smith had capacity and there is nothing that can be done.

Undertaking capacity assessments around decisions to refuse care and treatment can be complex. The Mental Capacity Act Code suggests that there may be concerns if someone repeatedly makes unwise decisions that put themselves as significant risk or harm or exploitation. The Code goes promotes staff to consider if more investigation and support is needed. For example, is information is needed to help the individual understand the consequences of the decision they are making?

Critical to Mrs Smith's situation would be for professionals to review and document ways to mitigate risks. For example, was there a means of supporting nutrition and hydration through supplements or dietary intake? Were agencies recording oral input, particularly where carers visited at home to support Mrs Smith? Was there an escalation plan in place when Mrs Smith self-discharged from hospital and were legal services consulted?

The Care Act (2014) has included self-neglect as a category of harm and there are local guidelines in place to support staff. When caring and supporting individuals who are at risk of self-neglect, advice and guidance should be taken from the safeguarding team. Newcastle Self Neglect Guidance

5.26 Statutory principles

The five key principles are set out in Section 1 of the MCA. They are designed to emphasise the fundamental concepts and core values of the MCA and to provide a benchmark to guide decision makers, professionals and carers acting under the MCA's provisions. The principles generally apply to all actions and decisions taken under the MCA (see page 7).

5.27 Wilful neglect

An intentional or deliberate omission or failure to carry out an act of care by someone who has responsibility for care of a person who lacks (or whom the person reasonably believes lacks) capacity to care for themselves. Section 44 introduces a new offence of wilful neglect of a person who lacks capacity.

5.28 Written statements of wishes and feelings

Written statements a person may have made, before losing capacity, about their wishes and feelings regarding issues such as the type of medical treatment they would want in the case of future illness, where they would prefer to live, or how they wish to be cared for. They should be used to help find out what someone's wishes and feelings might be, as part of working out their best interests. They are not the same as advance decisions to refuse treatment and are not legally binding.

6. Assumption of Capacity

The MCA's starting point is to confirm in legislation that it must be assumed that an individual (aged 16 or over) has full legal capacity to make decisions for themselves unless it can be shown that they lack capacity to make a decision at the time the decision needs to be made.

The MCA also states that people must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process.

7. The Five Statutory Principles

There are five statutory principles that apply to any act done or decision made under the MCA. When followed and applied to the Act's decision-making framework, they help people to take appropriate action in individual cases. They also help people to find solutions in difficult or uncertain situations. The principles are as follows:-

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

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

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

4. An act done, or decision made, under the MCA for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

5. Before an act is done, or the decision is made, regard must be had as 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.

Scenario

A patient, who lacked capacity to consent to being admitted to hospital, constantly wandered around the ward as if 'looking for something', and made several attempts to leave, as well as stating that she wanted to go home.

Ward staff considered options to ensure the patient's safety was maintained and discussed; sedation, physically preventing the patient leaving. It was decided to 'special the patient' from 8am to 8pm when the patient was most active.

The members of staff undertaking the "one to one" followed the patient as unobtrusively as possible. The patient knew they were being observed but this appeared to comfort the patient who became quite settled and stopped trying to leave the ward. The hospital applied to the Supervisory Body for a Deprivation of Liberty authorisation, which included an independent Best Interests Assessor to report on the measures being undertaken by the ward and to make recommendations for the ward staff to reduce the impact upon the patient.

8. Best Interests

The underlying philosophy of the MCA is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests.

The MCA is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. The MCA also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves.

9. Supporting the Person to Make the Required Decision

Before deciding that someone lacks capacity to make a particular decision, it is important to take all practical and appropriate steps to enable them to make that decision themselves.

Decision makers must take into account all relevant factors that would be reasonable to consider, not what they think are important. They must not act or make a decision based on what they would want to do if they were the person.

In addition, as section (2) of the MCA underlines, these steps (such as helping individuals to communicate) must be taken in a way which reflects the person's individual circumstances and meets their particular needs:-

- Providing relevant information

  Does the person have all the relevant information they need to make a particular decision?

- If they have a choice, have they been given information on all the alternatives?

- Communicating in an appropriate way

  Can information be explained or presented in a way that is easier for the person to understand (for example, by using simple language or visual aids)?

  Have different methods of communication been explored if required, including non-verbal communication?

  Could anyone else help with communication (for example, a family member, support worker, interpreter, speech and language therapist or advocate)?

- Making the person feel at ease

  Are there particular times of day when the person's understanding is better?

  Are there particular locations where they may feel more at ease?

  Could the decision be deferred in order to see whether the person can make the decision at a later time when circumstances are right for them?

- Supporting the person

  Can anyone else help or support the person to make choices or express a view?

10. The Decision Maker

Under the MCA, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves.

Generally, the senior person who is caring for or working with the patient on the particular decision at hand will be the decision maker.

For example, in most day-to-day actions or decisions, the decision-maker will be the carer most directly involved with the person at the time.

Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision-maker.

Where nursing or paid care is provided, the nurse or paid carer will be the decision-maker.

If a Lasting Power of Attorney has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority.

11. Advance Decision to Refuse Treatment (ADRT)

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

An advance decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity: the 'decision maker' must follow the decision.

Trust staff will be protected from liability if they:

– stop or withhold treatment because they reasonably believe that an advance decision exists, and that it is valid and applicable

– treat a person because, having taken all practical and appropriate steps to find out if the person has made an advance decision to refuse treatment, they do not know or are not satisfied that a valid and applicable advance decision exists.

If the advance decision refuses life-sustaining treatment, it must:

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

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

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

If there are any concerns regarding the validity, applicability of an ADRT then the Trust's legal services should be contacted for advice.

Out of hours the Patient Service Coordinators should be contacted and they will have access to the Trust solicitor, see Advanced Decision Making Policy

12. Lasting Power of Attorney (LPA)

The Mental Capacity Act replaces the EPA (Enduring Power of Attorney) with the Lasting Power of Attorney (LPA). It also increases the range of different types of decisions that people can authorise others to make on their behalf.

As well as property and affairs (including financial matters), LPAs can also cover personal welfare (including healthcare and consent to medical treatment) for people who lack capacity to make such decisions for themselves.
It is important to check that an LPA does grant power to make the decision to be made. An LPA (Property and Affairs) does **NOT** give the attorney power to make any decisions as to care, medical treatment or residence. This must be an LPA (Personal Welfare).

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

The Trust has an LPA policy which should be referred to for further in-depth information and guidance.

The Trust legal services department should be contacted if a patient's representative informs staff that they have LPA, to ensure that it is valid, applicable and registered with the OPG.

Out of hours the PSCs should be contacted and they will have access to the Trust solicitor.

13. Deputies Appointed by the Court of Protection

Section 45 of the MCA set up a specialist court, the Court of Protection, to deal with decision-making for adults (and children in a few cases) who may lack capacity to make specific decisions for themselves.

The Court of Protection replaces the old court of the same name, which only dealt with decisions about the property and financial affairs of people lacking capacity to manage their own affairs. As well as property and affairs, the new court also deals with serious decisions affecting healthcare and personal welfare matters

The Trust legal services department should be contacted if it is known that the Court of Protection is involved with a patient's care and welfare.

14. Making Decisions for Incapacitated Patients

The MCA sets out a legal framework for how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. It sets out core principles and methods for making decisions and carrying out actions in relation to personal welfare, healthcare and financial matters

affecting people who may lack capacity to make specific decisions about these issues for themselves.

The MCA covers a wide range of decisions made, or actions taken, on behalf of people who may lack capacity to make specific decisions for themselves.

These can be decisions about day-to-day matters
– such as what to wear, or what to buy when doing the weekly shopping
– Or decisions about major life-changing events, such as whether the person should move into a care home or undergo a major surgical operation or other medical procedure.

Where a decision is required to identify the most appropriate discharge destination, to a non NHS commissioned service, the social worker would likely be the designated decision maker.

Scenario (Taken from Code of Conduct 12.20)

"Mary is 16 and has Down's syndrome. Her mother wants Mary to have dental treatment that will improve her appearance but is not otherwise necessary.

To be protected under Section 5 of the Act, the dentist must consider whether Mary has the capacity to agree to the treatment and what would be in her best interests. He decides that she is unable to understand what is involved or the possible consequences of the proposed treatment and so lacks capacity to make the decisions.

But Mary wants the treatment and so he takes her view into account in deciding whether the treatment is in her best interests. He also consults with both her parents, with her teacher and GP to see if there are other relevant factors to be taken into account.

He decides that the treatment is likely to improve Mary's confidence and self-esteem and is in her best interests."

15.

Sections 27–29 and 62 of the MCA set out the specific decisions which can never be made or actions which can never be carried out under the Act, whether by family members, carers, professionals, attorneys or the Court of Protection.
These are summarised below.

16. Decisions concerning family relationships

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

- Consenting to marriage or a civil partnership
- Consenting to have sexual relations
- Consenting to a decree of divorce on the basis of two years' separation

- Consenting to the dissolution of a civil partnership
- Consenting to a child being placed for adoption or the making of an adoption order
- Discharging parental responsibility for a child in matters not relating to the child's property, or
- Giving consent under the Human Fertilisation and Embryology Act 1990.

17. Mental Health Acts

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

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

18. Voting rights

Nothing in the Act permits a decision on voting, at an election for any public office or at a referendum, to be made on behalf of a person who lacks capacity to vote.

19. Unlawful killing or assisting suicide

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

20. Assessing Capacity – The Two Stage Test

Anyone assessing someone's capacity to make a decision for themselves should use the two-stage test of capacity.

Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It does not matter whether the impairment or disturbance is temporary or permanent.) Examples of this can include some mental illnesses, dementia, significant learning disabilities, and concussion following a head injury, the symptoms of drug or alcohol use.

If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? Can the person communicate their decision, weight up risks, retain and understand the decision?

The Trust has developed forms:-

MCA1 to use and record an assessment of capacity and

MCA 2 to record the Best Interests decision-making process

These are both available on the Trust intranet (see Appendix 1). They should be used to document all significant decisions and retained in medical records.

21. Independent Mental Capacity Advocate (IMCA)

An IMCA must be appointed to support a person who lacks capacity and has no family or friends to consult when any of the following apply:

- It is considered that the person needs serious medical treatment. Emergency treatment however, can be carried out without waiting for the appointment or involvement of an IMCA.
- It is proposed that the person remain in hospital for more than 28 days
- It is proposed that the person is moved into long term care for more than 8 weeks
- It is proposed that the person is to be moved (for more than 8 weeks) to different accommodation such as a hospital or a care home.

An IMCA may also be appointed in cases of adult protection and care reviews. The IMCA may make representations about the person's wishes, feelings, beliefs and values, looking at all factors that are relevant to the decision. If necessary, the IMCA can challenge the decision maker on behalf of the person lacking capacity. Contact details for IMCA are on the Trust intranet:

22. Dispute

If there is a dispute about capacity, best interest decisions, ADRT, LPA etc one or more of the following actions may be required:

- A second opinion from a senior clinician
- An informal or formal multi agency case conference
- Mediation
- Application to the Court of Protection for a ruling
- Involvement of an independent advocate
- Referral to an IMCA.

Advice can initially be sought from the Trust's Adult Safeguarding Team and Legal Department who may contact the Trust solicitor.

23. Records

As part of the assessment processes, Assessors and IMCAs will have access to the patient's records. The assessment processes will be aided by well-maintained clinical documentation.

Completing the required forms and records also enables the Trust to demonstrate that staff acted lawfully, if their actions are later challenged. This

includes demonstrating that decisions were based on all available evidence and take into account the views of all relevant people, having regard to the five key principles of the MCA.

24. Research

The MCA sets out parameters for research which may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees it is safe, relates to the person's condition, and produces a benefit to the person that out-weighs risk, or burden.

Carers or nominated third parties must be consulted and agree. If the person shows any signs of resistance or indicates in any way that they did not want to take part they must be withdrawn from the research project.

25. Deprivation of Liberty Safeguards (DoL)

The Trust has a separate policy for the DoL Safeguards and this should be used when it is thought that a patient is, or potentially may be, subject to being deprived of their liberty, see Deprivation of Liberty Policy.

26. Mental Capacity and Young People

Most of the MCA applies to individuals aged 16 and over with the following exceptions:

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

It is important to recognise there is a significant overlap with the Children Act (1989). As with all safeguarding, "Thinking Family" is important and there should also be consideration of the mental capacity of parents or carers. For example a young mother with a learning disability who has recently had a child, are there reasonable adjustments that should be made and is there additional support required for the family?

(Chapter 12 Code of Practice)

27. Training

The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoL) are complex and can at times pose challenges to front line staff in different ways. Because of this, an online Breeze training package has been developed to assist staff in their understanding and implementation of the MCA and DoL safeguards in their daily role.

The Breeze package covers:

- Assessing capacity
- Record keeping
- Lasting Power of Attorney (LPA)
- Advance Decisions to Refuse Treatment (ADRT)
- Best Interests decision making
- Deprivation of Liberty Safeguards

This training is part of the suite of safeguarding mandatory training for many frontline clinicians but it is recommended that all staff who have patient contact undertake this training.

In addition the MCA lead, any member of the Safeguarding Adults team (282 0959), are available for advice and bespoke training.

28. Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds . This document has been appropriately assessed.

29. Monitoring compliance

Standard / process / issue	Monitoring and audit			
	Method	**By**	**Committee**	**Frequency**
MCA Audit	Audit of 30 medical records to review the application of MCA	MCA Lead/MCA Champions/Learning Disability Team	MCA steering group & Safeguarding Committee	Annually
Self-Neglect Audit	Audit of 30 cases related to self-neglect to explore the application of MCA, practice and risk mitigation	Safeguarding Adults Team	MCA steering group & Safeguarding Committee	Annually
Independent Mental Capacity Advocate (IMCA)	Monthly Report to identify potential qualifying patients	MCA lead	MCA steering group and Safeguarding Committee	Quarterly

30. Consultation and review

The MCA policy is reviewed informally on an ongoing basis via the MCA/DoL lead who maintains an up to date knowledge of latest case law that impacts upon the policy and as a consequence the Trust.

In addition the MCA Steering Group meet regularly to discuss and make recommendations that may lead to the policy being amended

The following are also considered when the policy is reviewed:

- CQC guidance and inspection reports
- Deprivation of Liberty Code of Practice
- DoH guidance
- MCA Code of Practice

The MCA Steering Group membership consists of a wide spectrum of professionals from across the Trust and any consultation, whether specifically on the MCA policy or otherwise, is cascaded/distributed by the membership to their respective departments for comment and feedback, and within the Policy Newsletter following amendment or review.

31. References

- Mental Capacity Act 2005 Code of Practice
- Deprivation of Liberty Code of Practice (2008)
- Mental Health Act 2007 – Code of Practice
- SCIE: PoC1B2B 100563 4.00 The Mental Capacity Act 2005: Guidance for providers
- Care and Support Statutory Guidance – Care Act 2014
- Self-Neglect Guidance

32 Associated documentation

The MCA policy impacts upon the Trust as a whole especially with regard to direct patient care. The following Trust policies:

- Advance Decisions to Refuse treatment (ADRT)
- Consent Policy
- Deciding Right
- Deprivation of Liberty of a Patient
- Transfer out of Hospital Policy
- Lasting Power of Attorney (LPA)
- Safeguarding Adults Policy
- Safeguarding Children's Policy
- Deprivation of Liberty Safeguards (DoLs) Handbook (2015), Mughal AF & Richards S. Bookwise

Appendices

1. MCA Quick Guide
2. MCA 1 & 2
3. Practise tips

APPENDIX 1

The Newcastle upon Tyne Hospitals NHS
NHS Foundation Trust

Mental Capacity Act 2005

Concerns about patient's (16yo+) capacity to make required decision.

Two Stage Test of Capacity

1. Does the person have an impairment of, or a disturbance in the functioning of their mind?
2. Does the impairment or disturbance mean that the person is unable to make a **specific decision when** they need to?

Complete form MCA 1

Fluctuating Capacity

A capacity assessment must only examine a person's capacity to **make a specific decision when it needs to be made.** If possible delay making the decision if the person will regain capacity.

If patient HAS capacity must respect their decision – even if unwise.

Best Interests Decision Making
A decision made, for or on behalf of a person who lacks capacity **must** be made, in the **Patients Best Interests**

Complete form MCA 2

5 Statutory Principles

1. Assume capacity unless established otherwise
2. Take all practicable steps to help the person to make a decision
3. Respect capacitated persons decision – even if unwise
4. Decision made on behalf of a person who lacks capacity must be done in their Best Interests
5. Decisions made for the person must be the least restrictive option

Lasting Power of Attorney

An LPA is a legal document by which one person gives another person the authority to act on their behalf.

2 types of LPA
1. Personal welfare
2. Property and affairs

LPA must be registered with the Office of the Public Guardian.

LPA's can only make decisions within their remit.

To confirm the LPA is registered with the OPG contact the Trust legal services: 28 37446

Advance Decision to Refuse Treatment (ADRT)

An ADRT enables someone (18+) with capacity to refuse specific medical treatment for a time in the future when they may lack capacity.
It must be valid and applicable to current circumstances.
If it relates to refusing life saving treatment:
- be in writing
- signed by the maker
- verified by a specific statement made by the maker

Any concerns about an ADRT contact the Trust legal services: 28 37446

Independent Mental Capacity Advocate (IMCA)

An IMCA **Must** be instructed and consulted when:
- The person lacks capacity, is un- befriended and either serious medical treatment is proposed or accommodation in hospital more than 28 days or stay in a care home for more than 8 weeks.

IMCA **may** be instructed
- Care reviews if the person is un befriended
- Adult protection cases whether family/friends etc are involved and they are not acting in persons Best Interests

For advice – Contact Trust MCA Lead
Safeguarding Adults Team Tel: Dect 29336/20959

Approved by MCA Steering Group 1st October 2013

Mental Capacity Act 2005 MCA1 Record of a Mental Capacity Assessment

This form must be completed by a healthcare professional involved in the decision to be made.

Patient	Name:	dob:	MRN
Assessor:	Name:	Status:	
Observer:	Name:	Status:	

Description of the decision to be made by the individual in relation to their care or treatment:

Date of assessment:

STAGE 1 - DETERMINING IMPAIRMENT OR DISTURBANCE OF MIND OR BRAIN

Q1. Is there an impairment or disturbance in the functioning of the individual's mind or brain? YES NO

If you have answered YES to Question 1, **proceed to stage 2**
If you have answered NO to the above then the individual has capacity for the above decision within the meaning of the Mental Capacity Act and must give valid consent.

STAGE 2 – ASSESSMENT

Q2. Do you consider the individual able to **understand the information** relevant to the decision and that this information has been provided in a way that they can understand? YES NO

Q3. Do you consider the individual able to **retain the information** for long enough to use it in order to make a choice or an effective decision? YES NO

Q4. Do you consider the individual able to **use or weigh that information** as part of the process of making the decision? YES NO

Q5. Do you consider the individual able to **communicate their decision**? YES NO

If you have answered YES to ALL questions 2-5, the individual is considered on the balance of probability, to have the capacity to make the decision above.

If you have answered NO to ANY of the questions, on the balance of probability, the impairment or disturbance as identified in STAGE 1 is sufficient that the patient lacks the capacity to make this particular decision.

Outcome (cross out statement that does not apply)

Individual has the capacity to make the decision above

Individual lacks the capacity to make the decision above

Signature:		**Date:**	
Summary added to patients notes on:		**Date:**	

Mental Capacity Act 2005 Form MCA2 Record of actions taken to make a best interest decision

Patient name:		
Encourage patient to take part	Dob:	MRN
Senior clinician:	Name:	Status:
Observer:	Name:	Status:
At least one person who knows the individual well	Name:	Status:
	Name:	Status:
NB. If no such person exists see Q1 below *	Name:	Status:

Description of the decision to be made by the individual in relation to their care or treatment:

Date of assessment:

PART 1 Confirming a lack of capacity
MCA 1 overleaf must have confirmed a lack of capacity before proceeding further

PART 2 – Determining best interests

Q1. Is an IMCA needed? YES NO
If there is no one who knows the patient well, you must consider instructing an Independent Mental Capacity Advocate (IMCA) and receive a report from an IMCA. However this must not delay urgent treatment.

Q2. Have you avoided making assumptions merely on the basis of the individual's age, appearance, condition or behaviour? YES NO

Q3. Have you identified all the things the individual would have taken into account when making the decision for them? YES NO

Q4. Have you considered if the individual is likely to have capacity at some date in the future and if the decision can be delayed until that time? YES NO

Q5. Have you done whatever is possible to permit and encourage the individual to take part in making the decision? YES NO

Q6. Where the decision relates to life sustaining treatment, have you ensured that the decision has not been motivated in any way, by a desire to bring about their death? YES NO

Q7. Has consideration been given to the least restrictive option for the individual? YES NO

Q8. Have you considered factors such as emotional bonds, family obligations that the person would be likely to consider if they were making the decision? YES NO

Q9. Having considered all the relevant circumstances, what is the decision/action to be taken in the best interests of the individual?

Please record summary in the patient's notes how and why you came to this best interests decision (eg. risks, benefits) Entry in patients notes dated: ……../……./…….

Signature: **Date**

Guidance notes on MCA 1 and MCA 2

MCA 1

Every individual should be assumed to have the capacity to make a decision unless it is proved that they lack capacity. An assumption about someone's capacity cannot be made merely on the basis of a patient's age or appearance, condition or aspect of his or her behaviour. You are completing this form because you are uncertain if the person identified below has mental capacity to make a particular decision

Stage 1: Assessment of capacity should only proceed if an impairment or disturbance of mind or brain is suspected.

Stage 2: You now need to complete your assessment and form your opinion as to whether the impairment or disturbance is sufficient to indicate that the patient lacks the capacity to make this particular decision at this moment in time.

Signature: the person completing the assessment should sign.

MCA 2

Any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's best interests. To do this, use this checklist.

The intention is not to decide for the individual, but to estimate what decision they would have made if they still had capacity for this decision.

People taking part: encourage the person to take part if they are able and wish to do so. Apart from the clinical staff, if there are no other carers, partners, relatives or LPA who know the individual, you must consider instructing an Independent Mental Capacity Advocate (IMCA) and receive a report from an IMCA. The meeting may have to be deferred until the IMCA is arranged. If the treatment is urgent the decision must be made by the clinicians present at the time.

Signature: the senior clinician responsible for the individual's care (and who was present at the best interests meeting) should sign this section.

Additional information

APPENDIX 3

Practice Tips in Conducting Capacity Assessments

- Remember that capacity is decision specific. The statement “the person lacks capacity” is, in law, meaningless
- Ask yourself, “what is the actual decision I am expecting the person to make?”
- Define and frame the question before you start any assessment – be precise
- Once you have defined and framed the question to yourself with sufficient precision, articulate the question to the person in whatever manner is appropriate
- Record the question and the answer verbatim
- Identify very carefully what information is relevant for the person to have to enable them to take the decision and what options must the person choose between: explain clearly the available options
- Record this information and explain which aspects of it the person is unable to understand, or retain, or use and weigh
- It is not necessary that the person understands every element of what is being explained to them. What is important is that they can understand the “salient factors”: the information relevant to the decision (1)
- The “level of understanding required must not be set too high” (2) but nor must you start with a “blank Canvas”(3): ie to go home without explaining what home support would be.
- Ensure you take all reasonable steps to help the person take the decision in compliance with the core principles of the Act at sec.1 (3) before concluding that they are unable to make the decisions.

Ensure you record what steps you took. All your work cannot be defensible if this has not taken place.

Checklist

Did You:

- Identify what method of communication the person is most familiar with?
- Identify what time of day is best to discuss the decision with the person?
- Consider the best location to discuss the decision in question with the person?
- Consider whether it would assist the person to have another person present who they know well. Ensure you agree what role that person will play
- Consider what help does the person require to learn about and understand the information relevant to the decision?
- Consider whether the person may need to be taken to visit the different options (for example in choosing residential care placements)
- Consider whether there is something that you can do which might mean that the person would be able to make the decision (4)

References

1) **LBJ v RYJ (2010) EWHC 2664 (Fam)**
2) **PH and A Local Authority v Z Limited & R (201) EWHC 1704 (Fam)**
3) **CC v KK & STCC EWHC 2136 (COP)**
4) **DE (2013) EWHC 2562 (Fam)**

Best Interests

Section 1 (5) of the Mental Capacity Act establishes the principle that "…an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his **best interests**"

Section 4 of the Act sets out a checklist of factors which must be considered before the decision is made, or the act is carried out. This is known as the **"Best Interests Checklist"**

1) **Avoid Discrimination**

   A decision must not be taken merely on the basis of a person's age, appearance, condition or any aspect of their behaviour

2) **Consider all relevant circumstances**

   No one factor necessarily takes precedence over any other consideration. Statute does not lay down a hierarchy as between the various factors. The magic is in the person making the determination as to what is of "magnetic" or "peripheral" importance.

3) **Consider whether it is likely that the person will at some time have capacity to the matter in question**

   Refer to the MCA Code of Practice, para. 5.28, which lists some factors which may indicate that a person may regain or develop capacity in the future (remember DE, 2013, who regained capacity following extensive education)

4) **As far as is practicable, permit and encourage the person to participate as fully as possible in any act done for him or any decision made affecting him**

   Generally, evidence of encouraging the person to participate is necessary. This may require using communication support where appropriate. There may be occasions where it is neither appropriate, nor practical or in a person's best interests to delay acting.

5) **Where the determination relates to life sustaining treatment must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about a person's death.**

   This is quite clear that no one is permitted to have the motivation of causing the person death following a best interests decision.

Doctors are not under any obligation to provide, or continue to provide, life-sustaining treatment where the treatment is not in the best interests of the patient. Sometimes treatment can be futile or overly burdensome:

[2012] EWHC 2741 (COP)

[2012] EWHC 1639 (COP)

6) **Consider, so far as is reasonably ascertainable the person's past and present wishes and feelings, beliefs and values and the other factors they would be likely to consider if they had capacity**

The evidence collected under this provision cannot determine the decision, however they should be weighed by the decision maker against other factors when taking the best interests decision. The emphasis should be on sensible risk appraisal, not striving to avoid all risk, whatever the price: "…what good is it making someone safer if it merely makes them miserable?" (LJ Munby, 2007)

7) **Must take into account, if it is practicable and appropriate to consult them, the views of:**
   a) Anyone named by the person to be consulted on the matter in question or on matters of that kind,
   b) Anyone engaged in caring for the person or interested in his welfare
   c) Any done of a lasting power of attorney granted by the person, and
   d) Any deputy appointed for the person by the court

   The purpose of consultation is to seek information which would assist the decision maker in making the best interests decision. It is not to ask the consultees what decision they would make.

8) **Take a Decision**

Once all the factors contained in this list are identified, the decision maker then has to weigh them up in order to work out what is in the person's best interests.

<u>Show all working out</u>

The Code of Practice states in para 5.15 that:

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

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

This record should then remain on the person's "file."