University Hospitals Bristol and Weston NHS Foundation Trust

Mental Capacity Act Policy

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Introduction

This policy will raise awareness of the recognition of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and ensure that University Hospitals Bristol and Weston NHS foundation Trust (the Trust) operates in compliance with the legislation

The Policy also enables the Trust to follow the principles embodied in the Mental Capacity Act 2005, meet statutory and practice requirements, directly ensure compliance with Core Healthcare Standards and be proactive in relation to the priority placed on risk management and the mitigation of risks to protect patients, staff and the organisation

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions (Job title only)**	**Type of Revision**	**Description of Revision**
11/08/2014	1.00	Adult Safeguarding Lead		New Policy
11/11/2016	2.00	Safeguarding Lead Nurse (Adults & Children		To include changes in legislation and case law.
30/11/2020	3.00	Safeguarding Lead Nurse (Adults & Children	Minor	Minor revisions to support merger with Weston General Hospital

Sign off Process and Dates	
Groups consulted	**Date agreed**
Policy Assurance Group	01/12/2020
Clinical Quality Group	04/02/2021

- **Stakeholder Group** can include any group that has been consulted over the content or requirement for this policy.
- **Steering Group** can include any meeting of professionals who has been involved in agreeing specific content relating to this policy.
- **Other Groups** include any meetings consulted over this policy.
- **Policy Assurance Group** must agree this document before it is sent to the **Approval Authority** for final sign off before upload to the DMS.

Contents

Do I need to read this Policy?

All Care-providing Staff

Must read the whole policy

1. Introduction

The Mental Capacity Act (MCA) 2005 provides a framework to empower and protect people (16 years and above) who may lack capacity to make some decisions for themselves. It identifies who can take decisions in which situations and how they should go about this. Anyone who works with or cares for an adult who lacks capacity must comply with the MCA when making decisions or acting for that person. This applies whether decisions are life changing events or more every day matters.

The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests.

The Act sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. It sets out some 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.

2. Purpose and Scope

The purpose of this policy is to provide guidance for all staff about the Mental Capacity Act and its application.

3. Definitions

3.1 The five statutory principles of the Legislation (as laid out in Section 1 of the Act)

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

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

(c) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(d) 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.

(e) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action. Having mental capacity means that a person is able to make their own decisions. A person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

The Act is specifically designed to cover situations where someone is unable to make a decision because the way their mind or brain works is affected, for instance, by illness or disability, or the effects of drugs or alcohol. A lack of mental capacity could be due to:

- A stroke or brain injury
- A mental health problem
- Dementia
- A phobia
- A learning disability
- Cognitive impairment, drowsiness or unconsciousness because of an illness or the treatment for it
- Alcohol/substance misuse

4. Duties, Roles and Responsibilities

4.1 Trust Board of Directors

The Board is ultimately accountable for ensuring compliance with the Act and that patient's human rights are protected. The Board monitors this via the Regulatory Compliance Group, and the Assurance Framework is considered quarterly for compliance.

4.2 Executive Lead for MCA and DOLS

The Chief Nurse is the Executive Lead responsible for the implementation of the Act.

4.3 Deputy Chief Nurse

Responsible for strategic lead in the Trust and will deputise for the Executive Lead in their absence.

4.4 Safeguarding Lead Nurse (Adults & Children)

(a) Fulfils the role of corporate lead for Adult Safeguarding, responsible for ensuring MCA & DOLS policies and procedures are up to date and embedded within all clinical areas and that awareness training is undertaken by all clinical staff.

(b) Acting as an expert with other clinicians and teams. The post holder will report to the Executive Lead for Adult Safeguarding.

4.5 Safeguarding Operational Lead Nurses

The Safeguarding Operational Lead Nurses are responsible for co-ordinating the Trust's involvement with external agencies regarding individual cases, and for assisting and supporting other Trust colleagues.

4.6 Adult Safeguarding Operational Group

(a) The Trust's Adult Safeguarding Operational Group will take the lead for the development and management of the agenda for MCA & DOLS within the organisation, advising the Safeguarding Steering Group.

(b) It will lead the development and implementation of policies and procedures, training design and delivery, work plans, audit and annual report.

4.7 The Safeguarding Steering Group

The Trust Adult and Children's Safeguarding Steering Group meets every quarter. This group is responsible for assurance in relation to all safeguarding in the Trust. The chair of this group is the executive lead of the Trust, the Chief Nurse

4.8 Divisional Boards

Divisional Boards are responsible for ensuring that corporate requirements in relation to MCA and DOLS are met within their area. They are also responsible for the implementation of the Act in their area.

4.9 Patient Safety Departments

They will share any incidents and Serious Incidents relating to the Acts implementation with the Safeguarding team for review.

4.10 Legal Services

They will provide advice to clinicians and the Safeguarding Operational Lead Nurses on the MCA and, in particular, where an Application to the Court of Protection may be required. In addition, they will support the Safeguarding team with training of clinical staff on such legislation.

4.11 All Trust Staff

All Trust staff have a duty to act in compliance with this legislation.

All care providing staff have a duty to be aware of, and act in accordance with the MCA Code of Practice. Additional information is available on the Safeguarding Adults pages on Connect

5. Policy Statement and Provisions

It is the Trust's policy that we follow the principles embodied in the Mental Capacity Act 2005. We establish policies and procedures to determine how we implement the Act and its principles. In particular we fully recognise our responsibilities to assess capacity of our patients under the principles of the Act (see Appendix D). To ensure compliance with the Deprivation of Liberty Safeguards (DOLS). We train the relevant staff to understand and fulfil their responsibilities under the Act. We establish means by which we can be assured that we are complying with the Act.

6. Standards and Key Performance Indicators

6.1 Applicable Standards

Care Quality Commission Fundamental Standard 13

6.2 Measurement and Key Performance Indicators

Bristol, North Somerset, South Gloucestershire Clinical Commissioning Group NHS Safeguarding Standard Contract

7. References

HO. Human Rights Act (1998), London. http://www.legislation.gov.uk/ukpga/1998/42/data.pdf

Mental Capacity Act (2005). London.
http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

Code of Practice MCA

Code of Practice DOLS

8. Associated Documentation

[redacted]

9. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this Policy.

Objective	Evidence	Method	Frequency	Responsible	Committee
Practice in line with Policy	Annual Safeguarding Report	Annual review of safeguarding activity and risks	Annual	Safeguarding Steering Group	Trust Board
Training is given to all care-providing staff	Compliance with training targets	Provision of training in line with Intercollegiate documents	Quarterly report	Leads for Areas	Safeguarding Operational groups
CQC Regulation 13 met	Datix system	Regulation 13 detailed review. Overview of incident reports	Quarterly	Safeguarding Operational group	Safeguarding Steering group
Process and procedures in line with Policy and legislation	Annual Safeguarding Audit plan	Internal and external assurance activities	Annual	Divisions/Safeguarding operational group	Safeguarding Steering Group

10. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Lead Nurse for Safeguarding
Is this document: A – replacing an expired policy, B – replacing an alternative policy, C – a new policy:	A
Alternative documentation this policy will replace (if applicable):	NA
This document is to be disseminated to:	All care-providing staff
Method of dissemination:	Training, intranet, Safeguarding operational and steering groups, link professional
Is Training required:	Yes
The Training Lead is:	Lead Nurse for Safeguarding

Plan Elements	Plan Details

Additional Comments
Mental Capacity Act training is delivered as part of Trust mandatory training

11. Appendix C – Equality Impact Assessment (EIA) Screening Tool

Further information and guidance about Equality Impact Assessments is available here:

[redacted]

Query	Response
What is the main purpose of the document?	To raise awareness of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and ensure that the Trust operates in compliance with the legislation
Who is the target audience of the document (which staff groups)? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ Staff ☑ Patients☑ Visitors☑ Carers☑ Others☑

Could the document have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment.
Age (including younger and older people)		☑	
Disability (including physical and sensory impairments, learning disabilities, mental health)		☑	
Gender reassignment		☑	
Pregnancy and maternity		☑	
Race (includes ethnicity as well as gypsy travelers)		☑	
Religion and belief (includes non-belief)		☑	
Sex (male and female)		☑	
Sexual Orientation (lesbian, gay, bisexual, other)		☑	
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		☑	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		☑	

Will the document create any problems or barriers to any community or group? NO

Will any group be excluded because of this document? NO

Will the document result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Could the document have a significant **positive** impact on inclusion by reducing inequalities?	YES	NO	If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?		Yes	Ensuring adherence to the Mental Capacity Act facilitates support for staff and patients
Will it help to get rid of discrimination?		Yes	Ensuring adherence to the Mental Capacity Act facilitates equal support for staff and patients
Will it help to get rid of harassment?	no		
Will it promote good relations between people from all groups?	no		
Will it promote and protect human rights?		yes	The provisions of the MCA are built on the Human rights articles

On the basis of the information / evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				Negative Impact		
Significant	Some ☑	Very Little	NONE	Very Little	Some	Significant

Is a full equality impact assessment required? NO

Date assessment completed: .....09/11/2020.....

Person completing the assessment: .....[redacted].....

12. Appendix D – Principles of the Act

12.1 Assessing Capacity (Capacity test)

How to conduct this test is set out in the Act. In order to decide whether an individual has the capacity to make a particular decision you must answer two questions:

Stage 1. Is there an impairment of, or disturbance in the functioning of a person's mind or brain?

If so,

Stage 2. Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision? In particular, can they:

- **Understand** information given to them
- **Retain** that information long enough to be able to make the decision
- **Weigh** up the information available to make the decision
- **Communicate** their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. If the patient is likely to regain capacity and the decision can be postponed until that time then that is what should happen.

The assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity? The patient's records must show why the conclusion was reached that capacity is lacking for the particular decision. The Trust Connect internet pages provide guidance and a form to record a capacity assessment.

12.2 When should Capacity be assessed?

The Act makes clear that any assessment of a person's capacity must be 'decision-specific', this means that:

- The assessment of capacity must be about the particular decision that has to be made at a particular time and is not about a range of decisions
- If someone cannot make complex decisions this does not mean that they cannot make simple decisions. For example, it is possible that someone with learning disabilities could make decisions about what to wear or eat but not about whether or not they need to live in a care home; and
- You cannot decide that someone lacks capacity based upon their age, appearance, condition or behaviour alone.

If there is doubt that a patient lacks the capacity to make a decision then an assessment is required. This must be a formal written assessment for all complex decisions, residence decisions and decisions relating to Serious Medical Treatment. **See section 12.7** for details in relation to `Serious Medical Treatment'.

12.3 Who Should Assess Capacity?

The MCA is designed to empower those in health and social care to carry out assessments themselves, rather than rely on expert testing by psychiatrists or psychologists.

"If a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity to consent. In settings such as a hospital, this can involve the multi-disciplinary team (a team of people from different professional backgrounds who share responsibility for a patient). ***But ultimately, it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed."*** MCA Code of Practice.

Under the Act, the person responsible for a capacity assessment is known as the "decision maker".

It is important to assess people when they are physically and mentally optimised to make the decision, if possible. Whether this is possible will depend on the nature and urgency of the decision to be made.

12.4 Best Interests

If an individual is assessed as lacking capacity in a specific area, one of the key principles of the Act is that any act done for, or any decision made on behalf of that person, must be done or made in the person's best interest. This applies to whoever is making the decision.

It is recognised that most significant decisions regarding someone who lacks capacity will be made in the context of a multi-disciplinary discussion. However, the 'decision maker' is the person who is likely to be proposing to take action, and is likely to be a nurse, social worker/care manager or doctor.

The Mental Capacity Act sets out a checklist of factors to be considered by the decision maker whilst considering the best interests of the person.

A brief summary is given below. Section 5d of the Mental Capacity Act Code of Practice, provides further detail.

10.4 Factors to be considered in the patents' best interest:-

10.4.1 No decision is made solely on the basis of a person's age, appearance or other aspect of behaviour that might lead others to make unjustified assumptions.

10.4.2 All relevant circumstances.

10.4.3 Likelihood of regaining capacity – if possible could the decision be delayed?

10.4.4 As far as possible encourage the person to participate.

10.4.5 If life-sustaining treatment then the decision must not be motivated by a desire to bring about their death.

10.4.6 Is it possible to ascertain the person's past and present wishes and feelings?

10.4.7 Is it possible to ascertain their beliefs and values?

10.4.8 The views of other people, in particular anyone formerly named by the person to be consulted, those involved in caring for the person, those interested in their welfare, donees of a Lasting Power of Attorney or any Court Deputy.

10.4.9 Consultation with Independent Mental Capacity Advocate (IMCA) if one is required. The decision maker has a duty to instruct an IMCA where there is no family or Power of Attorney to consult and a major decision needs to be made in the person's best interest.

Decisions must be clearly recorded in the notes.

12.5 Best Interests Meetings

For the more complex decisions, as above, a formal meeting must be held with all relevant parties invited to participate. The meeting should be chaired by the decision maker who is responsible for the final decision. A detailed record of the meeting must be made.

The Trust intranet pages contain the latest version of the Best Interest meeting recording form.

12.6 Independent Mental Capacity Advocate (IMCA)

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

An IMCA must be instructed, by the Local Authority or an NHS body, and then consulted, for people lacking capacity who are unbefriended (i.e. have no-one else other than paid staff to support them) whenever:

- An NHS body is proposing to provide serious medical treatment, or
- An NHS body or Local Authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home

and

- The person will stay in hospital longer than 28 days or
- They will stay in the care home for more than eight weeks

The IMCA's role is to support and represent the person who lacks capacity. Because of this, IMCAs have the right to be provided with access to relevant healthcare and social care records.

Any information or reports provided by an IMCA must be taken into account as part of the process of determining whether a proposed decision is in the person's best interests.

It is vital that clear, accurate and timely identification of the need for an IMCA is made in all cases. Delay in identifying the need for an IMCA is likely to cause delays in medical treatment, discharge from hospital and placement in care homes.

12.7 Serious Medical Treatment

The Code of Practice (10.43) describes `serious medical treatment' as follows:

Serious medical treatment is defined as treatment that involves giving new treatment, stopping treatment that has already started, or withholding treatment that could be offered in circumstances where:

- If a single treatment is being proposed there is a fine balance between the likely benefits and the likely burdens to the patient including the risks involved
- A decision between a choice of treatments is finely balanced, or
- What is proposed is likely to have serious consequences for the patient.

12.8 Court of Protection

Whilst Serious Medical Treatment is not exclusively defined, recent guidance from the **Court of Protection** confirms that in the following scenarios consideration must be given to seeking the Court's determination:

(a) Where finely balanced, or

(b) There is a difference of medical opinion, or

(c) A lack of agreement as to a proposed course of action from those with an interest in the person's welfare, or

(d) There is a potential conflict of interest on the part of those involved in the decision-making process

If, in addition to the above, there is a decision around life sustaining treatment, an Application must be made to Court.

Prompt advice should be sought from the Legal Services Team where the above issues arise to avoid any criticism of delay. You may wish to consider obtaining a second opinion on the assessment of capacity if it is uncertain.

The guidance supports mediation in an attempt to avoid making an Application to Court.

12.8 What Happens in Emergency Situations?

Sometimes people who lack capacity to consent will require emergency medical treatment to save their life or prevent them from serious harm. In these situations, what steps are 'reasonable' will differ to those in non-urgent cases. In emergencies, it will almost always be in the person's best interests to give urgent treatment without delay. One exception to this is when the healthcare staff giving treatment are satisfied that an advance decision to refuse treatment exists.

Wherever possible it remains best practice to consult with a relevant third party.

12.9 Advance Decisions to Refuse Treatment

The terms 'Advance Directives' and 'Living Wills' are replaced by the Act with the term 'Advance Decisions'. This is a means of planning ahead and allows a person with capacity to detail their wishes for treatment in the future when they may lack capacity. These have legal authority and MUST be followed.

Requirements:

- Can only be made by a person with capacity of 18 years and older.
- Can be expressed in lay terms, and will still be valid.
- Can be withdrawn at any time if the person has capacity.

Life-sustaining treatment:

- An advance decision can only be used in the refusal of life-sustaining treatment if: It is in writing (not necessarily physically by the person themselves).
- It is signed by the person, or in their presence by someone acting for them.
- Signature is witnessed.
- Witness signature is in the person's presence.
- It is supported by a statement saying that it applies even if life is at risk.

An advance decision is NOT valid if:

- A lasting power of attorney exists after the advance decision was made, giving the attorney authority to give or refuse consent to treatment, to which the advance decision relates.
- The person has clearly acted in a way contrary to the advance decision
- The person has capacity.
- The treatment planned is not specified in the advanced decision.
- Any circumstances specified in the advance decision are absent.
- There are reasonable grounds to believe that circumstances have changed to such an extent that they would affect the original decision.

Legal authority of advance decisions

A valid advance decision to refuse treatment has the same authority as if the person had capacity and refused treatment.

12.10 Lasting Power of Attorney

A power of attorney (POA or LPA) is a document which allows another person (the attorney) to make decisions on behalf of the patient in certain circumstances.

The Act introduced two different types:

(a) Property and affairs

(b) Health and Welfare

To be valid they must be registered with the Office of the Public Guardian (OPG) who will issue a certificate. A copy of the certificate must be placed in the patient's notes.

If there is a Health and Welfare POA for a patient **and** the patient has lost capacity to make a specific decision the clinician must consult the POA as they are the "decision maker".

12.11 Court Appointed Deputies

These may be made by the Court of Protection (COP) on behalf of a person who has already lost capacity. There function is as a POA above.

12.12 The Mental Capacity Act and Research

The Mental Capacity Act (MCA) 2005 enshrines in statute current best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. It applies these principles to research that seek to involve people without the capacity to provide informed consent to their participation. The aim is to balance the importance of properly conducted research with the need to protect the interests, and respect the current or previously expressed wishes, of those involved.

To undertake intrusive research with those who that lack capacity, the MCA requires a researcher to obtain approval from an 'appropriate body' (i.e. Research Ethics Committee – REC within the National Research Ethics Service) and to demonstrate that the study is likely to be of benefit to the person lacking capacity, (either directly or indirectly) and that the risks are negligible. The MCA sets out clear and detailed guidelines regarding this in the MCA Code of Practice, which can be found on the Safeguarding Adults pages on Connect.

12.13 Criminal Offence

Section 44 of the Act introduces the criminal offence of ill treatment and wilful neglect of a person who lacks capacity. It applies to:

- Anyone caring for a person who lacks capacity
- An attorney appointed under Lasting Power of Attorney
- A deputy appointed for the person by the Court

Ill treatment: the person must either have deliberately ill-treated the person or be reckless in the way they were treating the person such as to be likely to cause harm or damage to the victim's health.

Wilful neglect: the meaning varies depending on the circumstances but usually means a failure to carry out an act the person knew they had a duty to do.

Penalties will range from a fine to up to five years imprisonment.

13. Appendix E – Deprivation of Liberty Safeguards (DOLS)

The MCA 2005 introduced the Deprivation of Liberty Safeguards (DoLS) via the Mental Health Act 2007, which amended the MCA 2005. They aim to provide legal protection for vulnerable people (over 18years who lack capacity to choose/decide for themselves) who may be deprived of their liberty in a hospital or care home.

In March 2014 the Supreme Court made a judgement that resulted in a change in the interpretation of a deprivation of liberty, now referred to as the 'Acid Test', as follows:

- Does the patient lack capacity to consent to remain in hospital for treatment or care

and

- Is the person under continuous supervision and control?

and

- Are they free to leave?

If the answer is yes to the first and second question and no to the third question, then the person is being deprived of their liberty and the DoLS application process must be followed (Detailed information on the application process is available via the Trust Connect intranet pages).

The Supreme Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement. It was also held that the relative normality of the placement, given the person's needs, was not relevant.

Other factors for consideration of a potential Deprivation of liberty are:

- Restraint is used, including sedation, to admit a person to hospital where that person is resisting admission.
- Staff exercise complete and effective control over the care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment and contacts
- A decision has been taken by the organisation that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the organisation consider it appropriate.
- A request by carers for a person to be discharged to their care is refused – The person is unable to maintain social contacts because of restriction placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control. It is important to remember that the above list is not exclusive; other factors may need to be considered in particular cases.

There are two kinds of authorisation: Urgent and Standard.

Urgent Authorisations:

These are made by the hospital itself (`The Managing Authority') but must be accompanied by a simultaneous application for a Standard authorisation to the Supervisory body (The patient's local authority). The Urgent Authorisation must be made in the 'Best Interests' of the patient and if any 'Restrictive Intervention' (Restraint / clinical holding) is used it must comply with the Trusts `Restrictive Intervention Policy'.

Once the member of staff has submitted the DoLS application according to the Trust DoLs process, this will grant the Trust an Urgent Authorisation, which will last for seven days. The Safeguarding Nursing Team will then verify the completed application and send on to the relevant Local Authority and update the patient's electronic records. The clinical team should inform the patient and their family/ carer that the DoLS process has been followed. The DOLS Code of Practice and an Easy Read leaflet are available on the trust intranet site.

Standard Authorisation:

The application for a Standard Authorisation will be made at the same time as the Urgent application. The Supervisory body is then required to obtain medical and other assessments to support the Standard authorisation and to undertake regular reviews of the authorisation arrangements. The patient (or someone acting on their behalf) have full rights to appeal during this process.

13.1 Changes in circumstances of a patient who is subject to a DoLs authorisation

If any of the circumstances of the patient change, for example a ward move or discharge, the Safeguarding Nursing Team should be notified as soon as possible.

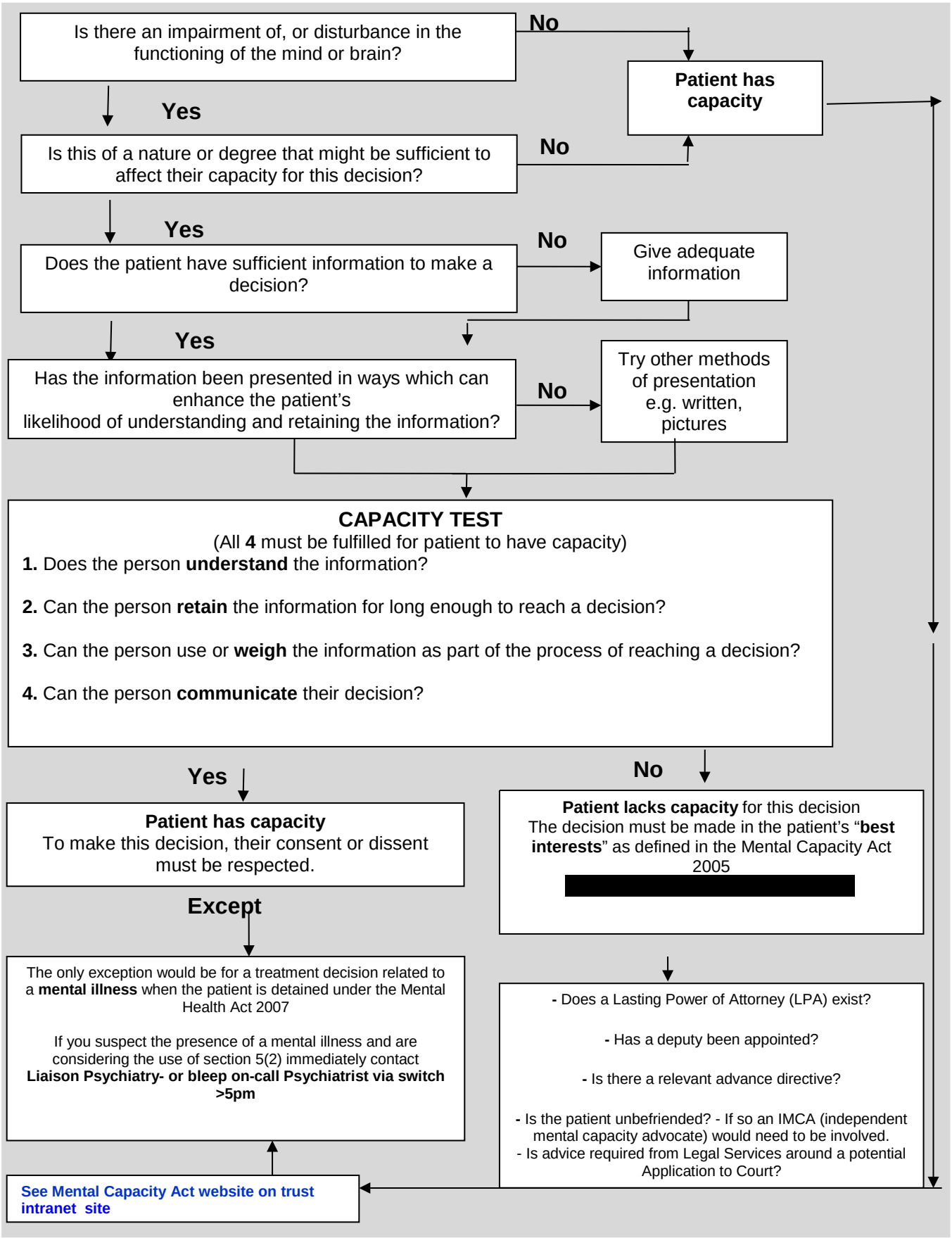
The DOLS ceases to be required when either:

- The patient regains capacity to consent to remain in hospital for care and treatment
- The patient is medically fit and is discharged with an agreed safe discharge plan
- The patient is deemed to be eligible for detention under the Mental Health Act

NB. A deprivation of liberty authorisation – whether urgent or standard – relates solely to the issue of deprivation of liberty.

It does not give authority to treat people, nor to do anything else that would normally require their consent. The arrangements for providing care and treatment to people in respect of whom a deprivation of liberty authorisation is in force are subject to the wider provisions of the MCA. Once a patient is discharged from hospital, a notification form is sent to the Care Quality Commission (CQC)

13.1 Mental Capacity Algorithm for a patient to consent to any care/treatment intervention



14. Appendix F – Best Interest decision process for planned procedures.

Referral made to service by GP/Clinician

GP/Clinician to undertake an initial **capacity assessment** regarding decisions around healthcare treatment.

If thought to lack capacity - Follow pathway below

NB- Need to explore whether there is a valid Advance Decision to Refuse Treatment

When patient has Next Of Kin (NOK) or equivalent advocate

Mental capacity assessment by decision maker (Consultant team) to confirm lacks capacity for this decision at this time

Consult with 3rd party

– NOK or equivalent. This cannot be a paid carer.

IF NOK not in attendance a consultation discussion can take place with them over the telephone

Consultant team Complete Consent form 4

When patient has donated a Power of Attorney (POA) for Health and Welfare

1.

Mental capacity assessment by decision maker (Consultant team) to confirm lacks capacity for this decision at this time

Consult with POA

Confirm POA is valid. View document to confirm it is specifically for Health and Welfare and registered with the Office of the Public Guardian. Check with legal team or Safeguarding team

Consultant team and POA Complete Consent form 4

When patient has no Next Of Kin or unpaid carers.

GP /referrer makes referral to Independent Mental Capacity Advocate (IMCA)
ICMA gains information to support decision maker

Mental capacity assessment by decision maker (Consultant team) to confirm lacks capacity for this decision at this time

Consult with IMCA

Or review IMCA written report

Consultant team Complete Consent form 4

NB Ideally this process should take place on attendance at pre-op assessment but may be completed on day of procedure in special circumstances

15. Appendix G – Mental Capacity Assessment Consent Form 4

Hospital no: _____
NHS no: _____
Surname: _____
Forename: _____
Gender: _____ **D.o.B**: ___ /___ /___

Mental Capacity Assessment

(Mental Capacity Act 2005)

This form should be used to record an assessment of capacity for all interventions where a person's capacity to consent is in question (the person must be aged 16+). The Mental Capacity Act 2005 states '**All adults are assumed to have capacity; any assessment of capacity is time and decision specific**'.

Assessment of Capacity using the 2 stage test of capacity (Part 1)

A. What is the specific decision that the person needs to make?		
B. Is there an impairment of, or disturbance in the functioning of the person's mind or brain? If yes, specify what this is?	**Yes**	**No**
Cognitive impairment, substance misuse or other, summarise how you have reached your conclusion If there are doubts refer for further opinion. If you have answered **YES** to the above continue with this assessment		

If you have answered **NO** this assessment must not be completed (MCA 2005). Go to the **outcome of assessment section** and record that the person `has capacity' and the decision they have made

Does this decision need to be taken now?	**Yes**	**No**
Please state reason for this decision. Can the decision be delayed? Is there a likelihood of the person regaining capacity if decision is delayed? What is the timescale for making this decision?		
What information is relevant to this decision?		
What choices are available? What are the likely consequences or risks involved in deciding one way or another or making no decision? What are the benefits?		
How have you planned this assessment?		
Specify what information has been shared and how you have supported the individual in the decision making process, e.g. time preference, offer of a different venue, use of photographs, use of imaging/cue cards, `easy read' and use of interpreter if required. Possible effects of medication minimised?		

Assessment of Capacity using the 2 stage test of capacity (Part 2)

1. Do you consider the person able to understand the information relevant to the decision to be made?	**Yes**	**No**
Summarise how you reached your conclusion by reference to the relevant information and the circumstances under which you discussed it with the person		

2. Do you consider the person able to retain the information for long enough to use it in order to make the decision?	**Yes**	**No**
Most decisions require a person to be able to retain the information for a short time only. Significant or more difficult decisions may require that the information is retained for several days. Summarise how you reached your conclusion and the circumstances under which you discussed it with the person.		
3. Do you consider the person able to use or weigh that information as part of the decision-making process?	**Yes**	**No**
Was the person able to consider the advantages and disadvantages of possible outcomes? Were they able to adjust their view in the light of new information? Summarise how you reached your conclusion and the circumstances under which you discussed it with the person.		
4. Do you consider the person able to communicate their decision verbally or non-verbally?	**Yes**	**No**
Summarise how you reached your conclusion and the circumstances under which you discussed it with the person.		

Outcome of assessment:	**Tick**
If the answer to **All** of the questions 1-4 is **Yes -** The person **`has capacity'** at this time for this decision only. Decision can be made on the balance of probability.	
If the answer to **Any** of the questions 1-4 is **No -** The person **does not have capacity'** at this time for this decision only.	

Unless there is a valid and applicable advance decision or another person has the authority to make this decision, for example a *Power of Attorney or a Court Appointed Deputy*, a decision must be made following the best interests process. (Complete Best Interest Meeting form and appoint an IMCA if the individual is unbefriended)

Details of those consulted / involved in this assessment:
Including an independent 3rd party such as: relative, friend or an Independent Mental Capacity Advocate (IMCA)

Name	**Role / Relationship**	**Views**

Name of Consultant team / Name of Decision Maker :	
Signature of assessor:	**Date and Time of Assessment:**
Name and Job Title:	**Contact Details:**

16. Appendix H – Interests Meeting Discussion and Outcome Form

Hospital no:

NHS no:

Surname:

Forename:

Gender: **D.o.B**: ___ / ___

Best Interest Meeting/Discussion

(Mental Capacity Act 2005)

To use this form the person must be aged 16+ and a documented test of capacity under the Mental Capacity Act 2005 shows that they lack capacity to make the decision in question at that time.

The Act 2005 states: '**Any act or decision made for or on behalf of a person who lacks capacity must be done, or made in his/her best interest'.** Before the act is done, or the decision made, regard must be had as to whether the outcome can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Does the decision involve serious medical treatment or a change of residence?	**Yes**	**No**
What is the decision or action being considered on behalf of the person named above?		
Is there an impairment of, or disturbance in the functioning of the person's mind or brain? If yes, specify below	**Yes**	**No**
Cognitive impairment, substance misuse or other and summarise how you have reached your conclusion		
Will the individual recover capacity if the decision is delayed?	**Yes**	**No**
If Yes, delay until capacity regained and when will this be likely, but state reason why capacity may be recovered?		
Does this decision need to be taken now?	**Yes**	**No**
Please state reason for decision to be taken now. Can it be delayed? Is there a likelihood of the person regaining capacity? What is the timescale for making this decision?		
Document below evidence that you have considered the individual's past and present wishes, feelings, beliefs, values and other relevant factors	**Yes**	**No**
If no, please state reasons, e.g. unresponsive and/ or no third party to consult and an emergency life sustaining decision needs to be made.		
Is a Best Interests Meeting indicated? **Details of those consulted/ involved in this decision making process:** Including an independent 3rd party e.g. relative or friend. **NB** if unbefriended an Independent Mental Capacity Advocate (IMCA) is required		

Name	Role/Relationship	Views
Name (insert)	Relationship (insert)	Final view/action plan (insert)

Is there a valid Power of Attorney (POA) for <u>Health and Welfare</u> or a Court of Protection Appointed Deputy?	**Yes**	**No**

If yes, please verify name/s, full contact details and place copy of documentation in medical notes

If yes, state date POA registered (once verified, place copy in medical notes and inform the adult safeguarding team: Ext 21697

Is there a valid advance decision to refuse treatment (ADRT) or Advance care plan?	**Yes**	**No**

If yes, please evidence, seek advice from Trust Legal Team/ Safeguarding Team

Summary of Best Interests discussion

Please document available options highlighting the risks and benefits

Document what action or decision has been decided in the person's Best Interests and how has this been communicated to the person?

Please record forward management plan

Signature of decision maker:	**Date & Time:**
Name and Job Title:	**Contact Details:**