University Hospitals of Leicester NHS
NHS Trust

MENTAL CAPACITY ACT POLICY

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

April 2023
Change to title page to reflect current Chief Nurse details.
Changes to section 5.3.3 - the two stage test of mental capacity, to reflect latest national guidance.
Appendix Two added to assist clinicians in practice.

KEY WORDS

Mental Capacity

Mental Capacity Act

Mental Capacity Act Policy

1.0 INTRODUCTION AND OVERVIEW

1.1 The Mental Capacity Act 2005 (the Act) provides the legal framework for people who lack capacity to make their own decisions, or who have capacity and want to make preparations for a time when they may lack capacity in the future. Everyone working with and / or caring for a person aged 16 and over years of age must comply with this Act when making decisions or acting for that person, when they lack the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

1.2 The Act's starting point is to confirm in legislation that it should be assumed that any person aged 16 or over has full mental capacity to make their own decisions (the right to autonomy), unless it can be shown that they lack capacity to make a specific decision for themselves at the material time it is needed. This is known as the presumption of capacity.

1.3 The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. But the Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make their own decision(s). The underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests.

1.4 The Act introduced a new offence which will apply to anyone, including healthcare workers, who ill-treat or wilfully neglect a person lacking mental capacity. Failure to observe the provisions of the Act could be deemed to constitute ill-treatment or neglect. The penalty for the offence will range from a fine to a prison sentence of up to 5 years.

1.5 This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for the local implementation of the Mental Capacity Act (MCA). This document must be read in conjunction with the Mental Capacity Act Code of Practice which gives legal guidance for anyone who is involved in caring for someone who lacks capacity to make a specific decision. The Code of Practice is available on INsite and via the following link https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice. UHL staff have a formal duty to have regard to the Code and it is not the intention of this Policy to replace the Code which staff are advised to read and refer to as necessary.

2 POLICY SCOPE

2.1 This policy is applicable to all Trust staff and Bank, Agency and Locum staff who are involved in the care of patients who meet all of the following criteria:

a) Where they are aged 16 or over **and;**

b) Where there are doubts about the person's mental capacity to make their own care, treatment and accommodation decisions **and;**

c) Where staff are required to make decisions on behalf of the person who lacks capacity to make those decisions for himself/herself.

2.2 All staff who have **direct clinical contact** with patients must complete the Trust's Mental Capacity Act and Deprivation of Liberty Safeguards (eLearning) training modules at least once every 3 years.

3 DEFINITIONS AND ABBREVIATIONS

a) Advance Decision to Refuse Treatment (ADRT)

A decision to refuse specified treatment made in advance by a person (aged 18 and over) who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, that treatment. Where they involve life sustaining decisions they must be in writing, signed and witnessed and must be expressly worded.

b) Best Interests

Any decision made, or action taken, on behalf of someone who lacks the capacity to make specific decisions, must be in the peron'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 Code of Practice, section 5.13)

c) Code of Practice

This refers to the Mental Capacity Act 2005 Code of Practice.

d) Court of Protection

The specialist Court for all issues relating to people who lack capacity to make specific decisions.

e) 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 specific decision is referred to 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. This could be a Care Assistant, a Nurse, a Doctor or a family member, depending on the decision required.

f) Independent Mental Capacity Advocate (IMCA)

This is someone who provides support and representation for a person who lacks capacity to make specific decisions. An IMCA is not the same as an ordinary advocate. The Act imposes a **legal duty** on NHS bodies to instruct and consult with an IMCA for people lacking capacity who have no-one appropriate to support or represent them (other than paid staff), whenever:

- *hospital staff are proposing to provide serious medical treatment*
- *the patient will stay in hospital longer than 28 days*

g) Lack of Mental Capacity (Incapacity)

A person lacks capacity if they have an impairment or disturbance in their mind or brain, and the impairment or disturbance means that they are unable to make a **specific** decision or take a particular action for themselves at the **material time** the decision or action needs to be taken.

h) Lasting Power of Attorney (LPA)

Allows an individual (the donor) to give another person (the attorney or donee) the authority to make a specific decision(s) on their behalf. Under a power of attorney, the chosen person (the attorney) can make decisions about the donor's personal welfare (including healthcare) and / or deal with the donor's property and affairs. In order to be valid a LPA should be executed on the prescribed form and registered with the Office of the Public Guardian. Please refer to the UHL Advance Decisions and Lasting Power of Attorney Policy for further information (Trust Reference Number: B21/2004).

i) Mental Capacity

The ability of an individual to make their own decision about a particular matter at the time the decision needs to be made.

4 ROLES

Responsibilities within the Organisation

4.1 The **Chief Executive and Board of Directors** have overall responsibility for Trust compliance with the Law and Trust Policies and Procedures

4.2 The **Chief Nurse** is the Executive Director with lead responsibility for ensuring compliance with the Act.

4.3 The **Deputy Chief Nurse** is the Nominated Deputy for the Chief Nurse.

4.4 The **Head of Safeguarding** is the strategic lead and will provide operational cover for the Matron – Adult Safeguarding when required.

4.5 The **Matron for Adult Safeguarding** is the operational lead for the MCA and is responsible for supporting UHL staff with the implementation of the MCA and DoLS, alongside the adult safeguarding specialist nurses.

4.6 **Clinical Directors, General Managers and Heads of Nursing** are the leads for disseminating the policy to staff within their Clinical Management Groups.

4.7 **All Staff** who work with patients who may lack decision specific capacity must comply with this Policy. All staff are responsible for identifying which policies are applicable to their area of work and for following Trust policy documents. All staff must attend mental capacity act training, as appropriate for individual role.

5 POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

This policy is supported by the following statements and processes, which must be used in conjunction with this policy.

5.1 THE FIVE STATUTORY PRINCIPLES OF THE MCA

(i) **A person over the age of 16 must be assumed to have capacity unless it is established that they lack capacity**.
Every person from the age of 16 has the right to make their own decisions if they have the capacity to do so. Family carers, healthcare or social care staff must assume that a person has the capacity to make decisions, unless it can be established that the person does not have capacity.

(ii) **A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.**
People should receive support to help them make their own decisions. Before concluding that individuals lack capacity to make a particular decision, it is important to take all possible steps to try to help them reach a decision themselves.

(iii) **A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.**
People have the right to make decisions that others might think are unwise. A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision.

(iv) **An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests**.
The act provides a checklist of factors which should be taken into consideration – see section 6.4 for further details.

(v) **Before the act is done, or the decision is made, regard must be given to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action**.
Any act done for, or any decision made on behalf of, someone who lacks capacity should be an option that is less restrictive of their basic rights and freedoms - as long as it is still in their best interests.

5.2 SUPPORTING PEOPLE WITH DECISION MAKING

5.2.1 Before deciding that someone lacks capacity to make a particular decision, **it is important to take all practical and appropriate steps to enable them to make that decision themselves.** In addition, steps (such as helping individuals to communicate) must be taken in a way which reflects the person's individual circumstances and meets their particular needs.

5.2.2 The Code of Practice identifies the following checklist (see page 32 of the Code for further details):

(a) **Providing relevant information**
- Does the person have all the **relevant** information they need to make a particular decision?
- Is the information in the easiest and most appropriate form for the person concerned?
- If they have a choice, have they been given information on all the alternatives?

(b) **Communicating in an appropriate way**
- Could information be explained or presented in a way that is easier for the person to understand (for example, by using simple language or visual aids)?
- Have different methods of communication been explored if required, including non-verbal communication?
- Could anyone else help with communication (for example, a family member, support worker, interpreter, speech and language therapist or advocate)?
- Are there particular times of day when the person's understanding is better?
- Are there particular locations where they may feel more at ease?
- Could the decision be put off to see whether the person can make the decision at a later time when circumstances are right for them?

(c) **Supporting the person**
- Can anyone else help or support the person to make choices or express a view?
- Might the person benefit from having another person present?

5.3 ASSESSING MENTAL CAPACITY

5.3.1 The starting assumption must always be that a person has the capacity to make a decision. The Act states that no one should be 'labelled' incapable as a result of a particular medical condition or diagnosis. In addition, the Act makes it clear that lack of capacity cannot be established by mere reference to a person's age, appearance or any condition/aspect of a person's behaviour which might lead others to make unjustified assumptions about capacity. However **doubts** may arise about a person's ability to make a specific decision(s) because:

a) of the person's behaviour or circumstances
b) of concerns raised by someone else
c) the person is declining help or is resistive to care delivery / treatment
d) it has already been shown they lack capacity to make other decisions in their life

5.3.2 In this situation the person's capacity to make a **specific** decision must be assessed using the **two-stage test of capacity** at the **material time it is needed** and the Act makes it clear that the test is 'decision specific' and healthcare professionals cannot rely on a 'blanket' test which covers all eventualities.

5.3.3 **THE TWO STAGE TEST:**

The order of the two stage test has been switched to ensure that the impairment is considered ***after*** the person's ability to make the decision has been assessed. The aim of this change is to prevent automatic assumptions that the person cannot make a decision just because of their condition.

1. **STAGE ONE:** You need to assess if the person is able to make the specific decision, at the time required. This is tested in four parts, and if the person cannot do one or more of the below, then they are deemed to lack capacity at that time

a) Can the person generally understand the information relevant / salient to the specific decision and why they need to make it?
b) Can the person retain the information, for the time it takes to make a decision?
c) Can the person use and weigh up the information relevant to this decision?
d) Can the person communicate their decision in any way? (by talking, using sign language or any other means)

The first three points should be applied together. If a person cannot do any of these three things, they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way, for example because they are in a coma.

2. **STAGE TWO:** If the person lacks capacity to make the specific decision following stage one, then you must consider whether there is an *impairment or disturbance in the functioning of the mind or brain* which is **causing** their inability to make the decision (this is known as the causal link). Impairment could be: delirium, dementia, significant learning disabilities, brain damage, mental disorder, unconsciousness, confusion, the effects of alcohol or drugs, psychosis. It doesn't matter whether the impairment or disturbance is temporary or permanent.

3. If the person in unable to make the specific decision, and this is because of an impairment or disturbance in their mind or brain, then they are deemed to lack capacity in accordance with the Mental Capacity Act.

4. If there is no impairment / disturbance then seek advice from Trust's Safeguarding Team ext. 17703 / Legal Services ext. 27079.

5.3.4 Who should assess capacity?

I. The person who assesses an individual's capacity to make a decision (the assessor) will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times.

II. For most day-to-day decisions, this will be the person caring for them at the time a decision must be made. For example, a care assistant might need to assess if the person can agree to have personal care delivered. A nurse might need to assess if a person can agree to have their medication.

III. However, where a Doctor or other healthcare professional **proposes treatment** or an **examination,** they must assess the person's capacity to consent. In settings such as a hospital, this can involve the multi-disciplinary team, but ultimately it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed.

IV. More complex decisions are likely to need more formal assessments. A professional opinion on the person's capacity will be necessary. This could be, for example, from a Doctor, a psychiatrist, psychologist, a speech and language therapist, occupational therapist or social worker. It might also be necessary to seek a second opinion. However, the final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person.

V. Where an element of doubt exists when determining whether a patient has capacity and / or where a dispute exists (with family members for example) it is always best practice to seek a second opinion from another appropriate professional and to fully record this in the healthcare notes.

5.3.5 What proof of lack of capacity does the Act require?

The Act requires the assessor to be able to show, *on the balance of probabilities*, that the individual lacks capacity to make a particular decision, at the time it needs to be made. This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question.

5.3.6 Fluctuating or Temporary Capacity

The Act makes it clear that persons can fluctuate in and out of capacity and this does not prevent them from being able to make a decision. It follows from this the person best disposed to assess capacity in an Acute Hospital setting will be those treating the patient on a regular basis and not necessarily an external specialist (e.g. a psychiatrist) who may only see the patient for a snapshot in time.

5.3.7 **Recording the Mental Capacity Assessment**

It is good practice for professionals to record the findings of a formal mental capacity assessment. University Hospitals of Leicester NHS Trust has a standardised Mental Capacity and Best Interests Assessment form which can be used to record the capacity assessment on Nerve Centre (paper version available on INsite for areas that cannot access Nerve Centre, and for Nerve centre downtimes). It is recommended that the Trust's standardised form is used for complex decisions. See appendix two for MCA flowchart.

5.4 BEST INTERESTS DECISION MAKING

5.4.1 Working out what is in someone's best interests may be difficult at times therefore the Act introduces a checklist of issues which must be considered when making such judgements.

5.4.2 A person trying to work out the best interests of a person who lacks capacity to make a particular decision is known as the **'Decision-maker'** (DM). The DM should:

a) Encourage Participation

- Do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision

b) Identify all relevant circumstances

- Try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves

c) Find out the person's views, as far as it is reasonably ascertainable. **Consider:-**

- the person's past and present wishes and feelings (in particular, any relevant written statement made by him when he had capacity),
- any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question
- any other factors that s/he would be likely to consider if s/he were able to do so.

d) Avoid discrimination

The Act requires that a decision must not be made merely on the basis of:

- the person's age or appearance, or
- a condition, or an aspect of behaviour, which might lead others to make unjustified assumptions about what might be in the patients best interests.

e) The DM must consider:-

- whether the person is likely to regain capacity in relation to the matter in question (e.g. after receiving medical treatment). If so, can the decision wait until then?

f) Consulting others

The DM, where it is practical and appropriate to do so, must consult other people for their views about the person's best interests. In particular, try to consult:

- anyone previously named by the person as someone to be consulted on the decision in question or on matters of that kind.
- anyone engaged in caring for the person
- close relatives, friends or others who are interested in the person's welfare.
- any attorney/donee under a Lasting Power of Attorney granted by the person
- any deputy appointed by the Court of protection
- For decisions about serious medical treatment or where the person should live and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted.

g) Life Sustaining Treatment

- If the decision concerns life-sustaining treatment the DM must not be motivated by a desire to bring about the patient's death.

h) Avoid restricting the person's rights

- The DM must see if there are other options that may be less restrictive of the person's rights.

i) Take all of this into account

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

5.4.2 **Who can be a decision-maker (DM)?**

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, e.g.

- Where nursing care is provided, the nurse is the DM.
- Where the decision involves the provision of medical treatment, the doctor responsible for carrying out the particular treatment or procedure is the DM.
- For most day to day decisions or actions, the DM will be the carer/person most directly involved with the person at the time.
- There are times when a joint decision might be made by a number of people.

It is the relevant decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.

5.5 GUIDANCE FOR BRINGING MEDICAL TREATMENT DECISIONS BEFORE THE COURTS

5.5.1 In January 2020 guidance was issued by the Vice President of the Court of Protection. This guidance sets out the procedure to be followed when a decision relating to medical treatment arises which requires consideration of bringing an application before the Court of Protection. The guidance is intended to operate until such time as it is superseded by a revised Code of Practice (Serious Medical Treatment, Guidance [2020] EWCOP 2 (17 January 2020)).

5.5.2 The starting point for the making of medical treatment decisions in relation to individuals lacking decision-making capacity is Section 5 Mental Capacity Act 2005. This provides a defence against liability for the medical professional(s) carrying out the relevant act (including, where relevant, withholding or withdrawing treatment) where they reasonably believe that the person in question lacks the necessary decision-making capacity and that the act in question is in the person's best interests.

5.5.3 However, court guidance states that there are some circumstances in which Section 5 either will not or may not provide a defence against liability, and if Section 5 does not provide a defence, then an application to the Court of Protection will be required.

5.5.4 **Situations where consideration should be given to bringing an application to court:**

If, at the conclusion of the medical decision-making process, there remain concerns that the way forward in any case is:

(a) **finely balanced**, or

(b) there **is a difference of medical opinion**, or

(c) a **lack of agreement** as to a proposed course of action from those with an interest in the person's welfare, or

(d) there is **a potential conflict of interest** on the part of those involved in the decision-making process

Then it is highly probable that an application to the Court of Protection is appropriate. In such an event consideration **must** always be given as to whether an application to the Court of Protection is required.

5.5.5 Where any of the matters above arise and the decision relates to the provision of life-sustaining treatment an application to the Court of Protection **must** be made. For the avoidance of any doubt, this specifically includes the withdrawal or withholding of clinically assisted nutrition and hydration.

5.5.6 In any case which is not about the provision of life-sustaining treatment, but involves the serious interference with the person's rights, then an application to the Court of Protection must be considered to facilitate a comprehensive analysis of capacity and best interests, with the individual having the benefit of legal representation and independent expert advice. This applies even in cases where there is agreement between all those with an interest in the person's welfare.

5.5.7 Examples of cases which may fall into the above will include, but are not limited to:

(a) where a medical procedure or treatment is for the primary purpose of sterilisation
(b) where a medical procedure is proposed to be performed on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation of an organ, bone marrow, stem cells, tissue or bodily fluid to another person;
(c) a procedure for the covert insertion of a contraceptive device or other means of contraception
(d) where it is proposed that an experimental or innovative treatment to be carried out
(e) a case involving a significant ethical question in an untested or controversial area of medicine.

5.5.8 In addition to the issues set out above, an application to court may also be **required** where the proposed procedure or treatment is to be carried out using a degree of force to restrain the person concerned and the restraint may go beyond the parameters set out in the Mental Capacity Act 2005. In such a case, the restraint will amount to a deprivation of the person's liberty and the authority of the court will be required to make this deprivation of liberty lawful.

5.5.9 The guidance also states that those providing clinical and caring services should approach the Court of Protection in any case in which they assess it as right to do so.

5.5.10 Clinicians and decision makers within UHL should consult with the Trust's Legal Services (ext. 8960) in the first instance when an application to the Court of Protection is being considered. Consultation must occur at the earliest opportunity to avoid delays in the decision making process.

5.6 LASTING POWERS OF ATTORNEY

5.6.1 The Act allows a person, aged 18 and over years of age, to appoint an Attorney (or donee) to act on their behalf if they should lose capacity in the future. A Lasting Power of Attorney (LPA) allows people to authorise an Attorney to make 'personal welfare' (including healthcare and consent to medical treatment) and/or 'property and financial' decisions. LPA's have to be registered with the Office of the Public Guardian before they are valid under the Act. It should be noted that an Attorney acting under a registered LPA has no power to consent to or refuse life-sustaining treatment unless the LPA expressly authorises it. It is essential that both the validity and intent of LPA's are firmly established before they are relied upon and, especially in the case of end-of-life decisions.

5.6.2 The LPA must be a written document set out in the statutory form prescribed by regulations. There are separate personal welfare LPA's and property and affairs LPA's.

5.6.3 Staff are advised that if they are faced with issues regarding LPAs they should seek further advice from Corporate and Legal Affairs and should always do so where these decisions involve end of life decisions. Please contact ext. 8960 for Trust Legal Services, or request contact out of hours via Trust Switchboard.

5.6.4 For further information, see the Trust's **Advance Decisions and Lasting Powers of Attorney Policy** which is available on INsite (Trust Reference Number: B21/2004).

5.7 ADVANCE DECISIONS TO REFUSE TREATMENT

5.7.1 An Advance Decision allows anyone aged 18 and over years of age, while still capable, to refuse specified medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment.

5.7.2 An advance decision to refuse treatment **must be valid and applicable to current circumstances**. If it is, it has the same effect as a decision made by a person with capacity: healthcare professionals must follow the decision.

5.7.3 An advance decision will not apply to treatment which a doctor considers necessary to sustain life **unless** strict formalities have been compiled with. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands 'even if life is at risk'. In cases of doubt further advice should be sought from the Corporate and Legal Affairs team.

5.7.4 For further information, see the Trust's **Advance Decisions and Lasting Powers of Attorney Policy** which is available on INsite (Trust Reference Number: B21/2004).

5.8 INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCA's)

5.8.1 The Act recognises that some patients who do not have capacity to make specific decisions will not have any family members, carers or close friends that it would be appropriate to consult with about those decisions. These patients are referred to as the 'unbefriended' under the MCA. To redress this, the Act provides for Independent Mental Capacity Advocates (IMCAS) to be appointed.

5.8.2 **The IMCA will:**

- Be independent of the person making the decision
- Provide support for the person who lacks capacity
- Represent the person without capacity in discussions to work out whether the proposed decision is in the persons best interests
- Provide information to work out what is in the persons best interests
- Raise questions or challenge decisions which appear not to be in the best interests of the person
- Provide statutory advocacy
- Be instructed to support and represent people who lack capacity to make decisions on specific issues
- Have a right to meet in private with the person they represent and are supporting
- Be allowed access to healthcare records and social care records
- Provide support and representation specifically while the decision is being made
- Act quickly so their report can form part of decision-making.

5.8.3 **Instructing and consulting an IMCA**

An IMCA *must* be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid carers) whenever:

- An NHS body is proposing to provide serious medical treatment (see 9.4 below)
- An NHS body or local authority is proposing to arrange accommodation in a care home and the person will stay there for more than 8 weeks (see 9.5 below)
- A patient will stay in hospital for more than 28 days

An IMCA *may* be instructed to support someone who lacks capacity to make decisions concerning adult safeguarding issues, whether or not family friends or others are involved, (especially where the concerns are raised against family/friends).

5.8.4 **Serious Medical Treatment**

Serious medical treatment is defined as treatment which involves giving new treatment, stopping treatment that has already started, or withholding treatment that could be offered in circumstances where:

- if a single treatment is proposed there is a fine balance between the likely benefits and the burdens to the patient and the risks involved.

- a decision between a choice of treatments is finely balanced, or

- what is proposed is likely to have serious consequences for the patient.

Serious consequences are those which could have a serious impact on the patient, either from the effects of the treatment itself or its wider implications. This may include treatments which:

- cause serious and prolonged pain, distress or side effects
- have potentially major consequences for the patient(for example stopping life sustaining treatment or having major surgery) or,
- have a serious impact on the patients future life choices (for example, interventions for ovarian cancer).

It is impossible to set all types of procedures that may amount to 'serious medical treatment', although some examples of medical treatments that might be considered serious include:

- Chemotherapy and surgery for cancer
- Electro-convulsive therapy
- Therapeutic sterilisation
- Major surgery (eg open heart surgery or neuro surgery)
- Major amputations (eg loss of arm or leg)
- Treatments which will result in loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration
- Termination of pregnancy
- DNRCPR decisions

These are illustrative examples only and whether these or any other procedures are considered as serious medical treatment will depend on the circumstances. Decision makers who are unsure should consult with colleagues, the Trusts legal department and/or the local IMCA provider.

5.8.5 While a decision maker is waiting for the appointment of an IMCA or for the IMCAs report they must still continue to act in the best interests of the patient (for example to give treatment to prevent the condition from worsening).

5.8.6 **Accommodation decisions**

For decisions about moves into long term accommodation (for 8 weeks or longer) or about a change of accommodation, the responsible body will be either

- The Trust, where it is responsible for providing or arranging the move or change of accommodation (e.g. through 100% health care funding to a nursing home)
- The local authority, where it is responsible for providing or arranging the move or change of accommodation the assessment of the person under the NHS and Community Care Act 1990 and decides that the move is or may be necessary.

5.8.7 **Emergency / Urgent Situations**

It is permissible in emergency situations and where urgent decisions are required to proceed before the appointment of an IMCA or before an IMCA has prepared his report. However, in all such circumstances the actions must be justified and appropriate and it is incumbent on the healthcare professionals to ensure that the grounds for this are fully recorded in the patients' healthcare records.

5.8.8 **Appointing and Instructing an IMCA**
The relevant 'decision-maker' has responsibility for appointing and instructing an IMCA, when required. Details of how to do this and the appropriate referral form can be found via the IMCA Webpage on INsite available at: http://insite.xuhl-tr.nhs.uk/homepage/clinical/safeguarding-adults/independent-mental-capacity-advocates. You may also telephone the local IMCA service duty desk on 0300 456 2370.

5.9 RESEARCH

5.9.1 Under the Act and Code, research involving a person lacking capacity may be carried out if an 'appropriate body' (normally a Research Ethics Committee) agrees that the research is safe, relates to the person's condition and cannot be done as effectively using people who have mental capacity. This research must produce a benefit to the person that outweighs any risk or burden. Alternatively, if it is to derive new scientific knowledge, it must be of minimal risk to the person and be carried out with minimal intrusion or interference with their rights.

5.9.2 Carers or nominated third parties must be consulted and agree that the person would want to join an approved research project. If the person shows any signs of resistance or indicates in any way that he/she does not wish to take part, the person must be withdrawn from the project immediately.

5.9.3 The Mental Capacity Act (Loss of Capacity During Research Project) (England) Regulations 2006 concerns itself with research subjects who lose capacity during the course of a research project which started before 1st April 2007. The continuation of the research is subject to further defined provisions. If these situations arise further advice should be sought.

5.10 RESTRAINT

5.10.1 Section 6(4) of the Act states that someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or
- restrict a person's freedom of movement, whether they are resisting or not.

5.10.2 Any action intended to restrain a person who lacks capacity will be protected from liability if the following two conditions are met:

I. the person taking action must reasonably believe that restraint is *necessary* to prevent *harm* to the person who lacks capacity, and
II. the amount or type of restraint used and the amount of time it lasts must be a *proportionate response* to the *likelihood* and *seriousness* of harm

5.10.3 **When might restraint be 'necessary'?**
Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used. A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible.

5.10.4 For further information please refer to the Mental Capacity Act Code of Practice, pages 105- 108, sections 6.40- 6.48

5.10.5 Restraint does not extend to include any acts the intention of which could be seen as depriving a person of his or her liberty. This may include, for example, where a patient without capacity wishes to leave the hospital - in circumstances such as these please refer

to the 'UHL Deprivation of Liberty Safeguards Policy' (Trust Reference Number: B15/2009).

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 All new starters to the Trust must attend the Trust Induction programme which includes a basic awareness level Safeguarding Adults training session incorporating a briefing on the Mental Capacity Act.

6.2 All staff, where it is deemed as essential for their role, must complete the Trust's mandatory Mental Capacity Act and Deprivation of Liberty Safeguards e-learning programme. The training will appear on individual staff's 'required training' page on their HELM account as appropriate.

7 PROCESS FOR MONITORING COMPLIANCE

7.1 See Appendix one on Page 16.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

a) MENTAL CAPACITY ACT 2005. London: The Stationery Office. Available at: https://www.legislation.gov.uk/ukpga/2005/9/contents

b) Mental Capacity Act Code of Practice 2007. London: The Stationery Office. Available at: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

c) UHL Advance Decisions and Lasting Power of Attorney Policy (Trust Reference Number: B21/2004)

d) UHL Policy for Consent to Examination or Treatment (Trust Reference Number: A16/2002)

e) UHL Deprivation of Liberty Safeguards Policy and Procedures (Trust Reference Number: B15/2009)

f) UHL Management of Violence, Aggression and Disruptive behaviour Policy –Including Restraint Guidance (Trust Reference Number: B11/2005)

g) Applications relating to medical treatment: Guidance authorised by the Honourable Mr Justice Hayden, The Vice President of the Court of Protection available at: https://www.bailii.org/ew/cases/EWCOP/2020/2.html

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 The updated version of the Policy will be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system

10.2 The policy will be referred to in all Trust MCA/DoLS training / education.

10.3 This policy and procedures contained within it will be reviewed after 3 years by the Policy Author.

APPENDIX ONE

POLICY MONITORING TABLE

The top row of the table provides information and descriptors and is to be removed in the final version of the document

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Lead(s) for acting on recommendations	Change in practice and lessons to be shared
All relevant staff attend MCA/DoLS training	CMG management teams	HELM reports	Quarterly	CMG Board	CMG Management Team	CMG Management Team
Evidence of capacity assessments being completed prior to DoLS application	Adult Safeguarding Team	Review of DoLS forms - sample	Annually	Safeguarding Assurance Committee	CMG Management Team	CMG Management Team
Evidence of mental capacity assessments being completed on Nerve Centre	Adult Safeguarding Team	Nerve Centre report	Annually	Safeguarding Assurance Committee	CMG Management Team	CMG Management Team

Mental Capacity Flowchart