

TRUST-WIDE CLINICAL POLICY DOCUMENT

Over-arching Policy and Procedure of the Mental Capacity Act (MCA) 2005

Policy Number:	MC01
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2017 – Version 5

Quality, recovery and
wellbeing at the heart
of everything we do

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Further information about this document:

Document name	MC01 Over-arching Policy and Procedure of the Mental Capacity Act 2005 V.5
Document summary	<p>This policy and procedure was introduced in 2007. It was subsequently reviewed in 2009, 2014 and 2016 This is a further review of that policy and procedure.</p> <p>The purpose of this corporate policy and procedure is to provide support and guidance for those working within the framework of the Mental Capacity Act 2005.</p>
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SUPPORTING STATEMENTS

this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line with a Human Rights based approach and the FREDA principles of **Fairness, Respect, Equality Dignity, and Autonomy**

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1 PURPOSE AND RATIONALE

- 1.2 The rationale for revising this policy and procedure is to ensure that it remains up-to-date with current legislation and thereby continues to assist Trust personnel to maintain compliance when working within the framework of the Mental Capacity Act 2005, its Code of Practice, the Mental Health Act Code of Practice (2015 edition) and to manage its interaction between associated legislation, particularly the Mental Capacity Act 2005 as a whole and the Mental Health Act 1983.
- 1.3 Furthermore, this policy has been updated to comply with the current Trust standard policy framework.

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

The aims of this policy and procedure are to describe the standards expected and the supporting processes for:-

1. The clinical and administrative application of the Mental Capacity Act 2005
2. Describing the interface processes that exist between the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
3. The monitoring of the clinical and administrative application of the Mental Capacity Act 1983.
4. Supporting those applying or monitoring the Mental Capacity Act 2005.
5. Review and monitoring of the above process.

3. SCOPE

This corporate policy and procedure applies in part and/or whole to:-

1. All Mersey Care NHS Trust staff in respect of all service users receiving assessment care and/or treatment within the organisation.
2. The Trust's Mental Health Act Managers (Hospital Managers)
3. The Trust's Mental Health Law Administrators
4. The Trust's Legal Team

4. DEFINITIONS

4.1 Key Words and Phrases

For a full list of definitions	Refer to <i>Section 11 Glossary of Terms</i> of this document
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5. DUTIES

5.1 Trust Board

The Trust Board has a duty to ensure that the Trust is compliant when operating within the framework of the Mental Capacity Act 2005

5.2 The Hospital Managers (Mental Health Act Managers, MHAM)

The Hospital Managers (also referred to as the Mental Health Act Managers) have specific statutory duties which effectively makes them responsible for the Trust's implementation and management of the Mental Capacity Act 2005 insofar as it interacts with the Mental Health Act 1983

5.3 Procedural Document Author

The document author (Trust Lead for the Mental Capacity Act and Deprivation of Liberty) is responsible for ensuring that it is compliant with the relevant legislation, case-law and that it is consistent with the Trust's standards for procedural document format.

5.4 Accountable Directors (or Chief Operating Officers):

The accountable person for each Division is the Chief Operating Officer who will be responsible for ensuring there are robust governance systems in place for the implementation and management of the Mental Capacity Act 2005 in their area.

5.5 The Trust's Legal Team; Risk Management Department; Learning and Development Team; Clinical Audit Team; Research and Development Team; Knowledge Management Team

5.5.1 The Trust's Legal Team will be consulted for advice and guidance in relation to mental capacity law (and related topics) practice.

5.5.2 Risk Management Department will be consulted when appropriate in consideration of any risks arising from mental capacity law practice.

5.5.3 The Learning and Development Team must be consulted to enable the identification of potential implications for staff learning and development, in relation to mental capacity law practice. This will include a careful consideration of the provision and method of delivery for education and development. Page 11 of 45

5.5.4 The Clinical Audit, Research and Knowledge Management Teams will be consulted for general advice in relation to mental capacity law audits, research, reports etc).

5.6 Managers:

5.6.1 Managers are responsible for ensuring:-

- That the staff for which they are responsible are aware of their responsibilities for Mental Capacity Act practice commensurate with their role.
- That an infrastructure is in place to support the training of all staff required for mental capacity law practice.
- All staff in their area are aware of their duty to pay due regard to the Code when working within the framework of mental capacity law.

5.6.2 All staff in their area have ready access to the Code of Practice and are aware of and understand their duty to apply the 5 Guiding (Key) Principles whenever they are working within the framework of the Act.

5.7 Responsible Clinicians (RCs)

All Responsible Clinicians employed within the Trust are responsible for ensuring that any assessment of capacity (including those required under the Mental Health Act 1983 – for example, in relation to consent to treatment) are Mental Capacity Act 2005 compliant.

5.8 Mental Health Act Assessors

All Mental Health Act Assessors (within the meaning of the Deprivation of Liberty Safeguards) employed within the Trust are responsible for ensuring that their registered Mental Health Act Assessor status is up-to-date. It is unlawful for a practitioner who does not have current Mental Health Act Assessor status to carry out such assessments.

5.9 Best Interest Assessors

All Best Interest Assessors (within the meaning of the Deprivation of Liberty Safeguards) working for or on behalf of the Trust must ensure that their registration with the relevant local social services authority is current at the time they conduct such assessments.

5.10 All staff:

5.10.1 Staff are responsible for:-

- Ensuring that they pay due regard to the respective Mental Capacity Act and Deprivation of Liberty Safeguards Codes of Practice when working within the framework of mental capacity.
- Ensuring that they apply the Mental Capacity Act's 5 Guiding (Key) Principles when working within the framework of mental capacity.
- Ensuring that they keep up-to-date with mental capacity law practice commensurate with their role.

6. PROCESS

6.1 Mental Capacity Act Supporting Procedures

6.1.1 Guidance within Chapter 13 of the Mental Health Act Code of Practice (2015 ed) takes precedence over corresponding guidance in the Mental Capacity Act and Deprivation of Liberty Codes of Practice, Transforming Care-Service Mode (ADASS 2015), Transforming Care-Next Steps (NHS England 2015), Transforming Care-Building the Right Support (ADASS 2015)

6.2 Mental Capacity, Mental Incapacity and the Mental Capacity Act 2005

6.2.1 See, MCA Code of Practice, Chapter 4). *Guidance within Chapter 13 Of the MHA Code of Practice takes precedence over corresponding guidance in the MCA Code of Practice as it is the more recent.*

6.2.2 "Mental Capacity is the ability to make a decision..." (MCA Code of Practice, Chapter 4, p.41).

6.2.3 "For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" (MCA, section 2(1)).

6.2.4 "The Mental Capacity Act 2005 (the Act) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with the Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for her/himself. The same general rules apply whether the decisions are life-changing events or everyday matters". (MCA Code of Practice, Chapter 1, paragraph 1.1, p.15).

6.2.5 Therefore:-

1. People who have capacity to make a decision cannot have their choice of decision made for them on their behalf under Mental Capacity Act powers
2. People who are shown to lack capacity to make a decision can have that choice of decision made for them on their behalf BUT...

3. Only at the time the choice of decision needs to be made AND only in relation to the specific decision in question.

6.3 The Mental Capacity Act 2005 Code of Practice (2007 edition)

6.3.1 “Certain categories of people are legally required to ‘have regard to’ relevant guidance in the Code of Practice. That means they must be aware of the Code of Practice when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves and they should be able to explain how they have had regard to the Code when acting or making decisions.” (MCA Code of Practice, Introduction, p.2).

6.3.2 The categories of people that are required to have regard to the Code of Practice include anyone who is acting in a professional capacity for, or in relation to, a person who lacks capacity... “ (MCA Code of Practice, Introduction, p.2)

6.4 Exclusions (See MCA Code of Practice, Introduction, p.2)

6.4.1 The MCA 2005 provides a statutory framework to empower and protect people who may not be able to make their own decisions.

6.4.2 However, there are certain decisions under the MCA 2005 which do not fall within the statutory framework:-

1. Family relationships

Nothing in the act permits a decision on **any** of the following matters to be made on behalf of a person:-

- Consenting to marriage or a civil partnership.
- Consenting to have sexual relationships.
- Consenting to a decree of divorce being granted on the basis of 2 years separation.
- Consenting to a dissolution order being made in relation to a civil partnership on the basis of 2 years separation.
- Consenting to a child being placed for adoption by an adoption agency.
- Consenting to the making of an adoption order.*
- Discharging parental responsibilities not relating to a Childs property.
- Giving a consent under the Human Fertilisation and Embryo Act 1990.

* “Adoption order” means an adoption order within the meaning of the Adoption and Children’s Act 2002 (chapter 38) (including a future adoption order) and an order under Section 84 of that act (parental responsibility prior to adoption board).

2. Mental Health Act Matters

“The MCA can be relied upon to treat mental disorder where the patient lacks capacity to make the decision in question and such treatment is in the patient’s best interests, provided that the treatment is not regulated by Part 4 (of the Mental Health) Act” (MHA Code of Practice, 2015ed., para.13.1, p.101)

* The terms “Medical treatment”, “mental disorder” and “patient” are defined within the meaning of section 145 of the Mental Health Act 1983.

.3. Voting Rights

Nothing in the act permits a decision on voting at an election for any public office or at a Referendum to be made on behalf of the person.

* “Referendum” has the same meaning as in Section 101 of the Political Parties, Elections and Referendums Act 2000 (chapter 41).

4. Unlawful Killing or Assisting Suicide

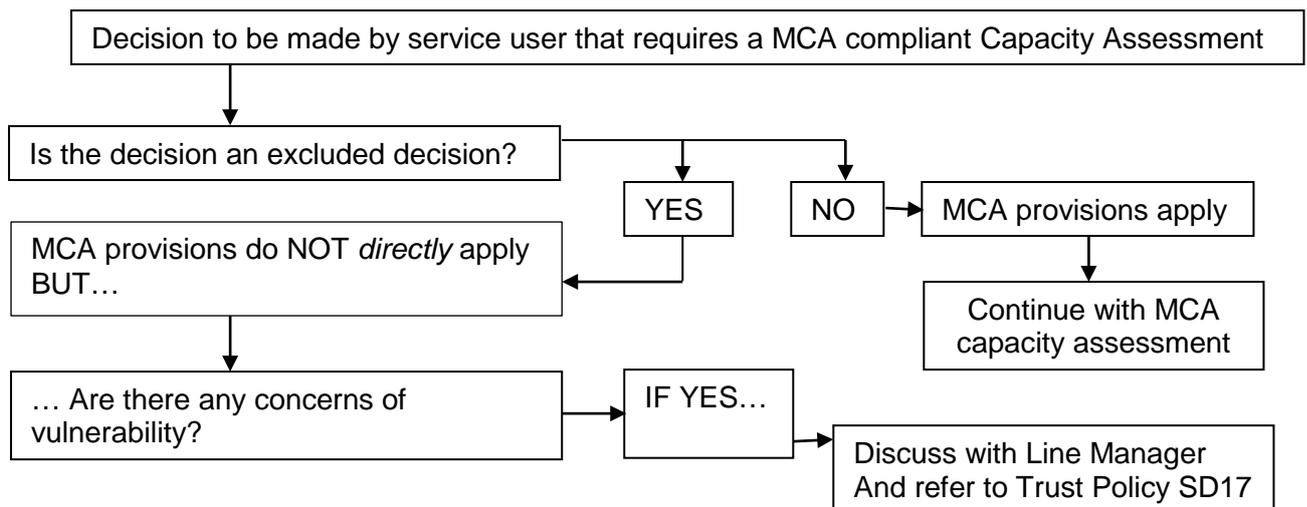
For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

6.4.3 “Although the Act does not allow anyone to make a decision about these matters on behalf of someone who lacks capacity to make such a decision for themselves (for example, consenting to have sexual relations), this does not prevent action being taken to protect a vulnerable person from abuse or exploitation. (MCA Code of Practice, 2007 ed., Chapter 1, paragraph 1.11, p.17)

6.4.4 The above issues may fall under the Protection of Vulnerable Adults. If there are such concerns Trust staff must follow appropriate guidelines for the protection of vulnerable adults using policy SD17 (Policy for the Protection Of Vulnerable Adults).

6.4.5 Flowchart with excluded decisions under the MCA 2005

(See Overleaf)



6.5 The 5 Statutory Key Principles of the Mental Capacity Act 2005 (See MCA Code of Practice, Chapters 2 & 3 and MHA Code of Practice para. 13.14, pp.98-99)

6.5.1 The Mental Capacity Act details 5 statutory guiding (or Key) principles which underpin its fundamental concepts and govern its implementation.

6.5.2 Since these are statutory principles *anyone* working within the framework of mental capacity must apply them without exception.

6.5.3 The 5 Key Principles are:-

1. *The Presumption of Capacity Principle* – Any person 18 years or older will always presumed to have the mental capacity to make an informed decision unless and until proven otherwise.

2. *The All Practicable Steps Principle* – A person cannot be said to lack the capacity to make a given informed decision unless and until all practicable steps have been taken to help her/him achieve this.
3. *The Unwise Decisions Principle* – A person cannot be said to lack the capacity to make a given informed decision *solely* on the grounds that the decision in question is seen to be unwise or eccentric.
4. *The Best Interests Principle* – Once it is confirmed that a person lacks the mental capacity to make a given informed decision then... any decision made on her/his behalf must be one that meets her/his best interests.
5. *The Least Restrictive Principle* - Once it is confirmed that a person lacks the mental capacity to make a given informed decision then... any decision made on her/his behalf must be considered to be the least restrictive option likely to achieve the required outcome.

6.5.4 The above principles should not be applied in isolation but should support and compliment each other.

6.6 Assessment of Capacity (See MCA Code of Practice, Chapter 4 and 5)

Introduction (See MCA Code of Practice, Chapter 4, pp. 40-43)

- 6.6.1 Irrespective of purpose, any mental capacity assessment must be Mental Capacity Act compliant.
- 6.6.2 Capacity Assessments must be decision-specific and must apply at the time the intervention is to be carried out.
- 6.6.3 A person can only be deemed to lack capacity to make a given decision if the following two-stage test of incapacity is satisfied:-
 1. They have an impairment or disturbance of the mind and/or brain
AND
 2. That impairment or disturbance means they are unable to make an informed, specific decision at the time it needs to be made
- 6.6.4 “A person’s capacity cannot be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour” (MCA Code of Practice, Chapter 4, p.40)

Who can conduct a Capacity Assessment? (See MCA Code of Practice, Chapter 5, p.68))

- 6.6.5 “The person who assesses an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made” AND...
- 6.6.6 “This means that different people will be involved in assessing someone’s capacity to make different decisions at different times.” (MCA Code of Practice, Chapter 4, paragraph 4.38, p.53)
- 6.6.7 BUT... in effect this also means that only the person responsible for making the decision or the person executing that decision can conduct the assessment.

What is an ‘inability to make a decision?’ (See, MCA Code of Practice, Chapter 4, p.41)

- 6.6.8 A person is unable to make a decision for her/himself if s/he is unable to:

- to understand the information relevant to the decision,
- to retain that information in their mind,
- to use or weigh that information as part of the process of making the decision, or
- communicate their decision (whether by talking, using sign language or any other means).

(for more detail and examples of these four points see MCA 2005 COP, paragraphs 4.16 – 4.25 pages 46 – 49)

- 6.6.9 To help a person understand the information relevant to the nature and consequences of a decision (including making no decision at all) the explanation of the information must be given to her/him in a way that is appropriate to their circumstances (using simple language, visual aids or any other means).
- 6.6.10 The fact that a person is able to retain the information relevant to a decision for a short period only, does not prevent her/him from being regarded as able to make the decision. Capacity is confirmed where a person is able to understand and retain information long enough to make an informed decision.
- 6.6.11 The information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision.
- 6.6.12 The situation may arise when it is necessary to get a professional opinion when assessing a person's capacity to make complex or major decisions. For example a person's General Practitioner may be contacted for an opinion or the skills of a speech therapist may be sought if there are communication difficulties. Further guidance and examples of when professional help should be sought are given in the *MCA 2005 COP at paragraphs 4.51 – 4.54, pages 59 – 61*.

When should capacity be assessed? (See, MCA Code of Practice, Chapter 4, p.52)

- 6.6.13 Nobody can be forced to undergo an assessment of capacity. Threats or attempts to force a person to agree to an assessment are unacceptable. In these circumstances it may help to explain to someone refusing an assessment why it is needed and what the consequences for refusal are.
- 6.6.14 If the person lacks capacity to agree or refuse, the assessment can normally go ahead, as long as the person does not object to the assessment, and it is in their best interests.
- 6.6.15 Where there is doubt about a service user's capacity to make a decision a capacity assessment should be carried out using the Trust's Capacity Assessment Form (CAF) and Best Interest Checklist Form. It is important that the person who does an assessment can justify their conclusions so the completion of a CAF is an important protection for them. The CAF is based on the nationally recognised CAF and guidance from Hill Dickinson Solicitors. The Capacity Assessment Form and Best Interests Checklist Form can be accessed as follows:-
- Epex (*Capacity Assessment Form*) Clinical Pathways/CPA Pathway/Mental Capacity 2 (*Best Interest Checklist Form*) Clinical Pathways/CPA Pathway/ Form 16
 - Pacis (*Capacity Assessment Form*) can be located via the Document Template Icon on the PC desk top or via the *Secure Division Document Templates* Icon within Share Point.
 - RiO Within the Case Record Menu, select the folder, *MHA* - expand the folder Click the link to *MHA Consent / Rights* – select the required document, *Mental Capacity Assessment* or *Best Interests Checklist*

6.6.16 Trust staff must ensure that a service user receives a formal capacity assessment in the following circumstances:

- At the point of hospital in-patient admission – “In considering whether it is necessary for the person to be detained under the Act, decision-makers must consider whether the person has the capacity to consent to or refuse admission and treatment” (MHA Code of Practice, para.14.2, p.116).
- The above bullet point applies equally to persons who are being considered for informal admission, a point which has been repeatedly reinforced by Hill Dickinson Solicitors and the Care Quality Commission

“In deciding whether it is necessary to detain patients, doctors and AMHPs must always consider the alternative ways of providing the treatment or care they need. Decision-makers should always consider whether there are less restrictive alternatives to detention under the (Mental Health) Act which may include:

- informal admission based on that person’s consent
- treatment under the Mental Capacity Act (MCA) [with or without Deprivation of Liberty Safeguards (DoLS) or Court of Protection authorisation] if that person lacks capacity to consent to informal admission” (MHA Code of Practice, para. 14.11, pp.115/6)

It follows that these distinctions cannot be determined unless and until a formal capacity assessment has been conducted.

- If there is a dispute between staff and/or carers regarding a service user’s capacity
- A change of residence
- Any significant medical intervention (clearly, in-patient hospital admission would amount to this)
- Any decision that carries with it a clear legal impact
- Any restriction of free movement (including recurrent instances of physical restraint)
- If a service user’s finances are to be managed by others
- If the service user behaves in a manner which may be harmful to themselves, others or the property of others

6.6.17 The above list is non-exhaustive. Trust staff must use their judgment as to when a capacity assessment is justified. When considering whether to carry out a formal assessment of capacity, staff must consider the gravity of the issue in question, the person’s behaviour and if somebody else has raised concerns .

6.6.18 **Fluctuating Capacity** In some instances the mental capacity of someone who has a mental impairment fluctuates. If the person retains capacity at the time the decision needs to be made long enough to make an informed decision then that decision remains valid unless and until s/he makes a further informed decision to the contrary.

6.6.19 Consequently, if that person subsequently loses capacity a capacity assessment will be required but their previous informed decision must be taken into account when reaching a best interests decision on her/his behalf.

6.6.20 It must be remembered that the assessment of capacity is an **ongoing process** and the possibility that a person has regained capacity must always be considered. Where there has been no apparent fluctuation or change in mental state, Trust staff must ensure that all formal

capacity assessments are *routinely* reviewed on an annual basis and more frequently if necessitated by events.

- 6.6.21 The *MCA 2005 COP, Chapter 3* gives a full description of how to deal with the question as to when capacity should be assessed and suggests steps to help people make their own decisions.

6.7 Mersey Care NHS Trust Formal Capacity Assessments

- 6.7.1 Whoever carries out an assessment of mental capacity must take reasonable steps to assess whether or not a person has capacity, and must decide whether there are reasonable grounds for believing that a person does not have capacity following an assessment.
- 6.7.2 The MCA Code of Practice recognises that assessments of capacity will vary in sophistication according to the circumstances. Trust staff are required to apply normal clinical and professional standards in determining capacity. The assessors must also determine whether the service user has the capacity to communicate in relation to the decision in question.
- 6.7.3 Before carrying out a formal capacity assessment, Trust staff should identify whether the service user has a diagnosis made by a psychiatrist that is current and that indicates that the service user does have a mental disability.
- 6.7.4 Before an assessment of capacity can commence, the staff carrying out the assessment must first formulate the question to which the assessment of capacity is intended to provide the answer.
- 6.7.5 Staff carrying out the assessment must gather appropriate evidence to formulate a judgement about whether the service user lacks capacity in relation to the issue in question. This evidence should be documented on the relevant Capacity Assessment Form (see 6.6.15 above)
- 6.7.6 Where there is doubt about a service user's capacity to make a decision a capacity assessment should be carried out using the Trust's Capacity Assessment Form (see 6.6.15 above)
- 6.7.7 It is important that the person who does an assessment can justify their conclusions so the completion of a Capacity Assessment Form is an important protection for them.
- 6.7.8 Where lack of capacity is established a best interests checklist form must also be completed (see 6.6.15 above)
- 6.7.8 A properly completed Capacity Assessment Form and Best Interest Checklist Form will be Mental Capacity Act compliant and is drawn from a draft provided by Hill Dickinson Solicitors.
- 6.7.9 The Capacity Assessment Form is located electronically (see 6.6.15 above)
- 6.7.10 The Best Interest Checklist Form is located electronically (see 6.6.15 above)
- 6.8 Factors which may affect capacity** (See MCA Code of practice, Chapter 4, pp. 55)

- 6.8.1 A person's mental capacity can fluctuate or be temporarily impaired due to (for example) mood or depression. In these circumstances, it may be possible to put off a decision until such time as the person has regained capacity.
- 6.8.2 A person's mental capacity may also vary or be temporarily impaired due to an underlying physical disorder e.g. urinary tract infection.
- 6.8.3 A person may have the capacity to make some decisions but not others. We must weigh up a person's capacity against the specific decision that needs to be made. For example, a person who cannot understand the financial issues around entering long term care might still have the capacity to make a choice about whether they want to go into long term care at all and, if so, which home.
- 6.8.4 A lack of information. We need to make sure that any information relevant to the decision is provided in a format that the person can understand.
- 6.8.5 Pressure. Carers or other family members may sometimes exert undue pressure when the person being cared for is actually capable of making their own decisions or where expert help may help them do so.
- 6.8.6 A lack of trust. A person may feel anxious about dealing with staff from social services or any other interested agency, so we must ensure that they have access to independent support, advice or advocacy in these circumstances
- 6.8.7 Race, culture creed etc. Specific behaviours may be attributable to these factors rather than a sign of incapacity.
- 6.8.8 The above are common examples but not a definitive list. There may be other factors specific to the individual her/himself that need to be considered.

6.9 Factors which may affect decisions to be made once the two-stage test for lack of capacity has been established (See, MCA Code of Practice, Chapter 5)

- 6.9.1 Once lack of capacity has been established any decision taken on that person's behalf must be the least restrictive and must be in her/his best interests. However, such decisions cannot be made in isolation and different circumstances will result in different outcomes.
- 6.9.2 In determining for the purposes of the MCA what is in a person's best interests, the person making the decision (decision-maker) must not make it merely on the basis of:
 - The person's age or appearance, or a condition of hers/his, or...
 - An aspect of her/his behaviour, which might lead others to make unjustified assumptions about what might be in her/his best interests
- 6.9.3 They must consider all the relevant circumstances and, in particular, take the following steps:
 - Consider whether it is likely that the person for whom the decision is to be made will at some point have capacity in relation to the matter in question, and
 - If it appears likely that s/he will do so, when that is likely to be, AND...
 - Decide if the decision can wait (to see if s/he regains capacity sufficient to make her/his own choice) or, alternatively, decide that it is necessary to make it before then.

- Consider the beliefs and values that would be likely to influence the person for whom the decision is being made if they had capacity; and...
- Address any other factors that the person for whom the decision is being made would be likely to consider if they were able to do
- Check to see if any Advance Decision or Advance Statement has been made and if so, do they conflict with any decision proposed on her/his behalf. (If they do please refer to Trust Policy Ref. SD19 *Advance statements and advance decisions*)
- Check to see if the person for whom the decision is to be made has a Lasting Power of Attorney (LPA). (If there is an LPA then s/he must be consulted as, *ordinarily*, s/he will have the authority to make legally binding decisions within the scope of the LPA directions as if s/he were the person for whom the decision is being made).
- Check to see if a deputy has been formally appointed by the Court of Protection as, again, they can make legally binding decisions on matters that fall within their range of authority.
- Obtain the views of anyone named by the person for whom the decision is being made as someone to be consulted on the matter in question (or related matters). If this person (or persons) is not an LPA or Court Appointed Deputy, s/he should nonetheless be consulted even though their views are not legally binding.
- Obtain the views of anyone engaged in caring for the person or interested in her/his welfare (the same principles apply here as in the above point regarding persons who are neither an LPA nor a Court Appointed Deputy)
- If the person for whom the decision is to be made does not have any relatives or significant others who can support her/him in the decision-making process a referral must be made to the relevant Independent Mental Capacity Advocacy Service (See below)

6.9.4 The decision-maker must, so far as is reasonably practicable, permit and encourage the person to participate, or to improve her/his ability to participate, as fully as possible, in any act done for them and any decision affecting them.

6.10 Restraint or Deprivation of Liberty?

6.10.1 Dependent upon the circumstances authority to manage a person who lacks capacity may have to be granted either through a Deprivation of Liberty Safeguard Order and/or the Court of Protection

6.10.2 Once a best interest decision has been made it must be established whether or not implementation of that decision amounts to any degree of restraint or deprivation of liberty within the meaning of the Human Rights Act 1998 (and the European Convention on Human Rights).

6.10.3 Within the above meaning there is a clear distinction between *Restraint* on one hand and *Deprivation* on the other (but only in broad terms)

6.10.4 Unfortunately, whilst the broad term distinction is clear, it is much more difficult (and becoming increasingly more so) to separate the two in live, case- by-case examples.

6.10.5 This is of significant concern because *restraint* is authorised under the general powers of the Mental Capacity Act (sections 5 and 6) but *deprivation* is not.

6.10.6 The distinction and process for managing persons who are deprived of their liberty is dealt with more fully in Policy Ref No. MC04.

6.10.7 However, because of the complexity and the frequently changing criteria regarding whether a person is or is not being deprived of her/his liberty, clinicians are advised to contact the Trust's Legal Team for advice and guidance in order to obtain clarity.

6.10.8 In particular, clinicians should contact the Legal Team if for an enduring period of time:-

- The control over all major decisions regarding a person's health and welfare [including treatment, place of residence, whether or not s/he can leave that place of residence and whether or not s/he can visit or be visited by other(s)] has been taken away from her/him and managed, instead, by services providing such care and treatment etc.
- *Any* person, acting on her/his behalf (eg relative or significant other) objects to the circumstances under which s/he is being managed.

6.10.9 Note that a Deprivation of Liberty Order simply authorizes an organisation to detain a person in a given place and prevent them from leaving.

6.10.10 It does **not** authorize the organization to continue making and revising decisions about that persons care and treatment.

6.10.11 Consequently, if a person is detained under the Deprivation of Liberty Safeguards, on-going treatment must still be subject to capacity assessments and best interest checklist assessments before it can be prescribed and administered.

6.11 The Decision-Makers (See, MCA Code of Practice, Chapters 7, 8 and 9)

6.11.1 Advance Decisions and Advance Statements (Please refer to Trust Policy Ref SD19 for full guidance and the MCA Code of Practice, Chapter 9)

- Advance Decisions and Advance Statements are decisions taken by an individual at the time s/he has the capacity to make such decisions with the intention of them taking effect at any point in the future should the person lose the capacity to make such decisions.
- *Advance Decisions* are decisions taken to *refuse* treatment(s) for specific medical conditions.
- *Advance Decisions* may be verbal or written (unless the treatment refused is life-saving treatment, in which case it *must* be written, signed, witnessed and include a statement acknowledging that such refusal may have the effect of fore-shortening life)
- If the treatment in question is covered by Part 4 of the Mental Health Act 1983 AND if the person is detained under sections applicable to Part 4 of that Act, THEN it is NOT binding in law. However, the clinician responsible must *consider* whether or not the Advance Decision can be complied with. Any decision to over-rule, must be evidenced in writing with reasons justifying why it was considered necessary to over-rule.
- Any treatment included in the Advance Decision that is NOT authorised under Part 4 of the Mental Health Act cannot be prescribed or administered without the patient's informed consent.
- An *Advance Statement* is a wish-list. It is not binding in law but must be respected unless it is not in the person's best interests.
- Any decision taken to over-rule an *Advance Statement* must be evidenced in writing with reasons justifying why it was considered necessary to over-rule.

6.11.2 Lasting Power of Attorney (LPA) [See MCA Code of Practice, Chapter 7]

- A person (18 years or over) with capacity can formally identify another person or persons to make decisions on their behalf by registering a certificated Lasting Power of Attorney with the Office of the Public Guardian.
- The person making the LPA is called the *Donor* and the person or persons named as having a Lasting Power of Attorney is/are the *Donee(s)*.
- There are two types of LPAs (A *Property and Affairs LPA* and a *Personal Welfare LPA*)
- The Donor can instruct a Property and Affairs LPA to take effect at any time after it has been formally registered and irrespective of whether or not the Donor has capacity or not.
- Personal Welfare LPAs can only act on the Donor's behalf once the LPA has been formally registered AND only once the Donor lacks the capacity to make such decisions for her/himself.
- Mersey Care NHS Trust staff must not assume that a person is an LPA Donee just because they say so. They must have had sight of the certificated LPA form stamped by the Office of the Public Guardian before they can accept a person as the Donee.
- Mersey Care NHS staff may advise persons how to go about making an LPA application. However, the Trust strongly advises against their agreeing to 'certificate' an LPA form.

6.11.3 The Court Appointed Deputy (CAD) [See MCA Code of Practice, Chapter 8]

- Where a person lacks the capacity to make an LPA application a third-party can apply to the Court of Protection to have a Court Appointed Deputy for that person.
- The Court will determine what decisions the CAD can make.

6.11.4 Court of Protection Decisions [See MCA Code of Practice, Chapter 8]

- The Court of Protection can make a range of decisions on behalf of a person lacking capacity.
- As seen above they can appoint (and remove) attorneys.
- In addition they can also:-
 - Decide if a person has the capacity to make a decision for themselves
 - Make declarations or orders on financial or welfare matters affecting people who lack capacity to make such decisions
 - Decide whether an LPA (or a pre-existing Enduring Power of Attorney) is valid.
 - Decide whether a given package of care amounts to restriction or deprivation within the meaning of the Human Rights Act 1998 (and the Articles of the European Convention on Human Rights).

6.12 Decisions that can be made without applying to the Court of Protection or the Office of the Public Guardian (See, MCA Code of Practice, Chapters 5 and 6)

6.12.1 Only difficult, controversial or contested health and welfare decisions need to be validated by the Court of Protection.

6.12.2 Otherwise, once lack of capacity is established, clinicians may prescribe and administer according to statute law (eg under Mental health Act 1983 powers, sections 5 and 6 of the Mental Capacity Act 2005, or the MCA Deprivation of Liberty Safeguards).

6.12.3 Where a person claims benefits but lacks the capacity to do this the Department of Health and Social Security can authorise named personnel to act on that person's behalf on receipt of a written request for the same (the same rules do not apply to accessing a

person's bank or building society account where authority from the Court of Protection is required).

6.12.4 The Court of Protection appoints deputies to manage a persons finances only where larger sums of money are involved.

6.12.5 The general provisions of the MCA allow person to use smaller amounts of monies to buy 'necessaries' in terms of both goods and services.

6.12.6 On this last point, a person acting under section 5 of the MCA may arrange something for a person's care or treatment and promise that the person receiving such care/treatment will pay for it.

6.13. The Independent Mental Capacity Advocate (IMCA) Service [See MCA Code of Practice, Chapter 10; Information is also available at www.dh.gov.uk/imca]

6.13.1 An IMCA is someone appointed to support a person who lacks capacity but has no one to speak for them in a dispute.

6.13.2 The IMCA service should be involved where the person has no friends or family or the Local Authority (LA)/NHS body deems there is no one appropriate or practicable to consult with on a decision regarding serious medical treatment or accommodation.

6.13.3 An IMCA should only deal with matters involving a serious medical matter or a change in residence.

6.13.4 The IMCA may make suggestions about a person's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision.

6.13.5 The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary (but note that IMCAs cannot assess a person's capacity or lack of it)

6.13.6 Arrangements must be made to allow the IMCA to meet the person concerned and see the relevant health, social services and care records. This is to enable the IMCA to perform properly his function of representing and supporting the person who lacks capacity.

6.13.7 Requests for an IMCA assessment made on behalf of Mersey Care NHS Trust must be referred to the following organisations as appropriate:-

1. Where the person is the responsibility of either Liverpool or Sefton Clinical Commissioning Group (CCG), referrals to be sent to:-

Advocacy Experience

Tel: Voice-ability/Advocacy Experience **0300 330 5499**

Email: imca@voiceability.org

Fax **0208-330-6622**

2. Where the person is the responsibility of St. Helens and Knowsley, Warrington or Halton Clinical Commissioning Group (CCG), referrals to be sent to:-

Together

Tel: **01744-451-531**

Email: hkwsimca@together-uk.org
Fax: **01704-759-937**

3. IMCA Lancashire

Advocacy Focus
54 Blackburn Road
ACCRINGTON
BB5 1LE
T: 0300 323 0965
Email: admin@advocacyfocus.org.uk
Website: www.advocacyfocus.org.uk
Fax: 0300 323 0966

4. Rochdale and District Mind

3-11 Drake Street
ROCHDALE
OL16 1RE
T: 01706 752350
Email: imca@rochdalemind.org.uk
Web: www.rochdalemind.org.uk
Fax: 01706 353281

6.14 Children, Young Persons and the Mental Capacity Act (See MCA Code of Practice, Chapter 12)

6.14.1 With two exceptions the Mental Capacity Act does not apply to children under the age of 16 years. These two exceptions are:-

- Under section 18(3) of the mental Capacity Act the Court of protection can make decisions about a child's property or finances provided s/he the child lacks the capacity to make such decisions

Alternatively, the Court of Protection can appoint a deputy to make these decisions

- Offences of ill treatment or wilful neglect of a person who lacks capacity can also apply to children under the age of 16 years.

6.14.2 In all other circumstances decisions made on behalf of children under the age of 16 years are authorised under the Children's Act 2004, the Childcare Act 2006, the zone of parental responsibility and the common law.

6.14.3 The Mental Capacity Act applies to young persons between the ages of 16 years and 18 years of age with three exceptions:-

- Only people of 18 years or older can make a Lasting Power of Attorney (LPA).
- Only people of 18 years or older can make an advance decision to refuse medical treatment
- The Court of Protection is authorised to make a statutory will only for those persons who are 18 years or older

6.14.4 The Court of Protection may settle disputes between two or more parties over a young person's treatment or welfare (they may transfer the case to the family courts or vice versa).

6.15 Children, Young Persons and Deprivation of Liberty

- 6.15.1 Nobody under the age of 18 years can be detained under the Mental Capacity Act's Deprivation of Liberty Safeguards.
- 6.15.2 A parent with *zone of parental responsibility* may make decisions that amount to deprivation of liberty where the child is under the age of 16 years.
- 6.15.3 However, even where this has been authorised, once that child attains the age of 16 years the zone of parental responsibility powers no longer apply.
- 6.15.4 Since a 16 year old cannot be detained under the Deprivation of Liberty Safeguards legislation, the only recourse is to apply to the Court of Protection.
- 6.15.5 This guidance follows a court ruling:- *Birmingham City Council v D [2016] EWCOP 8, [2016] MHLO 5*.*
- 6.15.6 Once the young person reaches the age of 18 years, the Deprivation of Liberty Safeguards powers under the Mental Capacity Act provide the authority to detain.
- 6.15.7 Note that this guidance does **not** apply to children and young persons who satisfy the criteria for detention under the Mental Health Act 1983 (for which there is no upper or lower age limit).

** NB: This judgment is the law as it stands but may be subject to change. Consequently, the guidance given in 6.15.2 – 6.15.7 above may also change. Clinicians are advised to contact the Trust's Legal team should they be faced with this situation.*

6.16 The Mental Capacity Act 2005 and the Care Programme Approach (CPA)

- 6.16.1 The Care Programme Approach (CPA) provides a framework for co-ordinating the assessment, planning and reviewing of high quality, person-centred care for those people in contact with secondary mental health services who have complex characteristics.
- 6.16.2 The MCA provides a statutory framework which empowers and protects vulnerable people who may not be able to make their own decisions within the CPA framework.
- 6.16.3 The CPA and the MCA should be used in conjunction where appropriate to promote social inclusion and recovery.

6.17. The Mental Capacity Act, the Mental Health Act and The Principles of the Transforming Care Initiative

- 6.17.1 *Transforming Care* is a national initiative introduced and represented by *NHS England, Association of Directors of Adult Social Services (ADASS), Department of Health (DoH), Care Quality Commission (CQC) and Health Education England*.
- 6.17.2 It is primarily, but not exclusively, directed at the management of people with learning disabilities and aims to maximise their quality of life. In particular it seeks to improve health and quality of life in ways that keeps them out of hospital and living, instead, in the community. It comes with 9 key principles which closely inter-relate with the key principles of the Mental Capacity and Mental Health Acts. A number of information

documents have been produced during 2015/16 and these are referenced in 6.1.1 above.

6.18 Ill-treatment or wilful neglect (See, MCA Code of Practice, Chapter 14)

6.18.1 Under the MCA it is a criminal offence to ill-treat or wilfully neglect a person who lacks capacity by anyone responsible for that person's care, donees of Lasting Powers of Attorney or Enduring Powers of Attorney, or deputies appointed by the Court.

6.18.2 A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

6.19 Research [See MCA, Code of Practice Chapter 11]

6.19.1 The MCA in sections 30,31,32,33 and 34 lays down clear parameters for research where people without capacity may be the subjects.

6.19.2 The provisions contained in the MCA are based on long-standing international standards e.g. World Medical Association.

6.19.3 The appropriate authority must be sought prior to launching a research project via the Chief Executives on behalf of. the Secretary the State in England.

6.19.4 If there are any queries regarding a research project these should be referred to the Trust's Medical Director in the first instance.

6.19.5 The Research Regulations may be found on the Department of Constitutional Affairs website www.dca.gov.uk/legal-policy/mental-capacity

7. CONSULTATION

7.1 The Mental Capacity Act and related legislation such as the Mental Health Act are the Trust's Core Business.

7.2 Consultation with all services is a seamless process that is continuously being developed.

7.3 This process will continue after ratification and without time-limit.

7.4 Any recommendations for change, at any time, will be seriously considered although it must be recognised that much of this policy is bound by statutory requirement

8. TRAINING AND SUPPORT

8.1 A Level 1, Mental Capacity Act E-Learning course has been developed and is currently available through the learning and Development Team.

8.2 This programme is mandatory for all staff working within the framework of the Mental Capacity Act, Mental Health Act and Deprivation of Liberty (Staff who have completed the level 2 training – see 8.3 and 8.4 below – do not have to complete Level 1)

8.3 A Level 2 classroom-based training programme has been running for many years and this includes Mental Capacity Act Training

- 8.4 Level 2 Training targets all qualified professionals working within the framework of the Mental Capacity Act, Mental Health Act and Deprivation of Liberty
- 8.5 Additional training is provided on request
- 8.6 Staff are further supported by the Trust's legal Team who advise on live cases
- 8.7 Members of the Legal Team also attend Multi Disciplinary Team Meetings, Professionals' Meetings on request

9. MONITORING

9.1 The process for monitoring compliance with the standards outlined in this policy is detailed below:

System for the Monitoring of Compliance with the Policy and Procedure for the Development, Ratification, Implementation, Review and Archive of Procedural Documents.	
Monitoring of compliance with this policy will be undertaken by:	Monitoring of the outcomes of MCA monitoring visits undertaken and through quarterly/annual audit.
Should shortfalls be identified the following actions will be taken:	Action plans will be developed for implementation and monitoring through the MHA managers committee
The results of monitoring will be reported to:	MHA Managers' Committee (who in turn report to the Quality Assurance Committee via minutes and the Chair's Report).

10. EQUALITY AND HUMAN RIGHTS ANALYSIS

Completed and submitted separately by George Sullivan

10 Equality and Human Rights Analysis

Title:
Area covered:

What are the intended outcomes of this work? <i>Include outline of objectives and function aims</i>
Who will be affected? <i>e.g. staff, patients, service users etc</i>

Evidence
What evidence have you considered?
Disability (including learning disability)
Sex
Race <i>Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.</i>
Age <i>Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.</i>
Gender reassignment (including transgender) <i>Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.</i>
Sexual orientation <i>Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.</i>
Religion or belief <i>Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.</i>
Pregnancy and maternity <i>Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.</i>
Carers <i>Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.</i>
Other identified groups <i>Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.</i>
Cross Cutting <i>implications to more than 1 protected characteristic</i>

Human Rights	Is there an impact? How this right could be protected?
Right to life (Article 2)	<i>Use not engaged if Not applicable</i>
Right of freedom from inhuman and degrading treatment (Article 3)	<i>Use supportive of a HRBA if applicable</i>
Right to liberty (Article 5)	
Right to a fair trial (Article 6)	
Right to private and family life (Article 8)	
Right of freedom of religion or belief (Article 9)	
Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	
Right freedom from discrimination (Article 14)	

Engagement and Involvement <i>detail any engagement and involvement that was completed inputting this together.</i>

Summary of Analysis <i>This highlights specific areas which indicate whether the whole of the document supports the trust to meet general duties of the Equality Act 2010</i>
Eliminate discrimination, harassment and victimisation
Advance equality of opportunity
Promote good relations between groups

What is the overall impact?

Addressing the impact on equalities

There needs to be greater consideration re health inequalities and the impact of each individual development /change in relation to the protected characteristics and vulnerable groups

Action planning for improvement

Detail in the action plan below the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment*

- *Plans already under way or in development to address the **challenges** and **priorities** identified.*
- *Arrangements for continued engagement of stakeholders.*
- *Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)*
- *Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies*
- *Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results*
- *Arrangements for making information accessible to staff, patients, service users and the public*
- *Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.*

For the record

Name of persons who carried out this assessment:

Date assessment completed:

Name of responsible Director:

Date assessment was signed:

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their area of responsibility
Monitoring			
Engagement			
Increasing accessibility			

11. APPENDIX 1 – Glossary of Terms

Phrase or Term	Definition and Explanation
(the) Act	In this document, unless specifically stated this will always refer to the Mental Capacity Act 2005
Acts in connection with care or treatment	Tasks carried out by carers, healthcare or social care staff which involve the personal care, healthcare or medical treatment of people who lack capacity to consent to them – referred to in the Act as ‘section 5 acts’ (MCA Code of Practice Cross Refs: 2.13-2.14, 4.39, 5.10, 5.39, 6.39, 6.49-6.52)
Advance Decision to refuse treatment	A decision under the Mental Capacity Act 2005 to refuse specified treatment made in advance by a person who has capacity to do so. This decision will apply at a point in the future should that person subsequently lack the capacity to refuse the specified treatment in question. (MCA Code of Practice Cross Refs: Chapter 9, and paras. 5.5, 5.35, 5.45, 6.37-6.38, 7.55, 8.28, 11.30, 12.9, 13.35-13.37)
Adult protection procedures	Procedures devised by local authorities, in conjunction with other relevant agencies, to investigate and deal with allegations of abuse or ill treatment of vulnerable adults, and to put in place safeguards to provide protection from abuse (MCA Code of Practice Cross Refs: Chapter 14 and paras. 10.66-10.67)
Agent	An application made by an approved mental health A person authorised to act on behalf of another person under the law of agency. Attorneys appointed under an LPA or EPA are agents and court-appointed deputies are deemed to be agents and must undertake certain duties as agents (MCA Code of Practice Cross Refs:7.58-7.68, 8-55-8.68)
Appointee	Someone appointed under Social Security regulations to claim and collect social security benefits or pensions on behalf of a person who lacks capacity to manage their own benefits. An appointee is permitted to use the money claimed to meet the person’s needs (MCA Code of Practice Cross Refs: 6.65-6.66, 8.56, 14.35-14.36)
Attorney	Someone appointed under either a Lasting Power of Attorney (LPA) or an Enduring Power of Attorney (EPA), who has the legal right to make decisions within the scope of their authority on behalf of the person (the donor) who made the Power of Attorney (MCA Code of Practice Cross Refs: Chapter 7 and paras. 5.2, 5.13, 5.49, 5.55, 6.54-6.55,8.30,9.33,13.38-13.45, 14.7-14.14, 15.39-15.42, 16.9-16.16)
Best interests	Any decisions made, or anything done for a person who lacks capacity to make specific decisions, must be in the person’s best interests. There are standard minimum steps to follow when working out someone’s best interests. These are set out in section 4 of the Act, and in the non-exhaustive checklist in the MCA Code of Practice, para. 5.13. (MCA Code of Practice Cross Refs: Chapters 2 and 5 and paras. 6.4-6.18, 6.32-6.36, 7.19-7.20, 7.29, 7.53, 8.14-8.26, 8.50-8.52, 9.4-9.5.)
Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition appears in section 2 of the Act (MCA Code of Practice Cross Refs: Chapter 4)
Carer	Someone who provides <i>unpaid care</i> by looking after a friend or neighbour who needs support because of sickness, age or disability. (MCA Code of Practice Cross Refs: 4.44-4.45, 5.8-5.10, 6.20-6.24, 6.29-6.34, 6.56-6.66, 16.26-16.32)
Care Programme Approach (CPA)	A system of care and support for individuals with complex needs which includes an assessment, a care plan and a care co-ordinator. It is used mainly for adults in England who receive specialist mental healthcare and in some CAMHS services. There are similar systems for supporting other groups of individuals, including children and young people (Children’s Assessment Framework), older adults (Single Assessment Process) and people with learning disabilities (Person Centred Planning).

Phrase or Term	Definition and Explanation
Care worker	Someone employed to provide personal care for people who need help because of sickness, age or disability. They could be employed by the person themselves, by someone acting on the person's behalf or by a care agency (MCA Code of Practice Cross Refs: Chapters 2 and 5 and paras. 4.38, 4.44-4.45, 6.20, 6.56-6.66, 7.10, 8.41)
Child (and children)	A person (or persons) under the age of 16 (MCA Code of Practice Cross Refs: Chapter 12)
Court of Protection	The specialist court set up under the Mental Capacity Act to deal with all issues relating to people who lack capacity to take decisions for themselves (MCA Code of Practice Cross Refs: Chapter 8 and paras. 5.33-5.36, 6.18, 7.45-7.49, 9.35, 9.54, 9.67-9.69, 12.3-12.4, 12.7, 12.10, 12.23-12.25, 15.40-15.44)
Decision-maker	Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout this policy as the decision-maker, and it is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity (MCA Code of Practice Cross Refs: Chapter 5 and paras. 10.4, 10.21-10.29, 13.3, 13.10, 13.27)
Deprivation of liberty	A term used in Article 5 of the European Convention on Human Rights (ECHR) to mean the circumstances in which a person's freedom is taken away. Its meaning in practice has been developed through case law (MCA Code of Practice Cross Refs: 6.13-6.14, 6.49-6.54, 7.44, 13.2, 13.16).
Deprivation of liberty safeguards	The framework of safeguards under the Mental Capacity Act (as amended by the Mental Health Act 2007) for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves (See MCA Deprivation of Liberty Safeguards Code of Practice)
Deputy (or Court-appointed deputy)	A person appointed by the Court of Protection under section 16 of the Mental Capacity Act to take specified decisions on behalf of someone who lacks capacity to take those decisions themselves. This is not the same thing as the nominated deputy sometimes appointed by the doctor or approved clinician in charge of a patient's treatment. (MCA Code of Practice Cross Refs: Chapter 8 and paras. 5.2, 5.13, 5.49, 5.55, 6.54-6.55, 7.56, 9.33, 10.70-10.72, 12.4, 12.7, 14.15-14.18, 16.9-16.16).
Donor	A person who makes a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) [See MCA Code of Practice Chapter 7]
Enduring Power of Attorney (EPA)	A Power of Attorney that pre-dates the MCA2005 and which have been replaced by Lasting Powers of Attorney. However, any EPAs active at the time the MCA 2005 was enacted remain valid provided they have been duly registered with the Office of the Public Guardian. (MCA Code of Practice Cross Refs: Chapter 7; see also LPA below)
European Convention on Human Rights (ECHR)	The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are largely incorporated into UK law by the Human Rights Act 1998
Guiding principles	See Statutory Principles below
Human Rights Act 1998	A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights (MCA Code of Practice Cross Refs: 6.49, 16.3).
Hospital managers	The organisation (or individual) responsible for the operation of the Act in a particular hospital (eg an NHS trust , an NHS foundation trust or the owners of an independent hospital). Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice, most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff. Hospital managers' decisions about

Phrase or Term	Definition and Explanation
	discharge are normally delegated to a “ managers’ panel ” of three or more people
Ill treatment	Section 44 of the Act makes it an offence to ill treat a person who lacks capacity by someone who is caring for them, or acting as a deputy or attorney for them. That person can be guilty of ill treatment if they have deliberately ill-treated a person who lacks capacity, 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 (MCA Code of Practice Cross Refs: 14.23-14.26).
Independent Mental Capacity Advocate (IMCA)	An advocate available to offer help to patients under arrangements which are specifically required to be made under the Mental Capacity Act 2005 (MCA Code of Practice Cross Refs: Chapter 10 and paras. 5.51, 6.9, 6.16, 13.46-13.48).
Lasting Power of Attorney (LPA)	A Power of Attorney created under the Act and replacing the previous Enduring Power of Attorney (EPA). (MCA Code of Practice Cross Refs: MCA Code of Practice Cross Refs: Chapter 7 and paras. 5.2, 5.13, 5.49, 5.55, 6.54-6.55, 8.30, 9.33, 13.38-13.45, 14.7-14.14, 15.39-15.42, 16.9-16.16).
Life-sustaining treatment	Treatment that, in the view of the person providing health care, is necessary to keep a person alive (MCA Code of Practice Cross Refs: 5.29-5.36, 6.16, 6.55, 7.22, 7.27, 7.29-7.30, 8.17, 8.46, 9.10-9.11, 9.19-9.20, 9.24-9.28, 9.61-9.63, 10.44).
Managers	See hospital managers
Mental capacity	See <i>Capacity</i>
Mental Capacity Act	The Mental Capacity Act 2005. An Act of Parliament that governs decision-making on behalf of people who lack capacity , both where they lose capacity at some point in their lives, eg as a result of dementia or brain injury, and where the incapacitating condition has been present since birth (MCA Code of Practice Cross Refs: Chapter 1).
Mental Health Act 1983	A law primarily dealing with the management and rights of persons detained in hospital for the purpose of assessment, care and treatment against their will. It also has limited application in the community through Community Treatment Orders, Guardianship, Conditional Discharge Leave of Absence and section 117 aftercare (MCA Code of Practice Cross Refs: Chapter 13).
Office of the Public Guardian (OPG)	The Public Guardian is an officer established under section 57 of the Act. The Public Guardian is supported by the OPG, which supervises deputies, keeps a register of deputies, LPAs, EPAs, checks on what attorneys are doing and investigates any complaints about attorneys or deputies (MCA Code of Practice Cross Refs: 7.14-7.17, 7.69-7.74, 7.78-7.79, 8.5, 8.35, 8.69-8.77, 14.8-14.22).
Personal welfare	Personal welfare decisions are any decisions about a person's healthcare, where they live, what clothes they wear, what they eat and anything needed for their general care and well-being. Attorneys and deputies can be appointed to make decisions about personal welfare on behalf of a person who lacks capacity (MCA Code of Practice Cross Refs: 7.21-7.31, 8.38-8.39, 9.4, 9.35, 15.44).
Property and affairs	Any possession owned by a person (such as a house or flat, jewellery or other possessions), the money they have as income, savings or investments and any expenditure. Attorneys and deputies can be appointed to make decisions about property and affairs on behalf of a person who lacks capacity (MCA Code of Practice Cross Refs: 7.32-7.42, 7.56, 7.58, 7.67-7.68, 7.76-7.77, 8.34-8.37, 8.56, 8.67-8.68, 12.3-12.4, 12.7).
Protection from liability	Legal protection, granted to anyone who has acted or made decisions in line with the Act's principles (MCA Code of Practice Cross Refs: Chapter 6).
Restraint	See section 6(4) of the Act. The use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint (and hence restriction of movement) <i>may</i> be authorised under the MCA but <i>only</i> where it is necessary

Phrase or Term	Definition and Explanation
	to protect the person from harm, is proportionate to the risk of harm posed AND does not amount to deprivation of liberty (the latter of which can only be authorised under the Act's Deprivation of Liberty Safeguards and/or the Court of Protection). (MCA Code of Practice Cross Refs: 6.11, 6.15, 6.39-6.44, 6.47-6.53, 7.43-7.44, 8.46, 13.5).
Statutory Principles	The principles set out in chapter 2 that have to be considered when decisions are made under the Act (MCA Code of Practice Cross Refs: Chapter 2).
Two-stage test of capacity	Using sections 2 and 3 of the Act to assess whether or not a person has capacity to make a decision for themselves at that time. (MCA Code of Practice Cross Refs: 4.10-4.13, 6.27, 9.39,)
Wilful neglect	An intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks (or whom the person reasonably believes lacks) capacity to care for themselves. Section 44 makes this an offence of wilful neglect of a person who lacks capacity (MCA Code of Practice Cross Refs: 14.23-14.26).
Written statements of wishes and feelings (also referred to as Advance Statements)	Written statements the person might have made before losing capacity about their wishes and feelings regarding issues such as the type of medical treatment they would like (as opposed to medical treatment they might refuse – see Advance Decision), where they may choose to live, or how they wish to be cared for. They are not the same as advance decisions and are not binding (MCA Code of Practice Cross Refs: 5.34, 5.37, 5.42-5.44).