Mental Capacity Act 2005 Policy

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The latest approved version of this document is online.
If the review date has passed please contact the Author for advice.

Version Control

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	02/03/2020
2	Policy re-write with practice guidance embedded	22/03/2024

ENGAGEMENT & CONSULTATION

Key Individuals/Groups Involved in Developing this Document

Role / Designation
MCA/DoLS Senior Practitioner
MCA Operational Group
Safeguarding team

Circulated to the following for Consultation

Date	Role / Designation
22/08/23	MCA Operational Group
22/08/23	Safeguarding Team

Evidence Base
Please list any National Guidelines, Legislation or Health and Care Standards relating to this subject area? Deprivation of Liberty Safeguards Code of Practice (2008) Equality Act 2010 Human Rights Act 1998 Mental Health Act 1983 (as amended by the 2007 Act) Mental Capacity Act 2005 Mental Capacity Act 2005 Code of Practice Mental Health Act 1983 Code of Practice for Wales (2016) NICE 2018 Decision making and mental capacity NICE guidelines PTHB Deprivation of Liberty policy and procedure SGP042 PTHB Safeguarding Policy SGP036 Royal College of Nursing, Adult Safeguarding Roles and Competencies for Health Care Staff first edition (2018) Reducing Restrictive Practices Framework (2022) Wales Safeguarding Procedures 2019 Well-being of Future Generations Act (Wales) 2015 Welsh Government Declaration for the Rights of Older People in Wales 2014

IMPACT ASSESSMENTS

Equality Impact Assessment Summary					
	No impact	**Adverse**	**Differential**	**Positive**	**Statement** ***Please provide supporting narrative for any adverse, differential or positive impacts that may arise from the implementation of this policy***
Age				x	**There is a training need for this policy to be embedded in practice.**
Disability				x	
Gender reassignment				x	
Pregnancy and Maternity				x	
Race				x	
Religion or Belief				x	
Sex				x	
Sexual Orientation				x	
Marriage and Civil Partnership				x	
Welsh Language				x	

Risk Assessment Summary
Have you identified any risks arising from the implementation of this policy / procedure / written control document? No risks identified
Have you identified any Information Governance issues arising from the implementation of this policy / procedure / written control document? No risks identified
Have you identified any training and / or resource implications as a result of implementing this? There is a training need for the MCA 2005 and this policy, to be embedded in practice. The PTHB MCA Operational Group have highlighted this within their MCA Improvement Action Plan.

1 Introduction

The Mental Capacity Act 2005 (MCA 2005) came into force in 2007 and provides a statutory framework to empower and protect people who may not be able to make their own decisions. The MCA 2005 sets out statutory principles, how to assess capacity, make substituted decisions and carry our actions affecting people who may lack capacity to make decisions for themselves. The MCA 2005 enables people to plan for a time when they may lose capacity and includes two criminal offences of ill treatment or willful neglect of a person who lacks capacity. The MCA 2005 includes several roles, bodies and powers, all of which support the Act's provisions.

Having mental capacity means a person can make their own decisions. There are many reasons why people could have difficulty making decisions from time to time. However, the MCA 2005 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. 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 the Act's requirements. The MCA 2005 provides safeguards for people who lack capacity and protection for 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 MCA 2005 emphasises they should be involved in the decision-making process as much as possible. The MCA 2005 also recognises adults with capacity have the right to make decisions that others may regard as unwise, for example refusing medical treatment.

Having capacity is based on a particular decision which needs to be made at a specific point in time. 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 are ill but regain capacity when they recover. PTHB have a dedicated page of resources and information about the MCA 2005 - Mental Capacity Act 2005 (sharepoint.com).

2 Objective

The three principal objectives of this policy are:

1. To ensure people are empowered, protected and supported in decision making.
2. Provide clear guidance on assessing decision-making capacity and best interest decision-making.
3. Ensure staff understand and demonstrate their statutory obligations under the Mental Capacity Act 2005.

3 Definitions/Abbreviations

Powys Teaching Health Board (PTHB)	Local Health Board.
Mental Capacity Act 2005 (MCA 2005)	This is the statute that informs this policy.
Deprivation of Liberty Safeguards (DoLS)	This is the statute that informs this policy.
Mental Health Act 1983 (MCA)	Mental Health Act 1983 (as amended by the 2007 Act). This is the statute that informs this policy.
Court of Protection (CP)	The court which considers matters in relation to people who may lack capacity for the related matter.
Code of Practice	Written to support the understanding and application of how the statute works in practice. There are codes of practice for the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards and Mental Health Act 1983.
Consent	The legal basis for undertaking any intervention with a patient is either the patient's valid consent, or a lawful basis for acting in the absence of a patient's valid consent.
Capacity	Capacity is the ability to make a specific decision at the time the decision needs to be made. Ability to make a decision is informed by, for example, a person's ability to understand the decision and why it needs to be made.
Lack of Capacity	The MCA 2005 defines a 'lack of capacity' as an inability to make a particular decision at a particular time due to "an impairment of or disturbance in the functioning of the mind or brain". There is a required test for capacity.
Decision Maker	The 'Decision Maker' is the person who is most appropriate to make a particular decision or who has the specific authority to make the decision. The 'Decision Maker' is the person responsible for an act in connection with care or treatment. That decision maker makes a decision where, on the balance of probabilities, they believe that a person lacks capacity to make a decision for themselves. Any staff who has contact with patients (particularly those who provide hands on care and treatment) may be 'decision makers' under the MCA 2005. A decision maker may include a nurse, occupational therapist, physiotherapist, healthcare assistant, or a doctor/clinician.
Capacity Assessment	The way in which a person is assessed to determine if they lack capacity for a particular decision at the time they need to make it. This is a prescribed legal test and the ordering of the test has been impacted by case law.

Best Interests	Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity. The person making the decision is referred to as the 'decision maker' for best interests. It is the decision maker's responsibility to work out what would be in the best interests of the person who lacks capacity. The Act does not define the term "best interest"; however, Section 4 of the Act (supported by the Code) sets down how to decide what is in the best interests of a person who lacks capacity in any particular situation.
Willful Neglect	The meaning varies depending on the circumstances. Usually, it means that a person has deliberately failed to carry out an act they knew they had a duty to do.
Lasting Power of Attorney (LPA)	This is a Power of Attorney created by the MCA 2005, appointing an attorney to make decisions in relation to personal welfare, including healthcare and/or deal with property and affairs.
Donor	A person who makes a Lasting Power of Attorney.
Court Appointed Deputy	A deputy is appointed by the Court of Protection to make decisions for someone who is unable to do so on their own. They are responsible for making these decisions until either the person they're looking after dies or is able to make decisions on their own again.
Restrictions, Restraint and Deprivation of Liberty	Section 6 of The MCA 2005 defines restraint as the use or threat of force where an incapacitated person resists, and any restriction of liberty or movement whether the person resists or not. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person or others, and if restraint is used is proportionate to the likelihood and seriousness of the harm. There is no single definition of deprivation of liberty. The starting point is the persons care plan and takes into consideration the "Acid Test"; the type, duration, effect, and manner of implementation of the restriction/restraint measures in question.
Advance Decisions to Refuse Treatment (ADRT)	Adults with capacity may make a decision in advance to refuse treatment if they should lose capacity in the future. An Advance Decision will have no application to any treatment which a doctor considers necessary to sustain life, unless required formalities have been complied with.
Independent Mental Capacity Advocate (IMCA)	The statutory advocacy service is required through the MCA 2005 to help people who lack capacity, make important decisions about serious medical treatment and changes of accommodation, and have no family or friends that it would be appropriate to consult about these decisions.

4 Responsibilities	
4.1	**Chief Executive** Responsible for: Ensuring that the Health Board operates in compliance with the legislation relevant to MCA 2005.
4.2	**Director of Nursing** Responsible for: • Ensuring compliance with the MCA 2005. • Compliance with this policy and procedure.
4.3	**Managers** Responsible for: • Ensuring that the staff, for whom they are responsible, are aware of their responsibilities under the MCA 2005 and practice commensurate with their role. • Supporting staff to attend MCA 2005 training commensurate with their role. • Ensuring all staff in their area are aware of their duty to pay due regard to the MCA 2005 Code of Practice • Ensuring staff have ready access to the relevant statutory Code of Practice and relevant resources.
4.4	**All Clinical Staff** Responsible for: • Ensuring they understand their duty under the MCA 2005, including the five statutory principles whenever they are working within the framework of the MCA 2005. • Complying with MCA 2005 training requirements and keeping abreast of legislative changes.

5 Purpose and Scope

The purpose of this policy is to support PTHB to discharge its duties and responsibilities. This requires an understanding and ability to apply the statutory requirements of the MCA 2005 alongside the Codes of Practice to the MCA 2005 and Deprivation of Liberty Safeguards as well as legal changes because of case law. PTHB need to be assured assessments of capacity are carried out appropriately and that decisions made on behalf of people who lack capacity are made in their best interests. It is vital that the Codes of Practice are followed as failure to comply can be used as evidence in civil or criminal proceedings. It is particularly important to keep detailed records of any reasons for departing from the Code.

The MCA 2005 applies to people 16 years of age and over. There are some exceptions: making a lasting power of attorney (LPA); making an advance decision to refuse treatment (ADRT) and being eligible for the Deprivation of Liberty Safeguards (DoLS) which only apply when a person is aged 18 or over.

The Act also introduces several bodies and regulations that staff must be aware of:
• Independent Mental Capacity Advocate (IMCA)

- The Office of the Public Guardian (OPG)
- The Court of Protection (CoP)
- Advance Decisions to refuse treatment (ADRT)
- Lasting Powers of Attorneys (LPA)

All patients where the MCA 2005 applies should expect appropriate care underpinned by this legal framework. Following this policy will help PTHB to meet its obligations that the MCA 2005 is used lawfully and guide staff in assessing decision-making capacity and providing care to patients who lack capacity to make specific decisions for themselves.

6 Consent

The legal basis for undertaking any care and treatment with a person is either the person's valid consent, or a lawful basis for acting in the absence of a person's valid consent. Valid consent requires 3 elements to be present: the person has been provided with appropriate information about the care and treatment with any potential options or choices in a format they can understand; the decision is made without duress/undue influence and the person has capacity to make and communicate the decision at that time. Valid informed consent cannot be given when the patient lacks the mental capacity for that decision at that time, or if one or both of the other elements are missing. The MCA 2005 provides a framework for the decision making process and a lawful basis for acting where because of a lack of capacity, there is no valid, informed consent. This policy must be read with PTHB Policy: CDP 011 All Wales Model Policy for Consent to Examination or Treatment.

7 How the MCA 2005 applies to Children and Young People

There is a section in the MCA 2005 Code of Practice that guides how to apply the MCA 2005 to children and young people. This can be accessed in Chapter 12 - Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk). Section 7 of PTHB policy - CDP 011 All Wales Model Policy for Consent to Examination or Treatment must be followed in relation to children and young people.

Children and Young people Children – aged under 16

The Act does not generally apply to people under the age of 16. There are 2 exceptions:

1) The Court of Protection can make decisions about a child's property or finances (or appoint a deputy to make these decisions) if: • the child lacks capacity to make such decisions; and • is still likely to lack capacity to make financial decisions when they reach the age of 18.
2) Offences of ill treatment or wilful neglect of a person who lacks capacity can also apply to victims younger than 16.

Care and treatment of young people aged 16 or 17

- The Family Reform Act 1969 presumes that young people have the legal capacity to agree to surgical, medical or dental treatment. This also applies to any associated procedure i.e., investigations, anesthesia or nursing care.

- As with adults, decision-makers should assess the young person's capacity to consent to the proposed treatment or care.
- If the young person lacks capacity to consent because of an impairment or disturbance in the functioning of their mind or brain, then the MCA 2005 will apply in the same way as it does to a person 18 and over.
- If they lack capacity for any other reason for example because they are overwhelmed by the implications of the decision, the MCA 2005 will not apply to them, and the legality of any treatment should be assessed under common law principles.
- The presumption of capacity does not apply to some rarer types of procedure (for example organ donation or other procedures which are not therapeutic for the young person) or research. In these cases, anyone under 18 is presumed to lack legal capacity, subject to the test of 'Gillick competence'
- If a young person has capacity to agree to treatment, their decision to consent must be respected. Difficult issues can arise if a young person has legal and mental capacity and refuses consent - especially if a person with parental responsibility wishes to give consent on the young person behalf. The Family Division of the High Court can hear cases where there is disagreement – the Court of Protection has no power to settle a dispute about a young person who is said to have the mental capacity to make the specific decision.

Most of the Act applies to young people aged 16 years and over.
There are 3 exceptions:

1) Only people aged 18 and over can make a Lasting Power of Attorney.
2) Only people aged 18 and over can make an advance decision to refuse medical treatment.
3) The Court of Protection may only make a statutory will for a person aged 18 and over.

8 Statutory Principles

The MCA 2005 is underpinned by five statutory principles. These must be adhered to and evident in clinical/practice records. The principles fall 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 apply only if the person is assessed to lack capacity for that particular decision at the time it is needed.

The Act does not prevent action being taken to protect a vulnerable person from abuse or exploitation.

The 5 statutory principles in Section 1 of the MCA 2005:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success

3. A person is not to be treated as unable to make a decision merely because they make an unwise decision
4. 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.
5. 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.

8.1 Statutory Principles Explained

Statutory Principle 1 – Presumption of Capacity

All persons over the age of 16 years must be assumed to have capacity unless it is established that they lack capacity. It is not expected to routinely assess capacity where it is not in doubt. Consent should be sought for any action/intervention. A valid consent consists of information, capacity to make the decision and that the decision is given without duress/undue influence. This principle highlights that the person does not have to prove their capacity, but it is the person undertaking the assessment who needs to demonstrate evidence to rebuff the presumption of capacity.

Statutory Principle 2 – Help for the person making the decision

People must be given **all** practicable help to make the specific decision/decisions for themselves. It is not necessary for the person to understand every detail of the issue and all the peripheral detail. Being able to understand and weigh up the key details relevant to the decision to be made will be sufficient.

It is the decision-maker who must ensure that all reasonable help for the person is given before deciding they lack capacity. What is reasonably practicable in one circumstance will be much less so in an emergency. This could mean thinking about the time of day for support to make a decision 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 improve and if the decision can wait, for example until they are medically fit or have more information or skills. If the decision can be put off until the person has capacity to make it for themselves, it should wait unless it is an emergency.

Statutory Principle 3 – Unwise Decisions

A decision that appears to others to be eccentric or unwise does not necessarily indicate a lack of capacity. A person with capacity can make decisions that others might not agree with. Repeated decisions that put the person at risk of harm might indicate the need for a capacity assessment. Members of staff have a duty of care to investigate carefully where it appears that the capacity to make a decision may be in doubt.

Statutory Principle 4 – 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 applied if the person is assessed to lack capacity for the decision in question. You cannot take any action under "best interests" if the person has capacity.

Statutory Principle 5 – Least Restrictive
A decision maker must consider what is the least restrictive option or whether an action or option is necessary at all. The decision maker must consider the restrictiveness of the options, identify the purpose of any restrictions, explore alternatives, the impact of these on a person and explore how restrictions can be lessened for the person. Any act of restrictive practice has a potential to interfere with a person's human rights. All acts of restrictive practice must be lawful, proportionate and the least restrictive option available.

9 Decisions not Permitted Under the MCA 2005

There are certain decisions where capacity may be doubted, and a capacity assessment is undertaken for this. However, there are certain best interest decisions that cannot be made under the MCA 2005. These decisions would need referring to the Court of Protection or are or are governed by other legislation and include:

- consenting to sex, marriage / civil partnership, or divorce / dissolution.
- decisions about parental responsibility for a child, adoption, or consent to fertility treatment.
- decisions to give, or to consent to, treatment for mental disorder of people who are liable for detention, assessment and treatment under the Mental Health Act 1983.
- decisions on voting.

If in doubt around this, please discuss with your manager or seek advice from the Safeguarding Hub - contact details are available in section 13 titled Safeguarding.

10 Assessment of Capacity

A person may lack capacity for the purposes of the MCA 2005 if the loss is partial or temporary or fluctuates over time. If there is a belief that a person lacks the capacity to make a specific decision, then it must be demonstrated on the balance of probabilities the person lacks the necessary capacity to make the decision at the time it needs to be made. We cannot "globally" assess or make statements that someone has capacity or not. The decision needs to be clarified and the options established before the assessment of capacity.

• Practice Guidance Note
Before undertaking any capacity assessment and where there is doubt about a person's capacity to make a specific decision, you must consider:
Does the decision need to be made immediately?
If not, is it possible to delay the decision until the person has capacity to make the decision themselves?

Has everything been done to help and support the person making the decision?
Has the person had all the relevant information needed to make the decision in question?
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 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 else help or support the person to make choices or express a view, such as an independent advocate or someone to assist communication.

10.1 When Should Capacity be Assessed?

Assessing capacity can be an intrusive process and should only be undertaken when there are good reasons to doubt the person can make the decision, at the time it is needed, because of an impairment or disturbance of the mind or brain. However, the presumption of capacity must not be used to avoid completing an assessment when there are genuine reasons to doubt a person's capacity and will be at risk as a result.

The MCA 2005 does not state how often capacity assessments need to be reviewed. A change may indicate an assessment needs to be reviewed. For example, if someone was found to lack capacity and appears to have improved to an extent it is felt they could now make the decision, the original assessment is no longer valid. If the current evidence has not changed, the assessment remains valid and does not need to be repeated.

The capacity assessment should be carried out at the point when a person needs to make their decision. The options available need to be identified and discussed with the person prior to an assessment of their decision-making capacity. Some people may require time to process the information or repeated discussions to aid their decision making and this needs to be in place **before** the assessment to ensure all practicable steps have been taken. It is not lawful to alter the options made available to people depending on whether they have the capacity to make the decision.

Care and treatment is often more than a one-off treatment such as an operation or other medical intervention, but of on-going care over a period of time. An assessment of capacity must therefore be a continuous process informed by the presumption of capacity principle until it is established otherwise. All professionals providing care and treatment must be satisfied that the person validly consents or where the person lacks capacity that care

	and treatment given is in the person's best interests in compliance with the MCA 2005, Section 5. Occasions may arise when a patient faces important decisions, in relation to care and treatment or something arising from it. Where there are any doubts about the ability of the patient to make the decision to give a valid consent to a treatment decision, e.g. because of borderline capacity or fluctuating capacity, a formal assessment of capacity must be carried out and documented. It is not possible to list all the eventualities when a formal assessment of capacity is required and professional judgement must be exercised, however, the following represent some instances: - • Informal admission to hospital. • Consideration or use of Safeguarding Procedures. • Serious medical treatment (as defined by the Mental Capacity Act 2005) S.37(6). • Significant change of accommodation (as defined by the Mental Capacity Act 2005) S.38 and S39. • Necessary breach of confidentiality (i.e. where personal information about the service user may be given to a third party). • Any situation where consideration is being given to a referral under DoLS.
10.2	**Who Should Assess Capacity?** The person who makes the assessment will usually be the person directly concerned with the person at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times. Where it is unclear who the decision maker is, it may help to consider who would be asking a person what their choice is if their capacity was not in question. That practitioner is likely to be the decision maker. In situations that are unclear or complex practitioners can access the PTHB Safeguarding hub for advice, contact details are available in section 13 titled Safeguarding. The MCA 2005 does not direct a certain professional/staff group to undertake a capacity assessment, but it is important to remember that professionals must not carry out a capacity assessment on decisions outside of their remit and knowledge. Sometimes, where the situation is complex or the difficulties a person may have making the decision are subtle or difficult to appraise, it might be appropriate to ask for support in undertaking the assessment. The more serious the decision, the more formal the assessment of capacity may need to be. In some complex cases, a multidisciplinary approach is best, using the skills and expertise of different professionals.

	PTHB should not be presumed to have a responsibility for providing initial or second opinion assessments of capacity which concern decisions that have no direct relevance to their core business; the provision of healthcare services. These could include decisions such as: • Testamentary capacity • 'Fitness to plead' and 'fitness to stand trial' • Capacity to instruct a solicitor • Capacity to manage property and affairs, grant a Lasting Power of Attorney (property and affairs) Where the healthcare professional is currently working with the person concerned, there may be occasions when the healthcare professional is satisfied that undertaking a capacity assessment of this type is appropriate. PTHB does not intend to preclude healthcare professionals from undertaking capacity assessments where they feel it is appropriate to their role and competence. Any healthcare professional who undertakes an assessment of a person's capacity to make a decision unrelated to Health Board business should ensure: • they are acting within the scope of their competence, • have necessary indemnity insurance and, • inform the referrer that they are acting in an individual capacity.
10.3	**Preparation** In undertaking an assessment of capacity the decision should be clearly defined with possible options identified – referred to as 'the relevant information'. This is required to effectively consider the person's understanding. The assessor needs to gather collateral information by reviewing the records, speaking to relevant staff and family members/friends. This will help decide what the 'relevant information' is and the issues that need to be discussed with the person. The assessor also needs to know the correct answers to the questions asked of the individual when testing their understanding, retention, and ability to use the relevant information in making a decision.

• **Practice Guidance Note**
Did you:
• Identify what method of communication the person is most familiar with?
• Identify what time of day is best to discuss the decision with the person?
• Consider the best location to discuss the decision with the person?
• Consider whether it would assist the person to have another person present who they know well. Ensure you agree what role that person will take.

	• Consider what help does the person require to learn about and understand the information relevant to the decision? • Consider whether there is something that you can do which might mean the person would be able to make the decision. • Define and frame the question precisely? • Ask the question of the person? • Identify the information that is relevant for the person to have to enable them to make the decision.
10.4	**Capacity Assessment** There are three elements to the assessment of capacity that must be completed in the following order to determine if a person is able to make a decision: 1) Functional assessment (Understand, Retain, Weigh and Use and Communicate), 2) Identify if the person has an impairment or disturbance in the functioning of the mind, and finally. 3) The assessor must determine that the inability to make a decision is because of the identified impairment or disturbance. The assessor must inform the individual: • That their capacity is being assessed • Why their capacity is being assessed • What the decision is that needs to be made. • Of the outcome of the assessment • What they can do if they are unhappy with the outcome. Each element is described below. **1 <u>The 'Functional Test'</u>** Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to? • i)Can the person **understand** the information relevant to the decision? • ii)Is the person able to **retain** that information long enough to make the decision? • iii)Can the person **use or weigh** the information to make this decision? • iv)Can the person **communicate** their decision by any means? e.g. muscle movements, blink, hand squeeze. **Understand** Does the person have any difficulty understanding the information? How do they respond to your questions, are their answers appropriate to the content and context of your conversation? Comment on any difficulties you felt the person had understanding information relevant to the decision. 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 the correct information 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 report back what you have been talking about? For example, "What did we say your son is worried about?"

Weigh or use
A person who can understand and retain that information must be able to weigh or use that information in the decision-making process. That means the person accepts the information given them and uses that to inform their decision-making. This is the most subjective part of the assessment.

Practice Guidance Note.

Weigh or Use - Can the person weigh up the risks or pros and cons in relation to the available options? Can the person take on new or corrective information? The person needs to consider all the key factors. Remember that people will put different value on these factors and the person's priority may not be the same as yours. This does not necessarily mean the person is unable to weigh up information and therefore lacks capacity. You need to try and get a feel for what issues the person believes are important to them in this decision – for example 'why is going home so important to you?', 'what is important to you about living at home?' - and whether they can incorporate other important issues, perhaps the risks they might face in a particular option, in their decision-making. For example, a person might value the emotional attachment they have to their own home that means they consider this as more important to them than any risks. Be aware that 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 the fact 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.

2. Is there an impairment or disturbance in the functioning of the persons mind or brain?

The test for capacity does not always involve the assessment of a patient by a doctor. The decision maker may have sufficient information available. It is

inappropriate to subject individuals to repeated medical or psychiatric assessments where there is sufficient information for the decision maker to determine their capacity.

The evidence required is an 'impairment or disturbance in the functioning of the persons mind or brain'. This can be temporary or permanent and can include medical conditions that cause drowsiness, confusion, concussion and the symptoms of drug or alcohol abuse. If there is no evidence, the individual cannot lack capacity under the MCA 2005.

Look for evidence of this during your preparation; do the records include descriptions of confusion, cognitive assessments etc., what are the family and staff worried about? Think about the questions you ask to check if the person is orientated to their situation. Sometimes the impact of any impairment might be more subtle, affecting judgement more than memory for example. Conditions that are used to evidence this are (but not exclusively):

- Dementia
- Stroke
- Significant learning disabilities
- The long-term effects of brain damage
- Physical or mental conditions that cause confusion, drowsiness or loss of consciousness.
- Delirium
- Concussion following a brain injury, and
- The symptoms of alcohol or drug use.

There does not need to be always a specific medical disease to impair capacity for example, a person might be severely intoxicated or under the influence of drugs rendering them unable to make a decision at the relevant time.

3. Is the person's inability to make the decision because of the identified impairment or disturbance?

There has to be a causal link between the inability to make a decision and the impairment of the mind or brain. This is known as the "causative nexus". The assessor must determine that the inability to make a decision is because of the identified impairment or disturbance.

Please note the ordering of the first and second question is different to the MCA 2005 code of practice due to subsequent case law. However, be aware that an understanding of a person and their needs which would usually necessitate an awareness of any identified impairment or functioning in the person's mind or brain is required to effectively apply principle 2 of the MCA 2005.

11 Recording Assessments of Capacity

An assessment of the individual's capacity to consent or agree to the provision of care and treatment will be part of the care planning processes and should be recorded in the relevant nursing and medical documentation. Apart from day-to-day decisions, a formal record of the assessment of capacity and the best interest decision making process must be recorded. For day-to-day decisions the practitioner must be able to demonstrate they had a "reasonable belief" that the individual lacked capacity to make the decision in question, and it was in the person's best interests to take the action they took. They must be able to describe their decision making if necessary. It is not necessary to record this in as much detail as for more complex decisions, but the recording must demonstrate that the MCA 2005 has been followed. Each service area within PTHB must have a policy to identify how and where they record mental capacity for decisions within patient records. PTHB have a form called 'Record of Mental Capacity Assessment' that is to record an assessment of capacity for a specific decision. This is available on the intranet and in Appendix 3.

The MCA 2005 Code of Practice states that:
'Where assessments of capacity relate to day-to-day decisions and caring actions, no formal assessment procedures or recorded documentation will be required'. However, the more important a decision is, the greater the need for clear recordings and it is 'good practice that a proper assessment of capacity is made and the findings of that assessment are recorded in the relevant professional records'.

- **Practice Guidance Note**

Within PTHB, any professional proposing care and treatment should consider an assessment of the individual's capacity to consent, where there is evidence to doubt a person's capacity, clearly documenting the steps taken or not taken. This should be filed in the appropriate record with the appropriate plan of care e.g. nursing care plan, medical treatment plan. Where there are concerns around whether the individual has the capacity to consent or refuse to consent to the treatment or act, or to make a specific decision, a formal assessment of mental capacity must be carried out and recorded by the decision maker.

If an individual is judged to lack capacity to make a decision, it is essential that all professional staff involved in that individual care and treatment keep an accurate record of all the decisions and discussions concerning their mental capacity, for example:

- What specific decision needed to be made and by when.
- The evidence indicating the individual lacks capacity for that specific decision.
- What steps were taken to support the individual to make their own decision.
- What decision(s) were taken in the best interest of the individual and who was involved in this process.
- The multi-disciplinary meeting notes should clearly indicate all of the above and be written in a clear and concise format, including consideration of the best interest decision checklist.

• This information should be stored in the patient medical and nursing notes, to ensure that all involved in care are aware of the best interest decision.
This information is an essential element of clinical practice. It provides evidence to support those staff involved within the decision making if they are called to account for their actions.
Your conclusion will be on the **balance of probabilities**. There is always an element of subjectivity. Based on the evidence you have gathered do you feel it is sufficient to disprove the presumption of capacity principle? You need to provide evidence for each of the three elements. Use direct quotes to illustrate the evidence. 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.

12 If a Person Refuses a Capacity Assessment

Sometimes a person will 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.

13 Fluctuating Capacity

The MCA 2005 requires an assessment of capacity to be undertaken when the person is at their best and an assessor can only give an opinion about the person's capacity at the time they see them. However, if a person's capacity fluctuates you can consider the evidence around their ability to understand, retain, weigh up and communicate the risks associated to the times they lack capacity. If the person does not accept the periods of time when they lack capacity and cannot weigh up the risks, this would suggest they lack capacity to make the decision in question. Case law has developed that can support practitioners to undertake assessments where the patient has fluctuating capacity and assessors should seek out resource and guidance around this. This would include speaking with your manager or seeking advice through PTHB Safeguarding hub, contact details are available in section 13 titled Safeguarding.

In some cases, a person may have a temporary impairment e.g. due to a severe infection, that can be resolved with treatment. However, it must be noted that others will have fluctuating capacity due to the nature of their condition. It may be possible to put off the decision until such time as the person has recovered and regained capacity to make his/her own decision.

14 Safeguarding

If any Safeguarding concerns are identified PTHB SGP 036 Safeguarding Policy should be followed with a safeguarding report completed that clearly identifies any issues around a person's capacity. PTHB Safeguarding Hub can be accessed for advice and support when you are unsure about what action may be required. The Safeguarding Hub is accessed via the generic email account PowysTHB.Safeguarding@wales.nhs.uk or by ringing the Central Safeguarding number 01686 25280. This is available Monday to Friday, 9 to 5, excluding bank holidays. Outside of these times, please contact the on call rota.

15 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 substituted decision making. The decision-maker in this last scenario would be the person who is proposing to take the next steps in question on the basis of best interests. If you are unsure of who is the decision maker, ask who would be asking the person what their choice is if they had capacity and that practitioner is likely to be the decision maker.

If a person has been assessed to lack capacity for a specific decision, then any act done for, or decision made on behalf of the person lacking capacity must be done or made in that person's best interests. The MCA 2005 does not specify what is in a person's best interests, nor does it define best interests. Section 4 of the MCA 2005 sets out how to determine best interests.

Exceptions to the best interest principle:

- When a person has previously made a valid and applicable advance decision to refuse medical treatment, their decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests.
- Concerns the involvement in research, in certain circumstances, of someone lacking capacity to consent.

Section 4 of the MCA 2005 sets out factors that must always be considered when trying to work out someone's best interests. These are summarised:

- Working out what is in someone's best interests cannot be based simply on someone's age appearance, condition or behaviour. Paragraphs 5.16-5.17 MCA Code of Practice.
- All relevant circumstances should be considered when working out someone's best interests. Paragraphs 5.18-5.20 MCA Code of Practice.
- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision. Paragraphs 5.21-5.24 MCA Code of Practice.

- If there is a chance that a person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent. Paragraphs 5.29-5.36 MCA Code of Practice.
- Special considerations apply to decisions about life-sustaining treatment. Paragraphs 5.29-5.36 MCA Code of Practice.
- The person's past and present wishes and feelings, beliefs and values should be taken into account. Paragraphs 5.37-5.48 MCA Code of Practice.

• **Practice Guidance Note** When making a best interest decision staff must consider:
Regaining capacity – it may be appropriate to delay the decision to allow further time for additional steps to be taken to restore the person's capacity or to provide support and assistance which would enable the person to make the decision themselves.
Encouraging participation – the person must be permitted and encouraged to participate as fully as possible in any act done for him/her and any decision affecting him/her. Time must be taken to try to seek their views. A trusted relative or friend, or an Independent Mental Capacity Advocate, may be able to help the person to express wishes or aspirations or to indicate a choice between different options.
The person's feelings and wishes – the person making the decision must consider so far as is reasonably ascertainable, the person's past and present wishes and feelings; the beliefs and values that would be likely to influence his/her decision if he/she had capacity; and the other factors that he/she would be likely to consider if he/she were able to do so. This also includes specific views may have been set out in an Advance Directive, communicated informally to relatives and carers or formally in the Lasting Power of Attorney. Those consulted will be asked what they consider to be in the person's best interests and whether they can provide any information on their wishes, feelings, values or beliefs (see paras 5.49 – 5.55).
The views of other people – the person making the decision must take into account, if it is practicable and appropriate to consult with them, the views of anyone named by the person as someone to be consulted on the matter in question or on matters of that kind; anyone engaged in caring for the person or interested in their welfare; any donee of a Lasting Power of Attorney. You may also need to consult with other professionals involved in the person's care.
Do not make assumptions – the person making the decision must not make any assumptions about the person based on age, condition, appearance, or behaviour.

Best interest decisions must be documented appropriately. PTHB has a form to record this. It is available on the intranet and in appendix 4.

If the decision is straightforward and everyone involved is in agreement, then the decision maker can make a best interest's 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. The decision-maker 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. If there are likely to be differing opinions, the decision is finely balanced or may conflict with the person's wishes and feelings or it is a complex decision, then a best interests meeting will need to be arranged.

15.1 Best Interests Meeting

They are not required under the MCA 2005 but the Code of Practice recommends they are used for serious decisions or where there is dispute.

- Practice Guidance Note

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 for decisions around future care and accommodation.
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 asking a senior colleague 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.

A sample agenda for a best interests meeting is included at Appendix 2.

16 Urgent Decisions

There are occasions when an urgent decision is required. In the absence of a valid and applicable advance decisions regarding refusal of treatment (ADRT), nothing should prevent immediate actions to preserve life, prevent homelessness or protect from serious harm. In specific situations there is a compulsion on doctors and other health care staff to make very rapid decisions in emergency situations where there is no time to consult (in the absence of any pre-existing or anticipatory treatment decision or ADRT). Urgent decisions will have to be made and immediate action taken in the person's best interests. In these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions, or to consult with any known attorneys or deputies. However, even with

urgent decisions, healthcare staff should try to communicate with the person and keep them informed of what is happening.

17 The Court of Protection (COP)

The Court of Protection rules on all matters for the MCA 2005. Chapter 8 of the Code of Practice provides further guidance on the COP. The COP can make judgements on healthcare, social care and finances - in relation to people who lack mental capacity. If a person lacks capacity, the court can make decisions on their behalf or it can appoint a deputy to make such decisions. The COP judgements include the areas of: contact, residence/living arrangements, deprivation of liberty, contact, best interests, mental capacity, sexual relations and marriage, treatment, lasting power of attorney, tenancies, deputies and finance. Generally the court will make decisions in disputed or complex cases.

The COP should be referred to where there are difficult or complex decisions to make on behalf of a patient who lacks capacity. The matter must be referred to the Court of Protection if all other options for making the decision or resolving differences have been exhausted. There are situations that must be referred to the COP. Refer to the section 'Referral to the Court of Protection', paragraphs 184-190 in PTHB policy: CDP 011 All Wales Model Policy for Consent to Examination or Treatment.

It is not required for all cases, where it is considered that continuing with Clinically Assisted Nutrition and Hydration (CANH) is not in the best interest of the person, need to be brought to the courts to decide this. The Supreme court in *An NHS Trust -v- Y* [2018] UKSC 46 decided that where there isn't doubt or disagreement about the proposed withdrawal of CANH this decision can be taken by the care team. However, in situations where there is doubt or disagreement by any party the matter should be brought to court to decide what is in the best interest of the person.

18 Designated Decision Makers

The MCA 2005 identifies two types of designated decision makers. Lasting Power of Attorney and Court Appointed Deputy.

18.1	**Lasting Power of Attorney** The MCA 2005 replaces Enduring Power of Attorney (EPA). An EPA can help make decisions about someone's property and money if they are appointed using an enduring power of attorney. Only EPAs made and signed before 1 October 2007 can still be used. After that date donors had to make a Lasting Power of Attorney instead. A Lasting Power of Attorney (LPA) is a legal document that allows a person (the Donor) with capacity to choose someone (the Attorney) to act on their behalf at a time in the future when they may lack the mental capacity to make those decisions themselves. An LPA can only be used after it is registered with the Office of the Public Guardian (OPG). There are two different types of LPA; a personal welfare LPA and a property and affairs LPA. A donor can identify more than one person to be their

attorney and the OPG forms allow a donor to state if they want their attorney's to act 'jointly and severally'. This means that a donor can act or decide separately or together with another donor A personal welfare LPA allows attorneys to make decisions to accept or refuse healthcare or treatment unless the donor has stated in the LPA that they do not want the attorney to make these decisions.

Personal Welfare LPA

A Personal Welfare LPA allows someone to plan ahead by choosing one or more people to make decisions on their behalf regarding personal healthcare and welfare. **These decisions can only be taken by somebody else when the person lacks the capacity to make them for themselves**. The Attorney(s) will only be able to use this power once the LPA has been registered with the OPG. The attorney can be given the power to make decisions about any or all personal welfare matters, including healthcare. This could involve some significant decisions such as:

- Giving or refusing consent to particular types of health care including medical treatment decisions.
- Decisions about whether the person continues to live at home or move into a residential care home.

If the Attorney(s) is to have the power to make decisions about 'life-sustaining treatment', this has to be expressly stated using the appropriate sections of the LPA form. The Attorney(s) can also be given the power to make decisions about day-to-day aspects of personal welfare, such as diet, dress, or daily routine. It is up to the Donor which of these decisions the Attorney is allowed to make.

Even where the LPA includes healthcare decisions, attorneys do not have the right to consent to or refuse treatment in situations where:

- The donor has capacity to make the particular healthcare decision (section 11(7)(a)) • An attorney has no decision making power if the donor can make their own treatment decisions.
- The donor has made an advance decision to refuse the proposed treatment (section 11(7)(b)) • An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment. But if the donor made an LPA after the advance decision and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the advance decision.
- A decision relates to life-sustaining treatment (section 11(7)(c)) - An attorney has no power to consent to or refuse life-sustaining treatment, **unless the LPA document expressly authorises this.**
- The donor is detained under the Mental Health Act 1983 (section 28) - An attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983.

	Property and Affairs LPA A Property and Affairs LPA allows someone to plan ahead by choosing one or more people to make decisions regarding property and financial affairs. A property and affairs Attorney can be appointed to act whilst the person still has capacity as well as when they lack capacity. For example, it may be easier to give someone the power to carry out tasks such as paying bills or collecting benefits or other income. This might be because it is difficult to get about or to talk on the telephone, or the person may be out of the country for long periods of time. The Attorney(s) can be given the power to make decisions about any or all of the property and affairs matters. This type of LPA does not allow the Attorney to make decisions about personal welfare. **Who can make an LPA?** Anyone aged 18 or over, with the capacity to do so, can make an LPA appointing one or more Attorneys to make decisions on their behalf. One person can be appointed to deal with finances and another to deal with health and welfare decisions for example.
18.2	**Court Appointed Deputies** Deputies are 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 They 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. The deputy is the decision maker only in the areas the Court of Protection has granted powers. Deputies cannot: • Override the person' 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.
18.3	**Identifying and Verifying an LPA or Deputy** Practitioners caring for an individual must identify if a person has an appointed LPA. If a person has capacity they can make their own decisions about their care and treatment. If they lack capacity to consent then the professional **must see evidence** of the LPA/Deputy authority and consider if a check of the LPA register with the Office of the Public Guardian is required. The practitioner must check the power on the form matches the decision to be made.

Confirming that a Person has LPA or Deputy Checks
Patient, family, carer or other identifies that there is a LPA or Deputy.
Ask them to identify what this is for – health and welfare or property and finance or both.
Ask them to bring in an original of the LPA document.
Check the names on the LPA (donor and attorney).
Check the authority is for health and welfare.
Check it is stamped by the OPG on each page.
Photocopy the document and sign to say you have seen the original.
File in the records.
The document will specify the acts of care and treatment it covers or does not cover.
You cannot assume the person has LPA until these checks are undertaken.

If there is difficulty in verifying this, you can approach the Office of Public Guardian directly and complete a search request form: Urgent enquiries: check if someone has an attorney or deputy - GOV.UK (www.gov.uk)

Alternatively, the OPG have a checking system that can be accessed if the attorney has signed up to this to enable checks online. This can be accessed: View a lasting power of attorney - GOV.UK (www.gov.uk). You will need the attorney to provide a key code.

- Practice Guidance Note

Within PTHB all staff must ensure that all patients are routinely asked if they have an LPA or deputy. The original document must be seen and a copy taken and placed in the patient's record.

It is essential that any member of staff wishing to make a decision or carry out an act can satisfy themselves that the attorney/deputy has the necessary authority to make decisions on behalf of the person lacking capacity, or that they must be consulted. For an LPA to be valid and binding, it must be registered with the Office of the Public Guardian (OPG). Any staff member wanting to confirm that an LPA is valid, i.e. registered, not revoked and the attorney has not been removed, should contact the OPG.
Advice can be sought from the Safeguarding Hub via the generic email account PowysTHB.Safeguarding@wales.nhs.uk or by ringing the Safeguarding hub 01686 25280. This is available Monday to Friday, 9 to 5, excluding bank holidays. Outside of these times, please contact the nurse on call.

19 Independent Mental Capacity Advocate (IMCA)

The purpose of the IMCA service is to provide independent safeguards and to help people who lack capacity to make certain important decisions about serious medical treatment and changes of accommodation, **and** who have no family or friends (other than paid carers) that it would be appropriate to consult about those decisions. It is a statutory advocacy service.

Whether a person is 'appropriate to consult' is referring to: whether they are able to be contacted, whether they are willing and able to be consulted or to represent the person. An IMCA is not the decision-maker, but the decision-maker has a duty to consider the information given by the IMCA. An IMCA must decide how best to represent and support the person who lacks capacity that they are helping. PTHB staff must ensure IMCAs are given all reasonably practicable assistance to carry out their function. This includes access to notes that the decision maker considers relevant to the decision.

19.1 When to instruct an IMCA

Where a person lacks capacity to make a particular decision and is "un-befriended" as described above, decision makers in Local Authorities and Local Health Boards **have a duty to instruct** an IMCA where:

- The decision is about serious medical treatment provided by or proposed by the NHS (but excludes treatment regulated under Part IV of the Mental Health Act 1983);
- It is proposed by the NHS or Local Authority that the person be moved to long-term care of more than 28 days in a hospital or 8 weeks in a care home (where that accommodation or move is not a requirement of the Mental Health Act 1983);

  A long-term move (8 weeks or more) to different accommodation is being proposed by the NHS or Local Authority, for example a move to a different hospital or care home (where that accommodation or move is not a requirement of the Mental Health Act 1983).

An IMCA **may also be instructed** on behalf of a person lacking capacity for:

- Care reviews, where no-one else is available to be consulted.
- Safeguarding adult cases, whether or not family or friends are involved and if the person who lacks capacity is either the alleged victim or alleged perpetrator.

The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Wales) Regulations 2007 define serious medical treatment as: treatment Serious medical treatment which involves providing, withdrawing or withholding treatment in circumstances where -(a)in a case where a single treatment is being proposed, there is a fine balance between its benefits to a person and the burdens and risks it is likely to entail, (b)in a case where there is a choice of treatments, a decision as to which one to use is finely balanced, or (c)what is proposed would be likely to involve serious consequences for the person.

- Practice Guidance Note

Where the decision concerns 'serious medical treatment' and there is no-one other than paid staff who are appropriate to consult about the person's best interests, an Independent Mental Capacity Advocate (IMCA) referral is mandatory. Within PTHB the decision maker who is in charge of the treatment, will be responsible for the referral.

If serious medical treatment or a change of accommodation needs to be provided urgently to save an incapacious person's life or prevent a serious deterioration, then this needs to be progressed and a referral made to IMCA as soon as possible. Where treatment is urgent, the need to instruct an IMCA should not delay the treatment, but an IMCA should be instructed with minimal delay after the treatment has begun. Serious medical treatment does not cover treatment for a mental disorder where the patient is detained under the Mental Health Act 1983.

- Practice Guidance Note

When a decision maker makes a referral to the IMCA Service, the referral should be to the IMCA Service in the Local Authority area where the incapacitated person currently is. Who to refer to is not based on ordinary residence but instead on the location of the person at the time the decision needs to be made/ treatment provided. It is necessary to confirm that the correct IMCA service is being approached and that the correct referral process is being used.

20 Acts in Connection with Care and Treatment

Section 5 of the MCA 2005 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 MCA 2005 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 full 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.

21 Restraint

Restraint is not just about 'hands on' interventions. Locking a door, telling a person that they cannot do something or go somewhere, giving medication to affect behaviour might have the effect of restraining a person. This applies even if they are not resisting. The MCA 2005 defines restraint in section 6, as the use or threat of force to make someone do something they are resisting or to restrict a person's freedom of movement whether they are resisting or not. Staff will have protection from liability when carrying out an action intended to restrain a person who lacks capacity if certain conditions are met.

To be lawful under the Act, any restraint must be:

- Reasonable, necessary, and proportionate to the harm that would come to the person who lacks capacity if the person were not subject to restraint.
- It must always be for the minimum necessary time, be clearly documented and subject to review.
- It must always be in the best interests of the person who lacks capacity and be least restrictive of the person's rights and freedoms.

It is important to note that section 5 and 6 of the MCA 2005 allows for restriction and restraint but does not allow a person to be deprived of their liberty. Appropriate use of restraint does not in itself amount to a deprivation of a person's liberty.

22 Deprivation of Liberty

Article 5 of the European Convention on Human Rights states:

- 5 (1) Everyone has the right to liberty & security of person. No one shall be deprived of his liberty save in the following cases [e – persons of unsound mind] and in accordance with a procedure prescribed by law.
- 5(4) Everyone who is deprived of their liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

The starting point in identifying a person deprived of their liberty is their care plan and requires consideration the "Acid Test" - the type, the duration, effect, and the manner of implementation of the restriction/restraint measures in question. PTHB staff must identify any patient who is deprived of their liberty and ensure the correct steps are undertaken to authorise this. You must consider whether:

- The person does not validly consent to their care arrangements (a person who lacks capacity to consent cannot validly consent)
- The State is responsible for the situation (As a Local health Board, PTHB is part of 'the State')
- The person is under both 'continuous supervision and control AND is not free to leave'. (the 'Acid Test' or the 'Cheshire West' test) and as such is 'deprived of their liberty'.

In order to comply with Article 5, a deprivation of liberty may occur lawfully by:

- Detention under the Mental Health Act 1983
- A Court Order (High Court or Court of Protection)
- The Mental Capacity Act Deprivation of Liberty Safeguards (DOLS). Patients over the age of 18 only.

Any inpatient in the care of PTHB who is **deprived of their liberty** must have one of the above legal frameworks in place. However, the first step following the identification of a potential deprivation of liberty is to review the patient's care/treatment plans to see if a less restrictive approach could be undertaken.

For detailed guidance on the DOLS process please refer to PTHB Policy: PTHB Deprivation of Liberty policy and procedure SGP042.

Sometimes a person may lack capacity due to an acute illness or infection which is likely to resolve in 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 MCA 2005. Advice can be obtained from the DoLS Office 01597 826843 if there is uncertainty whether an application under DoLS is required.

23 Limitations to Protection from Liability

Professionals will be protected under Section 5 if they can demonstrate that they have taken appropriate steps to assess capacity, reasonably believe that the person lacks capacity and that they have carried out a best interest assessment, so they reasonably believe the act is in the person's best interests.

• Practice Guidance Note
Section 5 does not provide a defence in cases of negligence – either in carrying out a particular act or by failing to act where necessary
Acts may not be protected from liability where there is inappropriate use of restraint
Acts may not be protected from liability where a person who lacks capacity is deprived of their liberty without authorisation. A deprivation of liberty that is not authorised is unlawful.

24 Interface with the Mental Health Act (1983) (as amended by the 2007 Act)(MHA 1983)

The MCA 2005 should be applied wherever possible to individuals who lack capacity and are detained under the MHA 1983. If the issue concerns treatment for the mental disorder or one of its symptoms/ manifestations, the MCA 2005 framework will be used to assess capacity, however, the legal basis for undertaking the treatment remains the MHA 1983. The MCA 2005 will be the legal framework for undertaking treatment for a physical condition which is unrelated to the mental disorder - even if the person who lacks capacity is a MHA 1983 detained patient. An Advance Decision to Refuse Treatment (ADRT) which refuses treatment for a mental disorder may be (but does not have to be) overridden if the patient is detained under the MHA 1983 and the responsible clinician considers that there is no alternative.

Treatment of a patient who is subject to sections 4, 5, 135 and 136 of the MHA 1983 cannot be given contrary to the patient's capacious objection. Where the patient lacks the capacity, it is possible to treat under the provisions of the MCA 2005. The MHA 1983 has a code of practice which includes a chapter on this interface that must referred to Mental Health Act 1983: code of practice | GOV.WALES.

• Practice Guidance Note
Professionals may need to think about using the MHA 1983 to detain and treat somebody who lacks capacity to consent to treatment (rather than use the MCA 2005), if:

- It is not possible to give the person the care or treatment they need without doing something that might deprive them of their liberty.
- The person needs treatment that cannot be given under the MCA 2005 (for example, because the person has made a valid and applicable advance decision to refuse an essential part of treatment).
- The person may need to be restrained in a way that is not allowed under the MCA 2005.
- It is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent but might then refuse to give consent).
- The person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so.
- There is some other reason why the person might not get treatment, and they or somebody else might suffer harm as a result.

Before making an application under the MHA 1983, decision-makers should consider whether they could achieve their aims safely and effectively by using the MCA 2005 instead. Compulsory treatment under the MHA 1983 is not an option if:

- The person's mental disorder does not justify detention in hospital, or
- The person needs treatment only for a physical illness or disability.

- Practice Guidance Note

The MCA 2005 applies to people subject to the MHA 1983 in the same way as it applies to anyone else, with four exceptions:

- If someone is detained under the MHA 1983, decision-makers cannot normally rely on the MCA 2005 to give treatment for mental disorder or make decisions about that treatment on that person's behalf.
- If somebody can be treated for their mental disorder without their consent because they are detained under the MHA 1983, healthcare staff can treat them even if it goes against an advance decision to refuse that treatment.
- If a person is subject to guardianship, the guardian has the exclusive right to take certain decisions, including where the person is to live.
- Independent Mental Capacity Advocates do not have to be involved in decisions about serious medical treatment or accommodation if those decisions are made under the MHA 1983.

25 Information Sharing

Much of the information required to assist and inform the decision-making process under the MCA 2005 is sensitive or confidential.

It is regulated by: • The Data Protection Act 1998 • GDPR • The common law duty of confidentiality • Professional codes of conduct on confidentiality • Information sharing protocols, and • The Human Rights Act 1998 and European Convention on Human Rights.

Staff should discuss any concerns with information governance, safeguarding team, and legal team, for support and guidance.

26 Offences

The MCA 2005 introduced two new criminal offences: ill treatment and willful neglect of a person who lacks capacity to make relevant decisions (section 44, MCA 2005). The offences may apply to:

- Anyone caring for a person who lacks capacity – this includes family carers, healthcare and social care staff in hospital or care homes and those providing care in a person's home, or
- An attorney appointed under a Lasting Power of Attorney or an Enduring Power of Attorney, or
- A deputy appointed for the person by the court.

These people may be guilty of an offence if they ill-treat or willfully neglect the person they care for or represent. Penalties will range from a fine to a sentence of imprisonment of up to five years – or both. Ill treatment and neglect are separate offences. For a person to be found guilty of ill treatment, they must either:

- Have deliberately ill-treated the person, or
- Been reckless as to whether they were ill-treating the person or not. It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

- Practice Guidance Note

The meaning of 'wilful neglect' varies depending on the circumstances. It usually means that a person has deliberately failed to carry out an act they knew they had a duty to do.

27 Challenge to the Decision Made.

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 a dispute is between professionals, the usual organisational procedures for disagreement need to be followed to attempt 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 assessments they can access the complaints procedure for PTHB. There are occasions when the decision maker will take a decision on a person's best interests that others disagree. As with disputes regarding capacity assessments, internal processes need to be followed in 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 interest's decision after the complaints procedure has been concluded then the decision maker needs to take action and seek legal advice to apply to the Court of Protection.

If someone wishes to challenge the decision made about capacity there are a number of options that can be explored:

- Involve an advocate
- Get a second opinion

- Inform the person of the 'putting it right' process.

Ultimately unresolved disagreement must be actively referred to the Court of Protection.

28 Training

All clinical staff working directly with patients should have an understanding of the MCA 2005 and must complete the mandatory training relevant to their role.

29 Monitoring Compliance, Audit & Review

- Managers will be required to monitor compliance with this policy
- Non-compliance with this policy amounting to an incident should be reported on Datix
- The Safeguarding Team will undertake or contribute to local, regional or national safeguarding audits as required and report relevant findings to PTHB MCA Operational Group.

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

30 References / Bibliography

Deprivation of Liberty Safeguards Code of Practice (2008)
Essex Chambers (2017) A Brief guide to carrying out capacity assessments
Equality Act 2010
Human Rights Act 1998
Mental Health Act 1983 (as amended by the 2007 Act)
NICE 2018 Decision making and mental capacity NICE guideline
Code of Practice Mental Health Act 1983 (2015)
Mental Capacity Act 2005
Mental Capacity Act 2005 Code of Practice
Royal College of Nursing, Adult Safeguarding Roles and Competencies for Health Care Staff first edition (2018)
Reducing Restrictive Practices Framework (2022)
PTHB Deprivation of Liberty policy and procedure SGP042
PTHB Safeguarding Policy SGP036
Regional Adult Safeguarding Threshold Document Social Services and Wellbeing Wales Act 2014
Wales Safeguarding Procedures 2019
Well-being of Future Generations Act (Wales) 2015
Welsh Government Declaration for the Rights of Older People in Wales 2014

PTHB Polcies:

CDP 011 All Wales Model Policy for Consent to Examination or Treatment.
PTHB Deprivation of Liberty Policy and Procedure SGP042
PTHB Safeguarding Policy SGP036

31 APPENDICES

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Appendix 1	Best Interests Checklist
Appendix 2	Sample Best Interest meeting Agenda
Appendix 3	MCA Form 1 – Recording a Capacity Assessment
Appendix 4	MCA Form 2 – Record of best Interests Decision-Making

Appendix 1

Best Interest Checklist

Weigh up all of the factors below in order to work out what is in a person's best interests.

If the decision concerns life-sustaining treatment . • Not to be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life.
Assess whether the person might regain capacity • Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?
Avoid restricting the person's rights • See if there are other options that may be less restrictive of the person's rights
Encourage participation • Do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision.
Identify all relevant circumstances • Try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.
Find out the person's views Try to find out the views of the person who lacks capacity, including: • The person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits. • Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question. . • Any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.
Avoid discrimination • Not make assumptions about someone's best interests simply on the basis of a person's age, appearance, condition or behaviour
Consult others • If it is practical and appropriate to do so, consult other people for their views about the person's best interests and see if they have any information about the person's wishes and feelings, beliefs and values. In particular, try to consult: a. Anyone previously named by the person as someone to be consulted on either the decision in question or similar issues. b. Anyone engaged in caring for the person. c. Close relatives, friends or others who take an interest in the person's welfare. d. Any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person. e. Any deputy appointed by the Court of Protection to make decisions for the person. • For the decisions about major medical treatment or where the person should live and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted. • When consulting, remember that the person who lacks the capacity to make the decision of or act for themselves still has a right to keep their affairs private – so it would not be right to share every piece of information with everyone

Exceptions to the best interest's principle There are circumstances when a best interest's principle will not apply. • Where someone has previously made an advance decision to refuse treatment while they had capacity to do so. Their advance decision should be respected when they lack capacity, even if others think that the decision to refuse treatment is not in their best interests. • Involvement in research, in certain circumstances, of someone lacking capacity to consent. For further information please consult: Mental Capacity Act 2005 Code of Practice and (Microsoft Word - What research does the Act cover formatted .doc (gov.wales))

Appendix 2

Best Interests Decision - Meeting Agenda Format	
Date of meeting	
Persons name	
Decision makers name	
Decision to be made	**Ensure that the options are clarified and be aware that other options may become apparent during the conversations.**
Area	**Action for Chair**
Welcome by the Chair including statement on capacity	*A best interest's decision can **only** be made where the person lacks capacity to make the specific decision themselves. Explain the particular decision on capacity and why it was felt the person lacks capacity.*
Introductions	*Introduce all those present at the meeting. If anyone has been specifically excluded in the persons best interests, this should also be explained.*
Confidentiality statement	*The Chair should make a statement about the confidentiality of the meeting.*
Explanation of meeting purpose and format	*This meeting will proceed by following the statutory checklist for decision making as described in the Mental Capacity Act 2005 and the Code of Practice. If any section is not relevant it can be omitted but only after it has been considered in the meeting.*
Equal consideration and non-discrimination	*This meeting will not make assumptions about the person's best interest based on their age or appearance or their condition. It will be an objective process without preconceptions or negative assumptions.*
Consider all relevant circumstances	*Use this time to have an open discussion about the wider aspects of the decision to be made.*
Regaining capacity	*Consider whether the person will regain capacity in time to make the decision or whether it can be delayed.*
Permitting and encouraging participation	*Discuss here to what extent the person has been included in the meeting, how their views have been sought outside the meeting.*
Persons wishes feelings, beliefs and values	*What is known about the person's past and present wishes?* *Was anything written whilst they had capacity? Record what you know about their values and beliefs, religious or political background that may impact on the decision, remember that the persons wishes are paramount in decision making but this does not mean they call always be adhered to.*
Views of other people	*What are the views of family members, partners, and carers? Anyone named or nominated by the person lacking capacity. Anyone involved in their welfare. Any attorney or deputy appointed.* *Specifically- what they think is in the person's best interests? And what information they can provide on the wishes/feelings/values and beliefs of the person. If there is no-one to consult with then an IMCA will be involved. Do not omit dissenting views.*
Life sustaining treatment Decisions	*Discuss whether it is a life sustaining treatment decision and if so the decision maker must not be motivated by the desire to bring about the persons death. Value judgements should not be made about the quality of a person's life.*
Burdens and benefits	*It will be useful to identify the benefits and burdens of each **available** option. Addressing the following areas; medical, welfare, social, emotional and ethical may help for complex cases.*
What is the decision at the conclusion of the meeting	
Why is this decision the	

less restrictive option	
Any further actions Needed	*Consider any further actions such as obtaining a legal opinion or other professional opinion or any application to the Court of Protection.*

Appendix 3

MCA Form 1 – Recording a Capacity Assessment

Date of Birth:	NHS number:	WCCIS number:
Patient Name:	Date and time/s of assessment:	Location of assessment:
Name of assessor/decision-maker:	Designation:	Work base:

Describe the reasons for this assessment.
Identify why the decision needs to be made and why at this time. Identify the reason to doubt capacity to make this decision at this time. Individuals are entitled to make decisions that others consider unwise. See MCA Code 4.35

Describe the specific decision.
Identify the decision to be made. The MCA Code 4.4 states 'An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general'.

Describe the relevant information for this decision. Identify the nature of the decision, the reason why the decision is needed and the likely effects of deciding one way or another or making no decision at all. Identify relevant and appropriate information from records, discussion with family, friends, and staff. See MCA Code 4.16. Consider confidentiality and consent – GDPR regulation article 9 exemption.
Prior to Undertaking a Capacity Assessment You must presume a person can make a decision for themselves, unless you can evidence a lack of capacity for the specific decision at the time it is needed. You must explain to the person concerned what the decision is and why it needs to be made. A person cannot be treated as unable to make a decision unless all practicable steps to help them have been taken without success. This might include providing information in an appropriate way, making the person feel at ease and supporting the person, communication support, providing education.
List all practicable steps taken to enhance capacity and to enable the person to make this decision.
Can the decision be delayed until recovery, or until the person has gained skills to make the decision themselves? Record below any reasons why the decision can or cannot be delayed.
Identify the records and people you have received information from.

Name	designation	Date spoken to/report accessed	Details of consultation or reports accessed

Essential checks in undertaking a capacity assessment:					
The person is informed their capacity is being assessed	Y	N	Is there an Advance Decision to Refuse Treatment (ADRT) or advance statement that covers this decision?	Y	N
The person is informed why their capacity is being assessed	Y	N	Is there a registered LPA/Deputy for health and welfare?	Y	N
Is the person able to consent to this assessment?	Y	N	Is an IMCA required?	Y	N
Have they consented?	Y	N	Is there any other advocate required?	Y	N
Summarise any actions needed/taken.					

Methods of Communication Used (Mark all that apply)							
Spoken Welsh		Spoken English		Other spoken language		British Sign Language	
Written Welsh		Written English		Other written language		Makaton	
Braille		Audiotape		Pictures / Photos		Other	
Comment:							
If used, name / details of interpreter or supporter assisting interview(s)							

Describe the steps taken to assist the person during this capacity assessment Consider timing of the assessment, support tools, having a preferred person support the assessment, an advocate present, communication aids, advice from others, e.g. input from speech and language therapy.

Mental Capacity Assessment. The test for capacity can be broken down into three elements:			
1. Is the person able to make the decision? (Functional Assessment) Describe your evidence for each of the functional assessment. Consider recording the questions used and how you presented the information (consider use of verbatim recording).			
i.Can the person **understand** the information relevant to the decision? *(Understanding that a decision needs to be made, the foreseeable consequences of the decision and of making no decision.)*	Y	N	
ii. Can the person able to **retain** that information long enough to make the decision? *(Support should be offered to retain information with memory; notebook, photograph, poster, video, voice recorder, computer, etc.)*	Y	N	
iii. Can the person **use and weigh** the information to make this decision? *(Decide without undue influence, persuasion or to please others)*	Y	N	
iv. Can the person **communicate** their decision by any means? *e.g. muscle movements, blink, hand squeeze.* *(If the person has capacity and can communicate their decision tick 'YES'. If the person is unable to understand*	Y	N	

and/or retain, and/or use or weigh relevant information, but is communicating something, then the record of your assessment should not say that they are unable to communicate their decision – it should say that they can communicate (so tick YES). Describe your evidence, noting any wishes and beliefs that were able to be expressed in relation to this decision.)			

Question 2. Does the person have an impairment of, or a disturbance in the functioning of their mind or brain?

This section does not require that a formal diagnosis has been made, sometimes you may need to use the Act based on the reasonable belief a person has or is showing signs of an impairment of or disturbance in the functioning of the mind or brain. You should record here your reasons for believing this to be the case. See 4.11 - 4.12 of the Code. *If it is likely that a continuing number of assessments and decisions will need to be made over time, then it would be good practice to request investigations into a diagnosis be made. Describe the evidence, its source and future investigations planned. Identify formal records, detailing location and the name, title and organisation of diagnostician.*

Yes ☐ **No** ☐

Evidence:

Is the impairment/ disturbance:	**Fluctuating**	**Temporary**	**Permanent**

Question 3. Is the person's inability to make the decision because of the identified impairment or disturbance in the functioning of their mind or brain?

*If the person is unable to make the decision you **must** identify the impairment or disturbance in the functioning of the mind or brain **and** confirm that the person's inability to make the decision is because of that impairment or disturbance. Professionals should be satisfied that the inability to make a decision is **because of the impairment of, or the disturbance in functioning of mind or brain**.*

Yes ☐ **No** ☐

Evidence:

Outcome of capacity assessment

Does the person lack capacity to make the specific decision at this specific time? *Evidence your decision on the balance of probability. Record your outcome considering any identified risks to the adult, limitations of the assessment and future indications to further assess.*

Yes ☐ No ☐

Evidence:

If the person does not have the capacity to make the decision in question, can they be assisted to make some contribution towards the decision?	Y	N	
Has the outcome of this assessment been explained to the person and their deputy/attorney for health and welfare?	Y	N	

Decision Maker's Details

Signature		Print Name	
Job Title		Date	
Address		Telephone Number	

Appendix 4

MCA Form 2 – Record of Best Interests Decision

Date of Birth:	NHS number:	WCCIS number:
Patient Name:	Date/s of Best Interests Decision:	Location of decision:
Name of decision-maker:	Designation:	Work base:

Complete this form after the **MCA Form 1 – Recording a Capacity Assessment**. This form is to record the process of Best Interests Decision for a specific decision at the time it is needed, where there is no one with a legal right to make decisions for that person (i.e. court order, Lasting Power of Attorney for health and welfare, court appointed Deputy). Carrying out of the decision should be evidenced in the care / treatment / support plan. Best Interest decision-making is considered in Section 4 of the MCA 2005.
Urgent treatment/prevention of homelessness and immediate safeguarding can take place with 'best interest' emergency decisions. Other decisions must wait until consultations and any IMCA report has been taken into account.

PTHB have a dedicated page of resources and information about the MCA 2005 - Mental Capacity Act 2005 (sharepoint.com). This includes the PTHB Mental Capacity Act 2005 Policy. You cannot base a best interest's decision on assumptions about the person's age, appearance, condition, or behaviour. You must consider all the circumstances of which you are aware that can reasonably be regarded as relevant.

Prior to Making a Best Interest Assessment The best interests process only applies to people who lack capacity for the decision. Provide the required information below to confirm the person lacks capacity.	
Decision maker for capacity assessment:	Date of capacity assessment:

Is the person likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision or action wait until then? If it can, do not make a best interest's decision, if it cannot, explain your reasons.

Alternative Decision Making Authority	
Does the person have a valid and applicable advance decision to refuse treatment (ADRT) that relates to this decision?	
Yes	**Stop.** Follow the advance decision.
No	**Continue with the assessment.**
Date of advance decision:	Date seen:
Details of advance decision and location:	
Is there a health and welfare lasting power of attorney/deputy/court of protection order, with authority over the decision?	
Yes	**Stop.** The best interest decision will be made by these people or stated in a court order. Even if you undertake a best interest assessment – you must ask for their authority or ensure the best interest decision is not in contradiction of the court order.
No.	**Continue with the assessment.**

Some treatment decisions must always be made by the Court of Protection.
You will not need to complete the remainder of this form if the authority for this decision is an advance decision or lies with an attorney or deputy. Consult your line manager, Safeguarding Hub or Legal Services Department if you are unsure of the validity of any advance decision, or the authority of an attorney or deputy, or if you feel an attorney or deputy is not acting in the person's best interests.

Who is the Decision-Maker?	
The decision-maker is the person who is proposing to take the next steps in question, on the basis of best interests. If you are unsure of who is the decision maker, ask who would be asking the person what their choice is if they had capacity and that practitioner is likely to be the decision maker	

Is there a verbal or written advance statement.	**Yes**	**No**
Details / whereabouts of advance statement.		

Has an IMCA been instructed?	**Yes**	**No**
If yes, has their views been considered?	**Yes**	**No**
If no, give an explanation why.		

Specific Options Available for this Decision

Identify what options have been considered below. Identify the benefits and consequences and consider which option is least restrictive in terms of the persons rights and freedoms.

Options	**Benefits**	**Consequences**

Record below what is known about the person's past and present wishes, feelings, beliefs, and values.
The MCA and the Code of Practice require that the views of a person who lacks capacity should be considered, and their wishes taken fully into account. If it is not possible to find out the person's views or wishes explain why this is the case:

Identify those that you have consulted with and their views. You must consult the following people where it is practical and appropriate to do so (even when they do not have authority to make the decision):

- Anyone previously named as someone the person wants to be consulted.
- Anyone interested in the person's welfare (Family, carers, close relatives, or an advocate for the person).
- A court appointed deputy/Lasting or Enduring Power of Attorney who does not have authority for this decision.
- Anyone involved in caring for the person.

Date/Time	Who consulted (Name/Role)	Views on best interest	Signature

It was not practicable/appropriate to consult the following people. Identify the reason why.

Are there relevant other factors?
The decision-maker is required to consider any other factors which the person who lacks capacity would consider if they were able to do so. These can include the effect of the decision on other people such as dependents. Record any such factors which are relevant to this decision below:

Life Saving Treatment. See 5.29 – 5.36 of the MCA code. A special factor in the checklist applies to decisions about treatment necessary to keep the person alive ('life-sustaining treatment') and this is set out in section 4(5) of the Act. The fundamental rule is that anyone who is deciding whether or not life-sustaining treatment is in the best interests of someone who lacks capacity to consent to or refuse such treatment must not be motivated by a desire to bring about the person's death.

Does this decision relate to life sustaining treatment?
Yes ☐ **No** ☐

Provide details:

Record below the nature of any unresolved disagreements: Disputes might be resolved through involvement of an advocate, getting a second opinion, holding a best interests meeting, attempting mediation, or pursuing a complaint. Unresolved disputes for important decisions may require referral to the Court of Protection.
Best Interests Decision and Reason Record the outcome of the decision-making and what is considered to be in the person's best interests with the reasons for this decision:
Detail who the best interest's decision has been shared with.

Decision Maker details	
Signature	Print Name
Job Title	Date
Address	Telephone Number