NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Mental Capacity Act (2005)
Policy and Guidance

Ratification Process

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Approved By	- CAPCCG Internal Performance and Assurance Committee (IPAC)
Ratified and Approved By	CAPCCG Governing Body
Version	1
Review Date	December 2020

People Consulted During Policy Development

Name	Designation	Organisation	Date Consulted
Carol Anderson	Chief Nurse	CAPCCG	May 2019
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Document Control Sheet

Development and Consultation	This MCA Policy was developed to ensure that the services provided by the CCG and those commissioned on behalf of the local population are compliant with the Mental Capacity Act legislation as mandated by NHS England. Feedback was sought from the key people listed above and comments from those who responded were considered during development of the policy.
Dissemination	This policy will be made available to all CCG staff including agency workers via the CAPCCG newsletter and website.
Implementation	This policy will underpin the implementation of the MCA in practice by all staff across the CAPCCG, thereby improving the quality of care received by the patients we serve
Training and Support	See page 13
Audit/ Monitoring	A record of all relevant policies is maintained by the Corporate Governance Team including details of when a policy is due for renewal. The IPAC will use a checklist to ensure the policy meets the requirements of the CCG's Policy Development, Approval and Implementation Policy (2019).
Review	The MCA/DOLS Lead will review this policy by the end of 2020, when the Mental Capacity Act Code of Practice is expected to have been reviewed
Associated Documents	This Policy should be read in conjunction with: - Mental Capacity Act[1] 2005 - Mental Capacity Act Code of Practice[2] - Mental Capacity (Amendment) Act 2019[3] - Deprivation of Liberty Safeguards 2007[4] - CCG's Operational Guidelines for DOLS[5] - NICE Guideline (108) on Decision-making and Mental Capacity (2018)[6]

[1] http://www.legislation.gov.uk/ukpga/2005/9/contents
[2] www.gov.uk/government/publications/mental-capacity-act-code-of-practice
[3] https://services.parliament.uk/bills/2017-19/mentalcapacityamendment.html
[4] www.gov.uk/government/collections/dh-mental-capacity-act-2005-deprivation-of-liberty-safeguards
[5] https://www.cambridgeshireandpeterboroughccg.nhs.uk/staff-homepage/guidance-and-information/safeguarding/mental-capacity-and-deprivation-of-liberty
[6] https://www.nice.org.uk/guidance/NG108

Equality Impact Assessment

- An Equality Impact Assessment[7] of the Mental Capacity Act (MCA 2005) was undertaken at the time of developing the Act by the Department of Justice

- Equality and diversity are therefore implicit within the policy

- This policy is mainly relevant to people who may lack the mental capacity to make health and welfare decisions for themselves due to an underlying disability or condition.

- This policy and guidance give due regard to the need for eliminating discrimination by putting the affected person at the centre of the decision-making process

- The policy document is therefore unlikely to produce a differential impact because of the protected characteristic as cited under the Equality Act (2010)

[7] http://webarchive.nationalarchives.gov.uk/20071204130111/http:/www.justice.gov.uk/docs/mc-equality-impact.pdf

Table of Contents

1. Introduction

1.1 The Mental Capacity Act[8] (MCA 2005), hereafter referred to as 'The Act' came into force in 2007 and only applies to people who live in England and Wales.

1.2 The Act provides a legal framework for decision making regarding adults aged16 years and above who are suspected of lacking capacity to make health and social care related decisions for themselves.

1.3 The Mental Capacity Act specifies some decisions which are excluded from provisions of the Act and must be referred to Court of Protection[9] (CoP) including:

- Making a will
- Making a gift (unless the person has a finance LPA)
- Entering into a contract
- Entering into litigation
- Entering into marriage
- Consenting to Sexual Relationships
- Divorce
- Adoption
- Voting or standing for office
- Organ or bone marrow donation
- Non-therapeutic sterilisation

1.4 The Act also provides for people to plan in advance for a time when they may lack capacity to make such decisions for themselves.

1.5 The Act is underpinned by 5 statutory principles which promote empowerment of individuals and protection of their rights during the decision-making process concerning their health and welfare.

1.6 Deprivation of Liberty Safeguards (DOLS), which were incorporated into the Act in 2007 are based on Article 5 of the European Convention on Human Rights (ECHR)[10]

1.7 The DOLS part of the legislation confers the right to liberty and provides protection in circumstances when someone who lacks capacity to make a decision may need to be deprived of their freedom in order to prevent harm to themselves

1.8 This Policy only covers the main MCA and does not include DOLS, which was recently replaced by Liberty Protection Safeguards (LPS) via the Mental Capacity (Amendment) Act (2019) and due to take effect from October 2020.

[9] https://www.gov.uk/courts-tribunals/court-of-protection
[10] www.echr.coe.int/Documents/Convention_ENG.pdf

2. Purpose and Scope

2.1 NHS England regards compliance with the MCA legislation within the services that we provide or commission on behalf of our community as the CCG's statutory responsibility

2.2 The Act specifies that everyone working with or caring for an adult lacking capacity to make specific decisions must comply with the law

2.3 Failure to comply with the legislation denies the affected people of their right of choice and involvement, which is central to quality improvement and patient experience

2.4 The Act also incorporates a criminal offence of ill-treatment and willful neglect of people who lack the mental capacity to make specific decisions for themselves. Compliance with this policy will therefore support CCG staff to exercise their responsibilities within the law.

2.5 This document was developed to summarise the statutory requirements of the MCA 2005 and to provide guidance and direction for its implementation by the CCG's staff.

2.6 The policy is not meant to replace but to compliment the MCA and its Code of Practice, which should be read in conjunction

2.7 The policy applies to all staff including temporary, bank or agency staff that are involved in provision and commissioning of services for adults among the population we serve.

2.8 This document is also informed by NHS England's (2014) Guide for Clinical Commissioning Groups for Compliance with the MCA 2005[11] and NICE Guideline 108 (2018) on decision-making and mental capacity

2.9 If appropriately followed, the policy should result in patient-focused outcomes through empowerment and respect for their rights whilst also achieving efficiency and financial savings for the CCG

3 Roles and Responsibilities

3.1 **The CCG** through the Accountable Officer has overall responsibility for:

3.1.1 Commissioning and providing services which demonstrate compliance with the MCA/DOLS legislation

3.1.2 Ensuring that the MCA/DOLS legislation has a high profile throughout the CCG and that priority is given to its compliance by all staff

3.1.3 Ensuring that all CCG staff are aware of their statutory responsibilities under this legislation

3.1.4 Including compliance with this legislation within the tendering and contracting Process

[11] https://www.england.nhs.uk/wp-content/uploads/2014/09/guide-for-clinical-commissioning.pdf

3.2 **The Chief Nurse** through the Designated Nurse for Safeguarding Adults ensures that:

3.2.1 MCA/DOLS features in the job descriptions for posts being recruited to where staff are expected to work directly with patients affected by this legislation

3.2.2 Compliance with this legislation forms part of personal development reviews of all staff working directly with the affected patients

3.2.3 Conducive working environments are created within the CCG to promote embedding of this legislation into practice

3.3 **The MCA/DOLS Lead's** primary responsibility is informed by NHS England's Guide for CCGs on Commissioning for Compliance (2014) including:

3.3.1 Developing and updating MCA and related policies and guidance based on statutory requirements and informed by evolving case law

3.3.2 Reviewing existing MCA related systems, identifying gaps and highlighting areas for improvement in order to minimize risk of breach

3.3.3 Developing systems and processes to help implement workflows that minimize MCA/DOLS related risk to the affected patients and the CCG

3.3.4 Formulating and ensuring access to tools and templates by staff in order to facilitate compliance with this policy

3.3.5 Designing and delivering staff training which is tailored to staff's roles and responsibilities based on learning needs analysis and appropriate Competency Framework

3.3.6 Monitoring contracts with provider services to ensure compliance with the MCA/DOLS legislation through auditing and performance reviews

3.3.7 Engaging with partner organisations including Care Homes, Local Authorities, Safeguarding Leads and the Care Quality Commission (CQC)

3.3.8 Collating relevant data, compiling and submitting reports on MCA related trends and performance to relevant committees/ boards and NHS Digital

3.4 **ALL CCG Staff** are individually and collectively responsible for:

3.4.1 Cooperating with development and implementation of this policy and guidance to ensure the rights conferred by the legislation are respected and upheld

3.4.2 Recognising their legal duty to comply with the MCA/DOLS legislation to minimize risk of breaching the law in line with legal, professional and best practice requirements

3.4.3 Understanding and implementing appropriate processes of seeking consent, assessing mental capacity and supporting best interests during their day-to-day work

3.4.4 Maintaining contemporaneous and accurate records including robust care plans and mental capacity assessments which reflect the MCA principles

3.4.5 Identifying restrictions or restraints which may require prioritization and authorization in line with the CCG's Prioritisation Tool (appendix 7)

3.4.6 Keeping up to date with changes in statutory requirements which may trigger a review of or change in practice

3.4.7 Identifying their own training needs in respect of their statutory requirements and bringing them to the attention of their Line Manager or MCA/DOLS Lead

3.4.8 Attending available training which is commensurate with their duties in order to equip and update themselves with the necessary knowledge and skills required in line with the MCA statutory duties, Standards of Proficiency for Registered Nurses[12] (NMC 2018) and Revised National Framework for CHC & NHS-funded Nursing Care[13] (DH 2018)

4. Mental Capacity Guidance

4.1 Definition - Metal capacity is the person's ability to make a specific decision at a time that it needs to be made (decision and time specific)

4.2 MCA Principles - The Act provides legal protection from liability for those who act in accordance with its underpinning principles;

4.2.1 Presumption of capacity – a person must be assumed to have capacity to consent or make a decision unless it is established that they lack capacity to do so

4.2.2 All practicable steps must be taken to help a person to make a decision for themselves before treating them as unable to do so

4.2.3 A person should not be treated as unable to make a decision merely because of making an unwise decision.

4.2.4 An act done, or decision made on behalf of a person who lacks capacity must be in that person's best interests

4.2.5 The least restrictive option must be considered for anything done for or on behalf of a person lacking capacity to make a decision for themselves

[12] https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf
[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/746063/20181001_National_Framework_for_CHC_and_FNC_-_October_2018_Revised.pdf

4.3 Consent

4.3.1 Consent is an informed and voluntary permission of a person to receive a particular treatment, care, or other proposed intervention and can be verbal or written

4.3.2 In line with the first MCA principle above, a person must be presumed to have the capacity to consent or make a decision unless it is proved that they lack capacity to do so

4.3.3 Informed consent must therefore be obtained prior to any intervention

4.3.4 Information provided for consent must include consequences of making a decision one way or the other and not making a decision at all

4.3.5 Consent to medical treatment or a procedure involves an understanding of the nature, purpose and effects of the proposed intervention including associated risks and benefits

4.3.6 Consent to a place of residence requires understanding of the type and nature of the options available including the location of the facilities, level of support available, whether temporary or permanent and access to friends/ family

4.3.7 Consent relating to care should be specific to the sort of support required including the name of provider and consequences of accepting or refusing the support

4.3.8 For consent to be valid, it must be specific, explicit and freely given

4.3.9 Consent should be given voluntarily without coercion and can be withdrawn

4.3.10 The person giving consent must have the mental capacity to do so

4.4 Basis for Questioning Mental Capacity

4.4.1 If there are any concerns about a patient's capacity and the person is over 16 years of age, a formal capacity assessment should be completed for all major decisions

4.4.2 Doubts about a person's capacity to make decisions may arise as a result of:

4.4.2.1 A change in the person's behaviour or circumstances

4.4.2.2 Concerns being raised by someone else about the person's mental capacity

4.4.2.3 A diagnosis of an impairment of or disturbance in the functioning of their mind or brain

4.4.2.4 The person has previously been assessed as lacking capacity to make a similar decision

4.5 Responsibility for Assessing Mental Capacity

4.5.1 NICE guideline 108 states that health and social care practitioners should routinely take a structured, person-centred, empowering and proportionate approach to assessing a person's mental capacity including everyday decisions

4.5.2 Sec 4.38 of the MCA Code of Practice specifies that the responsibility for completing a mental capacity assessment lies with the person directly concerned with the individual at the time that the decision needs to be made

4.5.3 A second opinion on the person's capacity might be sought for more complex decisions but ultimately the decision should be made by the person intending to make the decision – also referred to as the 'Decision-maker'

4.5.4 For all major decisions, a standardized mental capacity assessment form (appendix 2) must be used to formally assess a person whose ability to make a decision or give consent is questionable

4.4.8 In line with the second principle of the MCA, all practicable steps must be taken to help a person to make a decision before they are deemed as lacking capacity to do so

4.6 The 2 Stage Assessment of Capacity (Appendix 2)

4.6.1 **Stage One** - **Diagnostic Criteria**

4.6.1.1 A person's capacity to make a specific decision can only be questionable if they have an impairment of, or disturbance in the functioning of the mind or brain which is likely to be affecting their ability to make that specific decision

4.6.1.2 If the person does *not* meet that criteria, then they are legally considered as having the mental capacity to make such a decision under the MCA

4.6.2 **Stage Two - Functional Assessment**

4.6.2.1 Bearing in mind a person's right to make an unwise decision (third principle of the MCA), an individual is considered as having the mental capacity to make a decision if they are able to do ALL of the following:

- **Understand** the information relevant to the decision to be made
- **Retain** the information long enough to make the decision
- **Use or weigh** that information as part of the decision-making process
- **Communicate** their decision

4.6.2.2 An individual is deemed as lacking the mental capacity to make a decision if they cannot meet ANY of the above elements

4.7 Legal Authority to Make Decisions

4.7.1 If a person has been assessed as LACKING CAPACITY to make a specific decision, it should be ascertained if there are valid pre-existing arrangements providing legal authority for making a decision on behalf of the person lacking capacity;

4.7.1.1 A Lasting Power of Attorney (LPA) for Health and Welfare or Property & Finance may have been appointed by the affected person whilst they still had capacity to do so.

4.7.1.2 An Enduring Power of Attorney which was previously used prior to the MCA remains effective for Finance & Property decisions only

4.7.1.3 A Health and Welfare LPA is the only valid legal authority for care and treatment related decisions and the Donee (nominated person) is usually recognized as responsible for making such decisions on behalf of the person who lacks capacity to do so

4.7.1.4 An existing Advance Decision to Refuse Treatment (ADRT) may have been made by the person whilst they still had capacity to make such decisions and usually accessible through the GP

4.7.1.5 An ADRT is legally binding and any decision made should not be contradictory to it.

4.7.1.6 For an ADRT relating to life-saving treatment to be valid, it should be include the clause '*this decision applies even though my life may be at risk",* it should be dated, signed and witnessed by someone not likely to benefit from the person's death

4.7.1.7 A Court Appointed Deputy may have already been appointed by the Court of Protection (CoP) to make specific decisions on behalf of the person who lacks capacity to do so

4.7.2 Any concerns about validity of these arrangements can be verified with the Office of the Public Guardian (OPG) via email: customerservices@publicguardian.gov.uk or Telephone – 03004560300

4.8 Appointment of Independent Mental Capacity Advocate

4.8.1 Sometimes the person assessed as lacking capacity has no one available to be consulted or to represent their views during the decision-making process

4.8.2 An Independent Mental Capacity Advocate (IMCA) must be appointed to support and uphold views of such a person prior to commencement of the decision-making process relating to major decisions such as long-term change of accommodation

4.8.3 The MCA also makes provision for an IMCA to be appointed for proceedings relating to adult protection and care review of a person who lacks capacity to make decisions

4.8.4 The IMCA's role includes ascertaining the views, feelings and wishes of the person concerning that specific decision and communicating them to the Decision-Maker

4.8.5 The IMCA also ensures that the rights of the person who lacks capacity are upheld and remains involved in the decision-making process until a decision has been made

4.8.6 The IMCA should check that the decision made is in the best interests of the person lacking capacity and challenge the decision on behalf of the person where necessary

4.8.7 An IMCA can be requested via the local Advocacy Service:
VoiceAbility, Unit 1, The Old Granary, Westwick, Oakington, Cambridge. CB24 3AR
Telephone – 0300 2225704
Email – tvcp@voiceability.org

4.9 Best Interests Decision-Making Process

4.9.1 Where a person is assessed as lacking capacity to make a specific decision and in the absence of any pre-existing legal authority, the decision must be made by the person proposing the intervention, also known as the Decision-Maker

4.9.2 Any act or decision made on behalf of a person who lacks capacity must be in that person's best interests in line with the statutory Best Interests Checklist (appendix 5)

4.9.3 During the decision-making process, the person's known wishes, preferences and values must be established and placed at the heart of the decision-making process

4.9.4 An advance care plan, although not legally binding may have been made to help establish the person's wishes regarding their care needs

4.9.5 All people identified by the person who lacks capacity as significant and those actively involved in the person's care must be consulted in line with data protection regulations

4.9.6 Depending on the complexity, urgency and importance of the decision, a meeting involving the relevant people may be convened or the people can be consulted by other means to decide what is in the person's best interests

4.9.7 The role of each person involved or consulted must be clarified

4.9.8 Views of all people consulted must be respected but it is ultimately the responsibility of the Decision Maker to decide what is in the person's best interests.
4.9.9 If there is a dispute about a person's best interests, attempts must be made to resolve this where possible including seeking mediation

4.9.10 The MCA Code of Practice states that a Decision-Maker should demonstrate how they have reached a specific decision on behalf of a person who lacks capacity

4.9.11 A written record should be kept of the decision-making process including steps taken to support the person assessed as lacking capacity (appendix 3 and 4)

4.9.12 If the person objects to the decision made or there is a dispute about the decision, the MCA/DOLS Lead will refer the matter to the CCG legal team to consider possible application to Court of Protection (CoP)

4.10 Use of Restraint

4.10.1 The Act defines a restraint as use of, or threat to use force which a person who lacks capacity resists OR restricting the person's movement even if they do not resist

4.10.2 Under the MCA, restraint can be used lawfully if the person **lacks capacity**, the restraint is in that person's **best interest**, **necessary** to prevent harm and **proportionate** to the likelihood and seriousness of harm

4.10.3 It is also permissible to restrain someone outside the MCA in order to prevent harm or deterioration in condition whilst awaiting a decision by the Court of Protection

4.10.4 Restraint to prevent harm to others is not covered by the MCA but can be permissible within common law in an emergency or under the Mental Health Act

4.10.5 Health and Social Care professionals are protected by the MCA if they use restraint in line with the Act and justify its use through appropriate recording such as care planning

4.10.6 Use of a restraint should be considered for the shortest possible time and the least intensity to keep the person safe

4.10.7 Use of restraint should not overrule an ADRT, a decision by a Health and Welfare LPA or a court appointed Deputy acting within provisions of the Act

4.10.8 A restraint does not always amount to a deprivation of liberty (appendix 6), which requires authorization through additional legal procedures (see CCG's DOLS Operational Guidelines)

5. Links with Other Statutory Requirements

- European Convention on Human Rights

- Human Rights Act (1998)[14]

- Mental Health Act (1983)[15]

- Equality Act (2010)[16]

- Care Act (2014)[17]

6. Training and Support

6.1 All CCG staff should be made aware of this policy and guidance through various communication channels

6.2 Nursing and Midwifery Council Standards of Proficiency for Registered Nurses (2018) states that at the point of registration, registered nurses should be able to:

'3.6 effectively assess a person's capacity to make decisions about their own care and to give or withhold consent

3.7 understand and apply the principles and processes for making reasonable adjustments

3.8 understand and apply the relevant laws about mental capacity for the country in which they practice when making decisions in relation to people who do not have capacity'.

It follows therefore that this expectation applies to all registered nursing staff employed by the CCG,

6.3 All CAPCCG staff should ensure that they receive training to equip them with the necessary knowledge and skills to appropriately undertake their MCA/DOLS related responsibilities as specified above

6.4 MCA/DOLS related learning needs should be discussed by staff with their line managers when joining the CCG, on-going during 1:1 supervision, and form part of their appraisal process

6.5 The CCG should offer opportunities for their staff to embed their acquired knowledge and skills within their working environments

[14] www.legislation.gov.uk/ukpga/1998/42/contents
[15] https://www.legislation.gov.uk/ukpga/2007/12/contents
[16] https://www.gov.uk/guidance/equality-act-2010-guidance
[17] www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

6.6 The Competency Framework for CAPCCG MCA/DOLS training is informed by the Royal College of Nursing's Intercollegiate Document (2018) 'Adult Safeguarding: Roles and Competencies for Healthcare Staff'[18]

6.6.1 Levels 1&2 - An Introduction to the Mental Capacity Act and Deprivation of Liberty targeted at all staff working in the healthcare settings regardless of whether they come into contact with service users

6.6.2 Levels 3&4 – Advanced course on implementation of the Mental Capacity and Deprivation of Liberty in practice

6.6.3 Levels 5 & Board Level – As outlined in levels 1&2 but also focusing on responsibilities for training and leading in the organisation's cultural shift towards implementation of the law

6.7 Bespoke face-to-face and ad-hoc training sessions including practical hands-on sessions/ shadowing can be arranged at the request of specific CCG staff groups based on their roles and responsibilities

6.8 MCA/DOLS related resources including appendices to this policy are readily accessible via the CCG staff website[19]

[18] https://www.rcn.org.uk/professional-development/publications
[19] https://www.cambridgeshireandpeterboroughccg.nhs.uk/staff-homepage/guidance-and-information/safeguarding/mental-capacity-and-deprivation-of-liberty

Appendix 1 - Glossary of Terms

Abbreviations

Abbreviation	Full Term
ADRT	Advance Decision to Refuse Treatment
CoP	Court of Protection
DOL	Deprivation of Liberty
DOLS	Deprivation of Liberty Safeguards
IMCA	Independent Mental Capacity Advocate
LPA	Lasting Power of Attorney
MCA	Mental Capacity Act
MHA	Mental Health Act
OPG	Office of the Public Guardian

Definition of Common Terms

Advance decisions to refuse treatment - sometimes referred to as a living will, is an arrangement which an individual who still has capacity makes to refuse a specific type of treatment or care intervention in the event that they lose capacity to do so in the future.

Best Interests – a decision made or an act done on behalf of a person assessed as lacking capacity to make that decision for themselves

Mental Capacity Act (2005) - also referred as the Act in this document is legislation which confers rights of choice to patients, offering them protection and empowerment in advance of, as well as during decision making process about their care and treatment

Mental Capacity – relates to a person's ability to make a specific decision at a time that it needs to be made, not their ability to make decisions in general

Consent - an informed and voluntary permission of a person to receive a particular treatment or care intervention.

Court Appointed Deputy - a person appointed by the Court of Protection to make specific decisions on behalf of a person assessed as lacking capacity to make that decision

Court of Protection – a specialist court that handles issues relating to people who lack capacity to make specific decisions for themselves. It has the same powers, rights, privileges and authority as the High Court

Decision-Maker – a person responsible for leading in making a best-interests decision on behalf of a person who lacks capacity to make that specific decision for themselves

Deprivation of Liberty **–** when a person is subjected to continuous supervision or control AND they are not free to leave

Deprivation of Liberty Safeguards (2007) – measures which were incorporated into the Mental Capacity Act (2005) in order to provide a framework for lawfully depriving a person who lacks capacity of their liberty in order to prevent harm to that person.

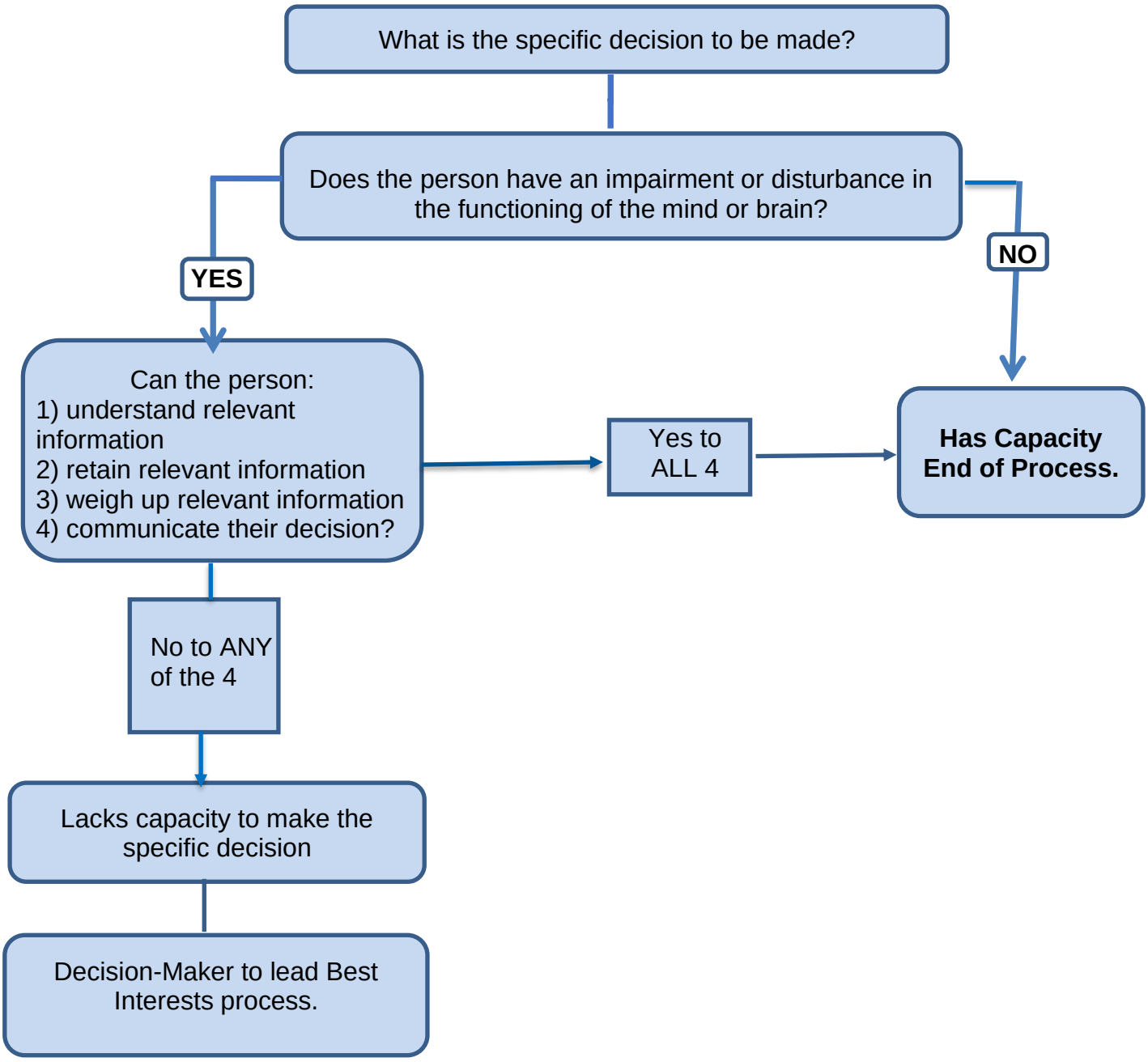
Independent Mental Capacity Advocate – A person appointed to support and uphold views of a person assessed as lacking the mental capacity to make a specific decision

Lasting Power of Attorney - a legal instrument that allows a person (donor) who still has capacity to appoint one or more people (attorneys) to make decisions on their behalf in the event of them losing capacity to make those decisions for themselves in future.

Mental Health Act 1983 - legislation which provides for detention of people in hospital for assessment and/ or treatment of a mental disorder and for treatment in the community.

Office of the Public Guardian – a department that maintains a register of Lasting Power of Attorneys and Court Appointed Deputies

Appendix 2 - **Capacity Assessment Flowcchart**



Appendix 3 – Mental Capacity Assessment Template

MENTAL CAPACITY ASSESSMENT FORM
Please Note: According to the Mental Capacity Act (2005) principles, an adult should be assumed to have the mental capacity to make their own decisions unless proven otherwise. A mental capacity assessment is completed when the person proposing the particular care or treatment arrangements is in doubt about the person's ability to make a specific decision at the time that it needs to be made.

RELEVANT PERSON'S DETAILS	
First Name	
Surname	
Date of Birth	
NHS Number	
ADDRESS	
Name of Next of Kin (NOK)	
Telephone Number of NOK	
Email Address of NOK	
Address of NOK	
DECISION-MAKER'S DETAILS	
Name	
Role/ Relationship to Relevant Person	
Address	
Telephone Number:	
Email Address:	

MENTAL CAPACITY ASSESSMENT

What is the specific decision to be made?

Decision:
Note. If more than one decision needs to be made, you must use a new assessment form for each separate decision.

Stage One

Is there an impairment of or disturbance in the functioning of the person's mind or brain which is likely to be affecting the person's ability to make this decision?

Response				**Evidence/Comments and Source**
Yes		**No**		

If you have answered No, the person is considered to have Mental Capacity to make their own decision within the meaning of the Mental Capacity Act (2005). You do not need to proceed any further, otherwise proceed to Stage 2.

Date Assessment Completed:	
Signature:	

Stage Two

If you have answered **YES** to **Stage One** above, please proceed with the functional assessment below

Does the person understand information relevant to the decision to be made?	Yes		No	
Explain your reasons				
Can the person retain relevant information long enough to make the decision?	Yes		No	
Explain your reasons				
Can the person use or weigh up that relevant information as part of the decision making process?	Yes		No	
Explain your reasons				
Can the person reliably communicate their decision?	Yes		No	
Explain your reasons				

If you answered **YES** to **ALL** of the questions above, then on the balance of probabilities the person is likely to have capacity to make this particular decision at this time.

If you have answered **NO** to **ANY** of the questions above, then on the balance of probabilities the person is likely to lack capacity to make this particular decision at this time.

Conclusion – Please tick the relevant box below and sign

If you have assessed the person as **HAVING CAPACITY** to make this specific decision, y**ou do not need to proceed any further.**	
If you have assessed the person as **LACKING CAPACITY** to make this specific decision, p**roceed to Best Interests Decision-Making process.**	
Date Assessment Completed:	
Signature:	

Appendix 4 - Best Interests Process Template

BEST INTERESTS DECISION-MAKING PROCESS				
Details of all relevant people been consulted				
Name	**Relationship/ Role**	**Address**	**Telephone**	**Email**
For major decisions and where the person who lacks capacity has no family or friend involved, please request involvement of an Independent Mental Capacity Advocate (IMCA) through VoiceAbility: Telephone – 0300 2225704 Email – tvcp@voiceability.org				
Is there a valid Advance Decision, Lasting Power of Attorney or Court Appointed Deputy?			**Yes**	**No**
If 'Yes', their decision takes precedence.				
Is the relevant person likely to regain Mental Capacity?			**Yes**	**No**
If 'Yes', can the decision be delayed?				
What are the person's past and present views/ wishes regarding this specific decision?				
What are the views of the consulted people listed above?				

Please indicate the options available including the benefits and risks identified for each option on the Balance Sheet below	
Option 1:	
Benefits:	Risks:
Option 2:	
Benefits:	Risks:
Option 3	
Benefits	Risks

Please use a separate balance sheet to record further options if required and attach

What Is The Best-Interests Decision Made?

Declaration of the Decision Maker – Please delete statement(s) not applicable

- I confirm that this decision is not based on the person's age, appearance, condition or behaviour. I have considered all relevant factors and there is no less restrictive option.

- Where the decision amounts to a deprivation of liberty, it is necessary and proportionate to the risk of harm to the person and an application for authorization has been initiated by completing a referral form.

- Where the decision relates to life-sustaining treatment, the decision has not been motivated by a desire to bring about the person's death.

Name of Decision-Maker		Signature	
Date		Time	

Appendix 5 – Statutory Best Interests Checklist (Sec 4 of MCA)

1. The decision-maker should avoid making assumptions based on appearance, age or condition of the person who lacks capacity

2. All background information and other relevant circumstances should be considered

3. The person who lacks capacity should be involved as much as possible throughout the decision-making process

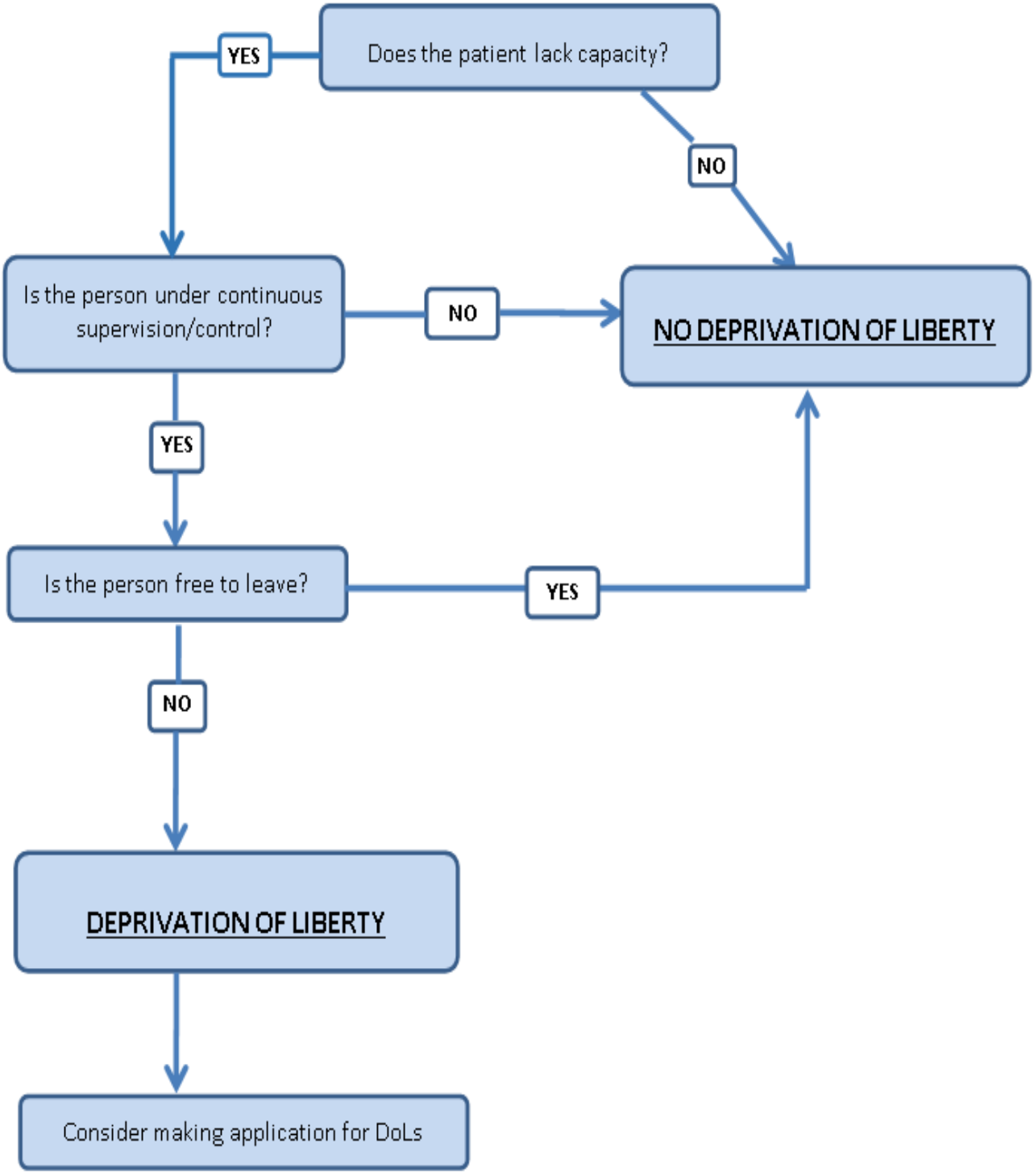
4. Where possible, the decision-making process should be delayed to allow for the affected person to regain capacity to make the decision themselves, especially where there is fluctuation of capacity

5. Where life-sustaining treatment is involved, the person making the decision should not be motivated by the desire to cause death

6. All past and present views, wishes, feelings and beliefs of the person who lacks capacity should be taken into consideration

7. Views of other relevant people consulted should be sought

Appendix 6 – **Identifying a DOL Flowchart**



Appendix 7 - **DOL Prioritisation Tool**

Examples of High Priority Cases

1. Frequent monitoring including 1:1 or more observations both day and night
2. On behaviour monitoring charts
3. Regular physical restraint including use of assistive technology
4. Use of chemical restraint such as sedating medication to control behaviour
5. Covert administration of medication
6. Confinement to a particular part of the establishment for any period of time
7. Person is not allowed out at all
8. Persistent expression of objection by relevant person including:

- verbalisation of wish to leave
- actual attempts to leave

9. Objections from relevant people including family/friends/representative
10. Restricted contact with family and friends
11. Serious concerns about person's well being
12. Existing DOLS authorisation due to expire

Examples of Medium Priority

1. Infrequent monitoring including general observations for part of the day
2. Proportionate restraint with no distress including side rails and wheelchair straps
3. The person is only allowed out for limited periods of time with escort
4. Minimal prompting required to return to the building
5. General concerns have been raised about care or placement

Examples of Low Priority

1. Person appears content and settled
2. Person is compliant with no use of restraint
3. Allowed out frequently with or without an escort
4. Person willingly returns to establishment