Assessing Mental Capacity

Helping service users make decisions for themselves
When a service user needs to make a decision you must start from the assumption that the person has capacity to make the decision in question. You should make every effort to encourage and support the person to make the decision themselves and you will have to consider a number of factors to assist in the decision making.

These could include:

- Does the person have all the relevant information needed to make the decision? If there is a choice, has information been given on the alternatives?

- Could the information be explained or presented in a way that is easier for the person to understand? Help should be given to communicate information wherever necessary. For example, a person with a learning disability might find it easier to communicate using pictures, photographs, videos, tapes or sign language.

- Are there particular times of the day when a person’s understanding is better or is there a particular place where they feel more at ease and able to make a decision? For example, if a person becomes drowsy soon after they have taken their medication this would not be a good time for them to make a decision.

- Can anyone else help or support the person to understand information or make a choice? For example, a relative, friend or advocate.

You must remember that if a person makes a decision, which you think is eccentric or unwise, this does not necessarily mean that the person lacks capacity to make the decision.

When there is reason to believe that a person lacks capacity to make a decision you will be expected to consider the following:

- Has everything been done to help and support the person to make a decision?

- Does this decision need to be made without delay?

- If not, is it possible to wait until the person does have the capacity to make the decision for himself or herself? For example, a person may be drowsy or disorientated because of the medication they are taking.

If the person’s ability to make a decision still seems questionable then you will need to move onto the next phase of assessing capacity as set out on the following page.
Assessing Mental Capacity

You should always start from the assumption that the person has capacity to make the decision in question. Under the MCA, you will be required to make an assessment of capacity before carrying out any care or treatment. Of course the more serious the decision, the more formal the assessment of capacity will need to be. Whether and how such assessments are recorded may vary according to the seriousness of the decision made.

You should always bear in mind that just because someone lacks capacity to make a decision on one occasion that does not mean that they will never have capacity to make a decision in the future, or about a different matter.

Example:
Joseph has dementia and lives in his own home.

Like many people with dementia his mental capacity fluctuates.

On most days he can make all the basic decisions about daily living such as washing, eating and drinking etc.

However, sometimes he lacks capacity to make the most basic of decisions, such as what to eat.

On these occasions, a possible entry in the care records could be “At lunch time today, Joseph lacked capacity to decide what to eat, so a decision about this was made in his best interests. At each mealtime we will assess his capacity to decide what he wants to eat. If Joseph has capacity to make this decision at any point he will decide what to eat”.

When should capacity be assessed?
Any assessment of a person’s capacity must be ‘decision-specific’, this means that:

- the assessment of capacity must be about the particular decision that has to be made at a particular time and is not about a range of decisions

- if someone cannot make complex decisions this does not mean that they cannot make simple decisions. For example, it is possible that someone with learning disabilities could make decisions about what to wear or eat but not about whether or not they need to live in a care home

- you cannot decide that someone lacks capacity based upon their, appearance, condition or behaviour alone.
Assessing Mental Capacity

The test to assess capacity
You will normally make an assessment of capacity without involving family, friends and/or carers or an Independent Mental Capacity Advocate (IMCA) if one has been appointed. This will depend on the situation and the decision that needs to be made.

You should never express an opinion, without first conducting a proper assessment of the person’s capacity to make a decision.

The functional test of capacity
In order to decide whether an individual has the mental capacity to make a particular decision, you must first decide whether there is an impairment of, or disturbance in, the functioning of the person’s mind or brain (it does not matter if this is permanent or temporary).

If so, the second question you must answer is does the impairment or disturbance make the person unable to make the particular decision?

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

- understand the information relevant to that decision, including understanding the likely consequences of making, or not making the decision
- retain that information
- use or weigh that information as part of the process of making the decision
- communicate their decision (whether by talking, using sign language or any other means).

Every effort should be made to find ways of communicating with someone before deciding what they lack capacity to make a decision based solely on their inability to communicate. Very few people will lack capacity on this ground alone. Those who do might include people who are unconscious or in a coma or who suffer from a rare neurological condition known as ‘locked-in syndrome’. In many other cases such simple actions as blinking or squeezing a hand may be enough to communicate a decision. The input of professionals with specialised skills in verbal and non-verbal communication is likely to be required when making decisions in this area.

As assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity? You should be able to show in the service user’s records why you have come to the conclusion that the person lacks capacity to make the particular decision.
MENTAL CAPACITY ACT POLICY

REGULATIONS
The service fully complies with:

Outcome: 2 of the Essential Standards of Quality and Safety “Consent to care and treatment”
Regulation: 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
Outcome group: Involvement and information

Outcome: 7 of the Essential Standards of Quality and Safety “Safeguarding people who use services from abuse”
Regulation: 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Outcome group: Safeguarding and safety


Outcome: 20 of the Essential Standards of Quality and Safety “Notification of other incidents” Regulation: 18 of the Care Quality Commission (Registration) Regulations 2009
Outcome group: Quality and management

OUTCOMES
Under the Health and Social Care Act 2008 there are clear requirements with regards to mental capacity and consent.

Outcome 2 of the Essential Standards of Quality and Safety requires that people who use services:

- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

This is because providers who comply with the regulations will have systems in place to gain and review consent from people who use services, and act on them.

Prompt 2A of the Essential Standards of Quality and Safety requires that where they are able, people who use services receive the examination, care, treatment and support they agree to. This is because clear procedures include following any advance decision made in line with the Mental Capacity Act 2005 that the person using the service may have made, wherever this is known by the provider.

Prompt 2C requires that there are clear procedures that are followed in practice, monitored and reviewed about decision making for people who are unable to give, or choose to withhold, consent for each individual care, treatment and support activity, including meeting the requirements of the Mental Health Act 1983 and the Mental Capacity Act 2005

Outcome 7 of the Essential Standards of Quality and Safety states that people who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.
This is because providers who comply with the regulations will:

- Where applicable, only use Deprivation of Liberty Safeguards when it is in the best interests of the person who uses the service and in accordance with the Mental Capacity Act 2005.

Prompt 7H requires that people who use services benefit from practice where the use of restraint and management of behaviour that presents a risk is:

- Where applicable, used in line with the restraint guidelines in the Mental Capacity Act 2005 Code of Practice and the Mental Health Act 1983 Code of Practice and including a best interest assessment.

Prompt 7I requires that people who use services that have been abused or are suspected of being abused (or where appropriate, people acting on their behalf) are:

- Made aware of, and supported to access, sources of support outside the service including local independent information advice, independent mental capacity advocacy services or independent mental health advocacy services where relevant.

Prompt 7L requires that people who use services are confident:

- That where they are not covered by the Mental Health Act 2007, the service will, if allowed by legislation, only request authorisation under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards, when it is in the best interests of the person who uses services and that person lacks capacity.
- The service will implement and review any subsequent authorisation in line with guidance.

Outcome 9 requires that people who use services:

- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

Prompt 9B requires that the provider has clear procedures followed in practice, monitored and reviewed for medicines handling that include obtaining, safe storage, prescribing, dispensing, preparation, administration, monitoring and disposal. Wherever they are required these procedures include the arrangements for giving medicines covertly where this is needed in accordance with the Mental Capacity Act 2005.

Outcome 20 requires that people who use services:

- Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

Prompt 20F states that the two kinds of incidents and events that must be notified to the Care Quality Commission are:

- Incidents affecting a person who uses the service
- Events involving the service in a way that could affect all of the people who use it

The former category above includes:

- Applications to deprive someone of their liberty under the Mental Capacity Act.
OTHER LEGISLATION

- Human Rights Act 1998
- Mental Health Act 2007
- Mental Capacity Act 2005
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

POLICY STATEMENT

The service complies with the principles and recommendations of the Mental Capacity Act 2005 (inc. Deprivation of Liberty Safeguards). The service will work in collaboration with all legal and caring agencies to ensure our service users are always treated in accordance with this framework. We will also follow the Codes of Practice published by the Department of Health.

Michelle Amesbury is the implementation lead for the service.

AIM OF THE POLICY

This policy is intended to:

- Set out the key principles of the Mental Capacity Act (inc. Deprivation of Liberty Safeguards)
- Define what may constitute a deprivation of liberty
- Identify those involved (the Multi Disciplinary Team)
- Set out the changes we have implemented to ensure we fully comply with the Mental Capacity Act (inc. Deprivation of Liberty Safeguards).
- Set out the actions that this service will undertake in order to meet the above Regulations and Standards.

THE FIVE KEY PRINCIPLES OF THE MENTAL CAPACITY ACT

1. A Presumption of Capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. The right for individuals to be supported to make their own decisions – people must be given all appropriate help before anyone concludes that they cannot make a particular decision for themselves;
3. That individual’s must retain the right to make what might be seen as eccentric or unwise decisions;
4. Best Interests – anything done for or on behalf of someone lacking capacity must be in their best interests; and
5. Least restrictive intervention – anything done for or on behalf of someone lacking capacity should be the least restrictive of their basic rights of freedoms.
DEPRIVATION OF LIBERTY DEFINITION

Based on existing case law, the following factors may be considered by the courts to be relevant when considering whether or not deprivation of liberty is occurring:

- The person is not allowed to leave the facility
- The person has no, or very limited, choice about their life within the service
- The person is prevented from maintaining contact with the world outside the service

Some examples of how staff actions can contribute to deprivation of liberty of a service user:

- Where restraint is used, including sedation, to admit a person to an institution where that person is resisting admission.
- When staff exercise control over assessments, treatment, or care, and people with whom the service user may or may not have contact.
- When staff exercise complete and effective control over the service user’s care and movements for a significant period. The length of time of the deprivation is a relevant factor, even when justified to keep the person safe, as it may still lead to a deprivation of liberty.
- When the person loses autonomy because they are under continuous supervision and control.
- When restrictions are placed on a person by actions or omissions of staff providing care or treatment. For example, when a service user is unable to maintain social contacts due to restrictions placed on them by staff – i.e. staff say that they cannot go out with a friend because they think it would not be safe to do so.

This service will always try to find the least restrictive way of providing care and support for our service users. Sunshine Care consider the application for authorisation to deprive someone of their liberty to be an absolute last resort.

THOSE INVOLVED

Under the Mental Capacity Act there are several people and agencies that can offer support and advice or act as an advocate when there is no one else who can. We will involve the following people when decision making for a person lacking capacity:

- Supervisory Body – the Local Authority
- Assessors
- The individual’s family and friends
- Independent Mental Capacity Advocate (IMCA). This service can be accessed in our area by contacting:
DOES THE PERSON NEED THE IMCA SERVICE?

Does the person have a condition which is affecting their ability to make decisions?

Is the person facing a decision about serious medical treatment or a change of accommodation?
Or are there decisions relating to Adult Protection Proceedings?
Or the person needs a care/accommodation review where it is felt that the person would benefit from IMCA?

Is the person 16 years or older?

Does the person lack capacity to make the particular decision?

Is there nobody (other than paid workers) whom the decision-maker considers are willing and able to be consulted about the decision?
(This does not apply for Adult Protection Proceedings – people can have family and still be eligible).

ROLE OF THE INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCA)

You must involve an IMCA in the following situations and where the person you are representing lacks capacity and has no relative, friend or unpaid carer:

An NHS body is proposing:
• Serious medical treatment
• A stay of more that 28 days in hospital or 8 weeks in a care home
• Change to a person’s accommodation to another hospital for more than 28 days or more than 8 weeks.

A local authority is proposing:
• To change or provide residential or supported accommodation for more than 8 weeks.

An IMCA would not necessarily be involved if:
• The treatment needed to be provided as a matter of urgency
• If the person lacking capacity would be made homeless unless they were admitted to a care home

An IMCA may also be involved in:

Accommodation reviews where there are concerns about the suitability of the placement and where the following three requirements are met:
1. The LA or NHS has arranged the original accommodation
2. The person lacks capacity
3. There is no other person appropriate to consult.

Adult protection cases if the two following criteria are met:
1. Where protective measures are being put in place in relation to the protection of a vulnerable adult from abuse; and
2. Where the person lacks capacity.

AN IMCA may also be involved where the person who lacks capacity is abusing another person.
An IMCA will not normally be used in accommodation reviews or adult protection cases where there is already appropriate family support or where an advocate is currently involved.
If you are in doubt about whether or not you should involve an IMCA please contact the IMCA Service on:

Plymouth Independent Mental Capacity Advocacy Service (IMCA)
Plymouth Highbury Trust
By phone: 01752 753718
Fax: 01752 796299
E mail: imca@plymouthhighburytrust.org.uk

Devon and Torbay Independent Mental Capacity Advocacy Service (IMCA)
Age Concern Devon
Unit 1, Manaton Court
Matford Business Park
Exeter
EX2 8PF
Tel: 0845 231 1900; Fax: 01392 829594; e-mail: imca.devon@nhs.net; www.livingoptions.org/imca

Devon Safeguarding Adults Team – 01752 306363
Devon Safeguarding Adults Team – 01392 383131
Torbay Safeguarding Adults Team – 01803 219831

The Court of Protection will look at cases where the persons carer and healthcare worker or social worker disagree on what are the person’s best interests regarding finance or serious healthcare issues.

Lasting Power of Attorney (LPA) is a new statutory form of power of attorney created by the Mental Capacity Act. Anyone who has capacity to do so may choose a person (an “attorney”) to take decisions on their behalf if they subsequently lose capacity.

THE CHANGES WE HAVE IMPLEMENTED
We have updated our initial assessment for prospective service users.

- We now ask if there are any:
  - Existing Enduring Powers of Attorney (EPA’s).
  - Lasting Powers of Attorney (LPA’s) regarding either personal welfare or property and affairs.
  - Background notes regarding the persons general mental capacity to make decisions (mental capacity is still judged on a single decision basis)

- We have amended care plans to reflect the changes in legislation.
- We have introduced a functional test of capacity. This is for staff to access a person’s capacity to make a specific decision and follow the guidelines of the MCA and DOLS.
- Training – Staff have been trained on the importance and implications of the MCA and DOLS. Case studies were examined and a real life incident was used to show staff how to test for capacity, contact an IMCA for advice, and fill out the relevant documentation. MCA and DOLS training has been added to our Induction.
- Mental Capacity Assessments in place are reviewed at least on a monthly basis.
BEST INTEREST CHECKLIST

Where a person lacks capacity all decisions must be made in the best interest of that person. The checklist below gives some common factors that you must always take into account where a decision is being made, or an act is being done for the person who lacks capacity:

- Involve the person who lacks capacity.
- Be aware of the person’s past and present wishes and feelings.
- Consult with others who are involved in the care of the person.
- Do not make assumptions based solely on the person’s age, appearance, condition or behaviour.
- Is the person likely to regain capacity to make the decision in the future.

You must record your decision by completing the MCA Checklist template and store this within the service users’ electronic file.

For more information on the Mental Capacity Act contact your named lead or visit http://www.dce.gov.uk/legalpolicy/mental-capacity/index.htm

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A local authority is proposing:
- To change or provide residential or supported accommodation for more than 8 weeks.

An IMCA would not necessarily be involved if:
- The treatment needed to be provided as a matter of urgency
- If the person lacking capacity would be made homeless unless they were admitted to a care home.

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1. The LA or NHS has arranged the original accommodation
2. The person lacks capacity
3. There is no other person appropriate to consult.

Adult protection cases if the two following criteria are met:
1. Where protective measures are being put in place in relation to the protection of a vulnerable adult from abuse; and
2. Where the person lacks capacity an IMCA may also be involved where the person who lacks capacity is abusing another person.

An IMCA will not normally be used in accommodation reviews or adult protection cases where there is already appropriate family support or where an advocate is currently involved.
If you are in doubt about whether or not you should involve an IMCA, please contact the IMCA Service on 01752 753718 for advice.

TRAINING
All administration and service coordination staff are asked to read this mental capacity act policy as part of their induction process. They should then fill out the appropriate question-and-answer worksheet which helps prove that they have read and understood the policy.

All staff are required to undertake formal safeguarding and abuse training on a regular basis.

APPLICABLE PUBLICATIONS
- Reference guide to consent for examination or treatment (DH, 2001)
- Relevant guidance and codes of conduct relating to consent published by professional registration councils such as the General Medical Council, Nursing & Midwifery Council, General Social Care Council and the Health Professions Council
- Mental Health Act Code of Practice (2007)
- No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (DH and Service Office, 2000)
- Safeguarding Adults: A National Framework of Standards for good practice and outcomes in adult protection work (Association of Directors of Adult Social Services, 2005)
- Deprivation of Liberty Safeguards: A guide for hospitals and care services (DH, 2009)
- Guidance for restrictive physical interventions: How to provide safe services for people with learning disabilities and autistic spectrum disorder (DH, 2002)
- Information Sharing: Guidance for practitioners and managers (DCSF, 2008)
- Mental Health Act Code of Practice (DH, 2008)
- Services for people with learning disabilities and challenging behaviour or mental health needs Mansell report: revised edition (DH, 2007)
- Relevant evidence-based guidance and alerts about medicines management and good practice published by appropriate expert and professional bodies, including:
  > National Patient Safety Agency
  > National Institute for Health and Clinical Excellence
  > Medicines and Healthcare products Regulatory Agency
  > Department of Health
  > Royal Pharmaceutical Society of Great Britain (RPSGB)
  > Social Care Institute for Excellence
  > Medical and other clinical royal colleges, faculties and professional associations
- The safe and secure handling of medicines: a team approach (RPSGB, 2005)
- Safer management of controlled drugs: Guidance on strengthened governance arrangements (DH, 2007)
- Safer management of controlled drugs: Guidance on standard operating procedures for controlled drugs (DH, 2007)
- The handling of medicines in social care (RPSGB, 2007)