

**NORTH SOMERSET**

**MENTAL CAPACITY ACT &**

**DEPRIVATION OF LIBERTY SAFEGAURDS**

**LOCAL PRACTICE GUIDELINES**

**(Revised October 2014)**

***(PLEASE NOTE THIS DOCUMENT IS UNDERGOING REVIEW AND REVISION 2024)***



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# **North Somerset Mental Capacity Act / Deprivation of Liberty Safeguards ( MCA / DoLS ) Local Practice Guidelines.**

Ratified by North Somerset Safeguarding Adults Partnership Board ( NSSAPB )

This local policy document cannot cover the wide range that is considered within the scope of the MCA and DoLS Codes of Practice and therefore does not attempt to replicate it. Since their publication a wealth of case law, research, & national guidance has developed in this area. In addition to this local practitioners now have 5 years of shared experience in attempting to implement this far reaching legislation. This local experience was captured both formally through completion of a MCA Audit in June 2013, and informally through feedback to the MCA / DoLS sub group and Mental Capacity Act Facilitator. The aim of this document in light of this has been to try and capture areas of best practice using these various sources and offer these as exemplars for practice. In addition to this there has been an attempt to identify areas where practitioners have struggled and to try and offer practicable & workable solutions. This document aims to ensure that local practice is not only compliant with the central tenants of the legislation but also serves to promote the underpinning values of positive risk taking and the protection of individual human rights bound up within both pieces of legislation.

The core of these practice guidelines are structured around the revised Capacity Assessment and Best Interest decision pro forma and it is these that are found at the very beginning of the document. Appended to these are their respective guidance notes. As the legislation has now been in place for several years it is assumed that as a minimum most practitioners will have a working knowledge of it alongside an awareness of their responsibilities to engage with it. Mindful of the large quantity of information that practitioners are expected to consider the MCA / DoLS sub group decided that it would be useful to link guidance explicitly with information requested on the pro forma. This enables practitioners to quickly access areas where there may be gaps in their knowledge and understanding.

The document is for guidance only and is a generic document designed for health and social settings across North Somerset. It has been designed to act as the guiding policy document on MCA / DoLS issues for the organisations listed below.

* North Somerset Community Partnership ( NSCP )
* Weston Area Health Trust ( WAHT )
* North Somerset Council ( NSC )
* North Somerset Clinical Commissioning Group ( NSCCG )
* Avon & Wiltshire Partnership ( AWP ) { North Somerset Services Only }

It is recommended that other providers or commissioners of care in the locality also use the pro forma and guidance. It should be read in conjunction with the relevant MCA and / or DoLS Code of Practice. Practitioners from across North Somerset should contact their line managers, the Mental Capacity Act Facilitator and / or legal advice for guidance on complex or contentious cases.

***North Somerset - Capacity Assessment***

Person's name:

Person’s DoB:

Name / Profession of Capacity Assessor(s):

**Please ensure that it is identified to the person that a capacity assessment in relation to the specific decision is being completed and why this is being done.**

A) What is the *specific* decision in question and why does it need to be made?

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B) Why is a capacity assessment being completed? (**1st stage of 2 stage capacity** **test: Functional -** *Is the person functionally able to make the decision being asked of them? Have they been offered all required support to assist them in making the decision for themselves?*)

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C) Does the person have a suspected (evidenced) or diagnosed *Mental Impairment?* (**2nd stage of 2 stage capacity test – Diagnostic**)

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D) Is the person’s inability (functional aspect) to make the specific decision because of the identified impairment or disturbance (diagnostic aspect)? Or to put it another way, is the mental impairment causing the person to be unable to make the decision in question? OR is there another reason they are unable to make the decision?

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E) What *relevant information* does the person need to understand in order to make this decision? (Note, the person must be told what the decision is and why they are being asked to make it)

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F) Record how you gave this *relevant information* to the person and steps you took to help them understand the issue (have you taken all practicable steps to do this? Is there something you could do to support the person to have the capacity to make this decision?)

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G) Interview - Assessment

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| --- | --- |
| G1. Does the person ***understand*** the relevant information detailed above? *Does the person understand the purpose of the assessment and what the decision is to be made? Do they understand the individual elements of the ‘relevant information’ as they are discussed with them? Have you presented the different available options if there is a choice to be made? (Ensure the bar is not set too high. Remember there are case law frameworks for some key decisions)* | Assessor’sJudgement  |
| Assessor’s observations & person’s response –  |  Yes / No  |

|  |  |
| --- | --- |
| G2. Can the person ***retain*** the relevant information detailed above? *The person only needs to be able to retain the information* *in order to make the decision at the material time – meaning when they are being asked to make the decision. If they can only make the decision in a short timeframe but cannot recall it over a longer period, that may be sufficient for them to HAVE capacity, although it this may be dependent on the specific decision in question (Please see guidance notes for fluctuating capacity if person is unlikely to retain information over a longer period.)*  | Assessor’sJudgement |
| Assessor’s observations & person’s response –  | Yes / No  |

|  |  |
| --- | --- |
| G3. Can the person ***use or weigh*** the relevant information detailed above as part of the process of making the decision? *Can the person weigh up the pros and cons of the decision (making the decision, or NOT making it), OR can they give an account of professional’s concerns and forward reasons why they disagree with them? Is there evidence of ‘reasoning’ being used to guide the person’s decision? Note – not agreeing with professional's concerns does not necessarily equate to a lack of capacity, also ensure that your own views / values are not influencing your assessment of their reasoning.* | Assessor’sJudgement |
|  | Yes / No |

|  |  |
| --- | --- |
| G4. Can the person ***Communicate*** their decision?*Usually only if the person has* ***no*** *verbal or nonverbal communication will they fail this element of the test (e.g., the person is unconscious or in a permanent vegetative state, minimally conscious state). If you have assessed that they are unable to understand, use or weigh or retain the information BUT they are able to communicate their wishes / feelings in some way, this should be recorded.*  | Assessor’sJudgement |
| Assessor’s observations & person’s response –  | Yes / No  |

H) Capacity Assessment Decision

Only one element must be ticked from the 3 choices below

{ } – 2 stage test of capacity: There is no evidence that they are functionally unable to make this specific decision due to a diagnosis or evidenced suspicion of a Mental Impairment. Therefore, the person **HAS** capacity to make the decision.

{ } - The 4 elements above are *all marked YES*therefore the person **HAS** capacity to make the decision.

{ } - *One or more* of the 4 elements above are marked NO therefore the person **LACKS** capacity to make the decision.

I) Follow on work

Any elements that apply should be ticked from below. If the person has been assessed to lack capacity for the specific decision in question, then the best interest process **MUST** now be followed.

{ } – As the person lacks capacity, a Best Interests meeting/discussion will take place ASAP

{ } – As the person lacks capacity, I am going to refer to an appropriate professional to organise a Best Interests meeting / discussion ASAP

{ } – The person has capacity and is subject to restrictions upon their choices that require urgent review.

{  } – I will seek a 2nd opinion on this individual’s capacity.

{ } - The person’s cognitive state is stable or deteriorating and, in my view, they are unlikely to regain capacity in relation to this matter in the near future.

{ } - The person’s cognitive state is improving, and I believe capacity should be re-assessed shortly.

{ } - I believe the person could regain capacity to make the decision with support and advice from others.

{ } - The person’s cognitive state is fluctuating on an hourly / daily / weekly \* basis. In my view there is a reasonable possibility they will have capacity in relation to the decision shortly. *\* Delete as applicable*

Please provide further detail on the boxes ticked above including pending actions. Please also use this space to record any other thoughts or recommendations you have regarding the issue.

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H) Signature(s) & date

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***Capacity Assessment Pro Forma Notes***

**A ) Why is a capacity assessment being completed ?**

For majority of decision’s that are made by patients / service users in your care there will be no need to assess capacity. Professionals and carers may progress under the ‘presumption of capacity’ which is a central tenet of the act. Further guidance is available in the MCA Code of Practice around what constitutes a ‘reasonable belief’ that the person lacks capacity where a formal assessment will not be required. This advice however is aimed mainly at family and carers. The MCA Code of Practice gives the following advice regarding possible ‘triggers’ for assessing capacity.

* The person’s behaviour or circumstances cause doubt as to whether they have capacity to make a decision.
* Somebody else says they are concerned about the person’s capacity, or
* The person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works, and it has already been shown they lack capacity to make other decisions in their life.

Local practitioners have struggled at times with this advice reporting that it remains unclear as to when practitioners can no longer use the ‘presumption of capacity’. The advice below may assist practitioners in making this decision. This local guidance recommends that a capacity assessment **must** be initiated whenever staff believe the patient / service user lacks capacity and in the following circumstances;

* The decision made by the patient / service user will have a significant impact upon their life now or in the future.
* The decision being made by the patient / service user will place them under physical or psychological risk.

In other situations it will be down to individual professional judgement as to the need for a capacity assessment. Considering the criteria above it is clear that capacity should also be assessed when the patient / service user is compliant with the proposed action and it is going to have a significant impact upon their life. For instance, an individual with a diagnosis of dementia stating ‘Yes’ when asked if they are happy to move into a nursing home. Staff suspect that they lack capacity and it is a decision that will have significant impact upon their life. The above criteria for carrying out a capacity assessment are met and practitioners should not rely upon the ‘presumption of capacity’ in these situations. An important point to remember here is that a person’s ability to clearly express themselves verbally, in this instance stating ‘yes’ does not provide evidence on its own that they have capacity. It is evidence of their ability to communicate their wishes ( meeting only the 4th element of the functional capacity test, see guidance in section F below )

If the threshold for an essential capacity assessment ( as described above ) has not been met professionals may be able to carry on under the ‘presumption of capacity’. It is not always necessary or practical to get verbal or written confirmation for every care intervention. In many cases practitioners will use the concept of ‘implied consent’ to proceed but this has also caused some confusion locally. Implied consent refers to an individual agreeing to a treatment through their behaviour. An example of implied consent might be an individual rolling up their shirt sleeve in response to a request from the doctor to take bloods. Another example might be an individual helping to shift their weight whilst nurses carry out a bed bath. Importantly it involves some positive behavioural action from the individual to take part in the care. Considering this it may be seen that an individual passively receiving care could not be termed ‘implied consent’ and the situation may require a capacity assessment. ( According to the judgement of the practitioner using criteria above )

**B) What is the *specific* decision to be made ?**

The Mental Capacity Act states that capacity must be assessed in relation to individual decisions. This means that capacity must not be expressed in relation to the person generally ( P has / lacks capacity ) but in relation to a specific decision they are making ( P has / lacks capacity in relation to decision X ) at a specific time. It is important here to note that a person can have capacity in relation to one of these decisions but not the other. For instance, the person may have capacity in relation to decision X, but lack capacity in relation to decision Y.

Careful consideration should therefore be given to what the actual decision in question is. Practitioners are often faced with complex situations and it can be difficult to pick out the actual decision from the wider context of concerns / issues.

Problems can arise when confusing a professional decision regarding the clinical appropriateness of treatment and the personal decision of a service user / patient. Put another way is this a professional decision about what treatments are clinically indicated OR is this a personal decision about whether to accept treatment. Baroness Hale *in Aintree University Hospitals NHS Foundation Trust v James { 2013 } UKSC 67* succinctly summarises existing law on the matter when she states “ ...no patient can demand particular medical treatment which clinicians do not consider appropriate to offer” This particular case involved end of life care decisions and it in these areas where identifying the decision can prove particularly difficult. An example of capacity assessment decisions applied to the area of DNCPR orders ( Do Not Attempt Cardio-Pulmonary Resuscitation ) could be as follows. a) under futility of treatment criteria – ‘ Does P have the capacity to be informed of the decision not to resuscitated’ or b) under benefits and burdens criteria – ‘Does P have capacity to be involved in discussion around the benefits and burdens of resuscitation’. It would not be ‘Does P have capacity to decide if he is resuscitated or not’.

Care must also be taken to phrase the decision as neutrally as possible. This is not just an exercise in semantics but helps practitioners from inadvertently conflating capacity assessment & best interests at the very start of the process. In the case of an individual refusing to take their anticonvulsant medication the decision in question could be ‘Does P have capacity to consent to their medication’ rather than ‘Does P understand the risks of not taking their medication’. The first formulation allows space for positives and negatives to the discussed, the second allows less room for this. This is important as the professional may not perceive there to be any advantages to refusing medication. In reality the patient / service user may be attempting to weigh up the risks and benefits ( epilepsy control vs increased drowsiness and sedation ). The first formulation allows more chance of this being considered.

**C) Does the service user / patient have a suspected or diagnosed *Mental Impairment*  ?**

Mental Impairment in the act is defined as “ a disturbance in the functioning of the mind or brain ”. The MCA Code of Practice gives the following examples; “conditions associated with some forms of mental illness, dementia, significant learning disabilities, the long term effects of brain damage, physical or medical conditions that cause confusion, drowsiness or loss of consciousness, delirium, concussion following head injury, the symptoms of alcohol or drug use“ ( NB. This list is not exclusive ) This is the 1st stage of the capacity assessment ( or the diagnostic test ) as defined in the Act. The Capacity Assessor may proceed without a formal diagnosis if the *symptoms* of a Mental Impairment are present. They should then follow up with a relevant health professional at a latter date / time regarding a more formal diagnosis.

**D) What *relevant information* does the service user / patient need to understand in order to make this decision ?**

Identifying the relevant information that the person needs to understand is an essential part of the capacity assessment. The MCA Code of Practice states that ‘relevant information’ needs to include the following;

* The nature of the decision
* The reason why the decision is needed
* The likely effects of deciding one way or another, or making no decision at all

This guidance however only deals in generalities, what might ‘relevant information’ look like around a specific issue ? An example of this may be found in the *D Borough Council v AB [ 2011 ] 2FLR72* and is further developed in *A Local Authority v H { 2012 } EWHC 49 (COP).* These cases dealt with the issue of capacity to consent to sexual relations. They determined what the court considered ‘relevant information’ which sets wider precedents for how practitioners should structure their own assessments.

Relevant Information that Courts decided the individual *would* need to understand

1. The mechanics of the act.
2. The person must understand that they have a choice and they can refuse.
3. That there are health risks involved, particularly the acquisition of sexually transmitted and sexually transmissible infections.
4. That sex between a man and a woman may result in the woman becoming pregnant.

It may be observed that the level of understanding required by the individual may be reduced further still depending on the circumstances of each situation. In respect of point 3 the presiding judge in *A Local Authority v H { 2012 } EWHC 49 ( COP )* remarks “ It seems to me that the knowledge required is fairly rudimentary, in my view it should suffice if a person understands that sexual relations may lead to significant ill health and that those risks can be reduced by precautions like a condom. I do not think more can be required” It may be observed that requiring the individual to have a basic awareness of the main sexually transmitted diseases and their symptoms would therefore be seen as unnecessary. In respect of point 4 if the sexual activity in question is homosexual, non penetrative, or between elderly individuals then it could be argued that the last point does not need not to be considered by the individual.

Information that the Court deemed *not relevant*

1. That sex is part of having relationships with people and may have emotional consequences
2. That only adults over the age of 16 should do it ( and therefore participants need to be able to accurately distinguish between adults and children )
3. That both (or all) parties need to consent to it.

It should be noted that this is the situation as of January 2014. The courts are continuing to grapple with this contentious area and further judgements may refine this advice / guidance in the future. As may be seen from the above the test for capacity to consent to sexual relations is set at a relatively low level. One of the reasons for this is articulated by Justice Baker in *A Local Authority v TZ { 2013 } EWHC 2322 (COP)* who states “... choices in sexual relations are generally made rather more by emotional drive and instinct than by rational choice. Impulsivity is a component in most sexual behaviour. Human society would be very different if such choices were made the morning after rather than the night before.”

As may be seen from the above the threshold for capacity to consent to sexual activity is set low. Case law related to other areas of decision making ( where there is perceived to be less of a immediate emotional drive ) also warns practitioners about setting the bar too high. Justice Munby in *Sheffield City Council v E { 2004 } EWHC 2808 ( Fam )* states “We must be careful not to set the test of capacity to high, lest it operate as an unfair, unnecessary and indeed discriminatory bar against the mentally disabled”. This thought is further developed by Justice Macur in *LBL v RYJ { 2010 } EWHC 2665 (COP)* who states“It is unnecessary that (s)he should be able to give weight to every consideration that would be utilised in formulating a decision…the person under review must weigh the salient details relevant to the decision to be made.”

The ‘relevant information’ around consent to sexual activity is offered as an example only. It will be different for each person and each decision. It is the responsibility of the person(s) assessing capacity to determine what they believe the ‘relevant information’ is. **Folstein scores, Mini mental assessments and other generic tools that measure cognitive functioning are not valid capacity assessments as defined by the Act**. A valid capacity assessment measures that individual’s comprehension of the specific risks regarding the decision in hand and is not an objective measurement of cognitive function.

Another important point of note when deciding upon the ‘relevant information’ is the link to the 2rd statutory principle of the Mental Capacity Act; section 1(3) “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” . A capacity assessment may consist of several stages and occur over a period of time. This approach can run counter to working practices which see the capacity assessment as a short time limited intervention possibly followed up by an in depth Best Interests process. In non urgent cases however ( see CC and KK and STCC below ) the courts have stated that it is essential that the former approach is taken.

Justice Baker in *CC and KK and STCC { 2012 } EWHC 2136 (COP )* { 2012 } MHLO 89 gave a judgment on an individual’s contested capacity around their wish to return home from a care facility. Justice Baker stated that in order for the person to be able to make a decision they must first know what options are available to them. Although this may seem like a self evident statement it must be remembered that many of the vulnerable individuals who are subject to the MCA process are often reliant upon those same professionals to give them information about potential care arrangements. This due to their cognitive and / or physical deficits or family members being supportive of a continued stay in residential care. The presiding judge ruled that capacity had not been properly assessed as the person concerned had not been given sufficient information about a supported package of care at home. Put simply how can a person make the decision when they don’t know what the actual options are?

This case law highlights the dangers in completing rudimentary capacity assessments on non urgent cases. It also places an onus on the practitioner in these cases to; a) carry out preparatory work prior to their assessments and b) help the person understand the decision to be made ( Statutory principle 2, MCA ). Other practical implications of this judgment lie in the review of the capacity assessment. In the case above it may have been perfectly valid to carry out the initial capacity assessment based on the knowledge of options available at the time. After further information becomes available however and possible resource conflicts resolved the capacity assessment should be re-visited. Although capacity assessment can be a one off event this case law highlights that at other times practitioners need an understanding that it may be a more dynamic, fluid process.

**E ) Record how you gave this *relevant information* to the service user / patient and steps you took to help them understand the issue.**

The Capacity Assessment should not be conducted as a test or a verbal exam. The assessor must give the relevant information to the patient / service user whilst assessing their comprehension of that information. It would be inappropriate for the capacity assessor to expect the patient / service user to second guess the assessor regarding what risks they feel are present and what care and support is available. As referred to in section D above it will often be necessary for the capacity assessor to carry out some preparatory work before hand. This may involve consideration of records and talking to the relevant family members / professionals in advance. This to establish a) what resources are available and b) what are the risks & benefits that the patient / service user needs to consider.

The Mental Capacity Act compels practitioners to take all practicable steps to develop the patient / service user’s capacity to allow them to make the decision for themselves. This includes thinking about how you present the relevant information to them and how they can communicate their decision to you. Example of this may include;

* Choosing a time of day when the patient / service user is at their most responsive / alert.
* Ensuring that the Capacity Assessment is sensitive to cultural factors.
* Ensuring that information is presented to the patient / service user in an appropriate manner.
* Ensuring that the patient / service user is given opportunity to communicate in an appropriate manner.

The later 2 points compel practitioners to assist the individual with their communication. This could involve a number of different strategies including;

* Capacity Assessor and / or patient / service user writing on paper
* Capacity Assessor and / or patient / service user typing on computer
* Utilising specialist resources ( e.g. light writers, eye pointing software, picture cards )
* Refer onto specialist input for assistance ( e.g. learning disability team, speech and language therapy )

The MCA compels practitioners to take *practicable* steps to develop capacity and then help the patient / service user make the decision. The Capacity Assessor needs to make a judgement as to what practicable means and balance this against the risk the person will be exposed to in the interim. If the risk posed to the person is particularly high the process should move forward without the intensive work and returned to a latter date.

**F) Interview – Assessment**

**F1 ) Does the person *understand* the relevant information detailed above ?**

The patient / service user must understand the information relevant to the decision. Initially it is about understanding why the decision needs to be made. The Capacity Assessor has a difficult job in balancing the need to put the person at ease whilst simultaneously ensuring the patient / service user is aware of the potential outcome of the assessment, that others may make the decision on their behalf. If this is not made clear then there is a possibility that the patient / service user will not properly engage with the assessor leading to an incorrect judgement that they lack capacity.

Following on from this the Capacity Assessor will need to look for evidence that P understands the individual elements of the relevant information as they are discussed. This is a test of the patients / services user’s ability to make links between their behaviour or decision and the possible consequences of their actions.

*Relevant Information* in a case where P is refusing to take diabetic medicationmight be judged by the Capacity Assessor as;

* Recognition of the main physical symptoms of abnormal blood sugars.
* That abnormal blood sugars can have negative implications on their health.
* How this may lead to ill health in the longer term. ( problems with eyesight, vulnerability with feet, increased risk of heart attack / stroke )
* How this may affect their health immediately.( loss of consciousness, death )
* That the medication helps to maintain her blood sugar at the correct level.

If P can understand these individual elements as they are discussed then they pass this element of the assessment. Possible questions to test this component of the capacity test might include;

* Why have I come to talk to you today ?
* What might happen if you decide that you don’t talk to me today ?
* Can you tell me how you may come to immediate harm if not taking your medication?
* Tell me some of the longer term health problems you might experience if you choose not to take your medication ?
* What symptoms might you experience that would tell you that you are becoming unwell ?
* Tell me in your own words what the diabetic medication does for you.

Remember that these questions should be asked *throughout the assessment* and used to structure the discussion. If the individual can understand the individual elements of the decision as they are discussed then they would pass this part of the assessment. The question as to if they can hold this information in their mind long enough is dealt with in F2. The question as to if they can pull their understanding of all the elements together and look at the ‘big picture’ is dealt with in F3 .

**F2. Can the person *retain* the relevant information detailed above ?**

A useful strategy for assessing this element is to ask the patient / service user to summarise your discussion at the ***end of the assessment***. At this point you would not be giving the information to the service user. You may have to help the patient / service user structure their response by repeating some of the questions above but at these would be prompts only.

The patient / service user only needs to retain the information long enough to make the decision in question. Typically this will be for the length of time that it takes you to complete the capacity assessment. This is summarised in the MCA Code of Practice which states “ The person must be able to hold the information in their mind long enough to use it to make an effective decision. But section 3(3) states that people who can only retain information for a short while must not automatically be assumed to lack the capacity to decide – it depends upon the decision in question. Items such as notebooks, photographs, posters, videos, and voice recorders can help people record and retain information.”

A common problem reported by local practitioners is around this issue of fluctuating capacity. Although the individual may have capacity at the time of the assessment they can forget the relevant information at a later time / date. An example of this is the individual with dementia who is trying to leave the home. They may understand the risks when the assessor is talking to them but not in the middle of night when they are attempting to leave.

The following strategies may be useful in fluctuating capacity assessment cases.

* Include in the relevant information ‘The patient / service user understands the risks brought about by their fluctuating cognition / memory deficits’. If the person does not understand that they are suffering with a fluctuating capacity then it is possible that they will be unable to make rational decisions regarding their safety.
* In addition to the advice around resources referred to in the MCA Code of Practice quote above ( notebooks, photographs etc ) professionals can also use assistive technology ( e.g. recorded reminders that are triggered when an individual opens the door to their home )
* Ask the individual if they will consent to restrictions until such time as their capacity returns. This should then be recorded in the care plan and notes alongside the capacity assessment. This last strategy should be used with caution as the person retains the right to withdraw their consent to the restrictions when they regain capacity.

In these cases it may be advisable to seek the advice of other colleagues or the Mental Capacity Act Facilitator. These strategies should be used in the place of returning to the patient / service user at a latter time to ‘test’ their knowledge.

**F3. Can the person *use or weigh* the relevant information detailed above ?**

OR – Can the assessor see evidence of *reasoning* in the individual when coming to their decision.

Finding evidence for this element can often prove challenging for the practitioner. The main approach here is to ask the patient / service user about the pros and cons of making or not making the decision. When the capacity assessment has been initiated because professionals believe the decision is unwise, assessors are likely to find themselves in the position of being able to freely identify disadvantages and may feel uncomfortable about forwarding advantages due to fears of ‘prompting’ dangerous behaviour. Whilst it is important to be as neutral as possible in a capacity assessment this does not have to undermine the objectivity of the assessment. The capacity assessor may put forward their concerns and invite the patient / service user to challenge them ( see example questions below ). Evidence that the individual is able to use and weigh therefore is found in the fact the individual is *using a degree of reasoning to make their decision*. The important point here is that reasoning in itself is sufficient, the assessor does not have to agree with their reasoning and must “recognise that different individuals may give weight to different factors “ Justice Macur in *LBL v RYJ { 2010 } EWHC 2665 (COP)*. Examples of this might include; a) a patient valuing the emotional security brought about by being in their own home over the physical safety gained through being care. b) a service user valuing the pleasure derived from a full diet over the safety derived from adhering to a diabetic diet.

Capacity assessment may prove particularly difficult if the service user / patient does not see any disadvantages or risks with the decision they are making or is in denial about any cognitive or physical deficits they have. The temptation in these cases may be to find that the person lacks capacity as the service user / patient’s views are ‘not based in reality’. A useful strategy here is to ask the patient / service user what the concerns of other family members and professionals are and why they are discounting them. This may be used in place of asking the patient service user to list the advantages and disadvantages. It can be used to provide evidence that the patient / service user can hold two differing points of view in their mind to choose between. This approach also may also help the capacity assessor differentiate between the professional view of risk and the patients / service users view of risk.

Example questions in the case where P is refusing to take diabetic medication for the ‘use and weigh’ element might include;

* Tell me why you don’t want to take the medication.
* How would you manage your diabetes and make yourself safe ?
* I understand that you disagree with the nurse / doctor about the issue. However I would like you to tell me why professionals are worried about you not taking your medication.
* Why do you think the medication has been prescribed ?
* Can you tell me why you disagree with the professional’s point of view ?
* What do you risk through not taking the medication ?
* How do you benefit through not taking the medication ?

Individuals who fail this element will be unable to demonstrate these reasoning skills. This often occurs as a result of the global impact upon cognitive function such as that brought about by dementia or a learning disability. Other cognitive impairments such as brain injury or stroke can sometimes prove more challenging for the assessor when there is a minimal impact upon global cognitive functioning but emotional control and/or flexibility of thought are affected. In these cases further advice should be sought from colleagues or the MCA Facilitator.

**F4. Can the person *Communicate* their decision ?**

The code of practice states that failure on this element is likely to apply only to a very limited amount of people. ( e.g. Individuals who are unconscious, comatose, suffering from ‘locked in syndrome, in a permanent vegetative state, or a minimally conscious state ) Communication is a broad spectrum ranging from verbal and written forms to facial expression and behaviour. Only if the patient / service user has ***no*** discernible communication at all will they fail this element.

Concern was raised by the local Community Learning Disability Team regarding assessing individuals with severe cognitive & communicative deficits. When assessing these individuals it may seem difficult or cause agitation to give them the relatively complex information required by the capacity assessment. In these cases it may be appropriate to attempt to establish a reliable yes / no response with basic questions around the capacity issue. If using pictures the assessor may wish to start off by gauging if the person is able to connect the picture to their meaning. For instance, can you point / eye point to the picture indicating Yes or No. If they are unable to demonstrate this a corollary is that they will not be able to consider more complex matters demanded by the assessment. The failure on this element would be on points F1, F2, F3, rather than F4 if they have some form of gestural or behavioural communication.

**G – Capacity Assessment Decision**

Occasionally there will be no need to test the persons understanding of the risks as there will be no evidence, symptoms, suspicion, or diagnosis of a Mental Impairment ( Stage 1 of the Capacity Assessment ) Practitioners should clearly detail their reasons for not carrying on to the second stage of the test in Part H below. Once the functional or 2nd stage of the test is completed the individual will LACK capacity if they have failed on **one or more** of the fourelements.

It is vital that a decision is reached at the end of this process. Responses such as the individual has ‘partial capacity’ are not acceptable. If the patient / service user has fluctuating capacity or the case is ‘borderline’ then a decision is should be made regarding their capacity **at that moment.** These cases often may provide an impetus for further work to develop the patient / service users understanding or closely monitor the situation. Decisions regarding capacity need to be made ‘on the balance of probabilities’. The practitioner needs to argue that it ‘is more likely than not’ that the person has / lacks capacity.

**H – Follow on work**

The completion of a capacity assessment helps to determine a number of points and directs care in the appropriate direction. It will establish what duty of care professionals have to that patient / service user. ( i.e. Is support limited to advice and guidance or are practitioners / carers able to place restrictions upon them. ) A number of common follow up actions are provided on the capacity assessment pro forma. These are placed here to act as a reminders and prompts to practitioners. If the practitioner has another action not identified in the pro forma this should be recorded in the box provided.

It should be noted that the Mental Capacity Act states that a capacity assessment only relates to making a *specific decision at a specific time*. Practitioners have reported practical issues with attempting to put this into practice particularly in light of ongoing and repeat decisions such as the daily administration of medication. This is why sections have been included asking for practitioners to comment on review periods and the frequency of the individual’s cognitive fluctuation. This enables practitioners to rely upon previous assessments without having to conduct a new written assessment on each occasion. The capacity assessment at the time would consist of judging if the persons cognitive state is any different than that detailed in the written assessment and relying upon this if there has been no change. When writing in the patient record the practitioner could record ‘Prescribed medication administered to patient in Best Interests as continues to lack capacity’. If of course the practitioner suspects that the person may have regained capacity they should carry out a new written assessment.

***North Somerset - Best Interests pro forma***

Name of person

DoB of person

Date of meeting / discussion

A) What is the Best Interests decision to be made?

|  |
| --- |
|  |

B) Has a capacity assessment been completed in relation to this decision?

If answer is ‘No’ then stop best interests process & initiate capacity assessment.

|  |
| --- |
|  |

C) Does the authority for making this decision lie under other provisions of the Mental Capacity Act (Lasting / Enduring Power of Attorney, Deputyship or Declarations made by the Court of Protection, Advance Decision to Refuse Treatment). If the answer is ‘Yes’, detail Authority below move to Part P, detail any follow up work in part R.

|  |
| --- |
| (What evidence have you seen? OPG100 check completed?) |

D) If there is no other Authority identified in C) above who is the ‘Decision Maker’ in regard to this issue?

|  |
| --- |
|  |

E) Is the decision one that can only be considered by directly the Court of Protection OR is the decision one that is excluded from the remit of the Mental Capacity Act?

If yes, then move to part P, record follow up work in part R.

|  |
| --- |
|  |

F) Is the Best Interests discussion taking place as a formal meeting / individual discussions / telephone conversation / written communication?More than one may apply.

|  |
| --- |
|  |

G) What are the person’s views on this matter, now and in the past? What decision would they have made if they had capacity? How have you ascertained this?

|  |
| --- |
|  |

H) Detail who has been consulted as part of this Best Interests discussion / meeting.

|  |
| --- |
|  |

I) If unable to ascertain an interested parties’ views on this matter detail the reason for this here.

|  |
| --- |
|  |

J) Are the conditions for appointing an IMCA met? If so, please detail the IMCA consulted.

If there are no interested parties to consult and the decision involves a serious medical treatment or a change of residence, then the decision maker MUST appoint an IMCA. (IMCAs may also be appointed if there are safeguarding concerns or doubts around family / friends acting in the individual’s best interests)

|  |
| --- |
|  |

K) Consider the different options for the person considering the available resources.

|  |
| --- |
| Does the decision need to be made now in full?  |

L) Consider the pros and cons of each option. Risks and benefits must include psychological & emotional elements alongside physical factors.

|  |
| --- |
|  |

M) Considering boxes J, K, & L above what do the group feel is the ***least restrictive option*** considering, ***best interests***, ***what the person would have wanted*** & ***available resources.***

|  |
| --- |
|  |

N) Follow on work - All parties **do** agree (tick all that apply)

{ } – Additional individuals need to be consulted and a repeat Best Interests decision made.

{ } – The individual’s cognition is fluctuating or improving and their capacity requires re-assessing shortly.

O) Follow on work – One or more parties ***do not*** agree (tick all that apply)

{ } – I will organise a formal ‘round table’ Best Interests Meeting.

{ } – I will make a referral for Advocacy Services.

{ } – I will refer the matter to my line manager.

{ } – I will investigate a referral to the Court of Protection.

{ } – There is a dispute as to the individual’s capacity and I will organise a re-assessment.

{ } – The individual’s cognition is fluctuating or improving and their capacity requires re-assessing shortly.

P) Other Decision Making Authority

{ } – The authority to make the decision lies under the following provisions of the Mental Capacity Act (Lasting /Enduring Power of Attorney, Deputyship / Declarations under the Court of Protection, Advance Decision to Refuse Treatment )

{ } - The decision is so serious it may only be considered by the Court of Protection.

{ } – The decision is one that is excluded from the remit of the MCA.

{ } – The decision made is likely to constitute a deprivation of liberty and a referral to the appropriate supervisory body must now be made.

Q) Review (best interest decisions should be periodically reviewed, frequency dependent on the individual circumstances)

The Best Interests decision should be reviewed by the following date:

The individual’s capacity should be reassessed by the following date:

R) Please provide detail here regarding any follow up work.

|  |
| --- |
|  |

S) Signature(s) & date

|  |
| --- |
|  |

***Best Interests Pro Forma Notes***

**A ) What is the Best Interests decision to be made ?**

The guidance forwarded in section B of the capacity assessment guidance ‘What is the specific decision to be made’ is relevant here. If thought has been given to properly consider the actual capacity assessment issue in question this may be simply transferred over to this section and recorded here.

**B) Has a capacity assessment been completed in relation to this decision ?**

The Best Interests process is only initiated once it has been established that the person LACKS capacity in relation to the specific decision identified above. If a capacity assessment has not occurred or the capacity assessment is unrelated to the decision being made then the Best Interests process should stop and arrangements made for the individual’s capacity to be assessed.

If a meeting or discussion has already been initiated / convened to discuss the issue then staff and family gathered may choose to progress. This may be of use to interested parties at that point in time to discuss the issue and may be termed a case conference or family meeting. The meeting or discussion however *would not* *be part of a Best Interests process*and this paperwork should not be used to record that discussion. It is important to note that any decision made on behalf of the person outside of the Best Interests process is unlikely to offer participants protection from liability ( unless covered by other legal frameworks such as the criminal justice system, or mental health act )

**C) Does the authority for making this decision lie under other provisions of the Mental Capacity Act ( Lasting / Enduring Power of Attorney, Declarations or Deputyship under the Court of Protection, Advance Decision to Refuse Treatment )**

Best Interests is only one form of substituted decision making. Others listed above also allow decisions to be made on behalf of incapacitated adults. Detailed information on these is provided in the MCA code of practice. A brief summary of the items listed above alongside issues that have arisen in local practice is offered below;

* Lasting Power of Attorney ( LPA )

*These documents can only be set up when the person HAS capacity to consent to the arrangements & cannot be set up once the person has lost capacity .*

This is a process whereby an individual ( the donor ) decides to grant their personal decision making authority to another individual ( the attorney ). This is usually a family member or friend but can also be a professional, such as a solicitor. They are devised to allow individuals to plan for a time when they may lose capacity. There are two types of LPA,

Health & Welfare – This gives the attorney power to make decisions around general welfare issues and consent to healthcare treatment. The attorney can only make decisions on behalf of the person only once they have lost capacity. This only gives the attorney scope over decisions that are *within the realms of the donor’s choice.* For instance an attorney could decide which nursing home the donor will reside in. Conversely they could not insist upon a treatment that a health care practitioner feels is clinically inappropriate.

Property and Affairs - This gives the attorney legal authority to manage the donors financial income and assets when they have lost capacity. If the donor wishes the attorney can also make financial decisions for the donor when they still have capacity. This is often chosen by donors who do not want the inconvenience of managing their financial affairs or who are struggling due to physical frailty.

Restrictions and caveats can be set on the attorney’s authority by the donor. For instance the donor can specify when appointing more than one attorney that some decisions need to be made with the agreement of both attorneys, where other decisions could be made independently from each other.

Donors can set up one type of LPA or both simultaneously. Practitioners should ensure that any decisions being made on behalf of the donor come within the scope of the attorney’s authority. For example an attorney who holds a property and affairs LPA would not be the ‘decision maker’ on where the donor resides ( although they may be consulted as part of a best interest process ). It may be useful for practitioners to confirm the LPA authority that the attorney is acting under, particularly where there is a dispute. This may be achieved by; a) asking the donor to provide copies of the LPA certification b) contacting the MCA Facilitator or c) searching the Office of the Public Guardian’s register, see <http://www.justice.gov.uk/downloads/forms/opg/opg-100.pdf>

The attorney is bound by the same Best Interests principles as practitioners would be. Becoming an attorney places the individual in the role of the ‘decision maker’ discussed in detail in point D) below. It is important that practitioners respect this legal authority where the donor has granted it to another. If however practitioners have doubts as to the abilities of the attorney or if they are acting in the donor’s best interests then concerns can be raised; a) directly to the attorney themselves if the concerns do not meet the Safeguarding Adults criteria b) though the Safeguarding Adults process if they do and c) through the Office of the Public Guardian. The route taken here will be dependent upon circumstances of the case. Members of North Somerset Adults Safeguarding team can be contacted for further advice if needed

* Enduring Power of Attorney ( EPA )

This is the provision for planned decision making that was in place before the introduction of the Mental Capacity Act in 2005. Although no new EPA’s may now be set up, existing ones that have been registered remain valid. They relate to an individual’s property and affairs only and give no formal decision making authority over health and welfare.

* Court of Protection Deputies and Declarations

Declarations - The Court of Protection may make individual ‘one off’ declarations on financial and welfare matters affecting people who lack, or are alleged to lack capacity ( MCA Code of Practice, 2005 ). This could include declarations as to the person’s capacity status and / or what is in their Best Interests regarding a financial or welfare issue.

Deputyship – The Court of Protection can appoint a deputiy if there is a need to make ongoing decisions for an individual who lacks capacity. The Court can appoint lay deputies ( i.e. family members ) or professionals to act on behalf of individuals. Their powers to act are organised in a similar fashion to the LPA arrangements described above. That is to say that a deputy may have a ‘property and affairs’ and /or a ‘personal welfare’ order. Within each order the Court will set particular caveats and limitations on decision making which are appropriate to that persons circumstances. If it is within the sphere of their authority the deputy would become the ‘decision maker’ on the issue at hand. If practitioners have doubts about the authority of a deputy to act they should use the strategies identified for confirming LPA authority detailed above. LPA’s and deputyships are both recorded on the LPA register.

For advice on when to apply to the Court please see guidance in section E of the Capacity Assessment guidance notes. Practical support in making a Court application may be found in a) MCA code of practice, b) via MCA Facilitator. c) <http://www.justice.gov.uk/protecting-the-vulnerable/cfo/court-of-protection>. A common referral to the Court occurs when a person’s assets and savings need to be managed. If the person has already lost capacity an application for deputyship through the Court of Protection would be appropriate. If the person still has capacity then it may be possible to set up an LPA. For smaller amounts of money and income such as management of benefit payments the MCA Code of Practice suggests that appointee arrangements set up by the Department of Work & Pensions may be an appropriate route forward.

**Advance Decisions to Refuse Treatment ( ADRT )**

An ADRT is when an individual decides against receiving a particular health care intervention in advance before they have lost capacity to make that decision. ( e.g. refusal to consent to the use of chemotherapy for treatment of cancer ) It an expression that the individual wishes to refuse consent to specified future treatment. It cannot be used to request or demand future treatment. These decisions may be given verbally or in writing. If they are in relation to the refusal of life sustaining treatment however they must be in writing and signed by the individual and a witness.

Professionals must also satisfy themselves that the ADRT is valid and applicable. This involves consideration of factors such as; a) is the proposed treatment or circumstances the same as that detailed on the ADRT, b) is there a conflict with decision making under another authority such as Lasting Power of Attorney, c) has there been a significant change in the persons circumstances or behaviour that would indicate their decision may now be different. Professionals should seek the support of senior colleagues or legal departments in complex cases or where the ADRT involves refusal to consent to life sustaining treatment.

There will then be two outcomes from this consideration;

a) Professional / Service decides that ADRT IS valid and applicable - The decision carries the same authority as if the individual was making a capacitious decision for themselves. Professionals must treat this as the individual refusing to give consent to for the procedure.

b) Professional / Service decides that ADRT IS NOT valid and applicable – This is not a decision that professionals are obliged to follow but can be used to determine the individuals wishes as part of a broader Best Interests decision.

Healthcare professionals responsibilities in relation to searching for ADRT’s are summarised in the following MCA Code Of Practice advice “9.56 – Healthcare professionals should not delay emergency treatment to look for an advance decision if there is no clear indication that one exists. But if it is clear that a person has made an advance decision that is likely to be relevant, healthcare professionals should assess its validity and applicability as soon as possible. Sometimes the urgency of treatment decisions will make this difficult.”

**D ) If there is no other Authority identified in C ) above who is the ‘Decision Maker’ in regard to this issue ?**

The ‘decision maker’ is a specific role identified in the Best Interests process and is a specific role identified within the Mental Capacity Act. This role involves *making the decision on behalf of the person.* This can cause some anxiety in professionals particularly when there is a high level of risk attached to the decision or a high level of restrictions are being proposed. Although engagement in the Best Interests process offers professionals the opportunity to share difficult and contentious decisions, making a decision within the context of an ongoing dispute or disagreement can prove difficult.

Williams et al ( 2012 ) suggests that practitioners have favoured a ‘consensus’ approach to decision making in best interest processes. The research goes onto state that although this has its benefits in respect of collaborative working it can also have adverse consequences in respect of creating unnecessary delay and increasing risk to the patient / service user. “Although decision makers all preferred the idea of a consensus decision, nevertheless there were situations where they in the end needed to be bold enough to take on that responsibility. The Code of Practice as it stands does not perhaps sufficiently deal with these issues about joint decision making, and the necessity for responsibility in certain cases. Further discussion or clarification could be helpful”. In light of this local guidance states that an *individual* decision maker should be appointed and *clearly identified at the start of the Best Interests process*.

The MCA code of practice identifies a number of individuals who should take on this role. In some cases this is clear and unambiguous. For instance; a family member has a Lasting Power of Attorney and the decision is under their jurisdiction OR a health care professional wants to carry out a specific health intervention with the individual. In other cases however it may be more difficult to identify the relevant individual particularly when the decision being made by the person in does not relate clearly to the provision of care and treatment, for instance an individual’s capacity to manage their finances who lives independently in the community.

The MCA code of practice does not state that the person conducting the capacity assessment must follow on and take up the role of the ‘decision maker’. In practice however these two roles are closely linked and this can often be a useful way of identifying who should take on the decision maker role. The issue as to who should take responsibility for initiating and leading these processes can prove contentious. Further local guidance produced by North Somerset Safeguarding Adults Partnership Board offers support on the issue ( Local guidance for identifying the relevant professional(s) to undertake Capacity Assessments) This can be obtained through contacting the MCA Facilitator (dols.service@n-somerset.gov.uk )

Elements of the ‘decision maker’ role can be shared and separated out. Some local professionals have taken on responsibility for organising the Best Interests process on behalf of the decision maker. This has proved useful when professionals that are less confident in using the provisions of the MCA are identified as decision makers. Sharing elements of the role also allows scope in ‘round table’ Best Interests meetings for them to be chaired by an individual who is not the ‘decision maker’.

**E) Is the decision; A) so serious that it can only be considered by directly the Court of Protection OR B) One that is excluded from the remit of the Mental Capacity Act ?**

A) Direct applications to the Court of Protection

Health Care Decisions

The MCA code of practice details the following occasions when an application *must* be made directly to the Court of Protection.

* Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS).
* Cases involving organ or bone marrow donation by a person who lacks capacity to consent.
* Cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this. (e.g. for contraceptive purposes)

Since the MCA Code of Practice was issued it’s guidance has been supplemented by case law and practice directions. For instance *Re M; W v M (2011) EWHC 2443 (COP)* broadens out the definition of permanent vegetative state ( PVS ) referred to above to include those who are ‘minimally conscious’. Practice direction 9E issued by the Court of Protection also goes on to list other matters of serious medical treatment that *may* have to be brought before the court. These are;

* Certain terminations of pregnancy in relation to a person who lacks capacity to consent to such a procedure.
* A medical procedure on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation to another person.
* A medical procedure or treatment to be carried out on a person who lacks capacity to consent to it, where that procedure or treatment must be carried out using a degree of force to restrain the person concerned.
* An experimental or innovative treatment for the benefit of a person who lacks capacity to consent to such treatment: and
* A case involving an ethical dilemma in an untested area.

In these cases it would be advisable for the body intending to carry out the procedure to seek legal advice.

Enforced removal of an individual from their home.

The decision to move an incapacitated individual from their home into a care environment or place of safety against their wishes will usually require a legal framework over and above the Mental Capacity Act. The route taken by practitioners and the necessity for an application to the Court of Protection will depend upon the following factors;

* Presence of any criminal activity.
* Presence of criteria for detention under the Mental Health Act.
* If the individual lives alone or cohabits with another individual.
* The views of the family / co-habitant regarding the individual’s removal.
* The degree to which least restrictive options have been considered.
* The intended destination for the individual. ( nursing / residential home or hospital )

Due to the complex overlap of several pieces of legislation specific guidance for these cases is not listed here. The points above are offered as a checklist for professionals to gather information which they may then present to their managers or legal advisors for guidance on how to proceed. Advice may also be sought from local AHMP leads or the Mental Capacity Act Facilitator.

B ) Excluded Decisions

There are certain decisions which can never be made on behalf of a person who lacks capacity. This is because they are either so personal to the individual concerned, or governed by other legislation. These are listed in the MCA Code of Practice as;

* consenting to marriage or a civil partnership.
* consenting to have sexual relations.
* consenting to a decree of divorce on the basis of two years separation.
* consenting to the dissolution of a civil partnership.
* consenting to a child being placed for adoption or the making of an adoption order.
* discharging parental responsibility for a child in matters not relating to the child’s property.
* giving consent under the Human Fertilisation and Embryology Act1990.

Within these situations a follow up Best Interests meeting would not be appropriate. Practitioners should however carry on with any relevant risk assessment or Safeguarding procedures.

**F ) Is the Best Interests discussion taking place as a formal meeting / individual discussions / telephone conversation / written communication ?**

The MCA code of practice does not prescribe what form the Best Interests discussion should take at any one point in the proceedings. A useful way of determining which format to follow is to consider what is ‘reasonably ascertainable’ in the time available.

“5.39 Reasonably ascertainable means considering all possible information in the time available. What is available in an emergency will be different to what is available in a non emergency situation...” ( MCA 2005 code of practice )

*The examples below highlight how the Best Interests process may progress in different circumstances. In all examples below it is assumed that the individual LACKS capacity.*

Emergency decision ( individual discussions / telephone conversation ) – P is a lady with dementia on a hospital ward and is refusing medication for her diabetes. This is placing her at immediate risk of a hypoglycaemic episode. The nurse speaks to the ward doctor and telephones P’s daughter. They decide under Best Interests criteria to hide the medication in food and give it covertly.

Non Emergency – simple decision / family and professional agreement - ( individual discussions / telephone conversation / written communication ) X, a gentleman with learning disabilities living with his parents requires a blood test to check his medication levels. The Learning Disability nurse discusses the case with the GP via secure email. She arranges a home visit and a prescription for sedation which she will give 30 minutes prior to the GP’s home visit. The mother and father who will also support X are consulted prior to the day on the telephone. On the day X’s bloods are taken under the Best Interests criteria.

Non Emergency – complex decision / family and professional disagreement – ( Formal Meeting ) – Y, a gentleman who has suffered with a brain injury needs to move into full time care. His family would like him to move to a local nursing home, whereas professionals feel that a specialist unit some distance away would better suit his needs. The social worker organises a ‘round table’ Best Interests meeting to discuss the issue.

The above examples highlight that Best Interests can often be embedded within normal working processes. This does not have to particularly onerous in respect of time and resources. A ‘round table’ formal meeting is only required in certain circumstances. More information on how the format of Best Interests discussions may change if parties cannot agree can be found in section O

**G ) Detail who has been consulted as part of this Best Interests discussion / meeting.**

**&**

**H) If unable to ascertain an interested parties views on this matter can you detail the reason for this here.**

There is no definitive list of who must be consulted in a Best Interests discussion. This will depend upon the decision and the urgency that it must be made in. It is important to note that decision makers can not pick and choose who they consult with but are instead guided by what is *practical and appropriate* as is illustrated in MCA code of practice guidance below.

5.49 ...the decision maker has a duty to take into account the views of the following people

* anyone the person has previously named as someone they want to be consulted
* anyone involved in caring for the person
* anyone interested in their welfare ( for example family carers, other close relatives, or an advocate already working with the person )
* an attorney appointed by the person under a Lasting Power of Attorney, and
* a deputy appointed for that person by the Court of Protection

5.51 – Decision makers must show that they have thought carefully about who to speak to. If it is *practical and appropriate* to speak to the above people, they must do so and must take their views into account. They must be able to explain “*why they did not speak to a particular person*.” ( MCA Code of Practice )

As may be seen the scope of who should be consulted is set wide and at the discretion of the decision maker. The following points may be of use to practitioners;

i) Other legal definitions of relationships such a Next of Kin or Nearest Relative ( Mental Health Act ) are only useful in terms of identifying an individual as an ‘interested party’. They do not bestow any specific decision making authority under the Mental Capacity Act nor give the input of those individual’s contributions any more weight. The MCA code of practice gives the following advice “In weighing up different contributions, the decision-maker should consider, how long an individual has known the person who lacks capacity and what their relationship is.”

ii) The MCA Code of Practice gives ‘family and close relatives’ as *examples* of relevant people to consult. Friends and other individuals who are not blood relations should also be considered by the decision maker if they declare an interest in the individual’s welfare.

iii) In respect of emergency or urgent Best Interest decisions it may not be *practical* to make contact with all of the interested parties. A wider group of individuals may be consulted at a follow up Best Interests discussion if the issue is one that is likely to re-occur ( e.g. ongoing refusal of medication ).

iv) Decisions about the *appropriateness* of consulting certain parties can cause difficulty for the decision maker. Decision makers *must not* exclude an interested party from the Best Interest discussion simply because they do not agree with the decision maker’s viewpoint. Genuine concerns however may arise when the decision maker has suspicions that interested parties do not have the ‘best interests’ of the individual as their priority. The route forward in these situations would be to seek and record the views of the interested party, clearly detailing the reasons why the decision maker decides not to follow their view. *Doubts* about an interested parties motivations within Best Interests discussions should not exclude them from the Best Interests process.

v) These situations have become particularly apparent locally when interested parties to Best Interests decisions are also alleged perpetrators under Safeguarding Adults procedures. Two possible routes are available here depending upon the progress of the Safeguarding Adults investigation. If the Safeguarding Adults case has already been closed, the allegation has been substantiated against the interested party AND the Best Interests decision relates closely to the Safeguarding Adults issue then the decision maker may offer this as a rationale for not consulting with that individual. If the Safeguarding Adults investigation is at an earlier stage and has not yet reached it’s conclusion then the decision maker should follow the advice detailed in point iv) above.

**I ) Are the conditions for appointing an IMCA met ? If so please detail the IMCA consulted.**

1 in 4 Ltd provides IMCA services to the whole of North Somerset, and referrals can be made either via the referral form (see pg 33 ) or by contacting 01934 622 292. Opening hours are 9am – 4.30pm Monday to Friday. There is no out of hours service so appropriate notice is kindly requested. 1 in 4 provide a service to the population of North Somerset regardless of that individuals formal residence status. ( Persons placed by other local authorities within North Somerset will be picked up by 1 in 4. North Somerset residents placed and funded by North Somerset in other areas will be picked up by the local IMCA service in that area.)

Once the original purpose for the referral has been addressed, the IMCA involvement ceases for that client and the case is closed. In the event of additional support being necessary, a further referral needs to be made to the IMCA service.

The requirements for instructing the services of an IMCA are highlighted in the Mental Capacity Act’s Code of Practice and include the following:

* Where an NHS body is proposing to provide or withdraw serious medical treatment;
* Where an NHS body or local authority is proposing to arrange a change of accommodation to a residential / nursing home;
* Where a person stays in a hospital for longer than 28 days;
* Where a person stays in a residential /nursing home for longer than 8 weeks;
* In care reviews when no-one else is available to be consulted;
* In adult protection cases.

Each referral must be accompanied with the name and contact details of the ‘Decision Maker’, without this information the referral cannot proceed. The ‘Decision Maker’ should be a medical practitioner in the case of Serious Medical Treatment, and care coordinator, Social Worker or equivalent for social care referrals such as Long Term Moves.

With the exception of adult protection cases, the person must be unbefriended, (ie no family or relative available), or if befriended, the family or relative is either unable or unwilling to become involved.

The person must also be assessed as lacking capacity to make the decision outlined above, and the IMCA will need evidence to support this assessment prior to taking on the IMCA role.

The IMCA Service will not undertake Capacity Assessments themselves, however will request a second opinion if the outcome of the assessment is disputed by the IMCA.

If the person has a Lasting Power of Attorney (LPA) that has been registered with the Office of Public Guardian for Health and Welfare, then this individual needs to be consulted rather than the IMCA unless it relates to a safeguarding issue. Likewise, any financial matters need to be addressed to a registered LPA with responsibility for Property and Financial affairs. The IMCA Report will be sent to the Decision Maker only. It is then the responsibility of the Decision Maker to ensure copies of the report are forwarded to all relevant individuals involved.

If in doubt regarding any aspect of the IMCA Service they may be contacted on advocacyworker@friendcmhrc.com.

**J ) Consider the different options for the person considering the available resources.**

As it is the job of the capacity assessor to help the individual understand the range of options available in respect of care and treatment ( detailed in *CC and KK and STCC { 2012 } EWHC 2136 (COP )* *{ 2012 } MHLO 89* ) this also needs consideration from the point of view of the decision maker when moving into the Best Interests sphere. What care and treatment options are *available* however may be affected by some of the following factors;

* Financial Resources - It may be observed that determining what is in an individual’s best interests will be constrained by what resources are available. An added complication for decision makers therefore can be determining what resources are actually available. This will not be helped by the fact that in contested cases there can often be a dispute between the commissioners of care and other parties as to what resources should be allocated to the individual’s case. Therefore an essential role of the decision maker in these cases is to determine exactly what resources commissioners of care are willing to allocate to the case. Commissioners of contested care packages should ensure that they have robust policies and procedures ( i.e. an exceptional funding process ) in place to ensure that decisions around these issues follow due process and are made in an open and transparent manner. A distinction can therefore be drawn between the resource allocation ( which an objecting party could challenge via a judicial review ) and the Best Interests decision. ( which an objecting party could challenge through the Court of Protection )
* Human Resources – Commissioners of care packages may also decide that they are unable to provide a particular resource or care package because it places an unacceptable risk upon an other party ( e.g paid care / support or a family member ) . As above care commissioners should ensure that they have followed due process such as the completion of an objective risk assessment in reaching this decision.
* Hypothetical Specifications – When determining the available options practitioners must also decide what is practically achievable. For instance the gathered Best Interests group might decide that providing renal dialysis 3 times a week, involving anaesthesia, sedation, and restraint was not actually possible within the confines of therapeutic worth, the environment, and staff resources.

**K ) What are the person’s views on this matter, What decision would they have made if they had capacity ? How have you ascertained this ?**

Completing section K) reminds practitioners of an essential role in taking into account the individuals wishes, views, values, and beliefs. These are summersied in the MCA Code of Practice as;

Try to find out the views of the person who lacks capacity, including:

– the person’s past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.

– any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.

– any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

One of the difficulties in achieving this is how to consult with the person when a formal meeting is required. Williams et al ( 2012 ) suggest best practice is to involve the incapacitated person at the meeting. If the person has a significant cognitive impairment attendance at a meeting may cause distress to the individual and their family however. It may also mean that a productive discussion may not occur. Decision makers should consider beforehand if any adjustments can be made to accommodate the person. If it is decided that this is not possible then of the ‘decision maker’ should consult with them separately.

Case law also draws a distinction between ‘substituted decision making’ and ‘best interests decisions’ *Re G (TJ) (2010) EWHC 3005 (COP)* *.*Practitioners do not always have to make the actual decision the person would have made if they had capacity. Best Interests can cause conflict for practitioners if it asks practitioners to take positive action themselves that would place the person at significant risk of harm. An example of this might be returning an immobile individual to a situation where high levels of domestic abuse had occurred previously. The decision maker may feel compelled to conclude that the persons previous behaviour ( staying with an abusive partner over many years ) indicated that they would wish to return home. The above case law states that Best Interests criteria are wider than just taking into account the individuals wishes, views, beliefs, and values. In this example therefore it may be appropriate to prevent a return home.

**L) Consider the pros and cons of each option. Risks and benefits must include psychological & emotional elements alongside physical factors.**

One method of considering Best Interest decisions is to imagine a set of weighing scales for each of the above options identified in J). The decision maker asks the group to consider the advantages and disadvantages for each option and then places them on opposite ends of the respective scale. The scale / option that is the most heavily weighted down on the ‘advantage side’ is the option that is chosen. This conceptualisation is useful to a point. Not all advantages and disadvantages will have equal ‘weight’. Deciding the individual’s best interests therefore becomes much more than simply counting the respective pro’s and con’s on each set of ‘scales’. Evidence from several cases that have come before the Court of Protection ( *GM; FP v GM and A Health Board (2011) EWHC 2778 (COP),* Cardiff Council v Peggy Ross (2011) COP 28/10/11 12063905 ) have shown that professionals can give more weight to physical safety. This has run counter to the views of the individual or family in these cases who have placed more weight upon elements such as emotional security from being back at home & pleasure derived from a holiday. The fact that professionals place more emphasis on the individual’s physical safety is perhaps unsurprising. It is easier to quantify, consider, & risk assess physical safety than more abstract concepts such as emotional security or ‘happiness’. In the cases referred to above the Courts found that the individual’s emotional needs were paramount and overturned existing ‘protective’ Best Interests decisions. This is not to say that in other past or future cases that physical safety has not or will not ‘trump’ emotional or psychological elements. These cases referred to however are useful reminders to professionals not to allow the ‘protection imperative’ to rule their decision making at the exclusion of considering the wider picture and the person’s emotional & psychological welfare. Perhaps the most succinct summing up of this approach to Best Interests decision making is given by Lord Justice Mumby ( 2010 ) who states;

“The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person’s happiness. **What good is it making someone safer if it merely makes them miserable**?”

M ) Considering boxes J,K, & L above what do the group feel is the ***least restrictive option*** considering ***best interests***, ***what the person would have wanted*** & ***available resources.***

This is the space where the Best Interest Decision is recorded taking into account the listed factors. The rationale for taking this decision should be recorded here. Alongside this the decision maker should record any dissenting views or disagreement detailing why their course of action was not followed.

N ) Follow on work - All parties **do** agree ( tick all that apply )

&

O ) Follow on work – One or more parties ***do not*** agree ( tick all that apply )

As previously stated if a decision was made ‘urgently’ then it may be incumbent on staff to carry out a follow up Best Interests discussion consulting with a wider group of individuals shortly afterwards.

The issue of dispute and disagreement is dealt with here. If an agreement cannot be sought then the decision maker should consider the advice in the MCA Code of Practice.

If someone wants to challenge a decision-maker’s conclusions, there are several options:

* Involve an advocate to act on behalf of the person who lacks capacity to make the decision .
* Get a second opinion.
* Hold a formal or informal ‘best interests’ case conference.
* Attempt some form of mediation.
* Pursue a complaint through the organisation’s formal procedures.

Ultimately, if all other attempts to resolve the dispute have failed, the Court of Protection might need to decide what is in the person’s best interests.

The capacity of the Court of Protection has been an issue over recent years with non urgent cases having to wait a considerable time before being heard. Mediation is often looked at by the courts in a favourable light in difficult and intractable cases. This however may come at a extra cost to their organisations so ‘decision makers’ need to argue a case if they feel this is an appropriate route for their case.

P ) Other Decision Making Authority

The alternative decision making authorities detailed previously on the form should be recorded here with the individual then moving to part R to detail any actions that are required. For instance this might include a professional getting hold of any LPA / documentation to confirm an attorney’s authority to act.

The Deprivation of Liberty Safeguards ( DoLS ) question is considered for the first time here. Best practice details that a Best Interests decision is made locally before a referral to the DoLS service is made. For instance a hospital would decide if it is in an individual’s Best Interests to remain in hospital contacting the DoLS team only once they have decided they the person must stay. Separate guidance on the Deprivation of Liberty Safeguards legislative framework may be found on page 29 of this document.

Q ) Review

Any review dates should be recorded here.

R) Please provide detail here regarding any follow up work.

The tick list detailed on page 3 of the pro forma is devised to act as a prompt to remind practitioners of common outcomes and follow up actions. This list is not exclusive and if actions are required that are not detailed in the prompts they should be recorded here.

**Deprivation of Liberty Safeguards ( DoLS ) - Local Guidance following P v Chester West & Chester Council P & Q v Surrey CC { 2014 } UKSC 19**

The latest Supreme Court Judgement regarding the Deprivation of Liberty Safeguards ( DoLS ) provisions has significantly lowered the threshold for when an individual is considered to be deprived of their liberty.

The Court has forwarded the following ‘acid test’ on the matter;

**•** The person is under continuous / constant supervision and control

**AND**

**•** The person is not free to leave

Factors that are no longer considered relevant include;

• Objection to the care or placement

• The purpose of the care or placement

• The relative normality of the care arrangements

Previous case law had suggested that relatively ‘normal’ living arrangements were unlikely to constitute a deprivation of liberty. For instance an individual not able to leave a care home on demand but given regular supported access to the community would not have met the criteria. This notion has been overturned in the recent case law with the presiding judge stating that “a gilded cage is still a cage”. The consideration given to the person’s objection has also changed. Rather than consider if a person is objecting to their residence professionals must now consider ‘would the person be stopped *if or when* they tried to leave ? ’

The implications of this judgement is that many more individuals will now require assessment under the DoLS regime. In addition to this care arrangements in domestic care settings ( such as supported living ) are now much more likely to constitute a deprivation of liberty. DoLS Authorisations however cannot be given in these ‘domestic’ settings necessitating a direct application to the Court of Protection. Following the local capacity, best interest consideration detailed below the body responsible for commissioning the care should be contacted to discuss potential court applications. This will usually be North Somerset Council but could also be other bodies such as the local NHS clinical commissioning group. The MCA / DoLS manager can be contacted for advice in this regard.

Involved professionals across the local health and social care sector will now need to carry out capacity assessments and where appropriate best interests decisions in relation to their residents or patients. Involved professionals should identify those most at risk and prioritise these individuals for local assessment and possible DoLS application. ‘At risk’ in this context would include individuals objecting to their residence & care or subject to high levels of restriction. Once this is completed involved professionals should then consider lower risk individuals. E.g. those who appear settled in their residence and are not objecting but meet the ‘acid test’ described above.

Although the DoLS provisions state responsibility for making DoLS referrals lies with the care provider ( ‘*the Managing Authority’* ) this does not mean they have sole responsibility in completing the preliminary Mental Capacity Act work. This should be a collaborative process with community staff and care commissioners. These external professionals should also identify ‘at risk’ individuals within their caseloads and consider the revised ‘acid test’ detailed above. Following this ongoing consideration should be made when reviewing their general caseload. Further support will be developed and offered to help embed DoLS consideration within generic review processes.

North Somerset Safeguarding Adults Partnership Board ( NSSAPB ) is advising against local care providers making ‘blanket applications’ for all residents in their home or hospital. This is consistent with the Association of Directors of Adult Social Services ( ADASS ) advice note issued in April 2014. This reminds professionals that capacity , best interests and deprivation of liberty should be defined in relation to individual cases and that local involved professionals have the initial responsibility in the consideration of this. Providers who submit DoLS applications which are not supported by local capacity / best interests paperwork will be asked to carry out this work out whilst waiting for the DoLS assessment process to commence.

Please contact the DoLS Office using the details below if you have any questions regarding this briefing note. Pro forma for both preliminary MCA work and DoLS applications can also be obtained through the office.

Contact details :

DOLS.Service@n-somerset.gov.uk

Fax : 01934 426434

MCA / DoLS Manager - 01275 885285, 07796611398, dameon.caddy@n-somerest.gov.uk, dameon.caddy@nhs.net

DoLS / safeguarding administrators 01275 885290 / 886547 / 885291 ashleigh.berryman@n-somerset.gov.uk, kay.cook@n-somerset.gov.uk, adjua.gyamfi@n-somerset.gov.uk

If making a DoLS referral via email please contact the office regarding secure transfer via the gcsx or nhs.net system. If making a referral via fax please use the number detailed above. Faxes are received in a secure inbox 24 hours a day. Office Hours ( Mon – Thurs 9-5, Fri 9-4.30 )

A flow chart is provided overleaf which summarises this guidance note. If involved professionals are uncertain as to an aspect of their decision making or interpretation of the ‘acid test’ when using this tool then they should seek support within their organisation or from the MCA/ DoLS manager.

Reviewed Sept 2014

Yes

Person consents to residence / restrictions OR restrictions stop / individual moves to a residence of their choosing. Capacity assessment recorded on MCA capacity pro forma

Involved Professionals assess capacity in relation to the following question – **Does the person have capacity to consent to the accommodation for the purposes of their care and treatment ?**

Yes

No

Conduct and record local best interests discussion with professionals, family, and IMCA ( if relevant ). Record discussion on MCA best interests pro forma.

Involved professionals consider the ‘acid test’. **Is the person under continuous / constant supervision and control AND Is the person not free to leave ?** The individual must meet both elements of this test

No

Yes

Record discussion on MCA best interests pro forma.

Local best interests discussion. **Can professionals, family, and IMCA ( if relevant ) organise individual’s care in a ‘less restrictive’ manner ?** e.g. person would be free to leave if they or family requested. Supervision and control can be significantly reduced below DoLS threshold.

Yes

Application to Court of Protection. Record discussion on MCA best interests pro forma.

No

No

**Is the individual currently resident in a registered nursing/residential home or hospital or is a move into one of these settings the planned course of action ?**

Conduct and record best interests discussion with professionals, family, and IMCA ( if relevant). Record decision on MCA best interests pro forma. Inform DoLS office of situation

Yes

**Will the restrictive care end in the next few days ? ( e.g person returning home )**

No

Managing Authority ( Care Home, Hospital ) make DoLS application. Submit;

* Standard Form 1 & 4 ( existing care ) OR Standard Form 4 ( planned care ) - *submit to DoLS Office*
* Supporting Capacity Assessment & Best Interests decision paperwork - *submit to* *DoLS Office*
* Care Quality Commission notification – *submit to direct to CQC*

***References***

The Mental Capacity Act 2005

Deprivation of Liberty Safeguards, Code of Practice, The Stationary Office, 2008

Mental Capacity Act 2005 Code of Practice, The Stationary Office, 2007

William V, Boyle G, Jepson M, Swift P, Williamson T, Heslop P, ‘Making Best Interests Decisions: People and Processes' Mental Health Foundation ( 2012 )

Munby, Lord Justice (2010) ‘What price dignity?’, keynote address at LAG Community Care conference: Protecting liberties, London, 14 July.

The Mental Capacity Act 2005, Practice Direction 9E and Serious Medical treatment.

*Aintree University Hospitals NHS Foundation Trust v James { 2013 } UKSC 67*

*D Borough Council v AB { 2011 } 2FLR72*

*A Local Authority v H { 2012 } EWHC 49 (COP).*

*A Local Authority v TZ { 2013 } EWHC 2322 (COP)*

*Sheffield City Council v E { 2004 } EWHC 2808 ( Fam )*

*LBL v RYJ { 2010 } EWHC 2665 (COP)*

*CC and KK and STCC { 2012 } EWHC 2136 (COP )* { 2012 } MHLO 89

Re M; W v M (2011) EWHC 2443 (COP)

*Re G (TJ) (2010) EWHC 3005 (COP)*

*GM; FP v GM and A Health Board (2011) EWHC 2778 (COP)*

*Cardiff Council v Peggy Ross (2011) COP 28/10/11 12063905*