



# Herefordshire Safeguarding Adults Board

**MENTAL CAPACITY ACT 2005**

**(MCA) POLICY, PROCEDURE AND  
GUIDANCE**

**DATE: January 2018**

**Version 2**

It is suggested that this policy is read in conjunction with Herefordshire Safeguarding Adults Board's Deprivation of Liberty Safeguards 2007 (DoLS) policy and with the Mental Capacity Act 2005 Code of Practice and Deprivation of Liberty Safeguards Code of Practice.

These Codes of Practice can be downloaded from:

MCA 2005 Code of Practice: <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

DoLS Code of Practice: <https://www.gov.uk/government/publications/mental-capacity-act-deprivation-of-liberty-safeguards>

## Contents

1 INTRODUCTION.....	
2. PURPOSE .....	
3. SCOPE .....	
4. POLICY STATEMENT .....	
5. DEFINITIONS.....	
6. LEGAL CONTEXT AND CARE QUALITY COMMISSION (CQC).....	
7. ASSESSMENT.....	
8. BEST INTEREST DECISION MAKING.....	
9. CONSULTATION AND FURTHER ADVICE.....	
10. QUALITY, ACCOUNTABILITY AND RECORDING.....	
11. INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA).....	
12. ADVANCE DECISIONS.....	
13. RESTRAINT – MCA AND DOLS.....	
14. FINANCES, POWER OF ATTORNEY AND DEPUTIES.....	
15. COURT OF PROTECTION AND OFFICE OF THE PUBLIC GUARDIAN.....	
16. CONSENT AND CAPACITY.....	
17. STAFF LIABILITY.....	
18. INTERFACE OF MHA 1983 AND MCA 2005.....	
19. CONVEYANCE TO HOSPITAL OR CARE HOME.....	
20. HOSPITAL	
21. POLICE.....	
22. AMBULANCE SERVICE.....	
23. RESEARCH.....	
24. CHILDREN AND YOUNG PEOPLE.....	
25. CARERS.....	
26. PERSONALISATION.....	
27. TRAINING.....	
28. INFORMATION GOVERNANCE.....	
29. RELATED POLICY AND PROCEDURES.....	
30. FURTHER INFORMATION AND RESOURCES.....	
31. MONITORING AND REVIEW.....	

## **1. INTRODUCTION**

1.1 The Mental Capacity Act (MCA) 2005 provides a legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The aim is to assist and support a person who may lack capacity and discourage anyone who is involved in caring for somebody who lacks capacity from being overly restrictive.

1.2 The Act provides legal protection for staff and others and protection for people who are assessed as lacking capacity by setting out a mandatory procedure for making decisions on their behalf. It provides three fundamental powers in relation to health and welfare decisions:

- Opportunities for people who have capacity to plan for a time when they may lack capacity;
- A legal framework for people with capacity to record their wishes for future treatment, especially the refusal of treatment; and
- A legal framework for staff and others to make a Best Interests decision on behalf of another person who is assessed as lacking capacity to make that decision at that time.

1.3 This Policy, Procedures and Guidance has been developed on behalf of Herefordshire Safeguarding Adults Board for adherence and implementation by all agencies and services operating within Herefordshire.

1.4 The overall aim of the policy and guidance in Herefordshire is to ensure good practice and a coherent approach across organisations.

1.5 The key messages of the Mental Capacity Act (MCA) 2005:

- The Act applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves.
- The Act is designed to protect and empower vulnerable people who lack capacity.

- The Act supports those over the age of 18 who have capacity and choose to plan for their future by creating a Lasting Power of Attorney.
- The Act provides legal protection in practice for health and social care staff and carers.
- The Act is supported by a Code of Practice, with which all professionals have a duty to comply.

1.5.1 The Act provides five statutory principles which are the benchmark of the MCA and must underpin all acts carried out and decisions taken in relation to the Act. They are as follows:

### **Principle One**

A person must be assumed to have capacity unless it is established that they lack capacity.

### **Principle Two**

A person is not to be treated as unable to make a decision unless all practicable steps to help have been taken without success.

### **Principle Three**

A person is not to be treated as unable to make a decision merely because they make an unwise decision.

### **Principle Four**

An act done, or decision made, on behalf of a person who lacks capacity, must be done or made, in their best interests.

## **Principle Five**

Before the act is done, or the decision is made, regard must be had as to whether the purpose of the act or the decision can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

1.5.2 The Act provides a two stage process for the assessment of capacity.

1.5.3 The Act emphasises that assessment of capacity and Best Interests decision making is integral to day to day practice.

1.5.4 The Act provides a Best Interests checklist to be implemented by anyone making best interests decisions for people who lack capacity.

1.5.5 The Act underlines the importance of the appropriate involvement of the individual, carers and families in capacity assessments and Best Interest decision making.

1.5.6 The Act establishes a criminal offence of ill treatment or neglect of a person who lacks capacity.

## **2. PURPOSE**

2.1 This document provides a guide for anyone involved in the assessment of capacity and related activities in health and social care practice. The principles within the document are applicable to anyone aged 16 years and above who may lack capacity. Guidelines and documentation relating to the assessments of capacity of Children & Young People (CYP) under the age of 16 are available in the Herefordshire Safeguarding Children Board Inter Agency Child Protection Procedures for Safeguarding Children.

2.2 Staff often have a key role in helping and supporting people to understand what decisions need to be made and why, and what the consequences of those decisions are. They are sometimes the only people in a position to provide information to individuals about the options available to them, or where they can get other help and/or advice. Staff should ensure that support is provided to enable people to make their own decisions whenever possible. This guidance should increase staff awareness when discussing the different options available to people to help them where they may lack capacity, now or in the future.

2.3 Everyone providing care and support to a person who lacks mental capacity must have regard to the Mental Capacity Act and its Code of Practice and act in accordance with it unless there are valid reasons from acting otherwise.

### **3. SCOPE**

3.1 The policy applies to all staff who work for agencies who are part of the Herefordshire Safeguarding Adult Board in Herefordshire as outlined in the policy statement below.

### **4. POLICY STATEMENT**

4.1 The issue of whether a person aged 16 years or over has the mental capacity to make a decision regarding his or her care commonly arises in health and social care settings. All health and social care professionals will potentially be in situations where they are required to assess the mental capacity of an individual to make a particular decision and to make Best Interests decisions. Everyone working with or caring for an adult who may lack capacity to make decisions must comply with the MCA 2005 when making decisions or when acting for such persons.

4.2 Professional staff have a duty and commitment to protect adults at risk. They need to work on the basis of an assumption of capacity and should consider people's capacity to take decisions as part of their normal assessment and care planning arrangements. Where there are doubts about an individual's ability to make a specific decision, a formal assessment of capacity may be necessary to determine capacity. Specific decisions or actions may need to be taken where an adult may not have capacity. Where an adult may be deemed to be at risk and may be being abused, the Herefordshire Safeguarding Adults Multiagency Policy and Procedures must be followed.

4.3 The MCA 2005 has implications for all aspects of the work with adults who may lack capacity and for all policies. All existing policies and procedures need to be MCA compliant.

### **5. DEFINITIONS**

#### **Advance decision:**

This is a written and witnessed decision made by an adult with capacity to refuse specific medical treatment in advance. The decision will apply at a future date when the person lacks the capacity to consent to or refuse the treatment specified in the advance decision. It has the same effect as a contemporaneous refusal of the specified medical treatment. An advance decision is legally binding.

**Adult:**

Schedule 3 of the MCA has been amended (with some exceptions with regard to legal processes for 16/17 year olds) and the term 'adult' now means a person who:

- (a) as a result of an impairment or insufficiency of his personal faculties, cannot protect his interests, and
- (b) has reached the age of 16.

**Attorney:**

This is a person who has been appointed under either a Lasting Power of Attorney or (prior to October 2007) an Enduring Power of Attorney. An attorney has the legal right to make decisions on behalf of the donor, providing these decisions are within the scope of their authority and have been registered with the Court of Protection. There are two types of Lasting Powers of Attorney – personal welfare and property and financial affairs.

**Best Interests:**

Any act done or decision made on behalf of a person who lacks capacity must be done or made in their Best Interests. Section 4 of the MCA 2005 sets out a non-exhaustive checklist.

**Carer:**

A Carer is someone of any age who provides unpaid support to family or friends who could not manage without this help due to illness, disability, mental ill-health or a substance misuse problem.

**Children:**

Within the MCA this refers to people who are below the age of 16 years. This is different from the definition within the Children Act 1989 and the law more generally where the term 'child' is used to refer to people aged under 18 years of age.

**CQC:**

The Care Quality Commission (CQC) is a non-departmental public body of the UK government established to regulate and inspect health and social care services in England. This includes services currently provided by the NHS, local authorities, private companies and voluntary organisations – whether in hospitals, care homes or people's own homes – dentist and GPs.

**Decision-maker:**

This is a person who is responsible for deciding what is in the Best Interests of a person who lacks capacity. Who this is, is dependent on the decision that needs to be made and sometimes will be a professional and at other times a family member, Carer or close friend. It is likely to be the person who is carrying out the action required to implement the decision.

**Deprivation of Liberty:**

This is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Case law (including that from the Court of Protection and Supreme Court) continues to define its meaning in practice. There is no simple definition of deprivation of liberty. See Chapter 2 of the DoLS Code of Practice and the Law Society Guidance <https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty>, for a more detailed understanding.

**Deputy:**

This is a person appointed by the Court of Protection with ongoing legal authority to make particular decisions on behalf of the person who lacks capacity. Deputies for personal welfare (including healthcare) decisions will only be required in the most complex cases where important and necessary actions cannot be carried out without the court's' authority or there is no other way of settling the matter in the Best Interests of the person who lacks capacity to make particular welfare decisions.

**Donor:**

This is a person who makes a Lasting Power of Attorney (LPA) to appoint a person to manage their financial and property affairs or to make personal health and welfare decisions or (prior to October 2007) an Enduring Power of Attorney.

**Enduring Power of Attorney (EPA):**

This is a power of attorney created under the Enduring Powers of Attorney Act 1985 to deal with property and financial affairs. Existing EPAs continue to be valid if registered with the office of the public guardian.

**Independent Mental Capacity Advocate (IMCA):**

This is a person who supports and represents a person who lacks capacity to make a specific decision, where that person has no one else who can support them. They make sure that major decisions for a person who lacks capacity are made in accordance with the Mental Capacity Act 2005. IMCAs appointed under DoLS are required to have

additional DoLS specific training. See DoLS Code of Practice 7.34 – 7.41 for details on the role of the DoLS IMCA.

### **Lasting Power of Attorney (LPA):**

This is a power of attorney created under the Mental Capacity Act 2005. It enables a person, initially with capacity, to appoint another person to act on their behalf in relation to decisions about the donor's financial and property affairs and/or personal welfare (including healthcare) at a time when they no longer have capacity. An LPA must be registered with the Office of the Public Guardian before it can be used and ceases on the death of the donor.

### **Managing Authority:**

The person or body with management responsibility for the hospital or care home in which a person is, or may become deprived of their liberty.

### **MCA and DoLS Lead:**

This is the named individual responsible for ensuring the quality and efficacy of the services provided to adults who may lack capacity within their Agency. They should provide a contact point for other agencies and are responsible for sharing information and providing specialist advice.

### **Mediation:**

A voluntary, facilitative process that assists parties to reach a mutually acceptable outcome. Mediation is a non-adversarial and voluntary process. A mediator is independent and acts as a facilitator. A mediator works with the parties to identify their concerns and helps them to resolve areas of disagreement. Parties who take part in mediation have a real stake in the process and a mediator empowers them to resolve the dispute themselves.

### **Mental Capacity:**

This describes a person's ability to make a decision about a particular matter at the time it needs to be made. A legal definition is contained in Section 2 of the Mental Capacity Act 2005.

### **Restraint:**

The use or threat of force to undertake an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm. Restraint can include physical restraint e.g. moving the person or blocking

their movement to stop them leaving, mechanical restraint involving the use of equipment such as using a belt to stop the person getting out of their chair or bedrails to stop the person from getting out of bed, chemical restraint e.g. using medication to restrain and psychological restraint e.g. telling a person not to do something or depriving a person of lifestyle choices by telling them what time to go to bed or get up.

### **Standard Authorisation:**

This is the formal agreement to deprive a person of their liberty in the relevant hospital or care home. It is given by the Supervisory Body, after completion of the statutory assessment process.

### **Statement of wishes and feelings:**

A person with capacity may express their wishes and feelings about their future medical treatment, where they would choose to live, how they would wish to be cared for, in the event they lose capacity in the future. These are not legally binding but should be used by relevant professionals for consideration when making Best Interests decisions for a person who lacks capacity.

### **Supervisory Body:**

A local authority that is responsible for considering a deprivation of liberty request, commissioning the assessments and, where all the assessments agree, authorising deprivation of liberty. Which local authority will be responsible will depend upon where the adult is ordinarily resident. This will be the area in which the adult was ordinarily resident immediately before they began to be accommodated in the care home or hospital, or if the adult was of no settled residence immediately before they were accommodated in the care home or hospital, it will be the area in which the adult was present at that time. Within Herefordshire, the Supervisory Body is Herefordshire Council.

### **Urgent Authorisation:**

An authorisation given by a Managing Authority for a maximum of seven days, which may be extended by a maximum of a further seven days by a Supervisory Body, that gives the Managing Authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.

### **Adult:**

The adult in need of care and support who has a physical/mental impairment or illness. The term replaces the previously used term 'adult at risk'

### **Young Carer:**

Young Carers are children and young people who look after someone in their family who has an illness, a disability, or is affected by mental ill-health or substance misuse. Young Carers often take on practical and/or emotional caring responsibilities that would normally be expected of an adult. The tasks undertaken can vary according to the nature of the illness or disability, the level and frequency of need for care and the structure of the family as a whole.

### **Young Person:**

Within the MCA this refers to people aged 16-18 years to whom most of the Act applies (but note amendment to Section 3 of the MCA re definition of adult).

## **6. LEGAL CONTEXT AND CARE QUALITY COMMISSION (CQC)**

6.1 Some of the most relevant Legislation, Codes of Practice and Statutory Instruments are as follows:

- Care Act 2014
- Mental Health Act 1983
- Human Rights Act 1998
- The European Convention on Human Rights and its five principles
- Disability Discrimination Act 1998
- General Data Protection Regulations 2017
- Care Standards Act 2000
- Human Tissue Act 2004
- Mental Capacity Act 2005
- Mental Capacity Act Code of Practice 2007
- Mental Health Act Code of Practice 2015
- Deprivation of Liberty Safeguards (DoLS) 2007
- Deprivation of Liberty Safeguards Code of Practice 2008

6.2 The Care Quality Commission (CQC) has developed Essential Standards of Quality and Safety which health and social care organisations, dentists and GPs must reach to be compliant with the MCA 2005 and to avoid sanctions. Further details are available at: <http://www.cqc.org.uk/content/essential-standards>.

6.3 CQC states in 'Essential Standards of Quality and Safety' (March 2010) that all people who use services should be protected from abuse, or the risk of abuse, and their

human rights be respected and upheld. Specifically, CQC outcome 7 states that all agencies must:

6.4. Make sure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual;

6.4.1 Where applicable, only use DoLS when it is in the Best Interests of the person who uses the service and in accordance with the MCA2005.

6.5 CQC have a duty to monitor the operation of DoLS in England and to report on the operation of DoLS to the Secretary of Health. The Commission may cancel a registration in respect of a care setting in England where DoLS legislation has not been carried out in accordance with requirements of the enactment.

## **7. ASSESSMENT**

7.1 Agencies should consider identifying a named MCA Lead across their team structures who will be responsible for ensuring the quality and efficacy of the services provided to adults who may lack capacity.

7.2 The named MCA Lead will provide a contact point for other agencies and be responsible for sharing information and providing specialist advice where required to other agencies in respect of services or information provided by the agency.

7.3 Individual assessments of capacity are the responsibility of every health and social care worker.

7.4 Defining a lack of capacity (MCA Code of Practice Chapter 4):

Any question as to whether a person lacks capacity must be decided on the balance of probabilities:

7.4.1 A person lacks capacity in relation to a matter if at the material time s/he is unable to make a decision for her/ himself in relation to the matter because of an impairment, or a disturbance in the functioning, of the mind or brain.

7.4.2 It does not matter whether the impairment is permanent or temporary, although if temporary, consideration should be given as to whether making the decision can wait until the person has regained capacity.

7.4.3 A lack of capacity cannot be established merely by reference to:

- A person's age or appearance;

- A condition or an aspect of their behaviour, which might lead others to make unjustified assumptions about their capacity.

## **7.5 Assessing capacity**

7.5.1 Mental capacity is the ability to make an informed decision. Consequently there are two basic questions to be considered once a decision (or decisions) has been defined and needs to be made:

- Is there an impairment of, or a disturbance in, the person's mind or brain? Examples of an impairment or disturbance include Brain Injury, Learning Disability, Dementia, Physical or Medical conditions that can cause drowsiness, delirium or loss of consciousness, if so:
- Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision at the time it needs to be made?

7.5.2 The person assessing capacity must ensure that they are providing the person with sufficient relevant information on which to make their decision, making every effort to provide that information in a way that is most appropriate to help the person understand.

7.5.3 A person is assessed as having the mental capacity to make the decision if they are:

- Able to understand information relevant to the decision
- Able to retain the information related to the decision which needs to be made
- Able to use or weigh that information as part of the decision-making process
- Able to communicate the decision by any means

7.5.4 If they are unable to do any of the four points, they will be assessed as not having the mental capacity to make the decision. An individual's capacity may fluctuate during the day or over the course of time. It is important to allow for this in any assessment and to repeat the assessment as appropriate to the situation. See APPENDIX 1 Assessing Capacity – Flowchart.

7.6 The MCA 2005 identifies the need for all practitioners to carry out situation and time specific assessments of mental capacity where there are doubts about a person's mental capacity. The kinds of decision which are covered by the MCA 2005 range from

day-to-day decisions to significant decisions. More serious decisions have greater consequences for the person who, it is thought, may lack capacity and justify a more formal assessment of capacity. Decisions relating to providing healthcare or treatment includes providing nursing and social care, carrying out diagnostic examinations and tests, providing professional medical treatment, giving medication, providing emergency care, carrying out other necessary medical procedures and therapies and arranging to refer someone to hospital for an assessment or for treatment. Some decisions can never be taken on someone else's behalf eg marriage, divorce, voting, sexual relationships.

7.7 All assessments of capacity must be conducted by the decision-maker who is the person responsible for deciding what is in the Best Interests of the person who lacks capacity. There are times when a number of people may be involved in making recommendations in relation to a decision. It is the decision-makers responsibility to work out what would be in the Best Interests of the person who lacks capacity. The decision maker is the person who is deciding whether or not to take action in connection with the care or treatment of an adult who lacks capacity or who is contemplating making a decision on their behalf. For example:

7.7.1 Where the decision involves medical treatment, the doctor proposing the treatment is the decision-maker;

7.7.2 Where nursing care is provided, the nurse is the decision-maker;

7.7.3 Where the decision involves social care or accommodation, the Social Worker or other professional proposing and responsible for the arrangements will be the decision-maker;

7.7.4 For more day-to-day decisions, the decision-maker will be the person most directly involved with the person at the time usually a family member, paid carer, carer or friend;

7.7.5 The holder of a valid Lasting Power of Attorney or a deputy will be the decision-maker for decisions within the scope of their authority but only in relation to decisions where the person lacks capacity.

7.8 Assessments of capacity in simple day to day decision making may be made solely by the decision-maker and may be documented within the person's case records.

7.9 A major decision is being made for example if there are concerns that an individual may not have the capacity to:

7.9.1 Consent to 'Serious Medical Treatment' (see MCA Code of Practice, Sections 6.15 – 6.19,);

- 7.9.2 Consent to an informal admission (to hospital, nursing or care home);
- 7.9.3 Consent to a change of accommodation;
- 7.9.4 Request a Tribunal Hearing when detained under the MHA (1983);
- 7.9.5 Manage their property or financial affairs, health or welfare.

The above list is not exhaustive and professional judgement must be used.

7.10 Best practice indicates assessments of capacity / Best Interest decisions where a major decision is being taken should, if possible, be taken by a multidisciplinary team including the decision-maker. One of these people should ideally have an established relationship with the individual whose capacity is being assessed for example a carer, close friend or family member or professional with a long standing relationship with the individual. Consideration should also be given as to whether the person themselves should be present for some or all of the meeting. However, there will be a number of situations when only one person, the decision-maker completes the assessment. Sec 5.39 of the MCA Code of Practice makes it clear that learning about a person's past and present views depends on circumstances and that what is available in an emergency will be different to what is available in a non-emergency. However '... even in an emergency there may still be an opportunity to try to communicate with the person or his friends, family or carers'.

7.11 Consideration of the skills and experience of those conducting the assessment must occur, for example where the individual has significant learning disabilities the assessor should have experience and expertise in that area.

7.12 All assessments of capacity in respect of significant decisions must be recorded on a capacity form and fully documented on a person's case notes. The two stages of the test must be recorded, with the steps taken to establish that the person does not lack capacity to make relevant decisions about their care or treatment and the outcome of the assessment.

7.13 It MUST be noted that all assessments of capacity are TIME AND ISSUE SPECIFIC; it is thus probable that an individual may have several different assessments of capacity in respect of different issues and decisions documented both on the electronic record and in their case notes.

7.13.1 It should also be noted that some people may have fluctuating capacity. In these cases if the person lacks capacity for most of the time, and have only fleeting periods where they have capacity then on balance it is likely that they will be assessed as lacking capacity to make specific decisions. Where the balance is the other way and the

person has capacity for the majority of the time attempts should be made to get them to make decisions at the times when they have capacity.

7.14 If someone wants to challenge an assessor's or decision maker's conclusions, there are several options:

7.14.1 Involve an advocate to act on behalf of the person who is deemed to lack capacity to make the decision

7.14.2 Get a second opinion

7.14.3 Hold a formal or informal best interests case conference

7.14.4 Attempt some form of mediation

7.14.5 Pursue a complaint through the organisation's formal procedure

7.14.6 Ultimately, if all other attempts to resolve the dispute have failed, an approach to the Court of Protection must be considered.

## **8. BEST INTEREST DECISION MAKING**

8.1 The Act sets out a checklist of factors to be considered by the decision maker whilst considering the best interests of the person. If an individual is assessed as lacking capacity to make a decision, one of the key principles of the legislation is that any act done for, or any decision made on behalf of the person, must be done in the person's best interests (Code of Practice Chapter 5)

8.2 Factors to be considered:

8.2.1 As far as possible encourage the person themselves to participate in the decision making process.

8.2.2 Identify the relevant circumstances which the person themselves would take into account if they were making the decision themselves.

8.2.3 Identify the person's past and present wishes and feelings, beliefs and values.

8.2.4 No decision is to be made solely on the basis of the person's age, appearance or other aspects of behaviour that might lead other to make unjustified assumptions.

8.2.5 Likelihood of regaining capacity. Does the decision need to be made now? If it is likely that capacity may be regained, can the decision making be delayed?

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

8.2.7 Ensure the views of others – in particular, anyone named by the person to be consulted, those involved in caring for the person, those interested in their welfare, anyone appointed as Power of Attorney or any Court Deputy – are taken into consideration to inform decision making.

8.2.8 Consult with the Independent Mental Capacity Advocate (IMCA) if one has been appointed.

8.2.9 Consider whether there are any other options where the outcome may be less restrictive for the person's rights.

8.3 Then weigh up all of these factors in order to work out what is in the person's best interests. There is no hierarchy of factors in determining what is in a person's best interests. Although Courts are now giving greater weight to the Person's wishes. Part of the decision making process will be to establish what are the most important issues given the circumstances and applying the statutory checklist.

8.4 Decisions must be clearly recorded in the case records. See Appendix 2 Determining Best Interests. NB: A decision not to make, or to delay making, a decision also needs to be recorded.

## **9. CONSULTATION AND FURTHER ADVICE**

9.1 Within Herefordshire not all professionals will routinely come into contact with adults who may lack capacity. All staff, however, should be familiar with the Mental Capacity Act Code of Practice (2007) and have access to their manager should they have any concerns. All managers are expected to have a good level of awareness with regard to the MCA, regardless of how often they are using the Act and must be able to support their staff where appropriate.

9.2 Where consultation or guidance is required or sought regarding an assessment of capacity or Best Interests' decision, this should be sought from the staff member's line manager, an experienced colleague, named Professional MCA Lead or Organisational MCA Lead. If the issue is not resolved the staff member should take advice from the agency's own Legal Services in line with agency procedures.

## **10. QUALITY, ACCOUNTABILITY AND RECORDING**

10.1 All assessments of an individual's capacity must be recorded in the individual's case records.

10.2 The Code of Practice gives guidance on when professionals should be involved and when, by implication, there is a need for clearly documented assessment ie:

10.2.1 A decision has major consequences (e.g. a decision to move accommodation, decision to accept /decline support at home, decision whether to report a criminal or abusive act etc).

10.2.2 There may be a dispute with the person, their family or the care team as to the capacity of the individual.

10.2.3 The person's capacity may be subject to challenge.

10.2.4 There may be legal consequences of a finding of capacity (e.g. as a result of a claim for personal injury).

10.2.5 The person is making decisions that put her / himself or others at risk or that result in preventable suffering or damage.

10.2.6 These examples are not exhaustive and each circumstance needs to be judged on its merit, using professional judgement with support from the line manager or relevant leads as appropriate. The anticipation is that staff will use their organisation's recording methods to document clearly when mental capacity assessments and associated best interest decisions are being made.

10.3 Each agency is expected to have their own quality assurances processes in place.

## **11. INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)**

11.1 The IMCA service commenced in April 2007 in England. The current IMCA and DoLS IMCA provider in Herefordshire is Onside Advocacy

11.2 An IMCA is someone appointed to support a person who lacks capacity and has no one to speak for them, such as family or friends. See APPENDIX 3 Independent Mental Capacity Advocate. There is a statutory duty to appoint an IMCA where the decision is any of the following:

11.2.1 Change of Accommodation: An IMCA must be instructed where a decision is proposed about a move to or a change in accommodation where the person lacks

capacity to make the decision and there are no family or friends who are willing and able to support the person. This includes moving to a care home for 8 weeks or more, or admission to hospital where admission is likely to last 28 days or more.

11.2.2 Serious Medical Treatment: NHS bodies must instruct and then take into account information from an IMCA where decisions are proposed about 'serious medical treatment' where the person lacks the capacity to make the decision and there are no family or friends who are willing and able to support the person.

11.2.3 Safeguarding Adults (Adult protection): LAs and the NHS have powers to instruct and must consider an IMCA to support and represent a person who lacks capacity to consent to the proposed measures where it is alleged that:

- i) The person is being or has been abused or neglected by another person; and/or
- ii) The person is abusing or has abused another person.

11.3 In safeguarding adult cases, access to IMCAs is not restricted to people who have no one else to support or represent them. People who lack capacity who do have family and friends are still entitled to have an IMCA to support them in safeguarding adult procedures. The decision-maker must be satisfied that having an IMCA will benefit the person.

11.3.1 Care Reviews: A responsible body can instruct and must consider an IMCA to support and represent a person who lacks capacity when:

- i) They have arranged accommodation for that person
- ii) They aim to review the arrangements (as part of a care plan or otherwise)
- iii) There are no family or friends whom it would be appropriate to consult.

11.3.2 Deprivation of Liberty Safeguards (DoLS): The MCA 2005 introduced the Deprivation of Liberty Safeguards (DoLS) via the Mental Health Act 2007, which has amended the MCA 2005. They provide legal protection for people who may be deprived of their liberty in a hospital (other than under the Mental Health Act 1983) or care home, whether placed there under public or private arrangements. In certain circumstances, a person who is subject to DoLS must have an IMCA instructed to support them. The DoLS Code of Practice provides details of when an IMCA should be instructed – sections 3.22 – 3.28 and 7.34 – 7.41. See HSAB DoLS Policy.

11.4 The IMCA makes representations about the person's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary. The decision maker must take the

IMCA report into account but does not necessarily have to accept the proposed suggestion or conclusion. If the decision maker's decision rejects the IMCA conclusion, then the written response to the IMCA service should include a statement indicating how the information has been considered and giving cogent reasoning to support why it was disregarded.

11.5 The IMCA must give supporting evidence in their final report that underpins their suggestions. To ensure appropriate consultation has occurred in the event of a challenge the following stages will be followed to achieve a satisfactory outcome:

11.5.1 Informal discussion with the decision maker

11.5.2 Request and attend a Best Interests meeting with relevant people invited to attend

11.5.3 Write a letter of concern to the decision maker highlighting the concerns. Copy the relevant Assistant Director and IMCA Manager into the communication

11.5.4 Senior Managers to discuss and respond

11.5.5 Official complaint process initiated

11.5.6 Approach Court of Protection

11.6 For further details see Good Practice Guidance:

<http://www.scie.org.uk/publications/guides/guide39/involvement/index.asp>

<http://www.scie.org.uk/publications/guides/guide39/challenges/index.asp>

## **12. ADVANCE DECISIONS**

12.1 The Act creates statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future. The Act sets out two important safeguards of validity and applicability in relation to Advance Decisions:

12.1.1 Where an Advance Decision concerns treatment that is necessary to sustain life, strict formalities must be complied with in order for the Advance Decision to be applicable.

12.1.2 These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands 'even if life is at risk' which must also be in writing, signed and witnessed.

### **13. RESTRAINT – MCA AND DOLS**

13.1 Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of the harm. Section 6 of the MCA sets out limitations on the use of restraint when taking action in connection with care and treatment. It defines restraint as the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement whether or not the person resists.

13.2 Many different actions can constitute restraint; physical intervention e.g. holding a person, mechanical restraint e.g. lap belts, chemical restraint e.g. medication and environmental restraint e.g. locked doors.

13.3 The Deprivation of Liberty Safeguards (DoLS) 2007 is an amendment to the Mental Capacity Act (MCA) 2005 and are additional safeguards for people who lack capacity and are deprived of their liberty, but are not subject to the Mental Health Act 1983. The DoLS Code of Practice is a supplement to the overarching MCA Code of Practice. They provide a legal framework to protect those who may lack the capacity to consent to the arrangements for their treatment or care and where levels of restriction or restraint used in delivering that care are so extensive as to be depriving the person of their liberty and using Section 6 of the MCA is no longer sufficient. These Codes of Practice should remain the main point of reference for staff working with deprivation of liberty issues.

13.4 The issue of covert medication is a Best Interests specific decision with significant implications. For a decision to be made to administer prescribed medication covertly, e.g. within food or drink unknown to the person, it would first need to be established that the person concerned lacked capacity to consent to the medication. Following a review of the medication, consideration would need to be given as to whether it might be acceptable to the person in an alternative form (e.g. a liquid). Prior to changing the state of any medication, eg by crushing or splitting a capsule open, consultation with a pharmacist is essential. The decision maker i.e. the person administering the medication, would be required to confirm that the medication was in their Best Interests at that time and would follow the care plan to ensure it was the least restrictive option.

13.5 Health and social care practitioners should not administer medicines to a resident without their knowledge (covert administration) if the resident has capacity to make decisions about their treatment and care.

13.6 Health and social care practitioners should ensure that covert administration only takes place in the context of existing legal and good practice frameworks to protect both the resident who is receiving the medicine(s) and the care home staff involved in administering the medicines.

13.7 Health and social care practitioners should ensure that the process for covert administration of medicines to adult residents in care homes includes:

- Assessing mental capacity
- Holding a best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests.
- Recording the reasons for presuming mental incapacity and the proposed management plan
- Planning how medicines will be administered without the resident knowing
- Regularly reviewing whether covert administration is still needed.

## **14. FINANCES, POWER OF ATTORNEY AND DEPUTIES**

14.1 An important change that the mental capacity legislation brought in was enabling individuals to be able to choose someone to take both property and affairs and personal welfare decisions on their behalf should they lose capacity to do so for themselves. A Lasting Power of Attorney (LPA) replaced the previous system of Enduring Powers of Attorney (EPA), which could only be used for decisions on property and financial affairs.

14.2 Professionals may need to confirm the validity of an LPA or EPA and approach can be made to the Office of the Public Guardian (<https://www.gov.uk/government/organisations/office-of-the-public-guardian>) to search the register for this information. Professionals need to have sight of the documentation confirming the scope of the Power and a copy should be held on the individual's notes for reference.

14.3 People who have been assessed as lacking capacity to manage their own financial affairs may still be offered the option of a personal budget or direct payment following a care needs assessment. For more detail:  
<http://www.scie.org.uk/publications/atagance/atagance33.asp>

14.4 No employee of any health and social care organisation in Herefordshire should act as LPA for an individual for whom their organisation holds a responsibility, except

where the employee is also a close friend or relative of the donor and has no professional involvement with the person.

14.5 If an individual wishes someone to act for them now and to be able to continue to act for them if they should lack capacity at some time in the future, then they should consider a LPA. An LPA is a legal document that appoints one or more people to act for a person, if in the future that person becomes incapable of managing for themselves. It must be created while the person has capacity and is capable of understanding the nature and effect of an LPA.

14.6 There are two types of LPA:

14.6.1 A Property and Affairs LPA – which gives the attorney authority to make decisions about property and financial affairs;

14.6.2 A Personal Welfare LPA – which gives the attorney authority to make decisions about healthcare and personal welfare.

14.7 An important distinction between the two types is that a property and affairs LPA can be used by the attorney even when the donor still has mental capacity to make their own decisions; a personal welfare LPA can only be used once the donor has lost capacity to make the relevant decisions themselves.

14.8 There are separate forms for creating the two different types of LPA; one form for personal welfare LPAs and one for property and affair LPAs. If a person wants to give their attorney the power to make both types of decision, they will have to set up two separate LPAs, even where the same person is appointed as attorney for both types of decision.

If you're appointing more than one person, you must decide if they'll make decisions:

- separately or together - called 'jointly and severally' - which means attorneys can make decisions on their own or with other attorney
- together - sometimes called 'jointly' - which means all the attorneys have to agree on the decision

14.9 You can also choose to let them make some decisions 'jointly', and others 'jointly and severally'. Attorneys who are appointed jointly must all agree or they can't make the decision.

14.10 Both types of LPA document must be registered before it can be used. The LPA is can be done before or after the donor loses mental capacity. If wished, the donor can register the LPA whilst they still have capacity, to avoid any delay when it needs to be

used. If a person loses capacity before the LPA is registered, their attorney will need to register it. There is a fee for registering the LPA. Whilst the registration process is taking place the attorneys have limited powers which are only to maintain the situation.

14.11 Any existing EPA can now be revoked and an LPA set up instead under the new system as long as the donor still has mental capacity to do so at the point the LPA is created. If an EPA has already been registered, it will continue.

14.12 Should there be concerns raised that the LPA or EPA may not be acting in the person's best interests, approach should be made to the Office of the Public Guardian for investigation

14.13 A decision must be made on whether to rely on a Power of Attorney granted/registered outside England and legal advice is likely to be required.

## **15. COURT OF PROTECTION AND OFFICE OF THE PUBLIC GUARDIAN**

15.1 The Court of Protection is the specialist court for all issues relating to people who lack capacity to make specific decisions. The Court can make decisions and appoint deputies to make decisions about someone's property and financial affairs or their healthcare and personal welfare.

15.2 Should a person lack capacity to manage their property and financial affairs but have not appointed an LPA or EPA prior to losing capacity, the Court of Protection will appoint a Deputy to have continued authority for that person's money and assets. There may be on occasion the need for the Court to appoint a personal welfare deputy.

15.3 Details about the Court of Protection (CoP) and Office of the Public Guardian can be found at <https://www.gov.uk> (search Court of Protection)

15.4 There are situations when decisions must be taken to the Court e.g. the proposed withholding or withdrawal of artificial nutrition and hydration from a patient in a permanent vegetative state and situations when the Court should be accessed e.g. a major disagreement regarding a serious decisions that cannot be settled in any other way such as where a person should live or the validity of an Advance Decision. Where someone suspects that a person who lacks capacity to make decisions to protect themselves is at risk of harm or abuse from a named individual the Court should be the arbiter for matters of no contact. An authorisation under MCA DOLS, other than as a very short-term measure, should not be relied upon to manage no contact cases which breach an individual's Article 8 right to respect for private and family life under The Human Rights Act. The Court should not only be accessed when there is a dispute, it

should also be used to ensure that the person can access the additional safeguards that the courts have to offer for decision making.

15.5 In cases where an application should be made to Court, the Code of Practice puts the responsibility to do this with the decision-making body. In most cases this will be a LA or NHS Trust. Staff should seek advice from legal services if an application to the Court is indicated. In accordance with the first principle of the Act, it should not be assumed that the person is unable to make an application to the court themselves. The Official Solicitor can act for people who lack capacity to instruct a solicitor. The Official Solicitor acts as a 'litigation friend' of last resort. Where a person does not have capacity to instruct a solicitor, a litigation friend should be appointed. A person acting as a litigation friend can instruct a solicitor on the person's behalf. An IMCA could undertake the role of litigation friend.

15.6 Permission to make an application to the court is needed from LAs, NHS Trusts, family members or friends, professionals and advocates including IMCAs (with the exception of the DoLS 39C role). The person concerned and the person's litigation friends amongst others do not need permission to apply. All of the forms can be located on <https://www.gov.uk> (search Court of Protection). Applying to the court incurs costs which must be paid at the time of making the application. Applications can be 'fast-tracked' in circumstances where an immediate decision (or decisions) needs to be made.

15.7 If permission to apply has been sought, the Court will first consider whether it will grant permission to apply. If granted the applicant will receive a series of forms and there will be a number of people who will be informed that court proceedings have begun. When this is complete the court will either:

15.7.1 Make a decision based on the application without a hearing;

15.7.2 Give directions about the application and next steps to be taken;

15.7.3 Fix a date for the application to be heard by the Court

15.8 The court decides what will constitute the evidence for the case. An order for 'general' or 'specific' disclosure (stating that certain documents exist) will be made.

15.9 Every party will receive a copy of the courts decisions which is referred to as an 'order'. There are options to appeal against the decision.

## 16. CONSENT AND CAPACITY

16.1 Professionals have three over-riding responsibilities with regard to obtaining consent:

16.1.1 To make the care of people their first concern and ensure they gain consent before they begin any treatment or care.

16.1.2 Ensure that the process of establishing consent is rigorous, transparent and demonstrates a clear level of professional accountability.

16.1.3 Accurately record all discussions and decisions relating to obtaining consent.

16.2 In emergency situations, an adult who becomes temporarily unable to consent due to, for example, being unconscious, may receive treatment necessary to preserve life, as long as it is in the best interests of that person. Intervention considered being in the persons best interest, but which can be delayed until they can consent, should be carried out when consent can be given. Exceptions to this are where the person has issued an advanced directive detailing refusal of treatment.

16.3 Obtaining consent is a process rather than a one-off event. When a person is told about proposed treatment and care, it is important that sufficient information is given in a sensitive and understandable way. The person should be given enough time to consider the information and the opportunity to ask questions if they wish to.

16.4 Where any doubt about the patient's capacity to consent exists the decision maker should assess whether the person has capacity to make the decision in question. No-one (apart from personal welfare LPA) is able to give consent on behalf of an adult unable to give consent for him or herself, although Carers, family members and professionals involved in their care will contribute to the best interests decision making process.

16.5 Consent to care and treatment is one of the key outcomes in CQCs regulatory system. Assessments and recording of consent and capacity should be an integral part of care / treatment planning.

16.6 More reference and guidance on these complex issues can be found:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_103643](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643)[http://www.gmcuk.org/guidance/ethical\\_guidance/end\\_of\\_life\\_care.asp](http://www.gmcuk.org/guidance/ethical_guidance/end_of_life_care.asp)

16.7 In respect of mental health, the Mental Health Act provides a legal framework by which a detained patient's treatment may be made compulsory in the absence of their consent or their refusal to consent. However, the patient's consent should always be

sought and their mental capacity and consent or refusal should be recorded in full. When patients are detained under the Mental Health Act, they may be given treatment with medication for their mental disorder for the first three months of their treatment, even if they refuse to consent or are incapable of giving consent to that treatment. After this time (except in emergencies), the treatment can be given only under certain conditions and the authority for that treatment must be formally certified. Where the patient consents to the treatment, either the Approved Clinician in charge of it or a second opinion appointed doctor (SOAD) will certify that consent on form T2; where the patient lacks capacity to consent, or refuses to consent, the treatment may only be given following a SOAD certification, on form T3, that is appropriate for it to be given. A patient's capacity and consent status should be under continuous review, especially when they have been certified as consenting to treatment by the clinician in charge of treatment.

16.8 Additional safeguards with respect to consent for ECT (Electro-convulsive therapy) are in place.

[http://www.mentalhealthlaw.co.uk/Additional\\_safeguards\\_for\\_ECT\\_introduced\\_in\\_new\\_s58A](http://www.mentalhealthlaw.co.uk/Additional_safeguards_for_ECT_introduced_in_new_s58A)

16.9 Staff should follow their agency's policy on consent.

## **17. STAFF LIABILITY**

17.1 Staff have a legal duty to have regard to the Code when making any decision or performing any act for or on behalf of a person who lacks capacity. The MCA 2005 offers protection from risk of legal liability to staff in health and social care when performing an act of care or treatment in the Best Interests of a person who lacks capacity to consent to that act, providing they have followed the MCA 2005 and the Code of Practice. Staff need to be mindful of keeping updated of case law which can set precedent over the legislation and guidelines. In order for staff to receive this legal protection:

17.1.1 Staff must reasonably believe that the act is in the Best Interests of the person

17.1.2 The protection does not apply to an act which is negligently performed, or which may give rise to criminal liability.

17.1.3 Staff need to record acts taken in the person's best interests. This includes when actions have been taken in emergency situations.

17.2 In emergency situations, staff have less time to come to a conclusion about the steps above so it is recognised that it will almost always be in the person's Best

Interests to give emergency treatment. Advance Decisions apply in an emergency situation but need to be evidenced. Section 5.39 of the Code of Practice makes it clear that learning about a person's past and present views depends on circumstances and that what is available in an emergency will be different to what is available in a non-emergency. However '...even in an emergency there may still be an opportunity to try to communicate with the person or his friends, family or Carers'.

17.3 Further information can be found:

A Guide for Critical Care Settings Mental Capacity Act 2005 (Intensive Care Society) provides guidance on the application of the MCA in intensive care settings including emergency settings:

[http://www.ics.ac.uk/jicpublications/mental\\_capacity\\_act](http://www.ics.ac.uk/jicpublications/mental_capacity_act) and guidance on end of life care: <http://www.gmc-uk.org/guidance/7046.asp>

## **18. INTERFACE OF MHA 1983 AND MCA 2005**

18.1 For some patients or residents, the MHA 1983 and the MCA 2005 are inextricably linked, interacting in many areas. If a person is over 16, has a mental disorder, needs treatment for their mental disorder and lacks capacity in relation to that treatment then either Act could apply. The Mental Health Code of Practice states "It will be difficult for professionals involved in providing care for people with mental health problems to carry out their work (including their responsibilities under the MHA) without an understanding of key concepts in the Mental Capacity Act".

18.2 Chapter 13 of the Mental Health Code of Practice 2014 looks in detail at the interface between the Mental Health Act and the Mental Capacity Act and Deprivation of Liberty Safeguards and should be considered in relation for people with mental health issues who lack capacity.

18.3 It is important for health and social care staff who work with client groups with mental health problems, particularly those with severe and enduring mental illness to have an understanding of this interface. This also includes the need to have an awareness of the Deprivation of Liberty Safeguards.

## **19. CONVEYANCE TO HOSPITAL OR CARE HOME**

19.1 Decisions on conveyance would be part of the best interest decision making process. Where conveyance to hospital or a care home involves the use of restraint, this must be shown to be proportionate to the level of risk. The use of the Mental Health

Act should be considered if the criteria for admission to hospital for assessment or treatment are likely to be met, or to remove a person who appears to have a mental disorder to a place of safety.

19.2 If there is a serious disagreement about the need to move the person that cannot be settled in any other way, the Court of Protection should be asked to decide what the person's best interests are and where they should live.

## **20. HOSPITALS**

### **20.1 Discharge planning**

Before discharging a patient from hospital who lacks capacity the following process must be followed:-

The Decision Maker must arrange a Best Interest discharge meeting or consult with the following:-

Family members or (close friend where there is no family involved) who are interested in the outcome for their relative

Any IMCA that has been appointed

Any Donee under a Lasting Power of attorney

Any Deputy appointed by the Court of Protection

Any member of clinical staff who has a significant role in the care and treatment of the person involved.

A member of the Local Authority where a care package/placement may be needed.

This process should also be followed for cases where the plan is to discharge the person to another hospital or medical unit such as a rehab unit or a Rapid Access to Assessed Care bed.

### **20.2 Decisions Regarding Do Not Attempt to Resuscitate, Palliative care, End of life care and decision not to readmit to hospital.**

In making any of the above significant decision about someone's ongoing treatment then the best interest process through a best interest meeting should be followed as outlined above.

### **20.3 Decisions to move patients from general hospital to community hospital**

Where a patient does not need to remain in the acute hospital, but still requires some level of hospital treatment the decision whether to move to a community hospital (Wye Valley Trust or other Community Hospitals) must be made again following a best interest decision making discussion. The reason for any move and who it has been discussed with must be clearly documented in medical records, to evidence that the decision has been made in the patient's best interests. Alternative options such as use of virtual wards at home should be considered. Repeated moves within the hospital system of incapacitated and confused patients should be avoided wherever possible.

### **20.4 Making care and treatment decisions about people in hospital who lack capacity.**

When making care and treatment decisions on behalf of a patient who does not have the capacity to consent to these decisions staff must evidence in the patient's notes that a capacity assessment has been completed and that a best interests decision making process has been followed.

When making any best interest decisions staff should consider if the person has fluctuating capacity (see 7.13.1)

### **20.5 Patients who regain capacity**

If it is thought that a patient who lacked capacity to make decisions about care and treatment has regained capacity, then a new capacity assessment should be undertaken and the outcome recorded on the patient's notes.

### **20.6 Patients who are subject to DoLS in hospital, but are to be discharged**

When a patient who is subject to DoLS is due to be discharged to a Care or Nursing home the hospital must inform the managers of the new placement that the person who is moving to them has been subject to a DoLS authorisation whilst in hospital and that therefore they need to consider making an application for a DoLS themselves.

## **21. THE POLICE SERVICE**

21.1 Principally, decisions around capacity and healthcare should be taken by healthcare professionals; however it will in some circumstances be applicable to police officers where intervention is necessary to mitigate an imminent, life-threatening risk. In these cases officers will usually need to make immediate decisions while awaiting

further assessment by a health or social care professional in order to preserve life or prevent serious injury.

21.2 The MCA applies in both public and private premises. The police may be able to gain entry to private premises through the power enacted under S.17 of PACE (Police Criminal Evidence Act) in order of saving life or limb or preventing serious damage to property where there is reasonable belief. The circumstances may then be such that subsequently the use of MCA is an appropriate solution to deal with the incident. When in public the use of S.136 MHA (Mental Health Act) may be the most appropriate solution. It should be noted however that in the case of R (Sessay) v (1) South London and Maudsley NHS Foundation Trust and (2) Commissioner of Police of the Metropolis [2012] 2 WLR 1071 it was made clear that the MCA cannot be used to remove apparently mentally disordered persons to a Place of Safety for the purposes set out in sections 135 and 136 of the MHA.

21.3 It may, in appropriate circumstances, be possible to rely on s.5 and s.6 MCA to provide protection from liability in civil and/or criminal proceedings for necessary acts done in the Best Interests of a person lacking capacity. This protection only applies where the officers have taken the following steps:

- a) Take reasonable steps to establish whether the person lacks capacity in relation to the matter in question;
- b) Reasonably believe that:
  - i. The person lacks capacity in relation to the matter; and
  - ii. . It is in the person's Best Interests for it to be done.
- c) Have regard to whether the purpose can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action (s.1(6));
- d) Consider all the relevant circumstances of which they are aware (s.4(2));
- e) So far as practicable, take the steps set out in s.4 (4), (6) and (7).1

21.4 The MCA Code of Practice para 6.5 sets out various actions that might be covered by s.5, including taking someone to hospital for assessment or treatment and providing care in an emergency.

21.5 Where restraint is carried out, officers must reasonably believe it is necessary to prevent harm to the person and the restraint must be a proportionate response to the likelihood of harm and the seriousness of that harm (s.6 (2) and (3)). Restraint occurs where there is force is used or threatened to secure the doing of an action which the person resists or where there is restriction of the person's liberty of movement, whether

or not s/he resists. Note that the MCA does not provide for restraint to be used where the threat of harm or damage is towards other persons or property, in these cases Police should rely upon their powers from PACE where a criminal offence has been committed.

21.6 Section 4A MCA states expressly that the Act does not authorise any person to deprive a person of his liberty, except in certain specified circumstances given in S. 4B relating to the giving of life sustaining treatment. Action taken under MCAs.5 (Best Interests) is not permitted to amount to a deprivation of liberty (within the meaning of Article 5 ECHR).

21.7 The Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice explains at paras 5-045 that transporting a person who lacks capacity to a hospital will not usually amount to a deprivation of liberty so long as it is in their Best Interests, but at 5-046 the point is made that “in a very few cases there may be exceptional circumstances where taking a person to a hospital ... amounts to a deprivation of liberty, for example where it is necessary to do more than persuade or restrain the person for the purpose of transportation ...”.

21.8 If officers encounter a person whom they reasonably believe to lack capacity in relation to the decision required, they should consider taking action to safeguard the person’s Best Interests, having regard to how that purpose can be achieved in a way that places the least restrictions on the person’s rights and freedom of action. Some people will experience fluctuating capacity which can affect their ability to understand information and make decisions over a period of time.

21.9 Where police are the only service on scene it may be necessary to make an assessment of capacity and act accordingly before other services arrive due to the seriousness or urgency of the situation. If the MCA is used officers should ensure they record the steps they took to establish the person lacked capacity. When a doctor, member of the ambulance service or other professional arrives on the scene, or is already present, police should defer to their expertise and provide support as appropriate.

21.10 Where an individual who lacks capacity is safe in their premises and there is a concern about their mental health, the police should contact the GP linked to the West Midlands Ambulance Service to review and refer to the Crisis Team if appropriate.

21.11 In certain circumstances officers may have a defence to a claim for false imprisonment/assault etc under s.5 MCA, e.g. where they take a person lacking capacity to hospital for urgent treatment of a physical condition or conditions, or where the officers themselves administer lifesaving treatment or facilitate its provision by ambulance staff, great care will have to be exercised to ensure that the statutory

requirements are met and that the level of restraint used does not reach a level where it amounts to a deprivation of liberty.

21.12 though it is not possible to be prescriptive in advance, because each case has to be assessed on its merits, officers may wish to consider carefully whether in any particular case it would be practicable to avoid transporting a person in a police van and to use an ambulance instead, and whether mechanical forms of restraint are absolutely necessary. If a person is restrained in handcuffs and leg restraints and transported in a police van, for example, there is likely to be a deprivation of liberty. In such a case the defence under the MCA cannot be relied upon and alternative solutions or other legislation should be used (the case of *ZH v Commissioner of Police for the Metropolis* (2013) EWHC provides an example of this).

21.13 should be borne in mind that s.5 MCA was not enacted as a way of supplementing police powers to deal with vulnerable people lacking capacity; its purpose was in large part to place on a clear legal footing the necessary acts of care and treatment carried out on a daily basis for such people lacking mental capacity by health and social care staff relatives and informal carers. As such there is no bar on police officers obtaining protection under the section, where used appropriately.

21.14 The police may also be involved in decisions to prosecute under Section 44 of the MCA. The Act introduces two new criminal offences: ill-treatment and willful neglect of a person who lacks capacity to make relevant decisions. These cases would involve an individual who is considered vulnerable and the DAVA (Domestic Abuse and Vulnerable Adults) team in the Public Protection Bureau should be consulted.

21.15 In summary the key advice to police officers is if you can avoid taking decisions – including mental health care decisions – implied by the MCA because there is time to call an ambulance or other health or social care professionals, you should do so. Any intervention should be restricted to those circumstances where you absolutely must intervene in order to preserve life or prevent serious injury and this means having regard to S. 4B MCA – only where intervention is necessary to mitigate an imminent, life threatening risk.

21.16 Further information can be found at <https://mentalhealthcop.wordpress.com/>

## **22. THE AMBULANCE SERVICE:**

22.1 West Midlands Ambulance Service provides ambulance services to Herefordshire.

22.2 Acting in the Best Interests of a resistant patient who lacks mental capacity.

22.2.1 Clinicians should use the 2 stage MCA test of capacity to make an assessment of mental capacity and a Best Interests decision. If a decision is made to convey in the persons' Best Interests clinicians should try to persuade the patient to cooperate with them using necessary and proportionate restraint. If the patient continues to actively resist and there is a significant risk of injury to either the patient or themselves they should request the assistance of Herefordshire Police.

If a decision is made not to convey the decision should be appropriately documented. Clinicians should also consider whether a 'Vulnerable Adults' referral is indicated in this incidence.

## **23. RESEARCH**

23.1 The Act lays down clear parameters for research where people without capacity may be the subjects. The Act provides detailed rules on the requirements and procedures to be followed for intrusive research involving people who lack capacity. Intrusive research is defined as any research that requires a person's consent.

23.2 To carry out intrusive research on a person who lacks capacity to consent the following criteria must be met:

23.2.1 It has been approved by an appropriate body and

23.2.2 Consultation with Carers and others has taken place and

23.2.3 Additional safeguards are followed.

23.3 An appropriate body is defined as a person, committee or other body as specified in the regulations by the Secretary of State for Health, for example a Research Ethics Committee.

23.4 The research project must take reasonable steps to identify and consult with someone involved in the care and welfare of the person, other than someone working in a professional capacity or in return for payment.

23.5 If a person who lacks capacity is taking part in research then a range of safeguards apply e.g. nothing is done that is contrary to an advance decision. All the normal decision maker's guidelines and other Code of Practice principles also apply to making decisions about taking part in research. Each partner organisation should refer to their own organisations governance policy or protocol. For more detail see the MCA Code of Practice, Chapter 11.

23.6 Further information:

National Research Ethics Service:  
<http://www.nres.npsa.nhs.uk/applications/guidance/consent-guidance-and-forms/>

## **24. CHILDREN AND YOUNG PEOPLE**

24.1 Within the MCA 2005 'children' referred to people aged below 16 while 'young people' referred to people aged 16 – 17. Schedule 3 of the MCA has been amended (with some exceptions with regard to legal processes for 16 / 17 year olds) and the term 'adult' now means a person who:

- (c) As a result of an impairment or insufficiency of his personal faculties, cannot protect his interests, and
- (d) Has reached 16.

This differs from the Children Act 1989 and the law more generally, where the term 'child' is used to refer to people aged under 18. See Chapter 12 of the MCA Code of Practice.

24.2 The Act does not generally apply to people under the age of 16 with the exception of:

24.2.1 Offences of ill-treatment or willful neglect; and

24.2.2 the Court of Protection's power to make decisions about a child's property or finances where the child lacks to capacity to make such decisions and is likely to still lack capacity to make such financial decisions when they reach the age of 18.

24.2.3 Further information is available at [www.dh.gov.uk/consent](http://www.dh.gov.uk/consent)

24.3 Most of the Act applies to people aged 16 years and over. There are four exceptions:

24.3.1 Only people aged 18 and over can make a Lasting Power of Attorney,

24.3.2 Only people aged 18 and over can make an Advance Decision to refuse medical treatment.

24.3.3 The Court of Protection may only make a statutory will for a person aged 18 and over.

24.3.4 The Deprivation of Liberty Safeguards only apply to people aged 18 and over.

24.4 There is an overlap with the Children Act 1989. For the Act to apply to a young person they must lack capacity to make a particular decision. Staff have to choose which Act they consider most appropriate to use. The MCA is particularly appropriate where it is expected that capacity will not be regained or attained on reaching majority and there may be continued interventions required. However, there are no legal tests for deciding which Act must be used.

24.5 When making a decision in the young person's best interests the person providing care and treatment must consult those involved in the young person's care and anyone interested in their welfare if it is practical and appropriate to do so. This may include the young person's parents. Care should be taken not to unlawfully breach the young person's right to confidentiality.

24.6 In respect of care or treatment of young people aged 16 or 17 the Family Law Reform Act 1969 presumes that young people have the legal capacity to agree to surgical, medical or dental treatment. It does not apply to some rarer types of procedures, e.g. organ donation. Even where a young person is presumed to have legal capacity to consent to treatment, they may not necessarily be able to make the relevant decision. As with adults, decision-makers should assess the young person's capacity to consent to the proposed care or treatment. If a young person has capacity to agree to treatment, their decision to consent must be respected. If the young person lacks capacity to make care or treatment decisions health or social care staff can carry out treatment or care with protection from liability, as long as they have assessed capacity and implemented best interest decision making process, whether or not a person with parental responsibility consents.

24.7 There may be particular difficulties where young people with mental health problems require in-patient psychiatric treatment and are treated informally rather than detained under the Mental Health Act 1983. The Legal Aspects of the Care and Treatment of Children and Young People with Mental Disorders: A guide for Professionals (NIMHE Jan 2009) provides guidance on the complex legal framework relevant to the provision of care and treatment to children and young people with severe mental disorders who may require a period of in-patient care.

## **25. CARERS**

25.1 The MCA is relevant to anyone who has a relative or friend who may be unable to make all or some decisions for themselves. Anyone in a position where they might

need to make a decision for someone who may lack capacity must decide whether that person is able to make that decision on their own.

25.2 A Carer may be involved in assessing capacity in two ways:

25.2.1 A professional may consult the Carer to understand more about the person in order to help with the capacity assessment. Whoever is assessing what is in the person's Best Interests must consult with the Carers and anyone with an interest in their welfare. Consultation does not mean that Carers are making the decision, and Carers should not be asked to give consent on behalf of another person. Sometimes it will not be practical and appropriate to consult e.g. in emergency situations.

25.2.1 The Carer may become the decision maker for the person who has to make the decision. Carers are not expected to be an expert in assessing capacity, but they should have a 'reasonable belief' that the person they care for lacks mental capacity to make certain decisions in certain situations e.g. day to day activities.

25.3 If a person has capacity, just because the person makes a different decision from the one the Carer would make or a decision the Carer considers to be 'unwise' does not mean that they lack capacity to make that decision.

25.4 Relatives, friends or other unpaid Carers may be appointed as an Attorney. However if the person lacks capacity, the Carer must apply to the Court of Protection in order to be granted permission to make decisions on their behalf as a Deputy

25.5 The MCA introduced a new criminal offence of ill-treatment or willful neglect of a person who lacks capacity. If a Carer thinks someone is abusing, ill-treating or neglecting a friend or relative they should contact Herefordshire Council's Advice and Referral Team (ART) on 01432 260101. Out of hours, weekends and public holidays: 0330 123 9309

25.6 There may be situations where Carers may wish to challenge a decision or need to find a way to resolve a dispute. This might happen if a Carer thinks they have not been consulted where it would be appropriate, or a decision is made which the Carer does not think is in the Best Interests of their friend or relative. Carers may involve an independent advocate, make a formal complaint, get advice from the Office of the Public Guardian or in the last resort go to the Court of Protection. Ultimately responsibility for working out the Best Interests lies with the decision-maker.

25.7 A person who lacks capacity to manage a direct payment or a personal budget may still receive one if a 'suitable' person is available to manage it for them. A suitable person can be a friend, Carer or family member. Identification of the suitable person will be done as part of the assessment process.

25.8 Where a young Carer is identified links should be made with the Multi Agency Safeguarding Hub (MASH) on 01432 260800 (01905 768020 out of hours) and Herefordshire Young Carers on 01432 356068. It may be appropriate and sometimes essential to take the views of young Carers into account when assessing mental capacity. A young Carer may be the only person that has insight into the situation and the person being assessed.

## **26. PERSONALISATION**

26.1 The Mental Capacity Act and personalisation share core values. The MCA emphasises the person being at the centre of decision making. Where this is not possible because of lack of capacity the person should be supported to be involved as much as possible. Personalisation starts with the person as an individual with strengths, preferences and aspirations and means putting them at the centre of the process of identifying their needs and making choices about what, who, how and when they are supported to live their lives.

26.2 There are a number of important decision-making points in setting up and managing self-directed support. Where a person lacks the capacity to make a particular decision, their views must still be sought. Their ability to make decisions on other matters should be assumed. For example, a person may be able to make a decision about who they would like to support them, but not about how to manage a personal budget.

26.3 Assessment is the starting point for identifying what a person's eligible needs are, the outcomes they want to achieve and an indicative amount of money available for their personal budget. Wherever possible a person should be supported to lead and participate in the self-assessment process.

If someone lacks capacity in relation to identifying eligible needs and financial assessment, an appropriate person needs to be identified to assist in providing the information for the assessment whilst being mindful of the person's rights to confidentiality. (See also Section 26 regarding information governance).

26.4 The local authority must make sure that the eligible person is fully supported to understand the range of personal budget options, the benefits and responsibilities involved in each, and the support available to manage them. A personal budget may be received by a direct (cash) payment paid to the eligible person, or where they lack capacity, to a 'suitable person'. The suitable person must be available and willing to make support decisions and manage the direct payment on the person's behalf. A managed personal budget can either be placed by the local authority with a third party

who works with the provider according to the eligible person's wishes or held by the local authority, who arranges and manages services on the eligible person's behalf.

26.5 If there are doubts about the eligible person being able to make the decision themselves about having a direct payment or a managed personal budget, this should be confirmed with a mental capacity assessment. The local authority should then lead the Best-Interests decision about the most suitable option. It should not be assumed that this will be the local authority continuing to manage the person's care and support.

26.6 The suitable person can be:

26.6.1 A friend, Carer or family member;

26.6.2 A Deputy appointed by the Court of Protection;

26.6.3 An Attorney with health and welfare or finance decision-making powers created by a lasting power of attorney;

26.6.4 An independent support broker.

26.7 The managed personal budget option may be appropriate where:

26.7.1 The eligible person is unable to manage a personal budget

26.7.2 There is not a suitable person available and willing to manage the direct payment

26.7.3 There is a person who has an active interest in supporting the person but does not want the responsibilities of managing a direct payment.

26.8 If a person lacks capacity to make some decisions about their support, the local authority staff are likely to need to put in place more frequent monitoring arrangements than for other people who use services. Attention will also need to be given to ensuring the person has as much opportunity as possible to control and review the support they receive.

26.9 Finally, there are a number of instances where it may be necessary to involve the Court of Protection. A suitable person may wish to make an application to the Court of Protection to be appointed as a property and affairs Deputy to enter contracts on behalf of the person, for example a tenancy agreement. It should also be used where there are disputes which cannot be resolved.

## **27. TRAINING**

27.1 Herefordshire Safeguarding Adult Board has implemented a multi-agency training framework which includes MCA and DoLS to support training and development of staff within Herefordshire's statutory, independent and third sector Health and Social Care workforce. The aim has been to provide knowledge and understanding to enable staff to carry out their duties and responsibilities under the MCA. Within this strategy partner organisations will have their own training strategies to meet the specialist needs of individual organisations teams and service.

27.2 Organisational specific training and implementation needs will be addressed within individual agencies within the context of the overall framework. All training should be linked to the MCA Competencies detailed in the competency framework.

## **28. INFORMATION GOVERNANCE**

28.1 Sometimes, third parties may request information about someone who lacks capacity. Chapter 16 of the MCA Code of Practice offers general guidance. See also The Information Commissioners Office at [www.ico.gov.uk](http://www.ico.gov.uk) and BMA guidance <http://bma.org.uk/practical-support-at-work/ethics/confidentiality-tool-kit>. Practitioners must have regard to the Data Protection Act and relevant organisational policy.

28.2 The following is a summary of key points:

28.2.1 It should always be considered first whether the person who lacks capacity in relation to a specific decision may nevertheless have the capacity to agree to that information being disclosed. If so, the person's consent to disclose the information should be sought.

28.2.2 It should always be considered whether the person making the request for confidential information has lawful authority to ask for it.

28.2.3 Staff must be satisfied that the person making the request for information is acting in the Best Interests of the person who lacks capacity and needs the information to act properly.

28.2.4 Staff must also be satisfied that the person making the request will respect confidentiality and will keep the information for no longer than is necessary.

28.2.5 If staff decide, based upon the Best Interests and needs of the person who lacks capacity, that information should not be revealed to the person's Carer, Chapter 15 of the MCA Code of Practice provides options to consider.

28.2.6 If staff reveal confidential information lawfully, they should ask the recipient to confirm that they will keep that information safe, confidential and for no longer than is reasonably necessary for the purpose requested.

28.2.7 Staff should ensure they record all incidents of information sharing and their justification for sharing at that point in time.

28.2.8 Individuals or their relatives may make requests to see their records, and the proper processes for such “subject access requests” must be followed within the organisation receiving the request to ensure that it is answered lawfully. Other data protection rights such as the right to correct inaccurate data must also be respected and the correct organisational procedures followed when these rights are invoked.

28.2.9 A privacy notice will be in place to inform individuals how their personal data will be processed and that a data sharing agreement will document the process for sharing information.

## **29. RELATED HSAB POLICY AND PROCEDURES**

- Adult Safeguarding: Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands.
- AMHP Guidance on S135
- Case Recording
- Decision Making Process and Recording
- DoLS Policy and Procedure
- Herefordshire Council Information Sharing Protocol
- Medication
- Ordinary Residence
- Physical Interventions of People with a Learning Disability
- Positive Approaches to Behaviour that Challenges

- Provider Concerns
- Risk Assessment and Reablement

### **30. FURTHER INFORMATION AND RESOURCES**

30.1 There is a wealth of published advice and guidance on assessment of mental capacity. See Appendix 5.

## **31. MONITORING AND REVIEW**

31.1 This policy will be monitored and reviewed annually

## **32. IMPLEMENTATION**

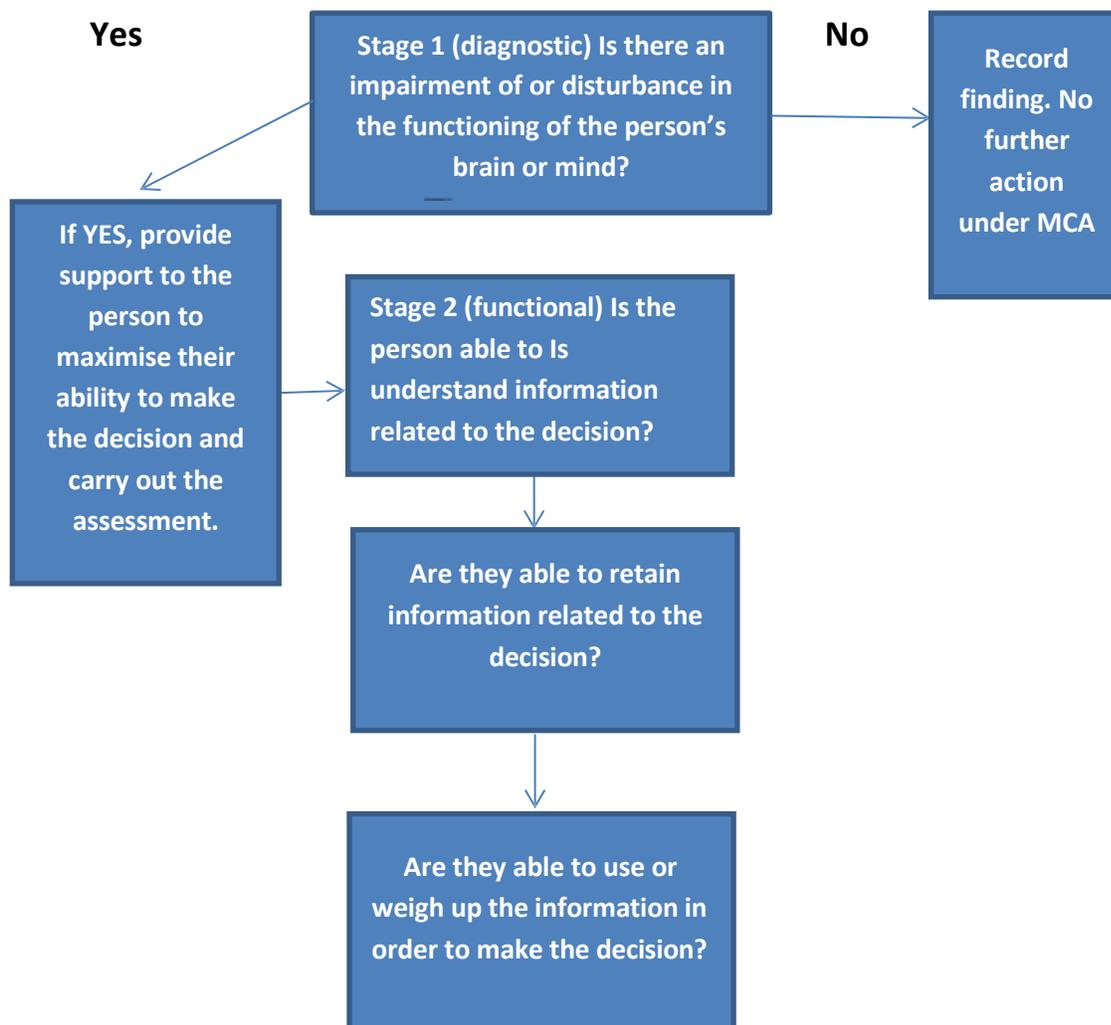
32.1 Partner agencies existing related policies and procedures will need to be reviewed to ensure consistency with this updated MCA policy, procedure and guidelines.

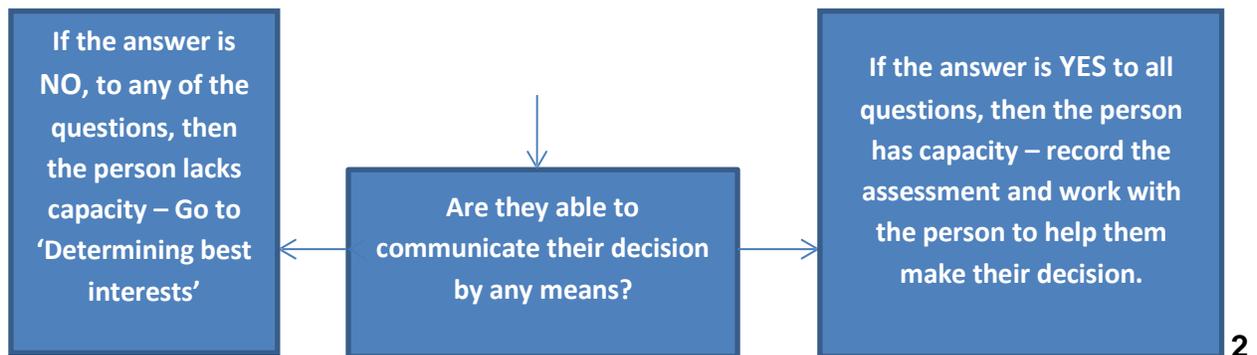
## APPENDIX 1

**Mental capacity is the ability to make a specific decision at the time it needs to be made**

Always presume the person has capacity but, if there are doubts because of their behaviour or circumstances, because they have previously shown they have lacked capacity or someone else has expressed concern about this – then assess their capacity:

### Assessment of Capacity





**Mental Capacity is the ability to make a specific decision at the time it needs to be made.**

### **Determining Best Interests Checklist**

The law gives a checklist of key factors which decision makers must consider when working out what is in the best interests of a person who lacks capacity. This list is not exhaustive and you should refer to the Code of Practice for more details.

- It is important not to make assumptions about someone’s best interests merely on the basis of the person’s age or appearance, condition or any aspect of their behaviour.
- The decision-maker must consider all the relevant circumstances relating to the decision in question.
- The decision-maker must consider whether the person is likely to regain capacity (for example, after receiving medical treatment). If so, can the decision or act wait until then?
- The decision-maker must involve the person as fully as possible in the decision that is being made on their behalf.
- If the decision concerns the provision or withdrawal of life-sustaining treatment the decision-maker must not be motivated by a desire to bring about the person’s death.

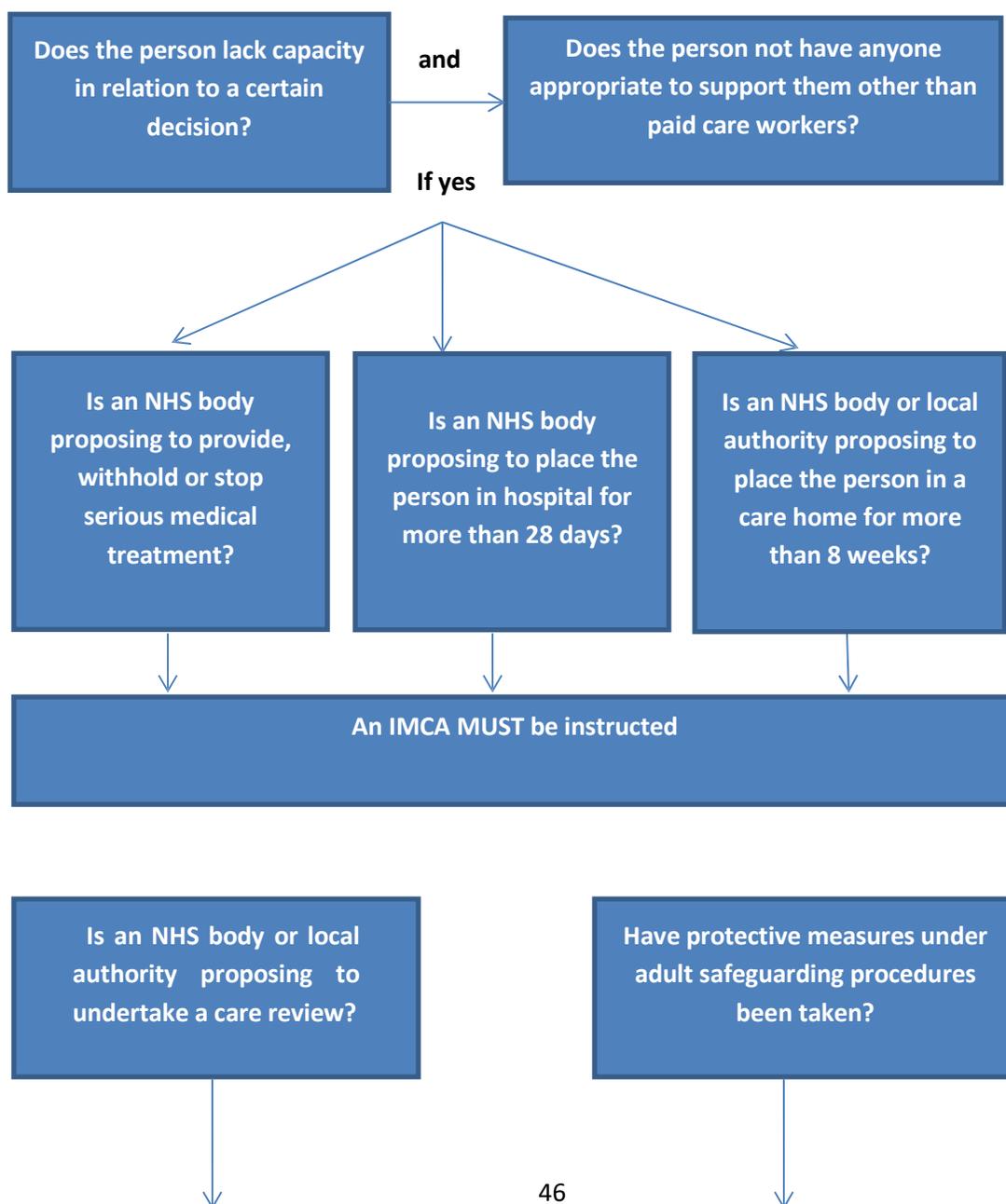
**The decision maker must consider:**

1. Have you consulted anyone previously named by the person lacking capacity as someone to be consulted?
2. Have you consulted the person's carers, close relatives, close friends or anyone else interested in the person's welfare?
3. Have you consulted any Attorney appointed under a Lasting Power of Attorney?
4. Have you consulted any Deputy appointed by the Court of Protection to make decisions for the person?
5. Are you able to establish the person's past and present wishes, views and feelings (both written and verbally) in relation to the decision?
6. Does the person hold any beliefs or values which are likely to influence the decision?
7. Have you consulted the IMCA if they have been instructed?
8. Are there any other factors that the person themselves would be likely to consider if they were making the decision themselves?

Take all views and findings into consideration to determine the best interests and record decisions.

If there is disagreement about what is in the person's best interest, this should be addressed locally but if all means to resolve this fail, then an application to the Court of Protection must be made to rule on the person's best interests.

Independent Mental Capacity Advocate (IMCA)



An IMCA MAY be instructed

Independent Mental Capacity Advocates: Onside Advocacy Tel: 01905 27525

Email: [imca@onside-advocacy.org.uk](mailto:imca@onside-advocacy.org.uk)

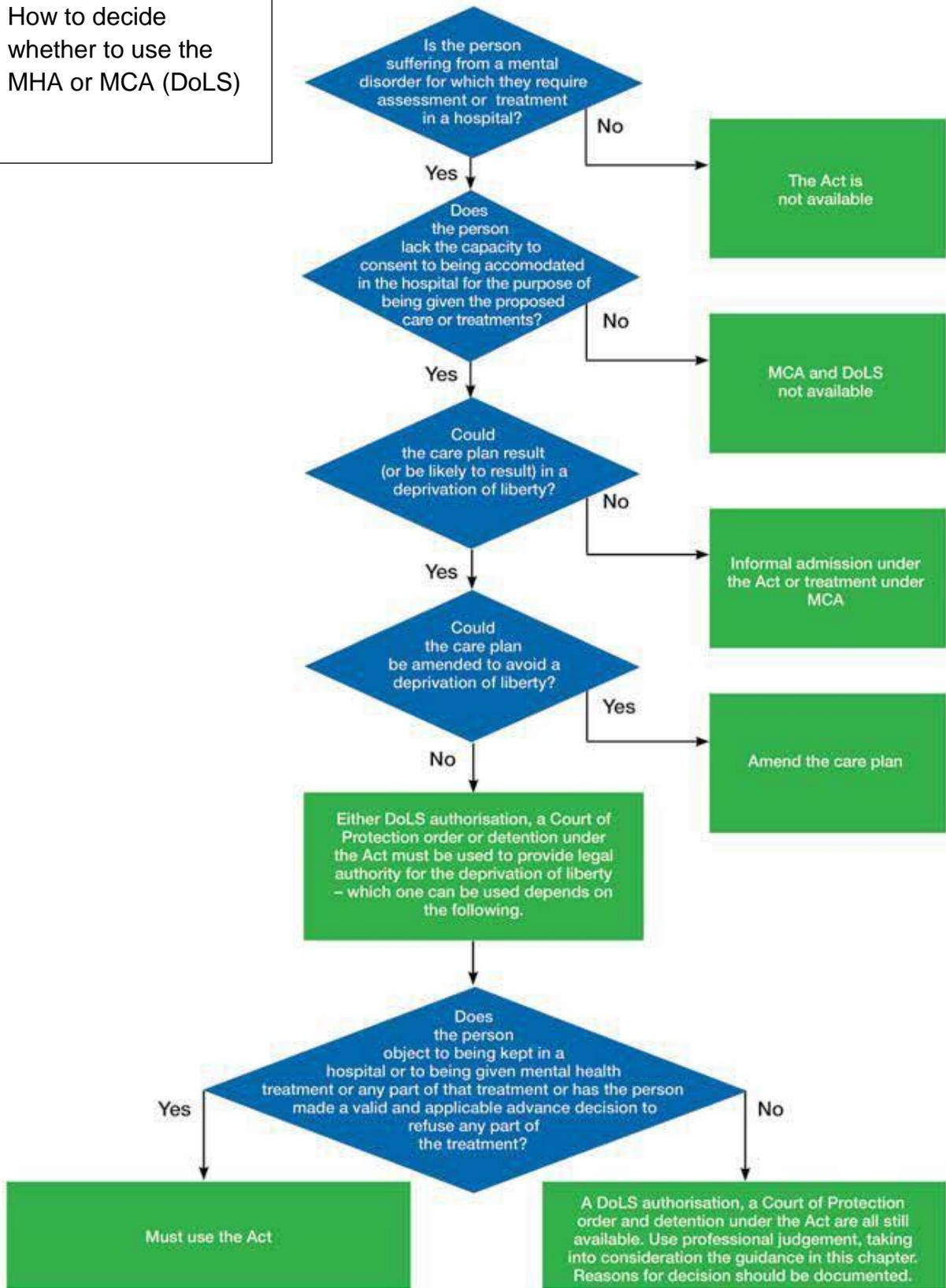
## APPENDIX 4

### **Deciding whether the Mental Health Act and/or the Mental Capacity Act will be available to be used (Taken from the Mental Health Code of Practice, 2015).**

- The first question in the flowchart is to ask whether the individual in question is suffering from a mental disorder for which they require assessment or treatment in a hospital. If the answer is 'no', then detention under the Mental Health Act is not an available option.
- If the answer is 'yes' then the decision-maker should consider a second question. The second question is: Does the individual in question lack the mental capacity to consent to being accommodated in the hospital for the purpose of being given the proposed care or treatment? If the answer is 'no' then the Mental Capacity Act and the deprivation of liberty safeguards are not an available option.
- However, if the answer is 'yes' (in other words the individual in question is suffering from a mental disorder for which they require assessment and treatment in hospital AND they lack the capacity to consent to being accommodated in the hospital for the proposed care or treatment) then the next question to be asked is: Could the care plan result, or be likely to result, in a deprivation of liberty? If the answer is 'no', then the individual could be admitted to the hospital on an informal basis (ie not detained under the Act) or treated under the provisions of the Mental Capacity Act (without the need to use the deprivation of liberty safeguards).
- If the answer is 'yes' (there is, or is likely to be, a deprivation of liberty) then the next question is whether the care and or treatment plan could be amended to reduce any restraints or restrictions in place – thereby preventing a deprivation of liberty from arising. If the answer is 'yes', the care and treatment plan should be amended so that there is no deprivation of liberty.

- If the care plan cannot be amended – so that there is (or is likely to be) an unavoidable deprivation of liberty, then the individual in question must either be detained under the Mental Health Act, a DoLS authorisation or Court of Protection order. The individual cannot be admitted on an informal basis.
- In determining whether the Mental Health Act or the DoLS is the most appropriate way of authorizing the deprivation of liberty the decision-maker should consider the question: does the individual object to being kept in the hospital or to being given mental health treatment or any part of that treatment, or has the individual made a valid and applicable advance decision to refuse any part of the treatment? If the answer to this question is ‘yes’ then use of the Mental Health Act is indicated – use of the DoLS would be inappropriate.
- However, if the answer is ‘no’ (in other words, the individual is not objecting) then both detention under the Mental Health Act a DOLS authorisation or Court of Protection order are available. Decision-makers must decide under which regime the individual will be detained; the individual cannot be detained under both regimes.
- The choice of which regime to use should be made in the best interests of the individual – not because of the personal preference of the decision-maker.

How to decide whether to use the MHA or MCA (DoLS)



### Mental Capacity Act Resource List

Mental Capacity Act 2005 - <http://www.legislation.gov.uk/ukpga/2005/9/contents>

Mental Capacity assessment - audit tool: <http://www.amcat.org.uk/>

Mental Capacity Law and Policy from Barrister Alex Ruck Keene -  
<http://www.mentalcapacitylawandpolicy.org.uk>

A Practical Guide to The Mental Capacity Act (2005) Putting The Principles of The Act Into Practice: Matthew Graham & Jakki Cowley (2015).

Mental Health Act Code of Practice 2015 -  
<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

Best Interest Decision Making – audit tool: <http://www.bestinterests.org.uk/>

Social Care Institute for Excellence, Mental Capacity resources -  
<http://www.scie.org.uk/topic/keyissues/mentalcapacity/mentalcapacityact>

<http://www.scie.org.uk/topic/keyissues/mentalcapacity>

[http://www.scie.org.uk/topic/keyissues/mentalcapacity/independentmentalcapacityadvocates:](http://www.scie.org.uk/topic/keyissues/mentalcapacity/independentmentalcapacityadvocates)

<http://www.communitycare.co.uk/static-pages/articles/Top-ten-resources-on-the-Mental-Capacity-Act-and-self-neglect-cases/>

Mental Capacity Act Manual: Richard Jones 6th Edition ISBN: 9780414034389 24<sup>th</sup> July 2014.

BMA consent toolkit - <http://bma.org.uk/practical-support-at-work/ethics/consent-tool-kit>

GMC Consent guidance -  
[http://www.gmcuk.org/guidance/ethical\\_guidance/consent\\_guidance\\_index.asp](http://www.gmcuk.org/guidance/ethical_guidance/consent_guidance_index.asp)

Covert medication - <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/Covert-administration-of-medicines/>

National End of Life Care Programme -  
<http://www.endoflifecareforadults.nhs.uk/tools/putting-into-practice/mental-capacity-act-tool>

Mencap – practical guide for parents and carers. <http://www.mencap.org.uk/all-about-learning-disability/health/mental-capacity-act>

Best Interest Decision Making – research study.

<http://www.mentalhealth.org.uk/publications/bids-report/>

Court of Protection: <https://www.gov.uk/court-of-protection>

Office of the Public Guardian: <http://www.justice.gov.uk/about/opg>

Power of Attorney: <http://www.justice.gov.uk/forms/opg/lasting-power-of-attorney>

**Local information and contact details:**

Herefordshire MCA DoLS Team Tel: 01432 383645. Fax: 01432 260957. Email  
[DoLS@herefordshire.gov.uk](mailto:DoLS@herefordshire.gov.uk)

Advice and Referral Team (ART) Tel: 01432 260101. Out of hours, weekends and  
public holidays: 0330 1239309

Independent Mental Capacity Advocates: Onside Advocacy Tel: 01905 27525

Email: [imca@onside-advocacy.org.uk](mailto:imca@onside-advocacy.org.uk)