Thames hospice

Policy: MENTAL CAPACITY ACT POLICY

Date	Author/ Reviewer	Approved by	Doc name	Comment	Responsible Committee	Next Review
Dec 2019 June 2019	Dr S Price, Lead Consultant Dr Cecily Wright, Medical Director	PCQC	CLIN-P-0006 Formerly: DRS-P-0008	Dec 2019 Policy reviewed and updated, including Appendix 1 June 2019 Policy reviewed and updated. Policy refers to the Hospice's new EMIS records system and electronic forms on the system (Appendix 1 removed). S3.6 added to account for the Mental Capacity Amendment Act (2019) June 2018 Policy reviewed and updated. Jan 2018 New section added 4.12.4. Updates to Appendices 1 and 2. June 2017 Policy Reviewed. Minor changes to text and layout only. Nov 2015 Policy reallocated to DRS section (previously IPU section). Created Dec 2014.	PCQC	June 2020

1 Purpose of Policy

1.1 To ensure staff are aware of and abide by the Mental Capacity Act (MCA) and Code of Practice.

- To ensure staff are made aware of legal responsibilities
- To ensure staff complete correct documentation

1.2 To summarise those areas of the Code of Practice that apply to the hospice and refer staff to the Code if they require more detailed information.

1.3 There is one appendix to this policy: Appendix 1 – Thames Hospice Best Interest Decision Record

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 Line Managers - Responsible for ensuring that staff in their department implement and comply with the policy.

2.3 All staff involved in the care of patients, including volunteers:

- Must follow the guidance in the Mental Capacity Act Code of Practice.
- Have an obligation to act in accordance with the principles of the Act and in the best interests of a person lacking capacity.
- Must seek advice from their line manager or clinical team if there is any doubt about the capacity of a person within our care.

3 Policy Statement

3.1 The MCA 2005 provides a statutory framework for people 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. The Act makes clear who can take decisions, in which situations, and how they should go about this. The MCA is accompanied by a statutory Code of Practice that explains how the Act works. The Code of Practice provides guidance to everyone who is working with and/or caring for adults who may lack capacity to make particular decisions.

3.2 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 In addition to the Mental Capacity Act 2005, the practice of care within the hospice must comply with the Human Rights Act 1998, The Equality Act 2010 and The Deprivation of Liberty Safeguards.

3.4 The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS), which came into force on 1st April 2009, provide a legal framework to ensure people are deprived of their liberty only when there is no other way to care for them safely or safely provide treatment. They were created to ensure that when a person is deprived of their liberty in a health or social care setting they have means of challenging that detention, and also to ensure that any deprivation is carried out in the least restrictive way, and only if it is in that person's best interests.

3.5 A separate hospice policy entitled Deprivation of Liberty Safeguards sets out the procedure to follow when considering a DOLS application and must be read in conjunction with this policy.

3.6 NOTE: The Mental Capacity (Amendment) Act 2019 became law in May 2019. This legislation provides for the repeal of the Deprivation of Liberty Safeguards (DoLS) contained in the Mental Capacity Act 2005 (MCA), and their replacement with a new scheme called the Liberty Protection Safeguards (LPS). It is anticipated that this will come into force in Spring 2020, but that the DOLS system will run alongside the LPS for up to a year.

3.7 A resource entitled "Working with the Mental Capacity Act 2005" is located in the doctors' office, and a copy of the full Code of Practice can be found in the Hospice's shared drive under Doctors' Policies.

4 Mental Capacity Act 2005 Principles

4.1 The MCA is designed to cover situations where someone is unable to make a decision because their mind or brain is affected, for example, by illness, disability or the effects of drugs. The type of decisions that are covered range from day to day decisions, such as what to eat, through to serious decisions about where to live, medical treatments or a person's finances/property. A person may lack capacity to make a particular decision at a particular time but this does not mean that the person lacks all capacity to make any decisions. Staff must be aware that lack of capacity may not be permanent and assessments of capacity should be limited and decision specific.

4.2 The MCA establishes five key principles that hospice staff and volunteers must follow:

- The presumption of capacity: adults should be assumed to have the capacity to make decisions unless it is proved otherwise.
- 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.
- Individuals retain the right to make what might be seen as eccentric or unwise decisions.
- Best interests: anything done for or on behalf of a person without capacity must be done in their best interests.
- 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.

5 Helping People to make decisions for themselves

5.1 When a person needs to make a decision, it must be assumed that the person has capacity to make the decision in question and every effort should be made to encourage and support the person to make the decision themselves.

5.2 Factors to consider include:

- Does the person have all the relevant information to make the decision? If there is a choice, has information been given regarding the alternatives?
- Could the information be explained or presented in a way that is easier for the person to understand?
- Are there particular times of the day when a person's understanding is better, or is there a particular place where they feel more at ease to make a decision?
- Can anyone else help or support the person to understand information or make a choice?

5.3 It must be remembered that if a person makes a decision that is thought to be eccentric or unwise, this does not necessarily mean that the person lacks capacity to make the decision.

5.4 When there is reason to believe that a person lacks capacity to make a decision, the following must be considered:

- Has everything been done to help the person to make the decision?
- Does this decision need to be made without delay? If not, are they likely to regain capacity and is it possible to wait until the person does have the capacity to make the decision for themselves?

5.5 If the person's ability to make a decision is still in doubt, then an assessment of mental capacity needs to be made.

6 Assessment of Mental Capacity

6.1 Any assessment must be 'decision-specific':

- The assessment of capacity must be about the particular decision that has to be made at a particular time and not about a range of decisions.
- If someone cannot make a complex decision that does not mean that they cannot make simple decisions - there should be no blanket decision that someone lacks capacity to make all decisions.
- A decision cannot be made that someone lacks capacity based upon their age, appearance, condition or behaviour alone.
- An assessment of capacity should not be made without involving family, friends and/or carers or an Independent Mental Capacity Advocate (IMCA) if one has been appointed. This depends on the situation and the decision that has to be made.

6.2 An assessment must be made using the two-stage test of capacity set out in the Code of Practice:

- 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?

6.3 The person will be unable to make the particular decision if, after all appropriate help and support to make the decision has been given to them, they cannot:

- Understand information relevant to the decision, including understanding the likely consequences of making or not making the decision
- Retain information for long enough to make the decision
- Use or weigh up that information to arrive at a decision
- Communicate the decision, whether by talking, using sign language or any other means

6.4 This process is referred to as the functional test of capacity. Day to day assessments of capacity may be relatively informal. Depending on the seriousness of the decision, specialist or expert opinion may be requested where the decision is complex or there is a difference of opinion amongst core MDT members or patient representatives.

6.5 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).

6.6 Situations where mental capacity is an issue at the hospice are likely to fall within the categories listed below where the person lacks 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.

7 Who should Assess Capacity?

7.1 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 for different decisions at different times; for example, a doctor for medical treatments, a nurse for personal care, a social worker for alternative placement.

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

7.3 If a healthcare professional proposes treatment or an examination they must assess the person's capacity to consent. This may be 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.

7.4 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.

8 Best Interest Decisions

8.1 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.

8.2 <u>The key steps for determining best interests</u>

8.2.1 The following provides a summary of the key factors that 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 that 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.

8.2.2 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.

8.2.3 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.

8.3 <u>Consent issues for patients who lack capacity</u>

8.3.1 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.

8.3.2 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.

8.3.3 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.

9 Lasting Power of Attorney

9.1 The Mental Capacity Act replaces the Enduring Power of Attorney (EPA) with the Lasting Power of Attorney (LPA). An LPA allows people over the age of 18 to formally appoint one or more people to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves.

9.2 The person making the LPA is called the donor and the person(s) appointed are known as attorney(s).

9.3 The introduction of LPAs for property and affairs means that no more EPAs can be made, but the MCA made transitional provisions for existing registered EPAs to continue to be used.

9.4 An LPA gives the attorney authority to make decisions on behalf of the donor and the attorney has a duty to act or make decisions in the best interests of the person who has made the LPA.

9.5 There are two different types of LPA:

- A Personal Welfare LPA is for decisions about both health and personal welfare
- A Property and Affairs LPA is for decisions about financial matters only

9.6 A LPA is a legal document that must be registered with the Office of the Public Guardian before it can be used.

9.7 The attorney can only act within the scope of their authority as set out in the LPA. Thus a Personal 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 and record this in the health record.

9.8 The attorney has the same decision–making powers that the patient would have had if they had capacity.

9.9 Unless the LPA specifies limits to the attorney's authority, the attorney can make personal and welfare decisions and consent to /refuse treatment (except life-sustaining treatment) on the donor's behalf.

9.10 If a donor wants their attorney to make decisions about 'life-sustaining treatment' they will need to specify this in the personal welfare LPA form.

10 Court Appointed Deputies

10.1 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.

10.2 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.

10.3 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.

11 Advance Decision to Refuse Treatment

11.1 An advance decision 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 consent to or refuse that treatment.

11.2 An Advance Decision to Refuse Treatment (ADRT) must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity: healthcare professionals must follow the decision.

11.3 An ADRT may be written or verbal. A verbal advance decision must be documented in the patient's healthcare record, which will then form a written record of the advance decision. It should include details of who was present at the time the decision was recorded, their role (e.g. family member or healthcare professional) and whether they heard or took part in the decision, or are simply aware it exists.

11.4 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.

11.5 An Advance Decision to refuse life-sustaining treatment must meet specific requirements:

- It must be written.
- It must be signed in the presence of a witness who must also sign.
- It must include a clear, specific statement from the person that the advance decision is to apply to the specific treatment even if life is at risk.

11.6 To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:

- Has done anything that clearly goes against their advance decision.
- Has withdrawn their decision.
- has subsequently conferred the power to make that decision on an attorney, or
- Would have changed their decision if they had known more about the current circumstances.

11.7 Healthcare professionals must enquire about and document the existence of an ADRT in the patient's healthcare record.

12 The Independent Mental Capacity Advocate

12.1 The aim of the Independent Mental Capacity Advocate (IMCA)service is to provide additional independent 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 (other than paid staff) to support, represent and protect their interests.

12.2 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.

12.3 IMCAs have the right to access the patient's relevant health and social care records.

12.4 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 into account any information or report provided during the best interests process. 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.

13 Research

13.1 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.

14 Documentation Required

14.1 For significant decisions, e.g. care home placement, major treatment decisions (MCA Code of Practice Para 4.61):

- The Hospice Mental Capacity Assessment record is available as an EMIS template and should be completed electronically to record the capacity assessment decision
- The Best Interests Decision Record form (appendix 1) is available as an EMIS document and must be completed to record the decision-making process, taking

into account any advance decision, statement of wishes and beliefs, LPA or IMCA input into the decision.

14.2 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.

14.3 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).

14.4 There will be a weekly review of any mental capacity issues as part of the inpatient MDT meeting process. These issues should be documented for individual patients by the medical team or delegated MDT administrator using the MDT template on EMIS and discussed by the multidisciplinary team. This does not replace the need to formally document a mental capacity assessment using the hospice's Mental Capacity Assessment template for major treatment or care decisions.

14.5 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?

15 Breach of Policy

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

15.2 Any breach of this policy by Thames Hospice employees may lead to formal disciplinary action.

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

16 References

16.1 The Mental Capacity Act 2005. Available from: https://www.legislation.gov.uk/ukpga/2005/9/contents (accessed 7 June 2019)

16.2 The Mental Capacity Act 2005 Code of Practice. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf (accessed 7 June 2019)

16.3 GMC Ethical Guidance on Mental Capacity, available from:

16.4 https://www.gmc-uk.org/ethical-guidance/ethical-hub/mental-capacity (accessed 7 June 2019)

16.5 How the law on authorising deprivation of liberty will change (e-article by Tim Spencer-Lane). Available from: https://www.communitycare.co.uk/2019/04/26/law-authorising-deprivation-liberty-will-change/ (accessed 7 June 2019)

APPENDIX 1 - BEST INTEREST DECISION RECORD

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 their best interests. (Principle 4, Mental Capacity Act 2005)		
Date of Best Interest Meeting: 15-Dec-2019	**Venue / By Phone**	
NHS Number:		
Chair:	**Decision maker(s):**	**Minute taker:**
People present		

Lasting Power of Attorney (LPA):

Enduring Power of Attorney (EPA) / LPA property and affairs (financial): No enduring power of attorney added

Court of Protection Deputy (CPD):

Other (please describe):

Decision to be made:
Details:

Confirmation of lack of capacity

A Mental Capacity Assessment must have been completed recently and attached to this form. The capacity assessment must cover the 2 stages of the capacity assessment, detailing why the person lacks capacity and name of the person/s involved in the assessment.
The assessment must be related to the decision that needs to be made and time specific.
Without a relevant capacity assessment a best interests decision cannot be made.

Date of capacity assessment:	**Name of assessor:**	**Designation:**
Note: In the event of anybody challenging the assessment result, and the disagreement cannot be resolved, then a second opinion or a ruling from the Court of Protection may be required. This will also depend on the urgency of the decision to be made.		
Please add details of any challenge of capacity assessment:		
Can the decision be delayed because the person is likely to regain capacity in the near future? Yes ☐ Not likely to regain capacity ☐ Not appropriate to delay ☐ *Details:*		
Views of the person: What are the person's past and present wishes and feelings (these may have been expressed verbally, in writing or through behaviour or habits)?		
Are there any beliefs and or values that would be likely to influence the decision, if they had capacity. (e.g. religious, cultural, moral or political)? Yes ☐ No ☐ *Details:*		
Please provide details of views of interested others. e.g. family, friends, carers (please give names and roles):		

Please provide details of views of professionals involved (please give names and roles):	
Is an Independent Mental Capacity Advocate (IMCA) required? Yes ☐ No ☐	
Name of IMCA if involved:	Telephone. No:
Please provide details of views of IMCA:	
Please describe any possible conflicts of interest with regard to this decision:	
Please provide details of risks related to the proposed care / treatment:	
Please provide details of risks related to <u>not</u> carrying out the proposed care / treatment:	
Is there a dispute about the best interests decision (include any possible conflicts of interest)? Yes ☐ No ☐ *Details:*	

Advance decisions to refuse treatment: Is there an advance decision relevant to the decision? Yes ☐ No ☐

Details (please also state if similar treatment or circumstances):

Advance decision type: Written ☐ Verbal ☐

Date of advance decision:

Is the advance decision still applicable? Yes ☐ No ☐

If "No" please select option below and provide details:

Withdrawn ☐
Unanticipated circumstances ☐
LPA / CPD granted regarding decision ☐
Inconsistent behaviour ☐
Detained under Mental Health Act 1983 ☐
Other ☐

Details:

Best Interest Decision Outcome

Details:

I confirm that this decision is the least restrictive option or intervention possible. Special considerations for life-sustaining treatment have been considered or are not applicable. This decision has not been biased by age, appearance, assumption about the person's condition or aspect of their behaviour, gender or race. Every effort has been made to communicate with the person concerned.

Decision Maker's signature	Role	Organisation / Profession
Date of Decision:		

Those trying to work out the best interests of a person who lacks capacity to make a particular decision should follow the Best Interests Checklist:

• Encourage participation. • Identify all relevant circumstances. • Find out the person's views. • Avoid discrimination. • Assess whether the person might regain capacity.	• If the decision concerns life-sustaining treatment. • Consult others. • Avoid restricting the person's rights. • Take all of the above factors into account.

Please see Chapter 5 Mental Capacity Act 2005 Code of Practice