

Mental Capacity Act (2005) Practice Guideline

GUIDELINE INFORMATION

Guideline number: 811

Classification:

Clinical

Supersedes:

Not applicable

Local Safety Standard for Invasive Procedures (LOCSSIP) reference: Not applicable

National Safety Standards for Invasive Procedures (NatSSIPs) standards: Not applicable

Version number: 2

Date of Equality Impact Assessment:

06/09/2024

APPROVAL INFORMATION

Approved by: Operational Quality Safety & Experience Sub Committee OQSECSC

Date of approval: 11/07/2024

Date made active: 30/08/2024

Review date: 11/07/2027

Summary of document:

This guidance is to clarify the implementation of the Mental Capacity Act 2005 by staff working for Hywel Dda University Health Board. This guidance is not a substitute for the more detailed information in the Code of Practice, which all staff are required to be familiar with. It is also not a comprehensive summary of the Mental Capacity Act, so should be used in conjunction with the Code of Practice and other related guidance.

Scope:

This guidance is relevant to all clinical areas and all clinical and support staff providing care to young people and adults. It supplements the statute and Code of Practice and should be used to assist compliance with statutory responsibilities.

To be read in conjunction with:

419 - [Advance Decisions to Refuse Treatment Policy](#) (opens in a new tab)

163 - [Deprivation of Liberty Safeguards Policy](#) (opens in a new tab)

141 - [Independent Mental Capacity Advocacy Service Policy](#) (opens in a new tab)

008 - [Consent to Examination and Treatment Policy](#) (opens in a new tab)

843 - [Reducing Restrictive Practice Policy](#) (opens in a new tab)

268 - [Medicines Policy](#) (opens in a new tab)

Patient information:

Not applicable

Owning group:

Mental Capacity & Consent Group

Discussed: 05/03/2024 Signed off 3.5.2024

Executive Director job title:

Director of Operations and Deputy Chief Executive

Reviews and updates:

Version 1 - 19.06.2019

Version 2 - (full review)

Keywords

Capacity, best interests

Glossary of terms

Mental capacity - The ability to make a decision

Decision-maker - The person intending to take an action or make a decision on behalf of a person believed to lack capacity

Lasting Power of Attorney - A formal authority empowering a trusted person to act on behalf of another adult

Fluctuating capacity - Where a person's decision making varies from periods where they can make certain decisions, to periods where their impaired or disturbed functioning of mind means they cannot

Court Appointed Deputy - A person empowered by the Court of Protection to act on behalf of a person who lacks decision making capacity

Best interests - The process required to make a decision on behalf of a person who lacks capacity to make the decision themselves

Independent Mental Capacity Advocate - A statutory advocate who represents the wishes, feelings, beliefs and values of a person who lacks capacity

Capacity assessment - The process required to determine whether or not a person can make a specific decision for themselves

Restraint - The threat of or use of force to make a person do something they are resisting or the restriction of movement (whether the person resists or not)

Deprivation of Liberty - Where a person who cannot consent to their accommodation (and related care or treatment) is subjected to continuous supervision and control and is not free to leave for a not insignificant period of time

Deprivation of Liberty Safeguards - A civil scheme for the assessment and authorisation of a deprivation of a person's liberty in a hospital or registered care home

Covert medication - Providing medication to a person without their knowledge or consent

Advance decision - A legal process for refusing certain medical treatments in the event of the person losing capacity to make decisions about these treatments

Court of Protection - The court which considers matters in relation to people who may lack capacity for the related matter

Key points:

The document covers when, how and who should assess decision-making capacity; how to formulate best interests decisions; guidance on protection from liability for acts of care and treatment; Advance Decisions; Lasting Powers of Attorney and Court Appointed Deputyships.

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SCOPE

This guidance is relevant to all clinical areas and all clinical and support staff providing care to young people and adults. It supplements the statute and Code of Practice and should be used to assist compliance with statutory responsibilities.

AIM

This guideline aims to supplement the Mental Capacity Act Code of Practice (2007) by providing some practical advice on key processes implicit to the implementation of the Mental Capacity Act (MCA) (2005). It does not replace the Code of Practice, nor does it provide guidance on all the provisions in the Act and so needs to be read in conjunction with the Code of Practice.

OBJECTIVES

This guideline provides practical advice in relation to some of the key processes in the MCA including:

- The meaning and implications of the statutory principles
- When, who and how to assess decision making capacity
- What is meant by best interests decision making and how to make a best interests decision
- What is an IMCA and when and how to refer to them
- What support the Mental Capacity Team can provide and how to refer to them
- Advice on forms of prior authority, including advance decision, lasting power of attorney and court appointed deputies

INTRODUCTION

Having mental capacity means a person is able to make their own decisions. There are many reasons why people could have difficulty making decisions from time to time but the Mental Capacity Act is designed to cover situations where someone is not able to make a decision because of the way their mind or brain is affected, for example by illness, disability or the effects of drugs or alcohol.

The Mental Capacity Act applies in England and Wales. Staff who are involved in the care, treatment or support of people over the age of sixteen who may lack capacity to make decisions for themselves must work within its requirements.

The Act provides safeguards for people who lack capacity and the people who work with, support or care for them. It puts the individual who lacks capacity at the centre of decision making and stresses the importance of enabling the individual to make their own decisions. If they are unable to make the decision themselves, the Act emphasises they should be involved in the decision-making process as much as possible.

The Mental Capacity Act also recognises adults with capacity can make decisions that others may regard as unwise, for example refusing medical treatment. It allows people with capacity to plan ahead should they be unable to make decisions in the future.

Capacity relates to a particular decision at the time it needs to be made. A person may be able to make some decisions but lack the capacity to make others. Decision making capacity can also vary over time, for example the person who can usually make decisions for themselves might lose that ability if they become unwell, but regain capacity when they recover.

THE STATUTORY PRINCIPLES

The Mental Capacity Act is underpinned by five statutory principles which must inform what we do when providing care or treatment to a person who lacks capacity. These principles are not to be seen as aspirations, they must be adhered to and our records show this if we are to be compliant with the Act.

The principles are divided into two parts; the first three are concerned with best practice in assessing capacity and the last two are relevant to supporting people who lack capacity. The last two principles only apply if the person is assessed as lacking capacity to make the particular decision.

A person must be presumed to have capacity unless it is established that they lack capacity

We must always start by presuming the person has the capacity to make this decision and are looking for evidence the person does not have capacity, not the other way round. If there is insufficient evidence to disprove / rebut the presumption of capacity principle, the person has the capacity to make that decision at that time. This principle is about the balance of power; traditionally we have required people to prove or defend their ability to make decisions but under the Mental Capacity Act if we feel the person lacks capacity to make the decision at the time it needs to be made, we need to find the evidence to support that.

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

It is the assessor's responsibility to do all that is reasonable to help the person to make the decision before deciding they lack capacity. For example, seeing people when they are more likely to be at their best, the time of day the assessment is carried out, or if communication can be enhanced through the support of speech and language therapists or an interpreter. Consideration needs to be given to whether the person's capacity is likely to return and if the decision can wait, for example until they are medically fit, or have more information or skills.

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

An unwise decision could be a reason to consider undertaking an assessment of the person's capacity however, the fact others feel the decision is unwise cannot be used as evidence the person lacks capacity. People can make unwise choices if they understand the likely consequences of their decision.

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

Any action taken or decision made on behalf of someone who lacks capacity must be done in their best interests. This is a *process* as well as an *outcome* and is only used as a substitute for a person who has been assessed as lacking capacity to make the decision in question. You cannot take any action under "best interests" if the person has capacity, regardless of how unwise you feel their decision might be.

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

Doing what has always been done, without considering the impact on the person is not good enough. By deciding someone lacks capacity, harm has already been inflicted, taking away their autonomy in

the matter. The best interests process needs to ensure more harm is not inflicted by excessive restrictions. For example, tying the individual to a chair is likely to keep them safe from falls, but would generally not be seen as a less restrictive option or a reasonable approach.

WHEN SHOULD CAPACITY BE ASSESSED?

As there is a presumption of capacity then not everyone should have a capacity assessment when faced with a decision. Assessing capacity is an intrusive process, only be undertaken when there are good reasons to doubt the person can make the decision at the time because of an impairment or disturbance of the mind or brain.

However, it is also important that the presumption of capacity is not used to avoid completing an assessment when there are genuine reasons to think the person may not be able to make the decision. The Act does not dictate how often capacity assessments need to be completed. However, if there has been a change suggesting the conclusion is no longer accurate, the assessment needs to be revisited. For example, if someone was found to lack capacity and appears to have improved and it is felt they could now make the decision, the original assessment is no longer valid. If an assessment has concluded the person had, or lacked capacity to make the decision and the evidence suggests this has not changed, the assessment does not need to be repeated.

It is important to ensure the capacity assessment is carried out at the right time. Generally, this would be when a capacitous person would be asked to make their decision. The options available need to be clear, and a discussion had with the person prior to any appraisal of their decision making capacity. Some people may require time to process the information or repeated discussions to aid their decision making. The options available to the person in relation to the decision are the same regardless of whether the person has capacity or not; we cannot restrict options depending on whether the person has capacity or not.

WHO ASSESSES CAPACITY?

The capacity assessment should usually be carried out by the decision-maker. This is the practitioner who is closest to the decision, or the person at the time the decision needs to be made. It is usually the professional who needs the decision to be made to progress their care and / or treatment of the individual. If you are unsure who the decision-maker is consider, if the person had undisputed capacity, who would be asking the individual for their choice, and that practitioner is likely to be the decision-maker.

The Act does not exclude any specific groups of staff as assessors, but professionals must not carry out a capacity assessment on decisions outside their remit and knowledge and the Health Board would only expect these assessments to be completed by registered professionals.

Sometimes, where the situation is complex, or the person's decision-making difficulties are subtle or difficult to appraise, it might be appropriate to ask an experienced capacity assessor to undertake the assessment or give a second opinion. The Mental Capacity Team can be contacted and advise in such circumstances.

HOW TO ASSESS CAPACITY

Capacity means the ability to decide and is time and issue specific. We cannot “globally” assess if someone has capacity or not; it must be considered in relation to the decision that needs to be made. The decision needs to be clarified, and the options established before the assessment of capacity. If this is not clear the assessor cannot effectively consider the person’s decision-making process. The decision to be made, and the potential options are the same regardless of capacity. If the person is assessed to have capacity, they make the decision. If not, the decision is made by the appropriate substitute; someone with a relevant Lasting Power of Attorney, a Court Appointed Deputy or the decision-maker through the best interests process.

Preparation

Gather collateral information by reviewing the records, speaking to relevant staff and family members. This will help you decide what the ‘relevant information’ is and the issues you need to discuss with the person. Also, you need to know the correct answers to the questions you ask the individual when you are assessing a person’s capacity.

Can the person make the decision?

This needs to be focussed on the decision in question and has four stages; the ability to understand, retain and use or weigh relevant information, and communicate their decision: if the person is able to do of these things, they will have capacity to make the decision.

Understand

Does the person have any difficulty understanding the information about the decision? Comment on any difficulties you felt the person had understanding information relevant to the decision - evidence of understanding would usually be found in the person’s responses to questions - were they appropriate to context and content, did they seem able to follow the ‘flow’ of a conversation?

It is important that you do not base your assessment on shortcomings in a person’s existing or intuitive understanding of the ‘relevant information’. You must give them ‘corrective information’ and ‘alternative perspectives’ to see if this improves their understanding. For example, if someone does not think there is a risk of their falling, you would need to give them information about past falls and injuries, etc.

Retain

The person needs to retain the information long enough to make the decision. Are they able to reflect back what you have been talking about? For example, ‘What did we say your son is worried about?’ The person normally only needs to retain information long enough to consider it in reaching a decision at the time it needs to be made; forgetting the conversation the next day would not usually be significant. Obviously, with more complicated decisions, the person needs to be able to retain a greater amount of information.

Weigh up

This is the most subjective part of the assessment. Can the person weigh up the pros, cons and risks and take on new or corrective information? The person needs to consider all the key factors, but remember that people may not share your values and priorities, and if they weigh things differently to you this does not mean they lack capacity.

You need to try and appreciate what is important to the person in making this decision, for example, 'why is going home so important to you?', and whether they can incorporate other important issues, such as the risks they might face in a particular option. A person might value the emotional attachment they have to their own home and consider this as more important to them than any risks. People will instinctively paint an overly 'positive' picture of the consequences of their preferred decision; it is important to 'dig' a little rather than accept this tendency as evidence of an inability to weigh information.

'Belief' is critical to an ability to 'use and weigh' information. For example, if a person can't remember, and doesn't believe that they have experienced numerous falls and injuries, this important factor will not figure in their consideration of the decision. This contrasts with an acceptance of past falls and the risk of similar future occurrences, which will suggest an ability to weigh such information, even if the person ultimately rejects this as the key issue for them.

Sometimes the person's mental disorder might directly impede their ability to reasonably consider key aspects of a decision. For example, a person with an eating disorder may understand information about the consequences of not eating, but their compulsion not to eat might be too strong for them to ignore.

Communicate

This will only be a factor if the person's communication is so impaired that they are simply unable to communicate their decision in any way which can be reliably understood. Remember to take all practicable steps to help you communicate with and understand the person.

Where a person has profoundly impaired communication, for example, limited to an ability to indicate 'yes' and 'no' in some way, it is important to test whether these responses are reliable. You can check this by asking the person a series of closed questions to which you know the answer, for example, 'do you live in London?' Similarly, using closed questions, you can provide relevant information about the decision in simple terms and offer the person opportunities to indicate their preferences.

When communication is so limited it is very difficult to evaluate the nuances of the person's decision-making. If a person's attempts to communicate are completely unable to convey any discernible meaning they cannot, in effect, communicate a decision. Conversely, meaningful and consistent responses might mean you are not able to evidence a lack of capacity. In cases like this it is advisable to seek support from a person who knows the individual very well, or an expert on communication such as a Speech and Language Therapist.

Does the person have an impairment or disturbance in the functioning of mind or brain?

There must be evidence of an impaired or disturbed functioning of the mind or brain. For example, do the records include descriptions of confusion, cognitive assessments, formal diagnoses of conditions which impair cognitive functioning, etc. Are the person's family and friends, or support staff worried about their cognitive functioning? Can they give examples of how any cognitive difficulties present? If there is no such evidence, then the individual cannot lack capacity under the Act and there is no reason to question the presumption of capacity

It is also helpful to check if the person is orientated to time, place, and person. For example;

- Time* - Does the person know the approximate time of day? Can they tell you the current month and year? Do they know roughly how long they have been in hospital?
- Place* - Is the person aware they are in hospital? Can they tell you their current address?
- Person* - Can the person tell you about key people in their life; their partner, children and very close friends?

Sometimes the impact of any impairment might be more subtle perhaps, for example, affecting judgement more than memory/orientation. These cases might require a second opinion from a person more expert in assessing and diagnosing mental disorder.

Is any inability to make the decision because of the impairment or disturbance to the mind or brain?

The Act defines incapacity as occurring where the person is unable to make a decision '*because of*' an impaired or disturbed functioning of mind - this is known as the 'causative nexus' - so if you are saying you think someone lacks capacity you must evidence that this is caused by the effects of their cognitive difficulties. For example, a lady with paranoid schizophrenia developed gangrene in her foot; her avoidance of making a decision was not accepted as indicating a lack of capacity since there was no clear link between this tendency and her underlying mental disorder (*Heart of England Trust v JB* (2014) EWHC 342 (COP)).

Conclusion and Recording

There is often an element of subjectivity, and you are not required to be absolutely certain about a person's capacity. Your conclusion will be on the balance of probabilities, which means the evidence suggests it is more likely than not that the person has or lacks capacity for this decision.

Based on the evidence you have gathered do you feel it is sufficient to disprove the presumption of capacity principle? What conclusion do you feel is more probable than not?

Make sure you fully record your assessment. Use direct quotes from the person to illustrate the evidence for your decision if you can. Record who you have spoken to, where the assessment took place and the general presentation of the individual. Good quality recording is the difference between it being an opinion or an evidenced appraisal and makes your assessment more robust. If it was a finely balanced assessment, say so.

Because you cannot be 100% sure, use expressions such as "my view is..." "I consider that...", "my impression was..." Your conclusion will be "on balance" or "on balance of probabilities" and recorded in this way.

If the person refuses a capacity assessment

Sometimes the person does not agree to engage with the assessment of their capacity. In some circumstances it is appropriate to reach a conclusion based on the available evidence in consultation with the relevant people. On occasion legal advice will need to be sought and potentially, for decisions of great importance, an application to the Court of Protection may be necessary.

Fluctuating capacity

The Act requires an assessment of capacity to be undertaken when the person is at their best.

However, if a person's cognitive functioning fluctuates and this is relevant to the decision being considered, they would need to be able to recognise and consider the consequences of that fluctuation in their functioning. For example, a person who is usually lucid and orientated who regularly becomes disorientated in the evenings, would need to appreciate the implications of these changes on their well-being.

Most decisions are isolated instances, but some 'decisions' involve an ongoing series of actions. In the latter case, a person may not be able to make ongoing decisions, sometimes at short notice due to fluctuating cognition. This might include managing your finances or a long-term complex health condition.

Equally, with some types of cognitive impairment, the person may be able to 'talk through' their decision-making process, identifying potential consequences, but have been shown to be unable to carry out the necessary steps in day-to-day life. For example, such a person may be able to describe how to safely cross the road but, in practice, are unable to use the identified strategies. This may mean the person will lack capacity, even though they seem able to provide reasonable responses during the assessment. These can be complicated cases and you may need additional support from a more expert practitioner.

BEST INTERESTS

When a person is found to lack capacity to make a decision, someone else needs to make this decision on their behalf. The decision-maker will have that authority either because they have a Lasting Power of Attorney or are a Court Appointed Deputy or because they are the most appropriate professional to undertake substitute decision making. This is the practitioner who is closest to the decision, or the person at the time the decision needs to be made. It is usually the professional who needs the decision to be made to progress their care and / or treatment of the individual. If you are unsure who the decision-maker is consider, if the person had undisputed capacity, who would be asking the individual for their choice, and that practitioner is likely to be the decision-maker. For cases considered in the Court of Protection, the judge will be the decision-maker.

Some decisions cannot be made on behalf of a person who lacks capacity as they are considered too personal or are covered by other legislation. The Code of Practice details these excluded decisions at paragraphs 1.8 - 1.11.

The decision-maker must follow the best interests checklist found in paragraph 5.13 of the Code of Practice which includes:

- Considering all relevant information
- Involving the person as much as possible in the decision
- Consulting people who have an interest in the welfare of the person
- Considering if the person is likely to regain capacity and whether the decision can wait
- Considering the person's past and present wishes, feelings, beliefs and values and any other factors the person would consider if able to do so
- Not basing the decision solely on the person's age, appearance, behaviour or condition

If the decision is straightforward and everyone involved is in agreement, then the decision-maker can make a best interests decision rather than arranging a best interests meeting. However, the decision-

maker must ensure they consult with all relevant people, particularly the individual who lacks capacity. He or she must document this consultation and their evaluation of the available options as well as their conclusion on which option is in the person's best interests and why. If there are likely to be differing opinions, the decision is finely balanced, or may conflict with the person's wishes and feelings, then a best interests meeting will need to be convened.

Best Interests Meetings

Best interests meetings are not required under the Act but the Code of Practice recommends they are used for serious decisions or where there is dispute.

Pre-meeting checklist

Make sure that:

- a) A documented assessment of the person's decision-making capacity relevant to the decision has been completed and is available for the meeting
- b) Any safeguarding concerns have been progressed and a protection plan (if required) has been developed and is available for the meeting
- c) If a DST is required this should be completed *before* best interests is considered
- d) Relevant people have been identified and invited to attend
- e) A person is available to record a summary of the discussion at the meeting
- f) Communication difficulties or any other special requirements of those invited to attend have been considered
- g) Consider how best the person can participate in the decision can they attend (part or all) of the meeting? If not, can they write down or record their views in some other way? If not, who is best placed to represent their views?
- h) Consider referring to the MCA Team to chair the meeting if:
 - The decision is finely balanced
 - A dispute is anticipated
 - There appears to be a likelihood that the person's expressed wishes may not represent their best interests

Below is a suggested structure for managing the discussion at a best interests meeting:

- **Welcome, purpose, introductions**
- **Decision**
Clarify the decision that the meeting is to consider
- **Capacity**
Clarify that the person has been assessed as lacking capacity for the decision at hand. Review the main thrust of the capacity assessment and summarise why it was felt that the person lacks capacity. Check that this outcome is accepted by the people present
- **Decision-maker**
If at all possible, its good practice to identify the person who will be making the best interests decision (can sometimes cause difficulties and some folk prefer them to be a group decision. My own view is that there should still be a person identified as the decision-maker)

- **Participation of the person who lacks capacity**
Check that the best way of enabling the person's participation has been considered (see pre-meeting checklist above)
- **Background**
Ask people who know the person well (relevant professionals and family) to summarise recent events leading to this decision as well as relevant information about the person's medical conditions/treatment and care needs, etc
- **Wishes and feelings** (beliefs and values)
Discuss what can be established about the person's wishes, feelings, beliefs and values in relation to *this* decision
- **Options**
Clarify the range of potential options available (that might be more than two! – and be aware that other options might become apparent during the discussion). This might be what the person has clearly indicated but it might also be what we know about the person's likes/dislikes, etc
- **Consultees not present**
If there are people who are not able to attend the meeting (especially where these are family/friends of the person) its really important to make sure their views have been sought and are represented
- **Balance sheet**
Facilitate discussion around the pros (and cons) of each of the options.
Summarise the key advantages for the various options
- **Making a decision**
Give each participant the opportunity to comment on the balance sheet and to indicate their views on weighing up the issues for the decision. Ask the decision-maker to make a decision, and to comment on how they have reached their conclusion.

A template form to support you in completing a balance sheet is available on the Mental Capacity Act intranet page: [Information and resources \(sharepoint.com\)](#) (opens in a new tab)

REFERRAL TO AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)

The IMCA service is a statutory form of advocacy for people who lack capacity to make certain decisions and, at the time such decisions need to be made, have no one else (other than paid staff) to support and represent them or be consulted.

It is not normally available to people who have family or close friends that can be consulted about the decision. However, an IMCA may become involved if there are safeguarding concerns or as a Paid Representative under the Deprivation of Liberty Safeguards.

IMCAs do not undertake capacity assessments and are not the decision-maker in the best interests process. They act as a substitute for interested family or friends when these are not available. The IMCA's main role is to give an independent report on the person's current or past wishes, culture,

beliefs and values in order to help the decision-maker ensure that he/she is working in the person's best interests. To do this, the IMCA will gather information about the person's wishes, values and circumstances, as well as identifying possible alternative courses of action, in order to inform the final decision.

There is a legal duty to refer to an IMCA if a person lacks capacity and has no friends or family appropriate to consult when the decision concerns:

- Serious medical treatment (which includes decisions about Do Not Attempt Cardio-Pulmonary Resuscitation)
- Whether to place the person into a care setting

A referral to the IMCA can also be made if it considered beneficial to the person:

- Where a change in the person's care placement is being considered

In addition, there are a number of situations where an IMCA referral is made by the DoLS Team for patients subject to the Deprivation of Liberty Safeguards.

The IMCA Service is not able to respond out-of-office hours or on an emergency basis. If serious medical treatment or a change of accommodation needs to be provided urgently to save an incapacitous person's life or prevent a serious deterioration, then this needs to be progressed and a referral made to IMCA as soon as possible.

More information and the referral form is available from the [IMCA Service webpage](#) (opens in a new tab) and the Health Board's Policy on the [Independent Mental Capacity Advocacy Service](#) (opens in a new tab)

REFERRALS TO THE MENTAL CAPACITY TEAM

The Mental Capacity Team provide support for staff in implementing the Mental Capacity Act. This can include advice, training, undertaking capacity assessments and chairing best interests meetings. The Team are not able to respond on an urgent basis or outside office hours so staff need to be aware of their responsibilities and the provisions under the Act as it is part of their day to day practice.

The Team should not need to be involved in straightforward capacity assessments or best interests meetings, but generally provide support in more complex situations. Usually, the professionals directly supporting the person are best placed to undertake necessary capacity assessments.

Referrals for capacity assessments need to be made using our [online referral form](#) (opens in a new tab). Referrals will not usually be accepted by telephone.

Capacity assessments for consent to medical treatment

The Team are not able to undertake these assessments independently so the relevant clinician needs to be involved. The Team can assist with the process to ensure the assessment has been completed in line with the requirements of the Mental Capacity Act. Prior to the capacity assessment staff need to ensure:

- They have established the person has an impairment of the mind or brain and there is reason to question their ability to make the decision
- They have clarified the decision to be made and the treatment options available to the person
- These have been discussed with the person

Capacity assessments for care and residence arrangements

The Team are able to assist in undertaking more complex capacity assessments for this decision, but the involved professionals are usually best placed to undertake more straight-forward assessments.

Prior to the referral being made, staff need to ensure:

- The person has an impairment of the mind or brain and there is a reason to question their ability to make the decision
- They have clarified the decision to be made
- The options available to the person have been established – this may require other assessments to be completed prior to the capacity assessment, for example occupational therapy or social work to be clear on what services will be available, and what the risks are with each option
- A discussion has been had with the person on the decision to be made and the available options
- The person is medically fit and has no infections or other treatable conditions that may temporarily affect their decision-making

The Team does not undertake capacity assessments in relation to decisions around managing property and finances as this is not within the remit of Health staff. They also do not assess capacity in relation to a person moving from one residential home to another or from a residential home to a nursing home. The capacity assessment in this case needs to be completed by the decision-maker who will have the required level of detail about the service provision.

For other decisions either contact the Team for advice or complete the referral form.

Requests for a team member to chair a best interests meeting need to be made using our [online referral form](#) (opens in a new tab). As availability cannot be guaranteed it is advisable to liaise with the Team before finalising the time and date of the best interests meeting

ACTS IN CONNECTION WITH CARE AND TREATMENT

Section 5 of the Mental Capacity Act allows carers and staff to carry out tasks such as the personal care, health care or treatment of people who lack capacity to consent. It provides protection from liability as long as the requirements of the Mental Capacity Act are followed.

For day-to-day decisions without significant consequences, and where there is no conflict, staff members do not need to follow formal processes such as undertaking a formal capacity assessment. However, they must be able to evidence why they have a reasonable belief the person lacks capacity and objective reasons to show why they believe the action they are taking is in the person's best interests.

For decisions that have a significant consequence for, or impact on, the person, formal procedures such as a capacity assessment and, if appropriate, best interests decision need to be used to ensure protection under section 5 of the Act.

Emergency situations

In an emergency, when the person does not have the capacity to consent to care or treatment that will potentially save their life or protect them from serious harm, there may not be time to consider 'all practicable steps' to help the person make a decision or to undertake formal processes such as a

capacity assessment or best interest decision. If there is a reasonable belief the person lacks capacity, and the decision cannot wait then the Code of Practice advises it is almost always in the person's best interests to provide care or treatment without delay. The exception to this being where there is a valid and applicable advance decision to refuse medical treatment (see section on advance decisions).

Negligence

The Mental Capacity Act does not provide protection in the case of negligent practice, either in carrying out a particular intervention or failing to act when necessary. Professionals can be challenged on negligent practice regardless of whether the person has capacity or not.

Restraint

In certain circumstances, The Mental Capacity Act offers protection from liability when restraining a person who lacks capacity. It defines restraint as:

- The use or threat of using force to make a person do something they are resisting **or**
- The restriction of liberty of movement, whether or not the person resists. For example, the use of mitts, lap-belts, etc.

Anyone using restraint must be able to justify the restraint is necessary and show that the person is likely to suffer harm unless proportionate restraint is used. To be protected from liability under section 5 to use restraint, the following criteria must be in place:

- The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity
- The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of the harm

The Mental Capacity Act does not provide protection for restraining the person to prevent harm to others, but protection may be afforded in urgent situations from the common law. Also, it does not provide protection for any act that deprives the person of their liberty. Any act that is a deprivation of, rather than a restriction on, the person's liberty must be authorised under the Deprivation of Liberty Safeguards or through the authority of the Court of Protection.

More information is available from the Health Board's [Reducing Restrictive Practice Policy](#). (opens in a new tab)

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

If the person lacks the capacity to consent to their care and treatment and it constitutes a deprivation of liberty, authorisation must be obtained through the Deprivation of Liberty Safeguards (DoLS). The safeguards apply to hospitals and registered care homes. Hywel Dda University Health Board has a DoLS Team that undertake assessments to ensure all the relevant criteria are met and it is in the person's best interests for the authorisation to be put in place.

A deprivation of liberty occurs when:

- The person is subject to continuous supervision and control **and**
- Is not free to leave **and**
- These measures are in place for a not insignificant period of time

This is known as the Supreme Court's 'acid test' (UKSC 19 [2014]) and authorisation must be obtained for a person who lacks capacity under these conditions. An application for an authorisation must also be made where the person lacks capacity to consent, regardless of whether the person is actively attempting to or requesting to leave or is seemingly compliant with the arrangements.

The Act has two types of authorisation: Standard and Urgent. The application for a Standard Authorisation needs to be made by ward staff to the DoLS Team when a patient lacks capacity and meets the acid test.

An Urgent Authorisation is completed on page 3 of the [Form 1](#) (opens in a new tab) DoLS application form. It is necessary to complete an Urgent Authorisation where the deprivation of the person's liberty is already occurring, and it has not been possible to apply for a Standard Authorisation in advance of a person's admission. This provides the power to detain the person for a maximum of seven days, with a possibility of extending to fourteen days if agreed by the DoLS Team. If an Urgent Authorisation is put in place, an application for a Standard Authorisation must be submitted at the same time.

Sometimes a person may lack capacity due to an acute illness or infection which is likely to resolve in a short space of time with treatment. Normally there would not be a requirement to seek authorisation under DoLS on these occasions but to use powers under section 5 of the Mental Capacity Act. Advice should be obtained from the DoLS Team if there is uncertainty of whether an application for an authorisation is required.

More information and the referral form can be found on the Health Board's [DoLS intranet page](#) (opens in a new tab) and the [Deprivation of Liberty Safeguards Policy](#). (opens in a new tab)

Covert medication

Administering covert medication to a person who lacks capacity must be done in line with the Mental Capacity Act. In the judgment in *AG v BMBC & Anor* [2016] EWCOP37, District Judge Bellamy gave clear guidance about the required steps as below:

- “(i) if a person lacks capacity and is unable to understand the risks to their health if they do not take their prescribed medication and the person is refusing to take the medication then it should only be administered covertly in exceptional circumstances;*
- (ii) before the medication is administered covertly there must be a best interest decision which includes the relevant health professionals and the person's family members;*
- (iii) if it is agreed that the administration of covert medication is in their best interests then this must be recorded and placed in the person's medical records/care home records and there must be an agreed management plan including details of how it is to be reviewed; and*
- (iv) all of the above documentation must be easily accessible on any viewing of the person's records within the care/nursing home.*
- (v) If there is no agreement then there should be an immediate application to Court.” (at 36)*

Advice should be sought from relevant professionals, such as a pharmacist, on how the medication can be administered for example, if it can be concealed in food or crushed.

The decision to administer covert medication is generally considered a deprivation of liberty so an application should normally be made for authorisation under the Deprivation of Liberty Safeguards. Further guidance is available in section 5.3 of the [Medicines Policy](#) (opens in a new tab).

Removal to hospital

The Mental Capacity Act does not provide a clear authority to remove a vulnerable person who is felt to lack capacity from their own home; in many instances such a step would require a court order. However, where the purpose is to take the person to hospital for urgently required medical assessment and treatment, it is believed that the protection from liability in sections 5 and 6 of the Act can apply. Further information is available in the Health Board's [Guidance on the urgent removal of vulnerable adults from their home to hospital](#) (opens in a new tab).

Advance Decisions

An advance decision to refuse treatment enables someone aged 18 and over, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to accept or refuse treatment. An advance decision only comes into force when a person loses capacity to accept or refuse the specific treatment or procedure to which it refers.

A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision made by a patient with decision-making capacity. Health care professionals must follow an advance decision if it is valid and applies to the particular circumstances. Section 5 of the Mental Capacity Act provides protection for staff who act in line with a valid and applicable advance decision.

For an advance decision refusing life-sustaining treatment to be applicable it must meet the following requirements:

- it must be in writing;
- the person making the advance decision must sign it in the presence of a witness;
- the witness must sign the document in the presence of the person making the advance decision;
- it must include a clear, specific written statement from the person making the advance decision that it is to apply to the specific treatment even if their life is at risk.

For full and detailed information about advance decisions please refer to [Policy 419, Advance Decisions to Refuse Treatment](#) (opens in a new tab). This includes the following information:

- how to decide if an advance decision is valid and applicable;
- what can and cannot be included in an advance decision;
- what to do where an advance decision refuses life sustaining treatment;
- how to help someone make an advance decision;
- how to find out if an advance decision exists;
- what to do in an emergency;
- what to do if you disagree in principle with the request in the advance decision;
- cancelling or making changes to an advance decision;
- and the relationship between advance decisions, Lasting Power of Attorney, and Court Appointed Deputies.

Any disagreement or uncertainty about the legal applicability or ramifications of an advance decision should be referred to the Legal Services Team expeditiously.

LASTING POWER OF ATTORNEY

Lasting Powers of Attorney (LPA) provide a means for people to plan ahead, by giving powers to another person to make decisions on their behalf should they lose capacity in the future.

There are two types of LPA:

- Property and affairs – this concerns managing the person’s financial affairs and can come into force even when the person has capacity if they agree to it
- Health and Welfare – this concerns treatment or other health and social care decisions. Health and Welfare LPAs only come into force when the person lacks capacity

To establish an LPA:

- The person must be aged 18 or over **and**
- Has the capacity to make an LPA at the time the power is granted **and**
- One or more people who agree to become their attorney if they lack capacity in the future

The person can decide who they wish to act as LPA and there is no limit to the number of people they can appoint into this role. If there is more than one attorney they can be required to act:

- Jointly – all attorneys must agree each decision
- Jointly and severally – any of the attorneys can make the decision without agreement from the others
- Jointly for some matters and jointly and severally for others – the person can specify whether the attorneys must all agree for certain decisions, for example refusal of life sustaining treatment

The LPA must be registered with the Office of the Public Guardian before it can be used. The Office of the Public Guardian also provide a free checking service for LPAs through their website www.gov.uk/government/publications/search-public-guardian-registers (opens in a new tab).

If the person lacks capacity to make decisions covered by the LPA, the attorney becomes the decision-maker. Staff must see the original LPA document to ensure the powers are in place and take a copy of the document and place in the records.

Attorneys must comply with the Mental Capacity Act and make decisions in the person’s best interests. If there are concerns that the attorney is not acting in the person’s best interests, then staff can raise their concerns directly with the attorney in the first instance. If concerns remain then the Office of the Public Guardian can be contacted as they have a legal authority to investigate.

To report concerns about an attorney to The Office of the Public Guardian
Email: opg.safeguardingunit@publicguardian.gsi.gov.uk (opens in a new tab)
Telephone: 0300 456 0300.

COURT APPOINTED DEPUTIES

Deputies can be appointed by the Court of Protection to make decisions on behalf of a person who lacks capacity.

There are two types:

- Property and affairs
- Health and Welfare

Deputies are appointed if the person does not have the capacity to make a Lasting Power of Attorney, particularly when the court believes there is a need for ongoing decision making in respect of the person's affairs. To become a deputy, an application needs to be made to the Court of Protection.

If there is more than one deputy they will be appointed to act:

- Jointly – all deputies must agree each decision
- Jointly and severally – any of the deputies can make the decision without agreement from the others
- Jointly for some matters and jointly and severally for others – the Court can specify that some decisions must be made with the agreement of all deputies, while others can be taken by individual deputies

Deputies cannot:

- Override the person's decision if they have the capacity to make a certain decision
- Override a Lasting Power of Attorney where the attorney has authority to make the decision
- Refuse or consent to life sustaining treatment for the person who lacks capacity

The deputy is the decision-maker in the areas the Court of Protection has granted **them** powers. The deputyship order must be seen by staff to ensure it is valid and a copy taken and placed in the records. The Office of the Public Guardian offers a free service to check the register of deputies at www.gov.uk/government/publications/search-public-guardian-registers (opens in a new tab)

Deputies are required to act in good faith and must:

- Follow the Mental Capacity Act's statutory principles
- Make decisions or act in the best interests of the person who lacks capacity
- Have regard to the Code of Practice
- Only make decisions the Court of Protection has given them the authority to make

If staff have concerns that a deputy is not acting in the person's best interests or not following the requirements of the Mental Capacity Act then they can raise their concerns with the deputy in the first instance. If concerns remain then The Office of the Public Guardian has the legal authority to investigate the practice of deputies and should be contacted.

To report concerns about a deputy to the Office of the Public Guardian:

Email: opg.safeguardingunit@publicguardian.gsi.gov.uk (opens in a new tab)

Telephone: 0300 456 0300.

DISPUTES

Disagreements can arise over the conclusions regarding the person's capacity to make the decision in question, or the action to be taken in their best interests.

If there is a dispute regarding the outcome of a capacity assessment, then a second opinion should be sought in the first instance. Contact the Mental Capacity Team to discuss if assistance is required to progress this.

If there remains a dispute and it is between professionals, the usual organisational procedures for disagreement need to be followed to provide a resolution, for example through discussion or multidisciplinary team meetings. If the person or their carers, relatives or friends disagree with the finding of the capacity assessment they can access the complaints procedure for Hywel Dda University Health Board.

If these methods of resolution are unsuccessful then, ultimately, an application will need to be made to the Court of Protection to make a decision about the person's mental capacity. Legal advice must be sought regarding any application to the Court of Protection.

When using the best interests process, the decision-maker must consult with the relevant people and try to find a consensus. However, there are occasions when the decision-maker will make a decision that they believe is in the person's best interests and others disagree. As with disputes regarding capacity assessments, internal processes need to be followed to attempt to resolve the disagreement in the first instance. If the dispute remains, then an application to the Court of Protection may be necessary and legal advice must be sought. If the person, family, carers or friends remain in dispute with the best interests decision then the decision-maker needs to take action and seek legal advice to apply to the Court of Protection.

REFERENCES

Statutes:

- Mental Capacity Act 2005. Access via <http://www.legislation.gov.uk/ukpga/2005/9/contents>. (opens in a new tab)
- Mental Health Act 1983. Access via <http://www.legislation.gov.uk/ukpga/1983/20/contents>. (opens in a new tab)

Cases:

- *AG v BMBC & Anor* [2016] EWCOP37
- *Heart of England Trust v JB* (2014) EWHC 342 (COP)
- *P v Cheshire West and Chester Council and P & Q v Surrey County Council* [2014] UKSC 19