CP19

Mental Capacity Act (2005) Policy

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Appendices:

1.0 Policy Statement (Purpose / Objectives of the policy)

1.1 The Mental Capacity Act (2005) is a piece of legislation enacted in 2007. Its purpose to empower and protect the rights of individuals' who may not have the ability to make a specific decision. The act is applicable to those aged 16 years or older residing in England or Wales. The legislation provides professionals with a statutory framework to support patients with decision making or to plan ahead if loss of capacity it anticipated. The overarching aims of the Act are to promote patient autonomy and protect vulnerable people from harm.

1.2 The purpose of this policy is to support staff in the understanding and application of the Mental Capacity Act (2005). This will ensure patients' rights are upheld and that staff act in the patients' best interests at all times. This policy identifies who can make decisions, in which circumstances and what actions must be taken that allow a person to lawfully provide care and treatment to someone who lacks capacity. This policy also sets out the actions to be taken if a patient presents with a valid Lasting Power of Attorney (LPA) or an advance decision document. An advance decision document may also be known as an advance directive or living will.

2.0 **Definitions:**

- The term 'patient' is used throughout to reflect the language of the Mental Capacity Act (2005) Code of Practice.

- **Advanced decision to refuse medical treatment (ADRT):** a written advanced decision made by a patient prior to loss of mental capacity. The document is valid and legally binding if it complies with the prerequisite of the Mental Capacity Act (2005). Most ADRT relate to decisions around life sustaining treatment.

- **Advocate:** an independent person to help and support someone to understand issues and express their own views, feelings and ideas. An independent advocate will be appointed under the Care Act (2014) where a person has substantial difficulty engaging with an assessment process and has no one suitable to represent them other than paid carers.

- **Best interests:** is not actually defined in the Mental Capacity Act (2005), but when working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision makers must take into account all relevant factors that would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do themselves if they were the person who lacked capacity (Section 4 Mental Capacity Act 2005).

- **Court of Protection:** a specialist court for all concerns relating to individuals who lack mental capacity to make specific decisions.

- **Decision Maker:** the person who is responsible for deciding what is in the best

interests of an individual who lacks capacity. Who this is depends on the decision that needs to be made and sometimes will be a professional and at other times a family member, carer or close friend.

- **Deprivation of Liberty Safeguards (DoLS):** the process of independent assessment to safeguard people whose care involves restrictions and, or restraint in their best interests, to which they cannot validly consent.

- **Enduring Power of Attorney (EPA):** A form of Power of Attorney role created under the Power of Attorney Act 1985. EPA pertains to finance and property of an individual.

- **Independent Mental Capacity Advocate (IMCA):** someone independently appointed to provide support and representation for a person who lacks capacity to make specific decisions, where the person has no one else to support them.

- **Lasting Power of Attorney (LPA):** the Mental Capacity Act allows a person (donor) to appoint an attorney (donee) to act on their behalf for health and welfare and, or financial decisions should they lose capacity in the future. Any decision by the attorney must be made in the donor's best interests and the donee must be registered with the Office of the Public Guardian.

- **Mental Capacity Act (2005):** a piece of legislation that is designed to protect and empower people who may lack capacity to make their own decisions relating to care and treatment.

- **Mental Capacity Assessment:** an assessment of a patients' ability to make an informed choice regarding a specific decision.

- **Mental Disorder:** A disturbance of the mind or brain that results in a cognitive impairment for instance dementia or a learning disability.

- **Office of Public Guardian (OPG):** A Government office that helps individuals in England and Wales to remain in control around decisions relating to finances and health and welfare including LPA and EPA.

3.0 Accountabilities

3.1 **The Trust Board** has overall responsibility for monitoring compliance with and the effectiveness of all trust policies and will ensure that effective management systems are in place.

3.2 **Chief Nursing Officer** is the nominated Director/Executive lead and has overall leadership responsibility for the trusts safeguarding arrangements. They are responsible for

the implementation of this organisation-wide process and the provision of assurance to the Trust Board that there is a safety culture to prevent harm to patients.

3.3 The Safeguarding Team has the knowledge and skills to support staff when caring for patients who are vulnerable and who may lack mental capacity to make specific decisions. They are responsible to provide support and advice and monitor compliance with this policy.

3.4 **Managers** have a responsibility to implement and monitor the use of this policy in their areas, ensuring that all staff are aware of their roles and responsibilities when involved in caring for patients who may lack capacity.

3.5 **All RWT Employees** All staff that treat, care for or support patients who are vulnerable and who may lack mental capacity to make specific decisions about their care and treatment are required to comply with the Mental Capacity Act (2005). It is everyone's responsibility to ensure they make themselves aware of this policy and receive sufficient training and information about the legislation to undertake their role. When capacity to make a decision with regards to the care and treatment options is in doubt, all staff must: -

- Be able to assess mental capacity in relation to a specific decision at a specific time.
- Always work in the best interests of the patient and document how best interest decisions were agreed covering discussions with family and any advocates (e.g., IMCA, LPA - see below)
- Involve an IMCA in relevant situations.
- Follow any valid and applicable advance decision made by the patient. Assessing mental capacity, dealing with patients who lack capacity and complying with the Mental Capacity Act (2005).
- Consult with and follow the instructions of any appointed attorney including a Lasting Power of Attorney (LPA), a Court Deputy or existing Enduring Power of Attorney (EPA).

4.0 Policy Detail:

Mental Capacity Act (2005)

4.1 Having mental capacity means that a person is able to make their own decisions or give informed consent. The act states a person should receive support to help them make their own decision before it is concluded they lack capacity to do so themselves. The act is specifically designed to cover situations where someone is unable to make a decision because their mind or brain is affected by illness or a disability. The Mental Capacity Act (2005) applies to situations where a person may be unable to make a particular decision at a particular time, but this does not mean that a person lacks all capacity to make any decisions. This policy applies to all employees of the trust and to all locum, bank staff and students who operate clinically with the trust.

4.2 Emergency and Time Limited Situations

In an emergency when urgent decisions must be made and immediate action needed, it is not practical to follow the MCA process. It is expected in these situations all decisions will be in the person's best interest. In these incidents, the reason for this should be recorded in the patient's documentation.

4.3 The Five Principles of the Mental Capacity Act (2005)

All employees must follow the MCA five key principles, which are:

1. A person must be assumed to have mental capacity unless it is proved otherwise. All people (aged 16 and over) must be assumed to have mental capacity to make their own decisions. The assumption of capacity means that staff should act on the basis that the patient is able to consent or make a relevant decision. If staff doubt a person's mental capacity, they should undertake a mental capacity assessment. The burden of proof as to whether someone lacks capacity falls on those assessing the person.

2. Until all practical steps have been taken to help someone make a decision without success they cannot be treated as lacking mental capacity. People must be supported as much as possible to make their own decisions before anyone concludes that they cannot make their own decisions.

3. A person is not treated as unable to make a decision themselves because they are making an unwise decision. A person can make a decision that may appear unwise. It is important to consider whether the person has the mental capacity to make that decision including an understanding and acceptance of the consequences of that decision.

4. Any act or decision taken on behalf of someone lacking mental capacity must be in the person's best interest. The act lists factors that must be taken into account for a best interest decision.

5. Any Act or decision taken on behalf of someone lacking mental capacity should aim to be the less restrictive option in terms of the persons rights and freedoms. There is a statutory obligation on the those making best interest decisions to consider least restrictive options and ensure any interventions are proportionate and necessary.

4.4 Supporting patients to make decisions from themselves:

Before mental capacity is assessed there must be a reasonable belief the person may lack the mental capacity to make the decision or give consent themselves. Some reasons to doubt capacity are the patient presents as confused; there are concerns regarding a person's cognition; a history of impaired mental capacity; difficulties in communicating; they may be making a decision that appears irrational or out of character or a decision appears to lack insight into the consequences. However, this does not mean a person lacks capacity but could indicate reasonable doubt and the consideration of a mental capacity assessment.

4.5 **Assessing mental capacity:**

The act makes clear that any assessment of a person's capacity must be 'decision' and 'time' specific.

The professional who assesses capacity is usually the person directly concerned with the individual at the time the decision needs to be made and who has the authority to carry out the act in relation to the decision or consent. It must be someone who understands the decision and associated risks. Examples of where an assessment maybe required include:

- Consent to accommodation for care and treatment (DoLS)
- Invasive procedures e.g. nasogastric tubes and urinary catheter insertion
- Surgical procedures
- Discharge destination
- Issues around non engagement e.g. rehabilitation or taking medicines
- Safeguarding concerns

This is not an exhaustive list of where assessments may be needed. For further advice contact the trust Safeguarding Team.

4.6 **Mental Capacity Assessment (MCA)**

Before an assessment of mental capacity is undertaken, there must be a reason to doubt the person's ability to make their own decisions or give informed consent.

Mental Capacity can only be assessed against a decision that needs to be made; it is not an assessment of a general ability to make decisions. The test of capacity is based on three questions: 1. Is the person able to make a decision (functional); 2. Is there an impairment or disturbance of the mind or brain (diagnostic); and 3. Is the inability to make the decision due to the aforementioned impairment or disturbance (Causation link).

The order of the test of capacity has been reversed due to current Case Law since the production of the MCA Code of Practice in 2007. The Law Commission state that, 'whilst the diagnostic test is in practice often applied before the functional test, the correct approach, and the wording of the Act, assessing mental capacity, dealing with patients who lack capacity and complying with the Mental Capacity Act (MCA) 2005.

Functional

To have mental capacity, for a specific decision at a specific time, a person must be able to meet the four elements as described in the MCA. These are:

1. Understand the information relevant to the decision including reasonably foreseeable consequences of making or not making the decision.
2. Retain the information long enough to make the decision.
3. Weigh-up that information as part of the process of making the decision.
4. Communicate the decision, whether by talking, using sign-language or other means.

All practical steps should be taken to support a person to make their own decision during the assessment. This support given should be evidenced in the patient's documentation. More detail is required for complex and disputed decisions. The mental capacity assessment is

based on a balance of probabilities, what is more likely than not, and will require a judgement from the assessor based on the evidence available at that time.

If the assessor has determined the person is able to understand, weigh-up, retain and communicate the information in relation to the decision then they must be considered as having mental capacity to make their own decisions; this must be respected even if the decision is not medically advised or considered an unwise decision. This should be evidenced in the patient's documentation.

If the assessor has determined the person is not able to do either one or more of the four elements: understand, weigh up, communicate, or understand information, in relation to the decision then the diagnostic part of the test must be applied. This should be evidenced, the more complex the decision, the more detailed this evidence should be.

Diagnostic element:
To lack mental capacity under the act, the person must be considered to have an impairment of, or a disturbance in the functioning or, their mind or brain. This needs to be recorded on the mental capacity assessment form. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the act.
An impairment of, or a disturbance in the functioning of the mind or brain could be temporary or permanent, it could be an informal or formal diagnosis (for important decisions it would be advisable to obtain a formal diagnosis if the decision can wait). It could be:
• Conditions associated with mental health illnesses.
• Dementia
• Learning Disabilities
• Brain injuries including stroke or hypoxia
• Physical or medical conditions such as stroke
• Delirium
• Concussion following head injury.
• Alcohol or substance abuse.

The diagnosis itself does not mean the person automatically lacks capacity.
If assessors are aware of an impairment or disturbance of the mind or brain before carrying out the functional part, they must not allow this to bias the assessment. The person should still receive all practical support to help them make their own decision. Contact the Safeguarding Team for further advice around support tools to aid assessment.

Causation Link:
If the person does have an impairment or disturbance of the mind or brain, the assessor must determine if this is the reason the person lacks capacity to make this decision; it must be the cause of the incapacity for the act to apply.

Documenting the outcome:
The Mental Capacity Assessment form (appendix 1) should be used to record the mental

capacity assessment and should be filed at the front of the patient's documentation. If a form cannot be located then the mental capacity assessment should be robustly documented within the patients' notes using the 3 steps within the assessment as a guide.
If a person is considered to lack capacity following this assessment, the MCA best interest decision-making process must be applied.

Fluctuating Capacity:
A person can be described as having fluctuating capacity when their decision-making ability varies. Someone who has the mental capacity to make a certain decision at a specific time can lose the ability at a later time, or someone who is found to lack capacity for a certain decision at a specific time can regain it. This could be a permanent or temporary impairment or disturbance of the mind that could be due to a deteriorating or improving underlying condition, for example a short-term impairment caused by intoxication or delirium, or a permanent progression of a condition such as dementia.

It is important therefore during a mental capacity assessment to be mindful of clients with fluctuating capacity because this can have a significant impact on the assessment as a whole and the outcome. It is important for the assessor to determine if the decision can wait until mental capacity has returned. Other matters require lots of ongoing and repeated decision making like deciding to continue living somewhere or to continue receiving a certain type of care package. In these situations, professionals assessing mental capacity, dealing with patients who lack capacity and complying with the Mental Capacity Act (MCA) 2005 must undertake several formal, documented capacity assessments so it can be determined whether or not the person has capacity.

4.7 **Best Interests Decision-Making:**
The person with the responsibility of making the decision on behalf of a person lacking capacity is known as the 'decision-maker'. The best interest decision process requires the decision maker to think what the 'best course of action' is for the person.
The act provides a best interest checklist for what factors should be considered when making decisions on behalf of another:

• **Identify relevant information** – such as diagnosis, prognosis, history, emotional and psychological factors, and care needs.

• **Find out the persons views as much as possible** – including past and present wishes, beliefs and values and any other factors the person would consider if they could.

• **Encourage Participation** – as far as practically possible, the person should be encouraged to participate in this process.

• **Consult with others** – where it is practical and appropriate to do so, others who have an interest in the persons care should be consulted. This could include family, friends, carers, legal representatives, and advocates.

• **Least restrictive** – least restrictive options must always be considered.

• **If capacity is likely to return, can the decision wait?** – always consider the likelihood that capacity in relation to this decision may return and if the decision can wait until then.

• **Do not discriminate** – do not base the decision solely on age, appearance, behaviour, or condition.

• **Life-sustaining Treatment** – if the decision concerns life-sustaining treatment there must be no motivation to bring about death. This does not mean doctors are obliged to continue life-sustaining treatment if it is not in the best interest of the person to do so.

• **Take all of this into account** – Weigh up all these factors considering what is in the best interest of a person. The decision-maker must take the above steps and weigh up the above factors in order to determine what decision or course of action is in the person's best interests. Appendix 2 can be used as an aid for professionals in best interest meetings.

For decisions about serious medical treatment and long-term accommodation changes, if the person has no-one to support the best interest process, (family, friends, unpaid carers), the decision maker will need to instruct an Independent Mental Capacity Advocate (IMCA). The Safeguarding Team should be contacted for advice and support when undertaking an IMCA referral.

Who is the Decision-Maker:
If a person has a Lasting Power of Attorney (LPA) or a Court Appointed Deputy and they meet the right conditions, they will be the decision-maker. If there is no LPA or Court Deputy, the decision maker will the health or social care worker responsible for the care and treatment of the person in relation to that decision. The decision-maker must be someone who understands the decision, consequences of the decision, and has the authority to carry out the decision or actions from it.

The act offers guidance on this:
• For most day-to-day decisions, the decision maker will be the carer most directly involved with the person at that time.
• When the decision is about the medical provision of treatment the doctor or other healthcare professional responsible for carrying out the treatment is the decision-maker.
• Nursing interventions, a nurse would be the decision-maker.
There will be a range of different decision-makers for different decisions. For more complex decisions, it may be a joint decision is more appropriate, this needs to be clearly documented.
If the decision is contentious, the decision-maker should be the more senior professional involved in that aspect of the person's care and treatment.

Recording Best Interest Decisions

Any staff in involved in the care of a person who lacks capacity should ensure a record of the process is kept, including how the person's mental capacity to make this decision was assessed, how the decision was reached, what factors were considered, and who was consulted.

If a best interest decision has been made against a care or treatment plan, a mental capacity assessment should be carried out against each intervention or treatment, if there are no changes to capacity or circumstances, the initial best interest decision can be referred to in the patients notes.

4.8 **Disputes of assessment of capacity or best interest decision:**

If there is a conflict between colleagues regarding the outcome of a mental capacity assessment, it would be beneficial to complete a joint assessment. Before the assessment, an agreement should be reached on the level that the person is expected to meet the four elements of the functional test (understand, retain, weigh up and communicate) in relation to the decision. If there is still a dispute the outcome must be determined by the most senior professional involved and the rationale must be recorded. Sometimes the assessment and best interest decision will be challenged by the person who has been assessed or by someone acting for them, for instance a relative or an advocate. Resolution can be sought in the following ways:

• The first step will always be to raise the matter with the person who carried out the assessment and/or best interest decision. The records will be an important part of this process.
• A second opinion may be useful in some cases.
• Acknowledge concerns raised and address them.
• Ensure saliant information is given in a way people can understand.
• Involve an advocate who is independent of all parties.
• Hold informal/formal case conference and mediation.
• Family and friends can use the complaints process to raise their concerns. The Trust Medical Director or Chief Nurse should be informed of all potential or actual disputes.
• If medical staff believe a Lasting Power of Attorney(s) or Court Appointed Deputy are not acting in the best interest of a person this should be raised to the Office of Public Guardianship.
• If a resolution is not possible, for serious medical treatment or complex cases the Court of Protection may be asked to rule on this. Advice from the trust legal department should be sought in the first instance.

4.9 **Independent Mental Capacity Advocate (IMCA)**

In most situations, people who lack capacity will have a network of support from family members or friends who take an interest in their welfare, or from a deputy appointed by the Court of Protection or an attorney appointed under a Lasting Power of Attorney. However, some people who lack capacity may have no one to support them with major, potentially life-changing decisions so the act creates an Independent Mental Capacity Advocate (IMCA) to

represent and support them in certain situations only.

The IMCA Service in Wolverhampton is provided by POhWER, the referral form is available on the safeguarding intranet page. All referrals must be forwarded to the safeguarding adult team inbox prior to submission to the IMCA service. The IMCA service will require the name of the decision-maker, the decision, and a completed assessment to show the person lacks capacity for that decision.

4.10 **Advance Decisions to Refuse Treatment (ADRT):**
Sometimes people have clear views about what types of treatment they don't want to have and would not consent to. An ADRT is a legally binding decision and allows them to express these views clearly before they lose capacity. Advance decisions have also been called advance directives or 'living wills' the act puts them on a statutory footing.

4.11 **Statements of wishes, feelings, beliefs and values:**
Sometimes people will want to be able to write down or tell people about their wishes and preferences about future treatment and care and explain their feelings or values that govern how they make decisions. When assessing what treatment or care is in a person's best interests staff will have to take these statements into account. Such statements can request certain types of treatment, which staff must consider carefully, in particular if they have been written down.

However, the final decision must always be based on the assessment of what is in the person's best interests and using professional judgement of what is clinically necessary or appropriate. If this is different to what they have requested then staff should keep a record of this and be prepared to justify their decision if challenged.

4.12 **Lasting Powers of Attorney (LPAs)**
The act introduces a new form of Power of Attorney which will allow people over the age of 18 to formally appoint someone to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. The power which is given to someone else is called a Lasting Power of Attorney (LPA) and the person or persons appointed will be known as an attorney. The attorney should always act in the persons best interests. If there are any concerns the Office of the Public Guardian should be contacted.

If the Lasting Power of Attorney(s) meet the right conditions, they will be the decision-maker if the person lacks capacity to make their own decision. The LPA paperwork must be checked, and a copy kept in the patients notes.

There are three different types of LPA:
1. A personal welfare LPA is for decisions about both health and personal welfare.
2. A property and affairs LPA is for decision about financial matters.
3. An LPA for both welfare and property.

An LPA in welfare can only make decisions on behalf of the person if they lack capacity to make that decision themselves. To make decisions in relation to healthcare, the LPA must be in welfare.

Attorneys must provide a copy of the stamped original documentation and produce photographic ID. A copy of these documents should be filed within the patients notes.
When there are concerns regarding the authenticity of the documentation or they cannot be provided by the attorneys; then the Safeguarding Team should be contacted for advice.

4.13 PUBLIC BODIES AND SERVICES CREATED BY THE MCA 2005

Court of Protection

A specialist Court – the Court of Protection – has jurisdiction relating to the whole of the Mental Capacity Act (2005). It will deal with decisions concerning both the property and affairs and the health and welfare of people who lack capacity. It will be particularly important in resolving complex or disputed cases, for example, whether someone lacks capacity or what is in their best interests. In specific situations, the Court of Protection will also be able to consider cases relating to children who are under 16 years old.

The Court of Protection will have the power to:

- Make declarations about whether or not a person has capacity to make a particular decision.
- Make decision on serious issues about healthcare and treatment
- If there is a doubt or dispute about whether a treatment is in the person's best interest.
- Make decisions about the property and financial affairs of a person who lacks capacity.
- Appoint deputies to have on-going authority to make decisions.
- Make decisions in relation to Lasting Powers of Attorney (LPAs) and Enduring Powers of Attorney (EPAs).

RWT employees must contact the trust legal team to apply to the Court of Protection.

Court Appointed Deputies:

A deputy is someone (usually a family member) appointed by the Court of Protection to make decisions on behalf of a person who lacks capacity to make a particular decision for themselves. A deputy is different to an attorney. An attorney is appointed by the person at a time they still had capacity.

The court can appoint two different types of deputies. This is either to make decisions about personal welfare or, property and affairs. The power given to the deputy will vary from case to case. It can be to deal with a single issue or broader decisions on an on-going basis.
If a Court Appointed Deputy in personal welfare meets the right conditions, they will be the decision-maker for health decisions.

4.14 CHILDREN AND YOUNG PEOPLE.

Most of the act does not apply to children under the age of 16. Although the Court of

Protection can make decisions, or appoint a deputy to make decisions, regarding a child's property or finances where the child lacks capacity to make related decisions and is likely to still lack capacity at 18.

For 16 and 17 years old, the MCA overlaps with the Children's Act (1989). The Children's Act gives parental responsibility to parents up to the age of 18 years. It is considered, in law, that all people aged 16 and over have capacity to make their own decisions regarding their care and treatment, unless proved otherwise. Refer to the trust Consent Policy for additional guidance on consent for 16- and 17-year-olds.

Where there are disagreements concerning care, treatment or welfare of a young person aged 16-17 who lacks capacity to make related decisions, the case may be heard in the Court of Protection or the Family Court depending on circumstances. Cases can be transferred between the courts.

The Deprivation of Liberty Safeguards only applies to people aged 18 or over, for those deprived of their liberty at 16 and 17 years will need to go to the Court of Protection to authorise. Court of Protection applications will need to be submitted via the trust legal team.

4.15 THE USE OF RESTRAINT

Restraint is defined in Section 6(4) of the MCA (i.e., with relevance to persons who lack capacity) as:
"Uses (or threatens to use) force to secure the doing of an act which the individual resists; or the restriction of the individual's liberty of movement whether those individual resists or not."
The act identifies two conditions which must be satisfied in order for protection from liability for restraint to be available:

- Staff 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 staff liable to a range of civil and criminal penalties.

If a person is subjected to restrictions and restraints to the degree and intensity a deprivation may be occurring, the Deprivation of Liberty Safeguard must be applied for. Refer to the trust Restraint and Deprivation of Liberty Safeguards (DoLS) Policies for further guidance.

4.16 PROTECTIONS UNDER THE ACT

How the Mental Capacity Act (2005) will protect people who work in healthcare
The act provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity provided that:

- The individual staff member has observed the principles of the act.
- The staff member has carried out an assessment of capacity (and reasonably believe that the person lacks capacity in relation to the matter in question.
- The staff member reasonably believes the action they have taken is in the best interests of

the person.

Some decisions that staff make could result in major life changes or have significant consequences for the person concerned and these will need particularly careful consideration. Providing staff have complied with the MCA in assessing a person's capacity and best interests, they will be able to diagnose and treat patients, who lack capacity, without their consent.

It is important to keep a full record of what has happened. The protection from liability will only be available if staff can demonstrate that they have assessed mental capacity, reasonably believe it to be lacking and then acted in what they reasonably believe to be in the person's best interests.

4.17 Protecting People who lack Capacity from Ill-treatment or Neglect

The act introduces a new criminal offence of ill treatment or wilful neglect of a person who lacks capacity. This is intended to deter people from abusing, ill-treating, or neglecting people who lack capacity. If convicted, people can be imprisoned or fined. The offence could potentially cover restraining someone unreasonably against their will, failure to provide adequate care, and also the more commonly understood types of abuse such as financial, sexual, physical, and psychological abuse.

This offence will apply to a person who:
- has the care of a person who lacks capacity.
- Is an attorney appointed under an LPA or EPA.
- is a deputy appointed for the person by the court.

If an individual staff member thinks someone is being abused or ill-treated, they should follow the Safeguarding Adults at Risk Policy (CP53).

4.18 CONFIDENTIALITY

An assessment of capacity may require the sharing of information amongst health and social care workers. If a person lacks capacity to consent to a disclosure, then staff must work out whether it would in their best interests to disclose the information. Only as much information as necessary should be divulged and further advice must be sought from the Safeguarding Team.

Where an attorney under a personal welfare LPA has been appointed, they will determine if information can be disclosed, and staff must normally consult with them before sharing any information. 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.

Any member of staff assessing capacity needs to record accurately the decisions they make about the assessment of mental capacity and the determination of best interests. Following an assessment of capacity that results in either the conclusion that a patient lacks capacity or

where doubts exist about capacity, the details of the assessment MUST be fully documented. Similarly, in any case of dispute about capacity or best interests, the circumstances of the dispute and efforts to resolve the dispute should also be fully documented.

Staff should remember that the records they keep might in the future be referred to if there is a dispute or as part of legal proceedings.

5.0 CONCLUSION

Staff should continue to follow existing best practice when assessing and treating patients with mental capacity issues, taking into consideration both their own professional codes of conduct but, this policy and the Code of Practice of the Mental Capacity Act. A flow chart to help staff to act appropriately and comply with the MCA is attached in Appendix 3.

6.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resource of this policy require additional resources	No
3	Does the implementation revenue resource of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No

7.0 Equality Impact Assessment

The trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. An Equality Impact Assessment Screening has been undertaken and there are no adverse or positive impacts

8.0 Maintenance

This policy will be reviewed by the Head of Safeguarding within 3 years or earlier should relevant legislation or good practice guidance change.
This policy will be monitored by the Safeguarding Adult Lead against the following key performance indictors:

- Mental capacity assessment compliance during annual auditing processes.

9.0 Communication and Training

Directors and Managers are responsible for ensuring this policy is communicated to all staff. Clinical staff are responsible for undertaking Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) training part of their mandatory training every 3 years.

10.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Compliance to Policy	Head of Safeguarding	Presentation of an annual report	Annually	Trust Safeguarding Group
Training Compliance	Head of Safeguarding	Presentation of monthly data report	Monthly	Trust Safeguarding Group, Safeguarding Governance meetings and IMTG

11.0 References

Mental Capacity Act 2005 (legislation.gov.uk)
Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)

Office of the Public Guardian - GOV.UK (www.gov.uk)

Document Control

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Version / Amendment History	Version	Date	Author	Reason
	1	January 2024	Safeguarding Adult Lead	New policy
Intended Recipients: This policy applies to all employees and workers of the Trust including temporary and locum/bank workers, trainees, students, agency staff, self-employed NHS professionals, any contractors working for the Trust and volunteers.				
Consultation Group / Role Titles and Date Trust Safeguarding Group – January 2024				
Name and date of Trust level group where reviewed			Trust Policy Group – April 2024	
Name and date of final approval committee			Trust Management Committee – April 2024	
Date of Policy issue			May 2024	
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)			April 2027 every 3 years	
Training and Dissemination: Delivered as mandatory training- every three years in addition to bespoke face to face training and e-learning package.				
To be read in conjunction with: CP06 Consent to Treatment and Investigation Policy (xrwh.nhs.uk) CP02 Deprivation of Liberty Safeguards (DoLS) Policy (xrwh.nhs.uk) CP53 Safeguarding Adults at Risk (xrwh.nhs.uk) OP85 Information Sharing Policy (xrwh.nhs.uk) CP12 Care of People with Learning Disabilities (xrwh.nhs.uk) CP59 Restraint Policy (xrwh.nhs.uk) CP11 Resuscitation Policy (xrwh.nhs.uk)				

Initial Equality Impact Assessment (all policies): Completed Yes **Impact assessment (as required): NA**	
Monitoring arrangements and Committee	Training compliance monitored via Corporate Education Steering Group (CESG) and Trust Safeguarding Group (TSG). Annual trust audit of Mental Capacity Act (2005) compliance reported via Trust Safeguarding Group, Divisional Leads and Corporate Governance meetings.
Document summary/key issues covered: This policy aims to support clinical staff in ensuring patients' who lack capacity to make specific decisions relating to their care are treated lawfully and best interests process applied.	
Key words for intranet searching purposes	Safeguarding, Mental Capacity Act (2005)

NHS

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Mental Capacity Assessment for adults and young people

The first principle of the Mental Capacity Act 2005 is that a person must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack capacity for the specific 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 take that decision themselves.

Surname	Unit No
Forename	NHS No
Address	DOB
Postcode	(or affix patient label)

Please tick if this assessment applies to: ☐ A young person (16-17 years) ☐ An adult (18 years or over)

What is the specific decision that needs to be made?

.....

.....

Two stage test of mental capacity: Diagnostic element

As part of the decision making process can the person:

Understand the evidence relevant to the specific decision?

What evidence indicates that the person can or cannot understand the information? .....

.....

.....

Retain information?

What evidence indicates that the person can or cannot retain information?.....

.....

.....

Weigh up information?

What evidence indicates that the person can or cannot weigh up information?.....

.....

.....

Can the person communicate their decision verbally or non-verbally?

What evidence indicates that the person can or cannot communicate their decision?.....

.....

.....

Functional element

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? This may be permanent or temporary, ☐ Yes ☐ No

If Yes, provide detail.....

.....

.....

If no. No further action required.

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? ☐ Yes ☐ No

Outcome of Mental Capacity Assessment:

On the balance of probabilities, there is reasonable belief that:

☐ The person has capacity to make this decision at this time

Or

☐ The person does not have capacity to make this particular decision at this time

If the person is assessed as lacking capacity then a best interest meeting must be considered and documented in the notes.

Detail of Assessor:

Name:..... Signature: .....Designation:.....

Date:.....Time: ..... Stamp

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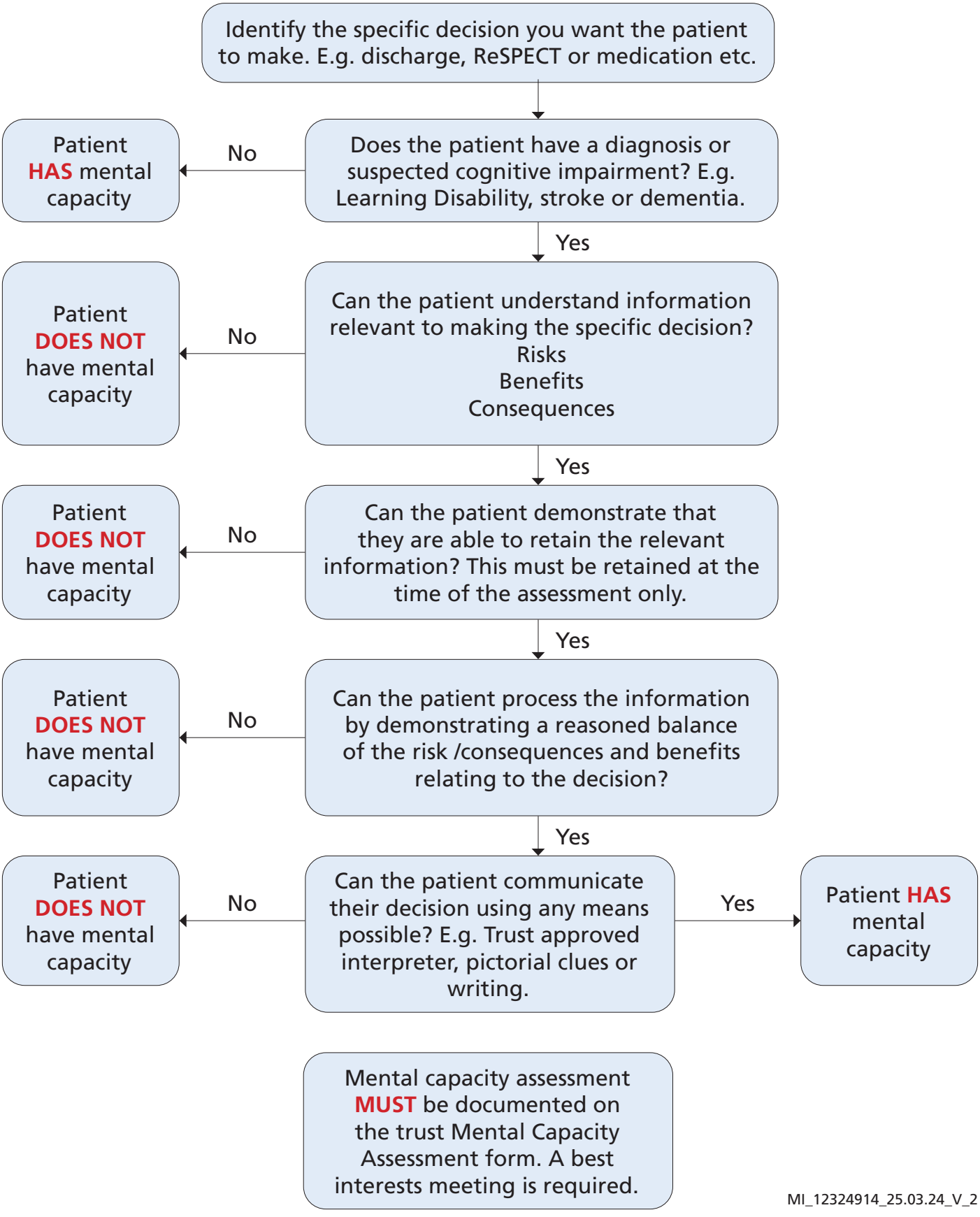
Mental Capacity Assessment



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Best Interest Decision Prompt Sheet

- What are the values and beliefs of the person? If they cannot be expressed now what do other people close to that person know of them (have they been previously recorded by others if unable to express these).
- What the person would have wanted before they lacked mental capacity?
- What are the views of others involved in the person's care e.g. family, carers, Last Powers of Attorney, Court of Protection Deputies, professional colleagues, multi-disciplinary team member's etc.
- Is this the least restrictive alternative or intervention (Principle 5?).
- Have you involved the person in the specific decision made?
- Are there any valid advance decisions to refuse medical treatment?
- Can you provide clear objective reasons why you are acting in the person's best interest (Principle 4?).
- Does the decision need to be made immediately - could the person regain mental capacity?
- Have you considered the views of any Independent Mental Capacity Advocate (IMCA), where involved?