## Policy: MENTAL CAPACITY ACT POLICY

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1 Purpose of policy

1.1 The aim of this procedure is to summarise those areas of the Code of Practice that apply to the hospice. In all cases, the procedure refers staff to the Code if they require detailed information.

1.2 The Mental Capacity Act 2005 establishes five key principles which hospice staff will follow:

1. The presumption of capacity: adults should be assumed to have the capacity to make decisions unless it is proved otherwise.

2. The right to be supported to make decisions: people should be given all appropriate help before it is decided that they cannot make their own decisions.

3. Individuals retain the right to make what might be seen as eccentric or unwise decisions.

4. Best interests: anything done for or on behalf of a person without capacity must be done in their best interests.

5. Least restrictive alternative: anything done for or on behalf of a person who lacks capacity should be done in the way that least restricts their basic rights and freedoms.

1.3 There are two appendices to this policy:

Appendix A – Thames Hospice Mental Capacity Assessment Form CG-F-0001
Appendix B – Thames Hospice Best Interest Decision Record Form CG-F-0002
2 Responsibilities

2.1 Director of Patient and Family Services - Overall responsibility to ensure that the policy is fit for purpose and disseminated throughout the organisation.

2.2 All staff involved in the care of patients, including volunteers, have an obligation to act in accordance with the principles of the Act and in the best interests of a person who may lack capacity to make specific decisions. All staff must:

- Follow the guidance in the Code.
- Have an obligation to act in accordance with the principles of the Act and in the best interests of a person lacking capacity.
- In addition to the above, will:
  - Ensure that all patients have been given the opportunity to make an ‘Advance Decision to Refuse Treatment.’
  - As required, provide patients with information on Advance Decisions.
  - To ask for advice if there is any doubt about the capacity of any person within our care.
  - To ask for advice in all cases where a patient lacks capacity.

3 Policy Statement

3.1 The hospice has a duty to have regard to the Mental Capacity Act 2005 (the Act) and the accompanying Code of Practice when acting in relation to a person aged 16 years and over who lacks capacity to act or make specific decisions for themselves.


3.3 The Deprivation of Liberty Safeguards are part of a legal framework set out in the Mental Capacity Act 2005, and their aim is to ensure that people’s human rights are protected in certain care settings when they are deprived of their liberty.

3.4 The Act sets out principles and mechanisms for making personal decisions on:
3.5 All clinical staff must be familiar with relevant parts of the Code or with the guidance produced on particular parts of the Code. Everyone involved in the care of patients, including volunteers, is expected to follow the guidance given in the Code. A copy of the Code of Practice can be located in the doctor’s office and electronically on the hospice shared folders.

3.6 The hospice acknowledges that a person must be assumed to have capacity to make their own decisions unless it is established that they lack capacity regarding specific decisions.

4 Policy Detail

4.1 Mental Capacity Act 2005

4.1.1 The Mental Capacity Act 2005 introduced new legal requirements relating to the assessment of mental capacity and guidelines on making decisions on behalf of people, aged 16 years or over, who lack capacity. Full guidance is contained in the Mental Capacity Act 2005 Code of Practice, which has the power of statutory guidance.

4.1.2 Many of the provisions in the Act are based upon existing common law principles. The Act aims to ensure that individuals who lack capacity are the focus of any decisions made, or actions taken, on their behalf.

4.1.3 The Act introduces a number of new areas:

- Lasting Powers of Attorney and deputies.
- Court of Protection.
- Office of the Public Guardian.
- Criminal offence.
- Independent Mental Capacity Act Advocacy service (IMCA).

4.1.4 The Act sets rules on:

- Acts in connection with treatment and care.
- Advance Decisions to Refuse Treatment.
- Research.
- Any concerns relating to mental capacity should always be addressed with reference to the Code of Practice.
4.2 **Assessment of Capacity**

4.2.1 Any assessment must relate to the decision in question and not to any wider matter.

4.2.2 There should be no blanket decision that someone lacks the capacity to make all decisions. Each area of decision-making should be assessed separately to enable the person concerned to participate in decision making as far as possible. It is essential that the people who know the person best are involved as fully as possible.

Situations where mental capacity is an issue at the hospice are likely to fall within the categories listed below:

- The person lacks the capacity:
  - To make decisions about their care.
  - To manage their finances or property.
  - To understand that they are being abused/neglected/exploited.
  - To understand that financial decisions are being made on their behalf which are not in their best interests.
  - To understand that they are placing themselves at risk of harm.

4.2.3 An assessment must be made in line with the principles set out in the Code of Practice. The Code describes a two-stage test of capacity:

- Is there an impairment or disturbance in the functioning of the person’s mind or brain?
- If so, is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

4.2.4 When making an assessment the following need to be considered:

- Does the person have all the relevant information to make the decision in question? If there is a choice, has the information been given on any alternatives?
- Could the information be explained or presented in a way that would be easier for the person to understand?
- Are there any times of day when the person’s understanding is better or particular locations where they feel more at ease? Can the decision be put off until the circumstances are right for the person concerned?
• Can anyone help or support the person to make choices or express a view, such as an independent advocate or someone to assist communication?
• The assessment of capacity must take full account of the knowledge and information held by those who know the person best (carers, advocates etc).

Detailed information is given in Chapter 3 of the Code of Practice

4.3 Who should assess capacity?

4.3.1 The person who assesses an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. So it may well be different people at different times for example, a doctor for medical treatments and care, a social worker for alternative placement.

4.3.2 For acts of care or treatment the assessor must have a reasonable belief that the person lacks capacity to agree to the decision that needs to be made.

4.3.3 If a healthcare professional proposes treatment or an examination they must assess the person’s capacity. This is best done within a multi-disciplinary setting, but ultimately it is up to the individual responsible for the treatment to make sure that capacity has been assessed.

4.3.4 In more complex cases it may be necessary to carry out a more formal assessment. This might be carried out by a psychologist or psychiatrist, for example. Nevertheless, the final decision about a person’s capacity must be made by the person intending to carry out the care.

Detailed information is given in Chapter 4 (4.38-4.43) of the Code of Practice

4.4 Best Interests

4.4.1 Once it has been assessed that a patient lacks capacity to make a particular decision it will be necessary to determine what action would be in the person’s best interests. The Code of Practice makes it clear that the Best Interests checklist must be used to demonstrate and to record the decision-making process; this can be summarised under the following headings:
Equal consideration and non-discrimination.
Considering all relevant circumstances.
Regaining capacity.
Permitting and encouraging participation.
Special consideration for life-sustaining treatment.
The person’s wishes and feelings, beliefs and values.
The views of other people.

Comprehensive guidance on the application of best interests is contained in Chapter 5 of the Code of Practice, which should always be available for reference.

4.5 The key steps for determining best interests

4.5.1 The following provides a summary of the key factors which should be taken into account in determining best interests of a person lacking capacity.

- Don’t make assumptions about someone’s best interests merely on the basis of the person’s age or appearance, condition or aspect of their behaviour.
- Try to identify all issues and circumstances relating to the decision in question which are most relevant to the person who lacks capacity.
- Consider whether the person is likely to regain capacity. If so, can the decision wait until then?
- Do whatever is possible to permit and encourage the person to participate, or improve their ability to participate, as fully as possible in making the decision.
- If the decision concerns provision or withdrawal of life-sustaining treatment, you must not be motivated by the desire to bring about the person’s death. Do not make assumptions about the person’s quality of life.

4.5.2 Try to find out the views of the person lacking capacity, including:

- The person’s past and present wishes and feelings – both their current views and whether the person has expressed any relevant views in the past, either verbally, in writing or through behaviour or habits.
- Any beliefs and values (religious, cultural or moral) that would be likely to influence the decision in question.
• Any other factors the person would be likely to consider if able to do so.

4.5.3 Consult other people for their views on the person’s best interests, remaining aware of the person’s confidentiality. In particular try to consult:

• Anyone previously named as someone to be consulted.
• Carers, close relatives or friends who take an interest in the person’s welfare.
• Any holder of a Lasting Power of Attorney made by the person
• Any deputy appointed by the Court of Protection to make decisions for the person.
• For decisions on major medical treatment or a change of residence and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate must be involved.
• Weigh up all the above factors in order to determine what decision or course of action is in the person’s best interests.

4.6 Consent issues for patients who lack capacity

4.6.1 Patients may be able to consent in some matters and not in others. Assessment of mental capacity is crucial. It is not possible for a patient to give informed consent on a matter where assessment has shown that they lack mental capacity. In cases where the patient is unable to give consent, the Best Interests Principles must be applied.

4.6.2 In practical terms, this could affect a wide range of decisions ranging from the sharing of information to the provision of medical examinations and treatment.

4.6.3 The Mental Capacity Act Code of Practice gives the following guidance regarding the assessment of capacity relating to any matter requiring consent to a course of action or any other type of decision:

• Does the person have a general understanding of what the decision is and why they are being asked to make it?
• Does the person have a general understanding of the consequences of making, or not making, this decision?
• Is the person able to understand, retain and weigh up the information relevant to the decision, and use it as part of the process of arriving at a decision?
4.6.4 Certain decisions and acts can never be carried out under the provisions of the Act:

- Decisions concerning family relationships – including consent to marriage or civil partnerships, sexual relationships, divorce.
- Any decisions concerning assisting suicide.

4.7 Lasting Power of Attorney and Deputies

4.7.1 A power of attorney is a legal document by which one person (the donor) gives another named person or persons (the attorney or donee) the authority to act as the donor’s agent on their behalf. The Lasting Power of Attorney (LPA) is a new power under the Mental Capacity Act. The attorney must act in the best interests of the person lacking mental capacity. The new power includes decisions on

- Health.
- Welfare.
- Property.
- Money.

4.7.2 This document must be registered with the Office of the Public Guardian before it can be used.

4.7.3 The attorney can only act within the scope of their authority as set out in the LPA. Thus a welfare attorney has no authority to act in relation to the donor’s property and affairs or vice versa. However, the same person may be appointed in separate LPAs to carry out both of these roles. Staff will need to determine in which area the attorney is authorised to make decisions.

4.7.4 This person has the same decision-making powers that the patient would have had if they had capacity.

4.7.5 If the person has not made a LPA whilst they had capacity, the Court of Protection may appoint a Deputy, who must act in the person’s best interests.

4.7.6 Alternatively, for single decisions, a judge may make a single order of the court.
4.8 Court Appointed Deputies

4.8.1 The Court of Protection can appoint deputies as substitute decision-makers where a person loses capacity in relation to a particular decision and has not completed a Lasting Power of Attorney. Deputies can make decisions on health, welfare and financial matters. A deputy may be appointed when an on-going series of decisions needs to be made. In most cases the deputy will be a family member or someone who knows the person well although a spouse does not have the legal right to act a deputy. In cases where a person’s affairs or needs are very complex the Court of Protection might appoint a deputy who is independent of the family.

4.8.2 The Mental Capacity Act makes provisions for existing Enduring Powers of Attorney to continue to be valid.

4.8.3 Detailed information is given in Chapters 7 and 8 of the Code of Practice.

4.9 Advance Decision to Refuse Treatment

4.9.1 An advance decision states that the person does not want a particular type of treatment. This decision must be respected irrespective of the style in which it was made or whether it was written or oral. An oral advance decision must be documented in the patient’s notes, which will then form a written record of the advance decision.

4.9.2 An Advance Decision to Refuse life-sustaining Treatment must be written.

4.9.3 An advance decision to refuse treatment:

- Must specify the treatment that is to be refused.
- May set out the circumstances in which the refusal will apply.
- Will only apply at a time when the person lacks capacity to consent to the specified treatment.

4.9.4 To meet the statutory requirements set out in the Mental Capacity Act, it must first be shown that an advance decision to refuse treatment exists.

4.9.5 Detailed information is given in Chapter 9 of the Code of Practice.
4.10 The Independent Mental Capacity Advocate

4.10.1 The new Independent Mental Capacity Advocate (IMCA) helps people who have no family of friends. Their role is to help people when important decisions have to be made involving health services and local authority services.

4.10.2 The IMCA must be involved in the following decisions:

- Decisions relating to providing, withholding or withdrawing serious medical treatment.
- Where it is proposed to move a person into long-term care in a hospital or care home.
- Where a long-term move to a different hospital or care home is proposed.

4.10.3 The aim of this service is to provide additional safeguards for people who lack capacity to take decisions in certain specific, important situations and who are particularly vulnerable because they have no close relatives, friends or any other person to protect their interests.

4.10.4 The IMCA is not the decision-maker. It is ultimately the responsibility of the healthcare professional proposing an action or decision to decide what is in the best interests of the person lacking capacity. However, the healthcare professional has a duty to contact the IMCA and take account of what they say. In most cases, a decision will be achieved through discussion and reaching a consensus with all those involved, including, so far as possible, the person lacking capacity.

Detailed information is given in Chapter 10 of the Code of Practice.

4.11 Research

4.11.1 There are clear rules about involving people in health and social care research studies when they are not able to consent to taking part. A family member or carer (the consultee) should be consulted about any proposed study. People who can be consultees include family members, carers, attorneys and deputies, as long as they are not paid to look after the person in question and their interest in the welfare of the person is not a professional one. If they say that the person who lacks capacity would not have wanted to take part, or to continue to take part, then this means that the research must not go ahead.

Detailed information is given in Chapter 11 of the Code of Practice.
4.12 DOCUMENTATION REQUIRED

4.12.1 Significant decisions e.g. placement, major treatment decisions (MCA Code of Practice Para 4.61):

- The Hospice Mental Capacity Assessment form should be completed to record the determination of lack of capacity and best interests taking into account any advance decision, statement of wishes and beliefs, LPA or IMCA input into the decision.

4.12.2 Routine care, day-to-day decisions (MCA Code of Practice Para 4.60)

- Assessments of capacity to take day-to-day decisions or consent to care require no formal assessment procedures or documentation. It is however good practice for health workers to keep a record of the steps they take when caring for the patient concerned.
- Patients with impaired conscious levels due to impending death will have their care recorded on their individualised care plan for managing the last days of life.

4.12.3 For acts of care or treatment, the health worker must have ‘reasonable belief’ that the patient lacks the capacity to agree to the action or decision and must establish that the act or decision is in the patient’s best interests (see above).

4.12.4 The steps that are regarded as reasonable will depend on the circumstances and the urgency of the decision: (MCA Code of Practice Para 4.45)

- Assume the patient has capacity unless there is a diagnosis of a condition leading to impaired brain function.
- Make every effort to explain, provide relevant information and help the patient make the decision in question.
- Can the decision be delayed to a time when the patient may have regained capacity?
- Can the patient understand, retain, use and weigh the information necessary to make the decision?
- Are they unable to communicate their decision by any means?
5 Breach of policy

5.1 Any deviation in practice from the above policy and procedure will be deemed a breach of policy.

5.2 Any breach of this policy by Thames Hospice employees may lead to formal disciplinary action. Any breach of this policy by Thames Hospice volunteers may lead to formal action under the Problem Solving Policy and Procedure.

6 References

6.1 The Mental Capacity Act, 2005.

6.2 The Mental Capacity Act Code of Practice.