POLICY/PROCEDURE INFORMATION (Policy no CS007)	
Subject	**Mental Capacity Act Policy CS007** *(This policy is non-contractual and is subject to periodic review and will be amended according to service development needs).*
Applicable to	All staff of Nottinghamshire Hospice
Target Audience	Others such as agents, consultants and other representatives of Nottinghamshire Hospice may be required to comply with the policy as a condition of appointment.
Date issued	7 March 2023
Next review date	7 March 2026 (or following completion of national review)
Lead responsible for Policy	Director of Care
Policy reviewed by	Governance Lead
Notified to (when)	Quality and Safety Group 7 March 2023
Authorised by (when)	Quality and Safety Group 7 March 2023
CQC Standard if applicable	Safe, effective, responsive, caring
Links to other Hospice Policies	Safeguarding Adults at Risk Policy CS003
Links to external policies	Safe, Caring, Effective, Responsive
Summary	This policy is based on the Mental Capacity Act 2005 Code of Practice but is not intended to replace it. References to the relevant sections of the Code are made in brackets. The Hospice as a health and social care provider has a statutory requirement to follow the Mental Capacity Act 2005 Code of Practice and the supplementary DOLS.
This policy replaces	Mental Capacity Act Policy CS007 2018-2020

IMPORTANT NOTICE

Staff should refer to the Hospice website or Policies and Procedures folder on the 'N' drive for the most up to date Policy. If the review date of this document has expired it is still valid for 3 months. After that staff should seek advice from their clinical lead or manager.

VERSION CONTROL		
Status	**Date**	**Reviewed date**
Original policy written by Dr Betsie van Niekerk (Hospice Physician)	June 2015	
Policy reviewed by Liz Morgan, Clinical Manager - Clinical Nurse Specialist	Aug 2018	
Updated control sheet and published on Policy Doc App	Sept 2018	
Minor amend to policy by Liz Morgan, Clinical Manager – Clinical Nurse Specialist (Stage 1 & 2 separated on the MC assessment form – no need for 2 separate forms).	Aug 2019	Sep 2020
Policy reviewed by Governance Lead	Jan 2023	
Policy notified to Quality and Safety Group	7 March 2023	
Policy ratified by Quality and Safety Group	7 March 2023	7 March 2026
Published on Policy Doc App	Aug 2019	
Logo updated and published on website	Dec 2020	
Policy updated and published on website	March 2023	

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1.	**Introduction** The Mental Capacity Act 2005 (MCA) provides the legal framework for acting and making decisions on behalf of individuals (adults aged over 16) who lack the mental capacity to make particular decisions for themselves. The Act covers a wide range of decisions made and actions taken on behalf of people who may lack capacity to make specific decisions for themselves. These can be decisions about day-to-day matters – like what to wear or life changing events such as whether the person should undergo a major surgical operation. ***The MCA is currently under review and it is expected that there will be changes to both the MCA and Deprivation of Liberty Legislation and responsibilities during 2023/4. This policy will be updated at the time that new legislation and guidance are issued.***
2.	**Policy Aim** This policy aims to outline the requirements of the Mental Capacity Act and provide staff with a guide to their duties under the Act and associated Code of Practice.
3.	**Training** Training is compulsory for all clinical staff (including bank staff), allied health professionals, frontline volunteers having patient contact and the Senior Management Team of Nottinghamshire Hospice. Training will be offered every three years and tailored to a level staff responsibilities.
4.	**Definitions (Introduction to the Code of Practice)** **Mental capacity** broadly refers to the ability of an individual to make a decision about specific elements of their life. It is also sometimes referred to as **competence**. It is not an absolute concept; different degrees of capacity are needed for different decisions, and the level of competence required rises with the complexity of the decision to be made. Mental capacity may fluctuate depending on the person's condition which may be temporary or permanent. In the case of a temporary condition, a judgement would have to be made as to whether the decision could be delayed until capacity

	returned. Both the Act and the Code of Practice refers specifically to a person's capacity to make a particular decision at the time it needs to be made. **Consent** is the voluntary and continuing permission of the person to the intervention or decision in question. Consent can only be based on an adequate knowledge and understanding of the purpose, nature, likely effects and risks of that intervention or decision, including the likelihood of success of that intervention and any alternatives to it. Permission given under any unfair or undue pressure is not consent. **Decision Maker** is anyone who is making a health and welfare decision on behalf of another person. This is about ensuring that everything done for (or on behalf of) a person who lacks capacity is in their best interest. This can be a carer or relative who makes a decision about everyday events such as ordering food or dressing. More serious decisions should be made by people who have the knowledge and understanding of what is involved. Significant decisions such as a change of accommodation should be made by a multi-disciplinary meeting or team. **Best Interests** is about ensuring that everything done for (or on behalf of) a person who lacks capacity is in their best interest. It is about making every effort to come to a decision the person would made themselves if they had the capacity to do so. The Act provides a checklist (Appendix 2) of factors that assessors must work through when making decisions on behalf of others. All decisions must be documented in care plans or patients records. **Restraint** is defined in the Act as the use or threat of force where an incapacitated person resists, and any restriction of liberty or movement, whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person and if the restraint used is proportionate to the likelihood and seriousness of the harm.
5.	**Principles (Chapter 2 of the Code of Practice)[1]** The Act establishes five "statutory principles" which underpin the legislation and which must be applied in all circumstances.

	These are: a) A person must be assumed to have capacity unless it is established that they lack capacity. b) A person is not to be treated as unable to make a decision unless all practicable steps to help him / her to do so have been taken without success. c) A person is not to be treated as unable to make a decision merely because they make a decision that others believe to be unwise. d) An act done on a decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interest. e) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the persons rights and freedom of action
6.	**Third Parties Involved in Decision Making** **Lasting Power of Attorney** Lasting Powers of Attorney (LPA) can apply to personal welfare decisions (including health care and consent to treatment) as well as property and financial affairs. To find out if an individual holds an LPA you can search via the Office of Public Guardian Register. www.gov.uk/find-someones-attorney-or-deputy Enduring Powers of Attorney remain if made before October 2007 for property and financial affairs only and will continue to be valid until the donor dies. **The Court of Protection** The Court makes decisions on financial or welfare matters for people who can't make decisions at the time they need to be made because they 'lack mental

capacity' and appoints Deputies to act for them..

Independent Mental Capacity Advocate (IMCA)

Independent Mental Capacity Advocate (IMCA) is a role to provide support and representation for people who lack capacity to make specific decisions in certain defined circumstances. The IMCA is not the same as an ordinary advocacy service. An IMCA must be instructed in certain decisions regarding serious medical procedures or changes of accommodation if there is no-one else to support, be consulted or represent the person who has lost capacity. (See a, b and c below)

The IMCA does not make decisions about capacity. The advocates check that the process of assessing capacity and determining best interest has been carried out.

Referral to the Independent Mental Capacity Act Service (IMCA) can happen in the following events (Chapter 10 of the Code of Practice)[1]

a) **Healthcare**

If a doctor or healthcare professional is proposing serious medical treatment for somebody who lacks the capacity to consent and there is nobody other than service providers. There is a statutory duty to refer to an IMCA in this case.

Serious medical treatment is defined as treatment that involves

- Giving new treatment,
- Stopping treatment that has already started
- Withholding treatment that could be offered in circumstances where:
    - If a single treatment is proposed and there is a fine balance between the likely benefits and the burdens to the individual and the risks involved
    - A decision between a choice of treatments if finely balanced
    - What is proposed is likely to have serious consequences for the individual.

If the treatment is urgent, that is treatment that cannot be delayed without

detriment to the individual, the NHS body is not required to instruct an IMCA before commencing lifesaving treatment. However should the treatment continue past the point of being urgent/lifesaving then a referral to the IMCA Service must take place.

b) **Accommodation**

If an NHS body is proposing to arrange or change accommodation in a hospital or care home (for 28 days or more) for an individual who lacks the capacity to consent **or**

If a Local Authority is proposing to arrange or change residential accommodation (for 8 weeks or more) for an individual who lacks the capacity to consent **and** if there is no family member or non-professional carer to support them through the assessment process, an IMCA must be instructed.

If the arrangements need to be made as a matter of urgency and there is no time to instruct an IMCA, the accommodation can proceed. However, if the person is then expected to be more than 28 days in hospital or 8 weeks in a care home or its equivalent an IMCA must be instructed as soon as possible after the move.

c) **Deprivation of Liberty Safeguards (DOLS)**

If a service provider (i.e., hospital or care home) makes an application under MCA DOLS to authorise a deprivation and there is no family member or non-professional carer to support the individual involved through the assessment process, then the supervisory body must appoint an IMCA.

d) **Discretionary Referrals**

In addition to (a) (b) and (c) above that require the mandatory involvement of an IMCA, the Act also outlines two circumstances in which NHS bodies and Local Authorities have additional discretion to instruct an IMCA.

Review of Accommodation

- Where an NHS body or a local authority has made arrangements for the accommodation of a person who does not have capacity to participate in the review what is being proposed in those arrangements and

- He / she has been in that accommodation for 12 weeks or more (continuously) and the accommodation is not provided under an obligation required by the Mental Health Act 1983 and
- There is nobody other than a paid carer to support and represent him / her
- The NHS body or local authority may instruct an IMCA if it is satisfied that it would be of particular benefit to him / her to be so represented
- Before making any decision resulting from the review of arrangements as to that person's accommodation must take into account any information given, or submissions made by the IMCA.

Adult Safeguarding Cases

- Where it is alleged or there is evidence that a person lacking capacity is or has been abused or neglected or that he / she is abusing or has abused another person
- Measures have been taken or are proposed by an NHS body or local authority in accordance with any adult safeguarding procedures
- The NHS body or local authority may instruct an IMCA if it is satisfied that it would be of particular benefit to the individual to be so represented, even if he or she has family or friends who can be consulted
- Before making any decision or further decision about protective measures, any information given or submissions made by the IMCA must be taken into account. (Appendix 7)

For further information please refer to The Nottinghamshire Hospice Safeguarding Adults at Risk Policy

Deprivation of Liberty Safeguards (DOLS)

The safeguards are designed to protect the interests of an extremely vulnerable group of service users who for their own safety and in their own best interests need

to be accommodated under care and treatment regimes that may have the effect of depriving them of their liberty, but who lack the capacity to consent. Any such decisions must only be made following defined processes and in consultation with specific authorities. A separate supplementary Code (which became effective in 2009) to the main Mental Capacity Act sets out these safeguards.

DOLS apply to anyone who is:

- aged 18 and over
- suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability
- lacks the capacity to give informed consent to the arrangements made for their care and / or treatment; and for whom deprivation of liberty (within the meaning of Article 5 of the European Court of Human Rights) is considered after an independent assessment to be necessary in their best interests to protect them from harm.

DOLS cover patients in hospitals and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

In effect, DOLS:

- ensure people can be given the care they need in the least restrictive regimes
- prevent arbitrary decisions that deprive vulnerable people of their liberty
- provide safeguards for vulnerable people
- provide them with rights of challenge against unlawful detention
- avoid unnecessary bureaucracy

Particular Challenges in Palliative Care[5,6]

It is challenging what constitutes a deprivation of liberty for someone in the last few weeks of their life. The Department of Health advises that a person who lacks

	capacity and is receiving palliative care is entitled to the same rights under the law as every other citizen. Such individuals can have a care and support package that results in a best interest deprivation of liberty. If there is no valid consent such a deprivation of liberty must be authorised. The reality on the ground is that in the great majority of palliative care cases, those important to the individual concerned do not recognise any 'deprivation of liberty' in a conventional sense. Rather they see a normal care situation. The care team should be aware that an unnecessary DOLs assessment could cause considerable distress to the family with no benefit to the individual.
7.	**Assessing Mental Capacity** Capacity should be judged in relation to a specific decision – some decisions are easier to make than others. A mentally competent adult has an absolute right to refuse to or consent to any intervention or medical treatment for a physical condition for any reason, rational or irrational, or for no reason at all, even where this decision may lead to his or her own death. Accepting an unwise decision as valid is evident of respecting the autonomy of a person who has capacity to make such a decision. The Act sets out a two-stage test to determine whether a person lacks the capacity to make a particular decision **Stage 1 – Establish whether a person has an impairment of, or disturbance in the functioning of, their mind or brain.** (Code of Practice) This needs to be established as without this the person will not lack capacity under the terms of the Act. The Code of Practice gives the following examples-: • conditions associated with some mental illnesses • dementia • significant learning disabilities • the long-term effects of brain damage

- physical or mental conditions leading to confusion, drowsiness or loss of consciousness
- delirium
- concussion
- the symptoms of alcohol or drug use

It should be stressed, though, that the issue is not the person's diagnosis, but their capacity to make a decision about a specific issue.

Stage 2 – Establish whether the impairment or disturbance means that the person cannot make a specific decision at the time a decision needs to be made. (Chapter 3 of the Code of Practice)

In order to demonstrate decision making capacity, a person should be able to:

- Understand the information relevant to the decision, including the purpose of any proposed course of action, the main benefits, risks and alternatives, and the consequences of refusing to follow the proposed course of action and of failing to make a decision.
- Retain that information for long enough to make a decision.
- Use or weigh that information as part of the process of making the decision. A person should be able to understand the benefits and burdens of the decision and being able to weigh that up.
- Communicate his or her decision, whether by speech, sign language or any other means.

A person who fails any one of the above four points is lacking in capacity in relation to that decision which could require the principles of the Act to be followed.

Every possible assistance and support must be given to the person to help him/her to arrive at a decision particularly as capacity can fluctuate.

8.	**Assessment and Care Planning (Appendix 1, 2 and 4)** The core principles of the Act (See Section 5) affect the Assessment and Care Planning process. a) The professional/or other responsible for the care / treatment is the one who has to make these decisions but can take advice from others in specialist areas as appropriate. It is a statutory duty to involve carers and those important to them in this process. b) The Act allows carers, healthcare and social care staff to carry out certain tasks with protection of liability provided the principles of the Act have been adhered to and there is evidence recorded as to how you are acting in those persons' best interests (See chapter 6 of the Code of Practice). These tasks involve the personal care, healthcare and treatment of individuals that lack capacity to consent. c) It is recommended that a record of the Mental Capacity Assessment is documented in the file. The 'Assessment of Mental Capacity' form **(Appendix 4)** should be used for this purpose. d) In order to ensure compliance with the Act and to protect staff from any liability with regard to the care/treatment of people who lack capacity it is important that all decisions are fully documented with reasons. e) The preparation of a care plan should always include an assessment of capacity to consent to the outcomes and actions and confirm that these are agreed to be in the person's best interests. This helps to evidence how staff are adhering to the principles of the Act and so give the protection from liability. f) The individual's capacity and best interests must be reviewed regularly. g) The Code of Practice suggests that if there are issues concerning capacity, it is good practice for a care plan to be prepared by a multi-disciplinary team.

	h) All assessments will be revised to include the following: • Does this person have capacity to consent to care /treatment? • Is the care /treatment assessed as being in their best interest?
9.	**Best Interest** It is a process of steps required by law for a person who lost capacity for a specific care decision in order to arrive at a decision that the person would have made themselves if they had capacity to do so. Having to decide a person's best interest means that person currently does not have the capacity to make the decision that is needed. If they had capacity the person would have made the decision for themselves. **Determining an individual's best Interest** In determining what is in a person's best interests, regard should be had to medical and welfare issues, but also to the religious, cultural, and ethical principles of the person. The following must be considered: - • Whether the person is likely, at some point in the future, to recover his or her decision-making capacity in relation to the matter in question. • The views of relatives, carers or other people involved whom it is appropriate and practicable to consult about the person's wishes and feelings, and what would be in his or her best interests. • Whether the purpose for which any action or decision is required can be as effectively achieved in a manner less invasive or restrictive of the person's freedom of action. **Encourage participation** • Health Care Professionals responsible for the person and representatives from the clinical team/s should be involved. • Other health professionals with specific expertise (Palliative Care).

	• Those important to them or the Lasting Power of Attorney. • Refer to IMCA services if there is no one to represent the person. • Although the person doesn't have capacity to make the decision, they should be encouraged to participate in discussions if appropriate. **Establish a person's views** The ascertainable past and present wishes and feelings of the person, and the beliefs, values and other factors that would be likely to influence him or her if had capacity. Other factors the person would have considered if they made the decision for themselves. Allow and encourage the person to participate as fully as possible in any act done for, and any decision affecting, him or her as far as possible and appropriate. **Avoid discrimination** In the case of a medical treatment, that treatment should be necessary to save life, prevent deterioration or ensure an improvement in the patient's physical or mental health and should be consistent with a reasonable body of current medical opinion. When decisions regarding life sustaining treatment need to be made assure: • No motivation by desire to bring about person's death • No assumptions should be made about a person's Quality of Life • Avoid restricting the person's rights **Exceptions of Best Interest** Where a valid Advance Decision to Refuse Treatment was made by the person when they had the capacity to do so
10.	**Advance decision to refuse treatment (ADRT)[2] (Appendix 5 and 6)** a) An Advance Decision to Refuse Treatment (ADRT) enables an individual aged 18 and over to specify medical treatment that they wish to refuse at a time in the future when they may lack the capacity to consent to or refuse

(except for treatment for a mental disorder under Part IV of The Mental Health Act 1983).

b) It is a general principle of law and medical practice that people have a right to consent to or refuse treatment. The courts have recognised that adults have the right to express in advance the treatment they would want to refuse in future if they lose capacity. (People have no legal right to demand any treatment). A person has the right to refuse life-sustaining treatment, even if this results in their death.

c) A valid and applicable ADRT has the same force as a contemporaneous (made at the time) decision. This is set out in Sections 24 to 27 of the Act (see Code of Practice Chapter 9) for further details.

d) Advance decisions can be verbal. However, if a decision involves a refusal of **life sustaining treatment**, it must be in writing and signed by the individual making it (or on their behalf at their direction if they are unable to sign) and witnessed.

e) Advanced decisions must be **valid and applicable** see (Code of Practice) and healthcare professionals must follow an advance decision if it is valid and applies to the particular circumstance. If they do not, they could face criminal prosecution or civil liability.

f) If there is any doubt over the existence, validity or applicability of such a*dvanced decisions* then it should be referred to The Court of Protection for determination. For instance, if it is unspecific or a change of circumstances has occurred (see section 25 of the Act and chapter 9 of The Code of Practice for further guidance). The Court of Protection can make declarations if there are particular conflicts/concerns or difficulties regarding a persons' capacity.

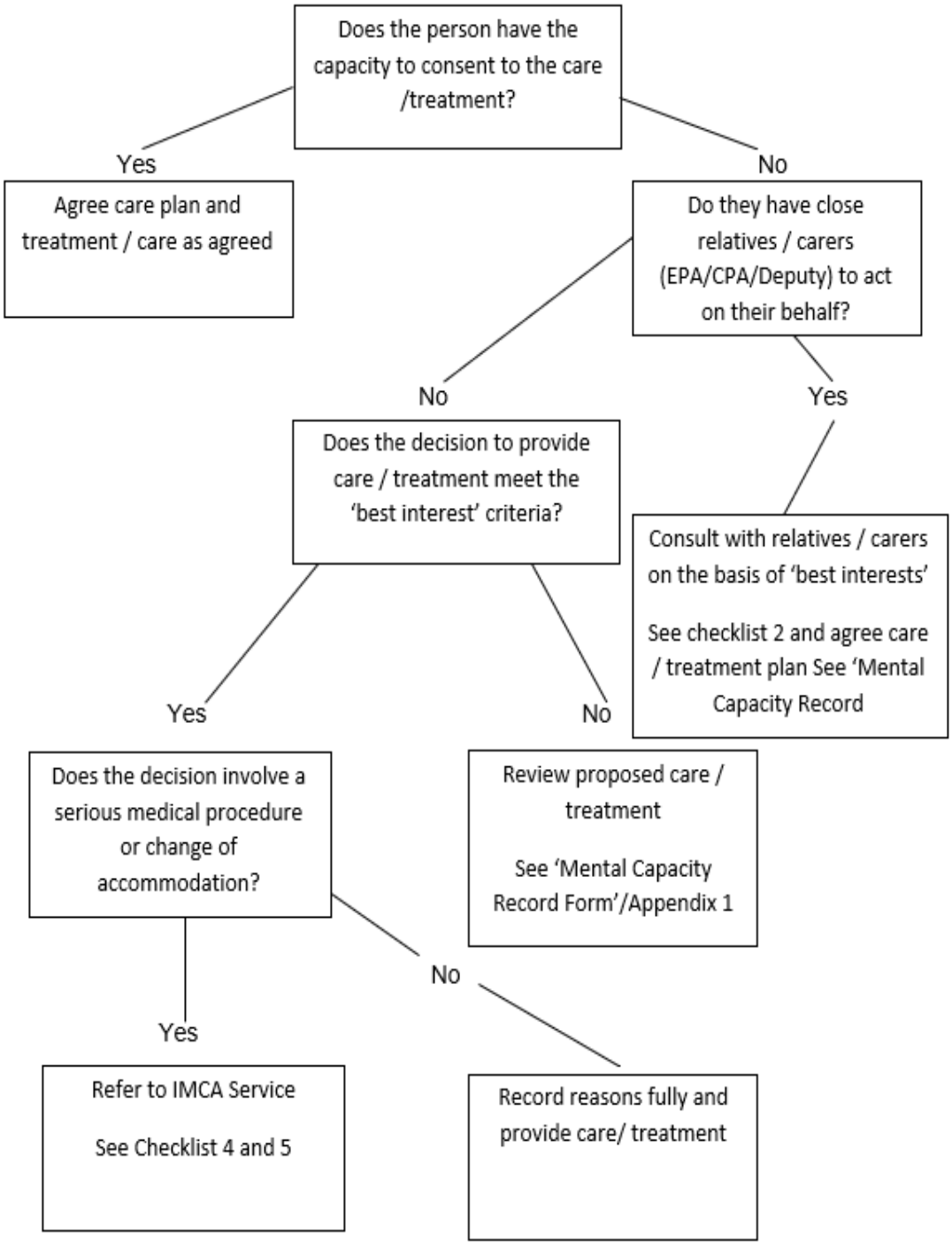
g) An ADRT may be withdrawn by the person (When they still have capacity) at any time by any means except in the case of life sustaining treatment where the withdrawal must be made in writing. Verbal *ADRT* may also be made and should be recorded in the individual's case notes.

h) If a doctor or other health care practitioner cannot, for reasons of conscience, comply with the decision outlined within an *advanced decision to refuse*

	treatment, for example, it would lead to the individual's death, arrangements must be made to transfer care to another practitioner. i) An advanced decision (ADRT) can only be overruled by a Lasting Power of Attorney (LPA) appointed before the ADRT was made. The Court of Protection may make declarations about the existence, validity and applicability of an ADRT. However, it has no power to overrule a valid and applicable Advance Decision to Refuse Treatment. The provisions of section 5 of the Act allow healthcare practitioners to act in an individual's best interests if they do not know of the existence of the ADRT or there are doubts as to its validity.
11.	**References** 1. Mental Capacity Code of practice: Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk) 2. ADRT 3. The Mental Capacity Act: update on progress and next steps: Mental Capacity (Amendment) Act 2019: Liberty Protection Safeguards (LPS) - GOV.UK (www.gov.uk) 4. Re X Process: https://courtofprotectionhandbook.com/2014/11/16/the-re-x-process-goes-live 5. Nottinghamshire Hospice Safeguarding Adults at Risk Policy CS003.

Appendix 1

Flow Chart for Making Decisions About People Who Lack Capacity



A Guide to Assessing Capacity

The Health or Social Care professional/or other responsible for the care/treatment has to take make the assessment as to the person's capacity to make a decision.

The Act sets out a "test" which is central to the principles underpinning the legislation.

The assessment of capacity must be: -

- **Time specific –** has the person the capacity to make a decision at the specific time (recognising that capacity can fluctuate over time)

- **Decision specific –** the assessment must relate to a specific decision and not decisions in general (recognising that people may be able to make some decisions but not others)

The test focuses on the process of making a decision rather than the decision itself.

There are four parts to the test and a failure at any stage indicates a lack of capacity.

To have the capacity to make a decision someone must be able to

1. Understand the information relevant to the decision (this must be presented in a way that is appropriate to the individual – signs, visual aids – given by someone they know etc.)

   and

2. Retain the information (not necessarily for a long period but long enough to make the decision)

   and

3. Use the information to make a choice (weigh up the options, understand the consequences etc.)

   and

4. Communicate the decision (by any method that is understood by the assessor, using a specialist worker to support this if necessary)

To Make a 'Best Interests' Decision

(Chapter 5 of the Code of Practice)

The Decision Maker Must

1. Consider all relevant circumstances

2. Consider if the person is likely to recover capacity at some point in the future and if so can the decision be delayed.

3. Involve the person in the decision as much as possible using whatever means may be most effective e.g. signs / pictures etc.

4. Consider the persons past and present wishes and feelings even if not expressed verbally.

5. Consider any written statement made when the person had capacity.

6. Consider the beliefs and values likely to influence the person's decision e.g. religious / cultural choices.

7. Take other factors, such as emotional bonds into consideration when deciding e.g. where someone should live.

8. Consult and take into account the views of key people such as carers / family / friends (including EPA and PA / Deputies from October 2007) as to what would be in the person's best interest/

9. Not be motivated by the desire to bring about the person's death when the decision relates to Life Sustaining Treatment (this does not mean that doctors must regard life sustaining treatment as always in the person's best interest.

10. Ensure that the decision reflects the fact that the Act deems the 'least restrictive option as being in the person's best interest.

11. Ensure that the person who lacks capacity is not treated in a discriminatory manner or less favorably than others.

Practitioners need to demonstrate that they have followed the 'Best Interests' check list to be assured of protection under the Act
Decisions should always be recorded

Assessment of Mental Capacity

1. Assessment (stage 1)

Patients Name _____

Address_____

DOB _____NHS No._____

Date of Assessment _____

Date of any previous assessment of capacity _____

Details of treatment decision(s) or other specific issue(s) in relation to which capacity is being assessed

_____

_____

The patient currently has a mental disorder resulting in Impairment/disturbance of the functioning of the mind or brain Yes / No

If yes, give a diagnosis or brief description _____

_____

Stage 2
In relation to the above decision/issue the patient can:

Understand information relevant to the decision? Yes / No
Comments:

Retain information long enough to make the decision? Yes / No
Comments:

Weigh the information in the balance in order to make a decision? Yes / No
Comments:

Communicate the decision? Yes / No
Comments:

Note that if the patient fails the test at any point, they lack capacity in relation to the decision at the time of the assessment. If they lack capacity, the 'Determination of Best Interests' Form should be completed at this point.

Is the patient likely to recover capacity? Yes / No

If yes, the assessment of capacity should be repeated at a future point.

Suggested time-interval before further assessment required _____

2. Referral to IMCA

Is the patient eligible to be referred to an IMCA Yes / No

If yes, has the patient been referred? Yes / No

If yes, date _____

And name of IMCA service _____

3. Determination of Best Interest

If the outcome of the assessment is that the person lacks capacity, it may be possible to treat/act in their best interest. To help determine this:

Have the patient's past and present wishes and feelings been taken into account as far as possible? Yes / No

_____

_____

Has account been taken of the patient's known beliefs and values? Yes / No

_____

_____

Have the patient's relatives/friends been consulted? Yes / No

_____

_____

Is there an IMCA/another advocate? Yes / No

If yes, have their views been taken into account? _____

_____

If there is an Advance Decision to Refuse Treatment/Lasting Power of Attorney/ deputy appointed by the Court of Protection, have they been consulted? Yes / No

Is the person subject to a DOLs authorisation? Yes / No

Proposed Course of actions and reasons:

_____

_____

_____

Completed by:

Name: _____

Position: _____

Date: _____

Summary of Steps in Assessing Mental Capacity

Capacity should be judged in relation to a specific decision – some decisions are easier to make than others. A mentally competent adult has an absolute right to refuse to consent to any intervention or medical treatment for a physical condition for any reason, rational or irrational, or for no reason at all, even where this decision may lead to his or her own death.

Principles of assessing mental capacity

- A person must be assumed to have capacity unless it is established that he or she lacks capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he or she makes a decision that others believe to be unwise
- An act done, or decision made, for or on behalf of a person who lacks capacity must be done, or made, in his or her best interests
- Before such an act is done, or decision made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less invasive or restrictive of the person's rights and freedom of action.

Demonstrating decision-making capacity

In order to demonstrate decision making capacity, a person should be able to:

- Understand the information relevant to the decision, including the purpose of any proposed course of action, the main benefits, risks and alternatives, and the consequences of refusing to follow the proposed course of action and of failing to make a decision
- Retain that information for long enough to make a decision
- Use or weigh that information as part of the process of making the decision
- Communicate his or her decision, whether by speech, sign language or any other means.

A person who fails any one of the above four points is lacking in capacity in relation to that decision.

Determining an individual's best interests

In determining what is in a person's best interests, regard should be had to medical and welfare issues, but also to the religious, cultural and ethical principles of the person. The following must be considered:

- Whether the person is likely, at some point in the future, to recover his or her decision-making capacity in relation to the matter in question
- The ascertainable past and present wishes and feelings of the person, and the beliefs, values and other factors that would be likely to influence him or her if he or she had capacity
- The need to allow and encourage the person to participate as fully as possible in any act done for, and any decision affecting, him or her
- The views of relatives, carers or other people involved whom it is appropriate and practicable to consult about the person's wishes and feelings, and what would be in his or her best interests
- Whether the purpose for which any action or decision is required can be as effectively achieved in a manner less invasive or restrictive of the person's freedom of action
- In the case of a medical treatment, that treatment should be necessary to save life, prevent a deterioration or ensure an improvement in the patient's physical or mental health and should be consistent with a reasonable body of current medical opinion (the "Bolam" test)
- The views of an IMCA/another advocate if appointed.

Advance Decisions to Refuse Treatment (ADRT)

If the ADRT incorporates **the refusal of life sustaining treatment** the following must apply:

1. **Be in writing**. If the person is unable to write, someone else must write it down for them e.g. a family member or a health social care professional.

2. **Be signed by the maker.** If they are unable to sign they can direct someone to sign on their behalf as long as it is in their presence and witnessed

3. **Be signed in the presence of the witness**. The witness must then sign in the presence of the person making the ADRT. If the person making ADRT cannot sign, he or she can direct someone to sign on his or her behalf in their presence.

4. **Include a clear, specific written statement** that the ADRT is to apply to a

   specific treatment "**even if life is at risk."** If this part of the ADRT is made at

   a separate time it must be signed and witnessed as previously stated.

Note: The witness is to the maker's signature and confirms the ADRT only. Just witnessing the signature does not imply the witness has assessed the capacity of the maker.

Verbal ADRT

These are valid for refusal of non-life-sustaining treatment. There is no set format for how a verbal (non-written) ADRT should be made. Remember if the person retains capacity it is necessary to obtain informed consent at that time of any proposed treatment (ADRT is not active). Practitioners should document any verbal ADRT's in case notes. Practitioners involved in the treatment will need to judge if this verbal ADRT to be used after loss of capacity is valid and applicable on each occasion

Emergency treatment

This should not be delayed in order to look for an Advance Decision to Refuse Treatment if there is no clear indication that one exists. If it is clear that a person has made an advanced decision, and it is likely to be relevant, healthcare professionals should assess its validity and applicability as soon as possible. Sometimes the urgency of treatment will make this difficult.

Practitioner with objections to carrying out the instructions in an ADRT should inform their line manager so that the appropriate arrangements can be made.

Nottinghamshire Hospice
adding life to days

My Advance Decision to Refuse Treatment

My Name:	Any distinguishing features in the event of unconsciousness:
Address:	Date of Birth:
	Telephone Number:

What is this document for?

This advance decision to refuse treatment has been written by me to specify in advance which treatments I do not want in the future. These are my decision about my healthcare, in the event that I have lost mental capacity and cannot consent to or refuse treatment. This advance decision replaces any previous advance decision I have made.

Advice to the reader

I have written this document to identify my advance decision. I would expect any health care professionals reading this document in the event I have lost capacity to check that my advance decision is valid and applicable, in the circumstances that exist at the time.

Please Check

Please do not assume I have lost capacity before any actions are taken. I might need help and time to communicate.

If I have lost capacity please check the validity and applicability of this advance decision.

This advance decision becomes legally binding and must be followed if professionals are satisfied it is valid and applicable. Please help to share this information with people who are involved in my treatment and care and need to know about this.

Please also check if I have made any other statements about my preferences or decision that might be relevant to my advance decision.

This advance decision does not refuse the offer and or provision of basic care, support and comfort.

My Advance Decision to Refuse Treatment

My Name	

I wish to refuse the following specific treatments:	In these circumstances:

(Note to the person making this statement: If you wish to refuse treatment that is or may be life-sustaining, you must state in the box above that you are refusing that treatment even if your life is at risk as a result. An advance decision refusing life-sustaining treatment must be signed and witnessed)

My Signature (or nominated person)	Date of Signature
Witness	Witness Signature
Name	Telephone
Address	Date
Person to be contacted to discuss my wishes:	
Name	Relationship
Address	Telephone

I have discussed this with (e.g. name of Healthcare Professional)
Profession / Job Title Contact **Details** **Date**
I give permission for this document to be discussed with my relatives / carers Yes No (Please circle one)
My General Practitioner is: (Name) Address Telephone
Optional Review Comment Date / Time Maker's Signature Witness Signature

The following list identifies which people have a copy and have been told about this Advance Decision to Refuse Treatment (and their contact details)

Name	Relationships	Telephone Number

Further Information (Optional)

I have written the following information that is important to me. It describes my hopes, fears and expectations of life and any potential health and social care problems. It does not directly affect my advance decision to refuse treatment but the reader might find it useful.

Referral to the IMCA Service in Cases of Adult Safeguarding

Staff involved in an Adult Safeguarding investigation must refer to the IMCA Service in the following circumstances:-

For someone who may have been abused or neglected

- Where there is a serious exposure to risk
    - risk of death
    - risk of serious physical injury or illness
    - risk of serious deterioration in physical or mental health
    - risk of serious emotional distress
- Where a life changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person's best interests at heart
- Where there is a conflict of views between the decision makers regarding the best interests of the person

For someone who is alleged to be the abuser

- Where a life changing decision is involved and consulting family or friends is compromised by the reasonable belief that they would not have the person's best interests at heart
- Where there is a conflict of views between the decision makers regarding the best interests of the person.

Useful Websites and Contact Details for Services in Nottingham and Nottinghamshire

- **Independent Mental Capacity Advocate Service in Nottingham**

  www.pohwer.net/in-your-area/where-you-live/nottingham-city

- **Alzheimer Society Nottingham Branch** 0115 9343800

  nottingham@alzheimers.org.uk

- **Age UK Nottingham Branch** 0115 8440011

  http://www.ageuk.org.uk/notts/

- **Multi-Agency Safeguarding Hub (MASH)** 0300 500 80 90

- **Court of Protection**

  www.gov.uk/court-of-protection

- **Mental Capacity Act Code of Practice**

  https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

- **Mental Capacity Act: making decisions**

  https://www.gov.uk/government/collections/mental-capacity-act-making-decisions