Mental Capacity Policy

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Policy

Document Control / History		
Revision No	**Date**	**Reason for change**
2	November 2019	Pre-existing policy requiring update in line with legislation change and Corporate changes
3	December 2020	Addition of Trust Covert Drug administration links and update of job roles and responsibilities.

Consultation
Safeguarding Assurance Group

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1 Introduction

1.1 The Mental Capacity Act 2005 (MCA) applies to care, treatment and support of people from 16 years and over, in England and Wales, who are unable or who may be unable to make all or some decisions for themselves. The Act is accompanied by a statutory Code of Practice, which explains how the MCA will work on a day-to-day basis, and provides guidance to all those working with, or caring for, people who may lack capacity. As the Code has statutory force, certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves e.g.

- An attorney under a Lasting Power of Attorney (LPA)
- A deputy appointed by the new Court of Protection
- An individual acting as an Independent Mental Capacity Advocate (IMCA)
- Any person carrying out research approved in accordance with the MCA
- Any person acting in a professional capacity for, or on relation to, a person who lacks capacity
- Any person being paid for acts in relation to a person who lacks capacity

1.2 The legal framework provided by the MCA 2005 is supported by the Code of Practice https://www.gov.uk/government/collections/mental-capacity-act-making-decisions which health and social care professionals must have regard to when making decisions. The document provides practical guidance on how the MCA will affect practitioners on a day-to-day basis and offers many examples of good practice

1.3 The Mental Capacity Act 2005 will apply in conjunction with other legislation affecting people who may lack capacity in relation to specific matters. Health and social care staff acting under the Act should also be aware of their obligations under other legislation, including (not limited to) the:

- General Data Protection Regulation and Data Protection Act 2018
- Human Rights Act 1998
- Mental Health Act 1983,
- Equality Act 2010
- Deprivation of Liberty Safeguards 2007

1.4 Any person working with, or caring for an individual who lacks capacity to make a decision must comply with the Act if they are to make a decision on the person's behalf.

1.5 The Act applies to individuals over the age of 16 who lack capacity to make a decision.

2 Purpose / Aim and Objective

2.1 This policy applies to all staff employed by Medway Foundation Trust involved in the care and management of patients. This policy sets out the requirements for Medway Foundation Trust staff in respect of the MCA Mental Capacity Act 2005.

2.2 The Mental Capacity Act (MCA) 2005 provides a statutory framework for those who lack capacity to make decisions for themselves or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations and how they should go about doing this

2.3 For Trust staff to provide care and treatment to patients whilst demonstrating understanding of the legislation and acting accordingly.

2.4 For Trust staff to act in the *best interest* of the individual who lacks capacity

2.5 For Trust staff to safeguard the rights of an individual who lacks capacity

2.6 For Trust staff to be able to recognise and assess lack of capacity and to be able to recognise when a Deprivation of Liberty may be occurring and to refer appropriately.

3 Principles of the Mental Capacity Act 2005

3.1 The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.

3.2 **The five statutory principles are**:

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

• 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.

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

• An act is done, or a decision is made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

• 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.

3.3 **Test of Capacity**

3.4 To determine if a patient lacks capacity to make particular decisions, the Act sets out a two-stage test of capacity.

• **Stage 1**: requires proof that the person has an impairment of the mind or brain. This can be a permanent condition (e.g. head trauma, dementia, significant learning disabilities) or a temporary condition (e.g. delirium, sepsis, hypo-natraemia or drug and alcohol use/withdrawal)

• **Stage 2**: the impairment means that the person is unable to make a specific decision when they need to

3.5 A person is unable to make a decision for him/herself if he/she is unable:

• To understand the information relevant to the decision

• To retain that information

• To use or weigh that information as part of the process of making a decision or

• To communicate their decision (whether by talking, using sign language or any other means)

Lack of ability in **any** of these four areas means the person lacks the capacity to make this decision.

*3.6 If the outcome of the Mental Capacity Assessment proves the patient has the capacity to make the decision **we must comply** with their choice, regardless of whether the professional deems this to be an 'unwise choice', for example, despite significant risks.*

3.7 A person must not be treated as unable to make a decision unless all practicable steps to help and support them make a decision or be involved in the decision-making process, have been taken without success. Depending on the circumstances, such steps may include (but not limited to) the following:

• Ensuring other people are present to assist with communication (e.g. friends, relatives, speech and language therapist).

• Using information aids.

• Using non-verbal forms of communication.

• Waiting until the patient's condition has improved.

• Discussing the decision with the person at the time of day when they are most able to participate and free of environmental distractions.

3.8 **Duty to Instruct an Independent Mental Capacity Advocate (IMCA)**

The decision maker has the duty to instruct the IMCA before making the best interest's decision (**except in an emergency**), in the following circumstances:

• The decision is about serious medical treatment provided by the NHS.

• It is proposed that the person be moved into long-term care of more than 28 days in a Hospital or 8 weeks in a care home.

• Long-term move (8 weeks or more) to different accommodation is being considered, to a different Hospital or care setting.

And the person without capacity has nobody else who is willing and appropriate to represent them or be consulted in the process of working out their best interests. In usual circumstances the representative will be appropriate family members or friends.

3.9 In an emergency situation, where treatment cannot be delayed while a person gets support to make a decision or when urgent immediate medical treatment is needed, the only practicable and appropriate steps are to keep the person who is unable to make a decision about the proposed emergency treatment is to keep them informed of what is happening and why, whilst proceeding with the urgent treatment.

3.10 Any decisions or actions taken on behalf of someone who lacks the capacity to make a decision that is required of them must be made in their best interests. Best interests are not defined because it will depend upon the individual circumstances of each case but the Act contains a best interest's checklist which should be followed. The guidance and form for this can be found on the intranet in the Safeguarding Page https://intranet.medway.nhs.uk/directorates-and-departments/safeguarding/mental-capacity-and-deprivation-of-liberty-safeguards-dols/

3.11 The relationship between MCA 2005 and MHA 1983

The principles of the MCA Code of Practice apply to patients subject to the MHA 1983 with few exceptions. For guidance on when to use the MCA 2005 guidance or the MHA 1983 guidance and the relationship between them please refer to Chapter 13 of the MCA Code of Practice.

https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

3.12 **Advanced Decisions**

- An advance decision allows an individual aged over 18 years, who has capacity, to refuse a specific treatment for a time in the future when they will lack capacity to consent to or refuse that treatment.
- An advance decision must be valid and applicable to the current circumstances. If it is, it has the same effect as a decision that is made by a person who has capacity: healthcare professionals must follow the decision (Mental Capacity Act (2005) Code of Practice p 158)
- The healthcare practitioner 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 steps to find out if the person has an advance decision and they do not know or are not satisfied that a valid and applicable decision exists.
- An advance decision must identify the treatment that they refuse; the maker can cancel a decision at any time.
- An advance decision to refuse life sustaining treatment must:

  Be in writing

  Be signed and witnessed.

  State clearly that the decision applies even if life is at risk.
- To establish if an advance decision is valid and applicable the health care practitioner must identify, where possible, if the individual:
- Has done anything that clearly goes against their decision.
- Has withdrawn their decision.
- Has subsequently conferred the power to make decisions to another.
- Would have changed their decision if they had known more about the current circumstances.

Healthcare practitioners who disagree with the patient's decision to refuse life sustaining treatment do not have to act against their beliefs. But they must not simply abandon the patient or act in a way that affects their care (CoP p159). It is recommended that they refer the patient to another practitioner who is able to abide by the individual's decision.

4 Deprivation of Liberty Safeguards

4.1 The Deprivation of Liberty Safeguards (DoLS) are a set of provisions added to the MCA 2005, that focus on some of the most vulnerable people in our society: those who for their own safety and in their own best interests need to be accommodated under care and treatment regimes that may have the effect of depriving them of their liberty, but who lack the capacity to consent.

4.2 These new provisions as set out in the DoLS Code of Practice as a supplement of the main MCA 2005 Code of Practice provide guidance and information for those implementing the DoLS legislation on a daily basis

https://webarchive.nationalarchives.gov.uk/20110322122009/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

4.3 Following this addition to the MCA in 2009 there have been a series of changes due to case law. Most noteably is the “Cheshire West” Supreme court ruling in 2014 by Lady Hale.

4.4 **The ‘acid test’:**

- Is the person subject to continuous supervision and control?

  All of these factors are necessary.

- Is the person free to leave?

  The focus is not on the person’s ability to express a desire to leave, but on what those with control over their care arrangements would do if they were to try to leave.

  NB: for a person to be deprived of their liberty, they must be subject both to continuous supervision and control and not be free to leave. In the healthcare setting this would apply to any patient that is confused and lacks mental capacity whether it is a temporary or permanent impairment of brain or mind.

  Please refer to **SOP0195** Standard Operating Procedure For the Process of Applying For a Deprivation of Liberty Safeguards (DoLS) available on the Trust intranet

5 Definitions

5.1 **Best Interests** – A concept where:

- Assumptions are never made simply on the basis of the person’s age, appearance, condition & behaviour.
- All relevant circumstances have been considered.
- Where consideration has been made to the possible regaining of capacity.
- Where the individual has been supported to take part in the decision making process.
- Where decision are not motivated by a wish to bring about the individuals death and where assumptions about the quality of the individuals life have not been made.
- The views of the individual must be taken into account along with their beliefs and values.

5.2 **Capacity Assessor** – the act is clear that anyone is able to assess capacity provided that they are directly concerned with the individual at the time that the decision needs to be made.

5.3 **Capacity** is defined as the ability to make a decision about a particular matter at the time the decision needs to be made.

5.4 **Decision Makers** – In day to day decisions i.e. what to wear or eat, it is likely that the decision maker will be the person caring for the individual. Where health care intervention is concerned the decision maker will be the person who will be delivering the intervention or treatment. In complex cases a multidisciplinary discussion may take place however the decision maker remains the person who will be carrying out the intervention.

5.5 **Designated Decision Maker** – An individual identified by the person lacking capacity whilst they still had capacity. Designated decision makers are Lasting Power of Attorney (LPA) for either property & affairs or a personal welfare or Court Appointed Deputy with delegated (by the Court of Protection) powers to make specific decisions.

5.6 **Donor** – A person who makes a lasting power of attorney, they have to be competent at the time of conferring the power.

5.7 **Independent Mental Capacity Advocate (IMCA)** – A person that represents an individual who lacks capacity when they have no family or significant others to support them i.e. un-befriended.

5.8 **Lasting Power of Attorney (LPA)** – A power of attorney created to make decisions on behalf of the donor regarding either personal welfare (health decisions) or property & affairs when the donor loses capacity to do so him/herself.

5.9 **Restraint** – The use of force or threat to use force to make someone do something that they are resisting, including the restriction of a person's freedom of movement, whether they are resisting or not.

6 (Duties) Roles & Responsibilities

6.1 **The Trust Board** has a responsibility to ensure that there is an overall policy, procedure & process in place to enable Trust staff to for fill their statutory duty under the Mental Capacity Act (2005).

6.2 The **Chief Nursing and Quality Officer** is the executive lead for Safeguarding.

6.3 The **Head of Safeguarding** is responsible for providing assurance to the Trust Safeguarding Assurance Group and the Quality Assurance Committee, that systems are in place to educate and guide staff to support patients within the scope of the Mental Capacity Act and Deprivation of Liberty Safeguards. This will include policies, procedures, training and expert advisors through the Safeguarding Practitioners.

6.4 The **Safeguarding Adults Lead** will be responsible for:

• Reporting on compliance with this policy.

• Producing a quarterly report to be presented to the Safeguarding Assurance Group for information on progress and compliance.

• Policy review and updates and information disseminated to all divisions via written briefings as and when required.

6.5 The **Divisional management teams** will be responsible for ensuring that staff are able to be released for training and to ensure that there are governance processes to provide them with assurance from the care groups to adherence of these Acts.

6.6 **Heads of Nursing** will support the **matrons** and **ward teams** to ensure that any patients identified as potentially requiring DOLS are assessed and the application made in a timely manner.

6.7 **All Staff** have the responsibility to ensure that they know the legal framework and tools available to support them in the care of patients especially when they have impaired ability to make decisions or to consent for themselves.

6.8 **All staff** must ensure that any restraints used must be the least restrictive option and proportionate to the anticipated risk of harm. This should always be reported on DATIX

6.9 **All staff** must ensure that patients are risk assessed and the appropriate restraints are agreed with the multidisciplinary team, implemented, reviewed regularly and documented in the health records.

6.10 **All staff** must be appropriately trained to understand and have a working knowledge of the MCA 2005 and DOLS requirements and be responsible for alerting the multi-disciplinary team of any potential DOL with regards to a patient in their care.

7 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Mental Capacity Act (2005) policy	Annually or as legislation changes.	Head of Safegaurding and Adult	Safeguarding assurance group	The Mental Capacity Amendment Act is now in place and implementation of Liberty Protection

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
		Safeguarding lead.		Safeguards will replace DoLS from 01/04/22
Compliance with Policy	Quarterly reports to produce training and audit updates	Adult Safeguarding lead	Safeguarding assurance group	

8 Training and Implementation

8.1 Mental Capacity and Deprivation of Liberty is a Mandatory Training Topic and is delivered by the Safeguarding Team.

8.2 The Training is delivered face to face.

8.3 The training is a minimum of 3 yearly, however staff should attend more regularly to maintain their knowledge if they need to.

8.4 An eLearning package will be made available to staff by January 2020

9 Equality Impact Assessment Statement & Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide “evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]”.

The policy owner must insert here a statement to summarise how they have assessed the policy for impact on the protected characteristics under the Equality Act 2010. Guidance on how to do this can be found in the Guidance Note on Equality Impact Assessment [AGN00168 - Equality Impact Assessment guidance note]. Key issues to include are:

- An assessment of how relevant the policy is to equality and diversity
- The key informants (e.g. data and/or consultees) of the assessment
- What, if anything, was learnt, and any actions that need to be taken to ensure that the policy can be delivered equitably.
- Where the impact assessment can be located (e.g. available from the document author)

10 References

Document	Ref No
References:	
The Mental Capacity ACT 2005	
Deprivation of Liberty Safeguards Code of Practice (2008)	
Bournewood Judgement (HL v United Kingdom 2004 App No 00045508/99)	
Human Rights Act (1998)	
The Care Act 2014	
Trust Associated Documents:	
Safeguarding Adults Policy	GUCPCM001
Corporate Safeguarding Policy	POLPCM082
SOP Process for applying for a deprivation of liberty safeguard	SOP0195
Inclusion policy	POLCHR044
Restraint procedures	SOP0401
Consent Policy	POLCGR034
Covert Administration of Medicines	SOP0627

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