MENTAL CAPACITY ACT POLICY

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'During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Advisory Group and where necessary other relevant Oversight Groups'

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DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
October 2019	0.1		Director of Mental Health and Learning Disabilities	New policy which was originally guidance to reflect policy and case law developments	
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NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

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1 Executive Summary

The Mental Capacity Act 2005 (MCA) was introduced in 2007 to empower and protect vulnerable persons over the age of 16 years. It enables people to plan ahead for a possible loss of capacity and provides a framework for decision-making on behalf of those who are unable to make at least some decisions for themselves. It has two overarching aims:

- To promote autonomy of decision making for all
- To protect vulnerable adults from harm.

The Act was amended in 2009 to provide safeguards for people who need to be cared for or treated under significant restrictions (the Deprivation of Liberty Safeguards). The Act reflects the development of case law relating to mental capacity and the European Convention on Human Rights.

This policy sets out what is expected of staff and volunteers in the Trust when working with people who may lack mental capacity within the meaning of the MCA. It provides guidance on the underlying principles, assessment of mental capacity and making best interests decisions on behalf of those who lack mental capacity.

It sets out what evidence is required to ensure healthcare staff are protected from liability when acting in a service user's best interests without their consent, including when using restraint.

The policy helps staff to identify when restraint of a service user results in a deprivation of liberty, which requires additional procedural safeguards under the Mental Health Act or the the Deprivation of Liberty Safeguards.

2 Introduction

This document is intended to assist all staff working with service users with impaired mental capacity. It sets out what is expected of staff to ensure compliance with the principles of the MCA. It provides guidance on how to support people to make decisions, to identify those who are unable to make decisions and the principles to follow when acting in their best interests.

This guidance should be read alongside the Isle of Wight NHS Trust's Consent and Adult Safeguarding Policies. This policy is not intended to replace the Code of Practice to the Mental Capacity Act, which should be referred to for more detailed guidance.

3 Definitions

Advance Decision to refuse medical treatment (ADRT) is a decision made by a person, which remains valid and binding after they lose mental capacity. An ADRT does not have to be in a specific format, but if it concerns life-sustaining treatment it must be in writing, include a statement that the person is aware their life is at risk and be signed and witnessed (Code of Practice (Code of Practice Chapter 9).

Advance Statement – a statement made by someone who has capacity setting out their views on aspects of lifestyle, care or treatment. (CoP chapter 9).

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Cognitive function/Cognition is the “act or process of knowing, including every mental process that may be described as an experience of knowing (including perceiving, recognizing, conceiving, and reasoning)” [*Encyclopaedia Britannica Online 2004*]. Measurement of impairment of cognitive functions involves assessment of the following elements of mental performance: orientation, registration, attention and calculation, recall, and language.

Some forms of cognitive impairment affect other elements of a person’s personality, while leaving the elements mentioned above, relatively intact. It may be less apparent that the person’s decision making is impaired and careful assessment will be required to ascertain whether the impairment amounts to a lack of capacity.

Consent is the voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

Court of Protection The specialist Court for all issues relating to people who lack capacity to make specific decisions (CoP Chapter 8).

Critical care / a vital act means care that is needed to save someone’s life or prevent a serious deterioration of their condition.

The **decision maker** is the person who makes a decision on behalf of a person who lacks mental capacity to make that decision. In the absence of any formally appointed authority (Power of Attorney or Deputy) this is usually the person who is requiring a decision to be made, for example the clinician proposing care and/or treatment for the service user.

Deprivation of liberty means being under continuous supervision and control and not free to leave.

The **Deprivation of Liberty Safeguards (DoLS)** are a legal procedure that authorises detention of a person in a hospital or care home and protects the person’s human rights. (MCA Deprivation of Liberty Safeguards Code of Practice)

DoLS Supervisory Body: the authority responsible for assessing and authorising requests for DoLS Authorisations, which is the local authority in whose area the person subject to deprivation of liberty resides (usually the Isle of Wight Council for Trust service users).

A Deputy is a person appointed by the Court of Protection to manage the affairs of a person who lacks mental capacity to make decisions about such matters. Deputies can be appointed for financial matters and/or health and welfare matters (CoP Chapter 8).

The Donor of an LPA is the person who has made the LPA to appoint a decision maker on their behalf.

Enduring Powers of Attorney are made before the MCA came into force and cover financial decisions only (CoP Chapter 7).

An Independent Mental Capacity Advocate (IMCA) is a qualified advocate who is appointed to represent the views of a person who lacks capacity in the decision making process (CoP Chapter 10).

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A **Lasting Power of Attorney (LPA)** transfers decision making authority from the donor to the attorney. It can be for either or both welfare and finance (CoP Chapter 7).

Mental capacity is the ability of an individual to make decisions about specific issues in their life. It is also sometimes referred to as 'competence'. Capacity is not an absolute concept: the level of understanding required will increase with the complexity of the decision and capacity can vary over time (CoP Chapter 4).

The Office of the Public Guardian supervises deputies, keeps a register of deputies, Lasting Powers of Attorney and Enduring Powers of Attorney, checks on what attorneys are doing, and investigates any complaints about attorneys or deputies (CoP 14.8-22).

Restraint is the use, or threatened use of force, to make someone do something, or prevent them from doing something, against their wish, or to restrict their movement, whether they resist or not.

Service users is used in this policy to cover all patients, whether inpatients, outpatients and those receiving short-term or emergency contact, whether face-to-face, by phone or video-link.

You in this policy means any person, whether staff member or volunteer, who interacts with patients.

4 Scope

This guidance applies to all staff, including bank, agency and volunteers in the Isle of Wight NHS Trust who have direct or indirect contact with service users and/or their family or carers, who may have impaired mental capacity.

The Mental Capacity Act applies to all persons over the age of 16 and to all decisions with the following exceptions:

- Decisions concerning family relationships, including marriage, sexual relationships etc.
- Voting rights
- Treatment under the Mental Health Act
- Unlawful killing or assisted suicide

5 Purpose

5.1 Overview

This policy provides a framework for assessing mental capacity and managing decision making for service users with cognitive impairments. It sets out how service users should be supported to make decisions for themselves, how to identify those who are unable to make decisions for themselves and how to make decisions on their behalf.

5.2 Principles

All staff who may come into contact with service users, their families or carers, who have cognitive impairments, must comply with this policy and in particular be aware of and follow the statutory principles of the MCA (Section 1; CoP Chapter 2):

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

6 Roles and Responsibilities

6.1 The Trust Board

The Trust Board is responsible for ensuring that there is Board-level leadership, an overall policy and an organisational culture which promotes understanding of the MCA and embeds the principles of the MCA in everyday practice.

6.2 Designated Executive Director with responsibility for MCA

The designated executive director for MCA is responsible for oversight of the MCA , executive leadership and reporting to the Board.

6.3 Trust Lead for MCA

6.3.1 The Trust Lead for MCA will provide expert guidance and leadership to support members of staff, and the organisation, to fulfil their obligations to service users and their families and carers in relation to the MCA.

6.3.2 The MCA Lead is responsible for developing policies and monitoring practice relating to the MCA.

6.3.3 The MCA Lead will provide training to support Trust compliance with the mandatory training relating to the MCA.

6.3.4 The MCA Lead will monitor the use of the Deprivation of Liberty Safeguards and liaise with the Supervisory Body in relation to all DoLS requests.

6.4 Line Managers / Service Leads

6.4.1 Line managers/service leads are responsible for ensuring that staff are aware of the Trust's policy.

6.4.2 They should also ensure that the level of responsibility for each staff member is explicit as a statement in all job descriptions, and actively review this via annual appraisal.

6.4.3 They should ensure that each staff member is able to access mandatory MCA training as appropriate to their role and relationship with service users.

6.5 Ward sisters and senior nurses on duty in inpatient wards

6.5.1 Nurses in charge of an inpatient unit must ensure that mental capacity and DoLS screening is undertaken for all inpatients.

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6.5.2 They must ensure that the need for an urgent DoLS authorisation is considered and a request for a standard DoLS authorisation is made for every service user who lacks capacity to consent to admission and treatment and who is deprived of liberty

6.6 All healthcare staff and volunteers

6.6.1 All employees and volunteers must be aware of and follow this policy.

6.6.2 They must apply the statutory principles of the MCA and the guidance in the Code of Practice when in contact with service users with impaired mental capacity.

6.6.3 When discussing any intervention with a service user staff must

- take all reasonable steps to support sevice users to make decisions for themselves;
- assess service users' mental capacity when there is reason to doubt the presumption of capacity and record evidence to support a conclusion of a lack of mental capacity;
- follow the best interests checklist when making decisions on behalf of service users who lack mental capacity.

7 Policy detail/Course of Action

7.1 The Statutory Principles (CoP Chapter 2)

These principles represent best practice and reflect a person-centred approach to supporting the two over-arching aims of the MCA: empowerment and protection.

7.1.1 Presumption of capacity:

- All adults over the age of 16 have the right to make their own decisions and you must assume that a service user has mental capacity to make a particular decision unless you can show that they lack the mental capacity to do so.
- Service users do not have to prove that they have mental capacity.
- If you conclude that a service user lacks mental capacity you must provide evidence that the individual lacks mental capacity to make the decision in question at the time it needs to be made.

7.1.2 Supported decision-making: (CoP Chapter 3)

- Before you conclude that a service user lacks mental capacity for a decision, you must take all practicable steps you can, to help them make their own decision.
- You must explain all the relevant information to the service user and strike a balance between giving sufficient information to enable them to make a decision and giving too much information or too great detail, which could be confusing.
- You must identify the most effective method of communication to help the service user to understand the nature of the decision and the choices available:
    - Use simple language avoiding jargon or technical language;
    - Use pictures or diagrams to help the service user visualise what you are explaining;
    - Involve family, carers and others who know the service user well, to advise on the most effective methods of communication;
    - The presence of relatives, friends or other people who know the service user, may reassure them and assist communication;

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- Use communication aids such as an interpreter or professional with specific skills (e.g. Speech and Language Therapist) if the service user has impaired communication;
- Consider the most appropriate location for the discussion to put the service user at ease. If poosible avoid noisy, busy environments;
- Consider the timing of the decision, as some people's functioning may vary between different times of the day, or may be affected by particular medication;
- The service user may benefit from having the support of another person in making their decision;
- You must address any cultural and ethical issues that may affect communication.

7.1.3 An unwise decision does not prove a lack of mental capacity:

- You must not conclude that a service user lacks mental capacity simply because they have made a bad or unwise decision that you disagree with.
- An unwise decision may be a warning sign that you need to assess whether the service user does in fact have mental capacity, in particular if the decision involves significant risks.

7.1.4 Best interests:

- When making a decision or acting for, or on behalf of a service user who lacks mental capacity you must do so in their best interests.
- You must consider the statutory "Best Interests Checklist" (see section 7.11.2) in deciding in the service user's best interests.

7.1.5 Less restrictive alternative:

- When acting in the service user's best interests you must consider whether you can achieve the desired outcome with less restrictions on the service user's freedom of choice.

7.2 Who can make decisions? (CoP 4.38 – 4.43)

7.2.1 Every person over the age of 16 years is entitled to make decisions for themself, unless it has been established that they lack the mental capacity to make the required decision at the time it needs to be made (Principles 1-3).

7.2.2 For decision making relating to children under the age of 16 years please refer to the *Trust Consent to Examination or Treatment Policy*.

7.2.3 A range of people may act as the **decision maker** on behalf of an individual who lacks the mental capacity to decide, depending on the type of decision that needs to be made.

- For social care decisions, the decision maker may be a care manager or a staff member in day services or a care home.
- For medical treatment issues, a doctor or nurse will be the decision maker.
- For day-to-day decisions, a family member, friend or formal or informal carer may assist the individual to make a decision.

7.2.4 If you are proposing or providing care or treatment for the service user, you are likely to be the decision maker in respect of that care or treatment, unless someone has been giving a formal authority to act on behalf of the person.

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Table 1: Identifying the Decision Maker

Decision level	Who should be involved in the assessment & decision making process?	Recording
Simple e.g. day to day decisions about what to wear, what to eat, where to go during the day	**Decision maker –** direct carer whether formal (e.g. domiciliary or residential care staff member, support worker) or informal (family/friend)	With formal relationships, the service user's care plan should be completed to show how the decision is made.
Significant e.g. longer term decisions involving care plans, arranging and reviewing packages of care.	**Decision maker -** allocated worker (e.g. care manager, nurse, OT, GP, care co-ordinator) who is managing the care. The decision maker must consult with relevant others (e.g. other involved professionals and family/friends)	**Use Forms at Appendices A and B to record:** Evidence that the service user lacks capacity Who was consulted in making the decision. Factors considered in making the best interests decision.
Complex, high risk or contentious e.g. decisions about long term accommodation, medical treatment, situations where risk levels are high, adult protection, cases where there are disagreements between those involved.	**Decision maker –** allocated worker e.g. care manager, nurse, doctor) using a multi-disciplinary approach and consulting relevant others family/friends, and possibly an advocate. A team or home manager may be appropriate to chair a planning meeting if required. The Adult Protection framework should be used where relevant.	**Use Forms at Appendices A and B to record:** Evidence that the service user lacks capacity Who was consulted in making the decision. Factors considered in making the best interests decision. Additional reports/second opinions may also be required.

7.3 Lasting powers of attorney (LPAs) (CoP Chapter 7)

7.3.1 Adults over the age of 18 years can authorise another adult over the age of 18 years to make decisions on their behalf in the event of a loss of capacity. Lasting powers of attorney can be made for financial and / or for health and welfare matters.

7.3.2 Once the LPA has been registered with the Office of the Public Guardian (OPG) the appointed attorney will have authority to make a decision on behalf of the donor, if the donor lacks capacity to make the decision, including consenting to medical treatment.

7.3.3 Professionals must ask to see evidence of a power of attorney, to check that the power has been registered and that the relevant decision falls within the scope of the power. A copy of the LPA should be taken and forwarded to the Trust Legal Services for recording on the service user's record.

7.3.4 Powers of attorney must act in the donor's best interests and if professionals have concerns about an attorney's actions, the matter must be referred to the Office of the Public Guardian (CoP 14.8 – 14.22).
https://www.gov.uk/government/organisations/office-of-the-public-guardian

7.4 Court-appointed Deputies (CoP Chapter 8)

7.4.1 When a person has lost capacity without making a power of attorney the Court of Protection can appoint a deputy to act on behalf of the person. This is normally only done for financial matters, but on rare occasions a welfare deputy may be appointed.

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7.4.2 Deputies for personal welfare decisions will only be required in the most difficult cases where:

- a series of linked welfare decisions are required over time, or
- there is a history of disputes as to what is in the best interests of the person, or
- the person is thought to be at risk of harm if left in the care of family members.

7.4.3 Professionals must ask to see evidence of the appointment and scope of authority before acting on the decision of a deputy.

7.4.4 Deputies must act in the donor's best interests and if professionals have concerns about an attorney's actions, the matter must be referred to the Office of the Public Guardian (CoP 14.8 – 14.22).

7.5 Advance Decisions to Refuse Treatment (ADRTs (CoP Chapter 9)

7.5.1 Adults over the age of 18 years who have capacity to make the decision can make an advance decision to refuse medical treatment at any time in the future when they have lost capacity to make that decision.

7.5.2 Advance decisions only apply to the refusal of medical treatment and do not cover basic care (warmth, food and drink by mouth, shelter, being kept clean etc.)

7.5.3 There are no legal requirements regarding format etc. for an ADRT, unless it concerns refusal of life-sustaining treatment, in which case it must be made in writing, including a statement that the person knows their life may be at risk, signed and witnessed.

7.5.4 Clinicians must comply with an advance decision unless they have evidence that the decision is not valid or applicable.

7.5.5 For further details see the Trust's Advance Decision to Refuse Treatment policy and chapter 9, MCA Code of Practice).

7.6 Assessment of Capacity – General points (CoP Chapter 4)

7.6.1 You are responsible for assessing a service user's mental capacity in respect of any decision you are asking them to make, such as consent to treatment or care interventions.

7.6.2 For complex or serious decisions or when the service user's presentation is complex, you may ask others with specific expert knowledge to advise in relation to an assessment of capacity, although the final determination of capacity is for you to make.

3.6.2 You must consider the need to assess a service user's capacity formally whenever there is a doubt about their mental capacity and a decision needs to be made. Doubts about capacity may arise because the service user:

1. has a diagnosis of a mental disorder
2. presents with confusion, disorientation or disturbed behaviour
3. makes a decision against medical advice which involves immediate or significant risks

7.6.3 Mental capacity is decision and time specific however it is not practicable to formally assess capacity every time a decision needs to be made. Mental capacity must be formally assessed and recorded for all service users whose capacity to make the following decisions is in doubt:

- admission to hospital for care and/or treatment

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- consent to medical treatment
- consent to a nursing or therapy care plan
- discharge from hospital

7.6.4 You do not need to formally assess mental capacity in respect of decisions about a service user's day-to-day care, such as administration of medication, provision of personal care, food and drink etc., which are set out in the care plan.

7.6.5 You must be aware of changes in the service user's functioning and presentation that suggest that they may have re-gained mental capacity and reassess mental capacity whenever there is a change in the service user's cognitive functioning.

7.6.6 Some individuals, for example those in the early stages of dementia, are able to retain information for a limited period only. This does not prevent them from being regarded as able to make the decision, even though they may forget having made a decision later. You should consider ways in which they can be reminded of decisions they have made.

7.6.7 When assessing a service user's capacity you should approach this as any clinical consultation, during which you try to understand how the service user makes a decision, the difficulties they are having and help them to overcome those difficulties, concluding in a determination as to whether they have or don't have capacity for that decision.

7.7 The Test of Capacity

7.7.1 MCA Section 2: ***'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'***

7.7.2 Before assessing a service user's capacity, the decision that needs to be made must be clearly formulated and the options identified, to ensure that the service user is given the information that is relevant to that decision, is supported to make the decision themselves as far as possible and that their capacity is assessed in relation to the specific decision.

7.7.3 If a service user's mental state is changeable, capacity should be assessed at a time when they are most likely to have capacity.

7.7.4 There are three elements to the test for capacity:

1. **Functional Test: Are they unable to make a decision?**

   A person will be unable to make a decision if they are unable to do **any one** of the following:
   - **understand** the information relevant to the decision, the reason it needs to be made, the options and consequences
   - **remember** that information long enough to make a decision
   - **use or weigh** that information as part of the process of making a decision, or
   - **communicate** that decision, by talking, sign language or any other means.

2. **Diagnostic Test: Does the person have an impairment of, or disturbance in the functioning of, the mind or brain (cognitive impairment)?**

   This impairment can be temporary or permanent and can result from a number of conditions such as:

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- dementia
- mental illness
- learning disabilities
- brain injuries including stroke
- physical or medical conditions such as infection causing delirium
- the effect of alcohol, prescribed and illegal drugs

3. Is the inability to make a decision caused by the cognitive impairment?

For the MCA to apply the inability to make a decision must be **caused** by the mental impairment, not by other factors such as stress, vulnerability or undue influence.

7.8 Vulnerable Adults and Capacity

7.8.1 A service user with or without a mental impairment may be unable to make a decision for other reasons, for example, because they feel overwhelmed by the situation. If this is the case, the service user must be supported to make a decision and cannot be deemed to lack mental capacity.

7.8.2 A valid decision must be made free from undue influence as well as with mental capacity. A service user with a cognitive impairment may be particularly vulnerable to undue influence, by others, including professionals, which would make any decision invalid.

7.8.3 You must consider what steps you can take to promote a service user's decision making, including considering the effect of your and other's influence and the service user's social situation. This is particularly important where vulnerable adults may be in abusive relationships.

7.8.4 If concerns that a service user is subject to undue influence cannot be resolved, you must refer the matter to Adult Safeguarding.

7.9 Recording assessments of capacity (CoP 4.60 – 4.62)

7.9.1 In recording your assessment of capacity you must take a proportionate approach. The level of detail to be recorded will depend on the type and seriousness of the decision, the role and qualifications of the decision maker and the urgency of making the decision.

7.9.2 To benefit from the protection from liability provided by the MCA section 5 (see 7.12 of this policy), you must record sufficient evidence to support a reasonable belief that the service user lacked mental capacity.

7.9.3 The evidence should include:

- the decision and why it needs to be made;
- the relevant information that you have given the services user, including the options and consequences;
- the help you have provided to them to make a decision
- the evidence that they are unable to make a decision;
- the evidence of the mental Impairment and how it causes the inability to make the decision.

7.9.4 The Mental Capacity Assessment Form (Hampshire MCA Toolkit Part A - see appendix A) must be completed when there is any doubt about the person's mental capacity to make a decision with potentially serious or significant consequences or impact on the person's quality or experience of life. The form is available as an e-form on eCareLogic.

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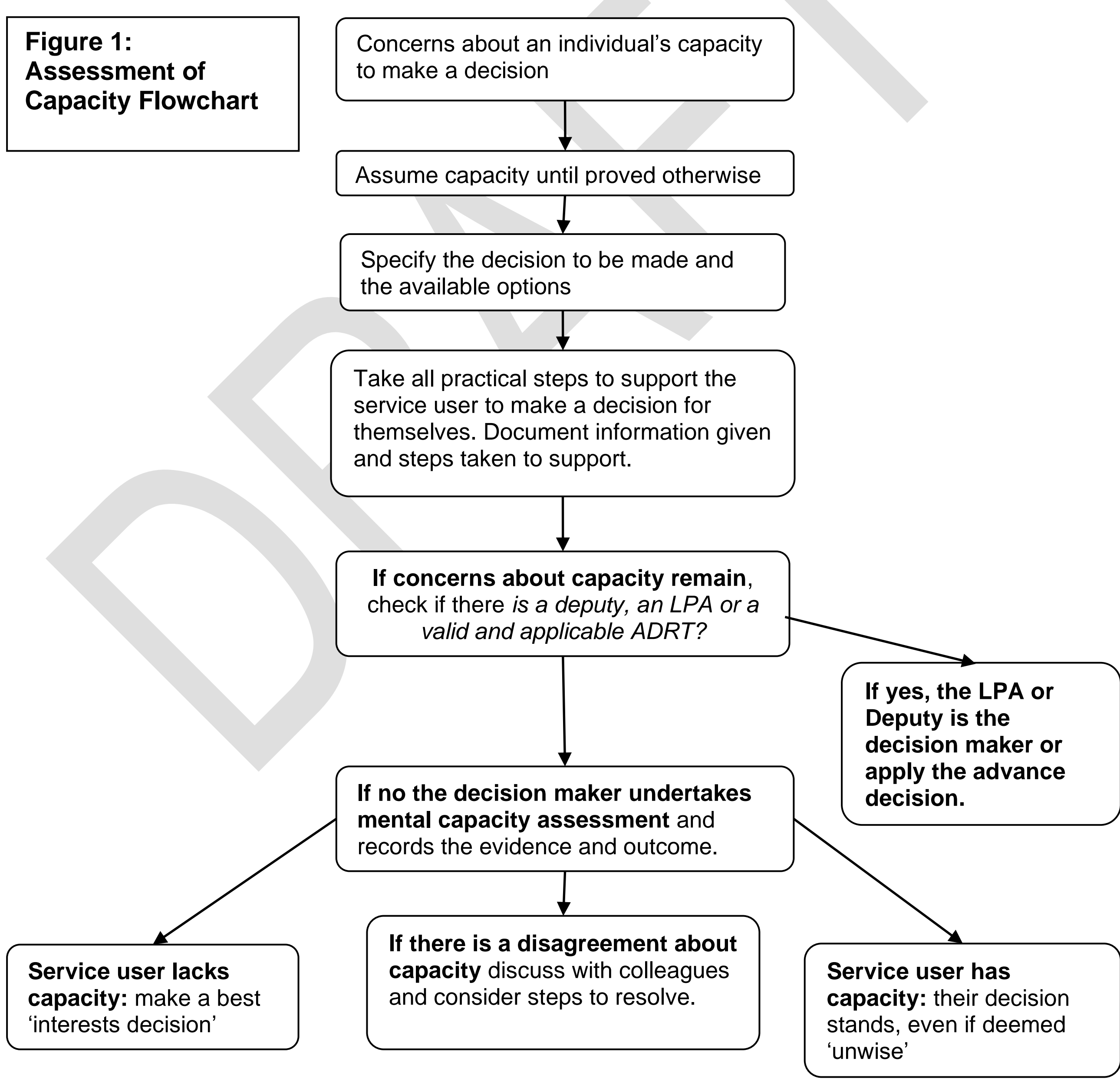
The following is a non-exhaustive list of decisions or situations where a formal record is required:

- at any clinical consultation in respect of care or treatment;
- on admission to hospital in respect of consent to admission and proposed treatment;
- on admission, in relation to the nursing needs assessment and care plan;
- whenever there is a significant change in the service user's cognitive functioning;
- for any subsequent significant decision, such as additional or change in treatment;
- the provision of treatment or care in the community;
- whenever a patient disengages or is non-compliant with care or treatment;
- before discharge from hospital;

7.9.5 Issues arising from a lack of mental capacity for decisions relating to day-to-day care interventions, including administration of regular medication, personal care, food and drink etc. should be set out in the care plan.

Figure 1: Assessment of Capacity Flowchart



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7.10 **Making a Best Interests** (CoP Chapter 5)

7.10.1 Once you have concluded that a service user lacks mental capacity to make a decision you must act in their best interests.

7.10.2 The **'Best Interests' Checklist** for decision makers set out in section 4 of the Act requires you to:

- **Avoid discrimination:** Your decision about the service user's best interests must be based on assessment, consultation and the establishment of information about them and their circumstances, not on assumptions about their age, appearance, condition or behaviour, although all of these will be relevant considerations.
- **Encourage participation:** do whatever you can to support and encourage the service user to take part in making the decision.
- **Consider all relevant circumstances relating to the decision:** the decision that needs to be made, why it needs to be made, what the options are, the outcomes, risks and benefits of each option, the impact it will have on the service user etc.. You must also:
- **consider the service user's views:** their past and present wishes, values and beliefs and how these would influence their decision if they were able to make it.
- **Consult others** including anyone named by the service user, anyone involved in their care or interested in their welfare, including family and friends and anyone with a Lasting Power of Attorney or Deputyship.
- **Assess whether the service user may regain capacity:** can you delay the decision to enable the service user to make their own decision?
- **Less restriction:** Any interference with the service user's freedom of choice must be kept to a minimum consistent with achieving what is in their best interests

7.10.3 The avoidance of pre-conceived ideas is particularly important for decisions that involve the provision or withdrawal of life sustaining treatment, when your decision must not be based on your own views about the service user's quality of life before treatment is given.

7.10.4 **Consultation:** In making a best interests decision you must consult in a "practical and appropriate" manner to the particular decision being considered. The more significant and complex the decision, the more formal and wide ranging the consultation process should be.

The following people must be included in a best interests consultation:

- Anyone named by the service user lacking capacity as someone to be consulted
- Anyone engaged in caring for the service user or interested in their welfare
- Any attorney appointed under a Lasting Power of Attorney
- Any deputy appointed by the Court of Protection.
- An Independent Mental Capacity Advocate if the decision is about serious medical treatment or a change of residence and the service user lacking capacity is unbefriended. (see section 7.19)

7.10.5 **Best Interests Meetings:** If your consultation establishes that there is a clear consensus as to what is in the service user's best interests, you do not need to arrange a best interests meeting. When there is a range of different views, any uncertainty or disagreement about what is in the service user's best interests, you must arrange a best interests meeting to try and achieve a consensus. You must consider whether it is

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appropriate to invite the service user to this meeting or whether they should be represented by an advocate (for example a IMCA). All consultees listed above must be invited.

7.10.6 **Recording a best interests decision:** You must record the best interests decision making process and consultation, including any conflicting opinions in relation to any major decision or decision with potentially serious or significant consequences on the Best Interests Form (Hampshire MCA Toolkit Part B – see Appendix B). This form is also available as an e-form on eCareLogic.

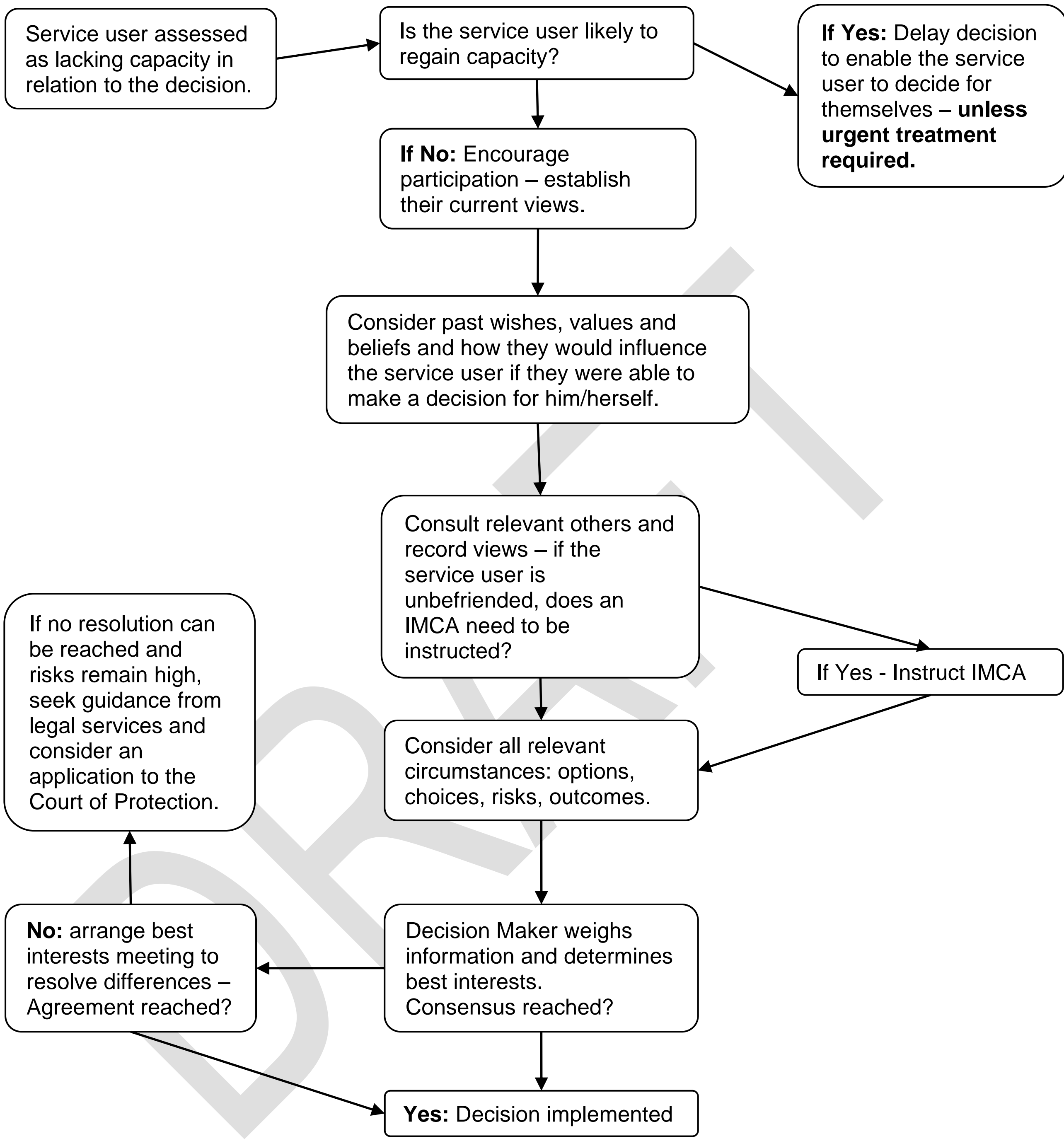
Such decisions include:

- hospital admission except in an emergency
- consent to medical treatment
- consent to a care plan involving any restraint
- discharge from hospital

7.10.7 In an emergency it will almost always be in the service user's best interests to give urgent treatment without delay, unless you are aware of a contrary ADRT.

7.10.8 If disagreements remain about what is in a service user's best interests after consultation and these cannot be resolved you will have to make an imterim decision and seek legal advice on referring the matter to the Court of Protection.

Figure 2: Best Interests Flowchart



7.11 Protection from Liability for Acts in Connection with Care and Treatment (CoP Chapter 6)

7.11.1 **Protection from liability:** when making a decision or carrying out an act which could give rise to charges of assault or interference with the service user, you will be protected from liability under Section 5 of the Mental Capacity Act provided you can evidence that you have:

- assessed whether the service user has mental capacity in relation to the decision or action;
- a reasonable belief that the service user lacks mental capacity, **and**
- acted in the service user's best interests.

7.11.2 The forms at Appendix A and B are designed to help you record the required evidence to support the above.

7.11.3 However, see Sections 7.13 of this policy in relation to additional requirements should an action involve restraint.

7.12 **Care and Treatment of Mental Disorder** (CoP Chapter 13)

7.12.1 The Mental Health Act 1983 (MHA) and Mental Capacity Act 2005 (MCA) have different purposes. The MCA has a broad scope and provides a legal framework for decision-making which applies in many situations where adults are unable to make decisions and act for themselves. The MHA provides a much narrower legal authority for the admission to hospital and treatment (where appropriate without consent) of people with a mental disorder because of the risk to their health, to their safety or the safety of others.

7.12.2 Service users detained under the MHA can be treated without consent, without reference to mental capacity and such decisions are specifically excluded from the scope of the MCA. The procedural safeguards in Part IV of the MHA must be followed when treating service users who are detained under the MHA.

7.12.3 The Mental Health Act 1983 only deals with treatment "for mental disorder". However, a service user detained under the Mental Health Act may lack capacity in relation to some other form of medical treatment or some other issues. For example, someone may be detained for treatment for a mental disorder but also require surgery. In these cases, the Mental Capacity Act will apply to decisions not covered by Part IV of the MHA.

7.12.4 In some limited instances a service user may be detained for treatment of mental disorder in hospital under the MCA/DoLS: the service user must lack mental capacity and not be objecting to the admission and/or all or part of the treatment. Whether a service user is 'objecting' must be considered in the round, including their behaviour, wishes, beliefs and values, both past and present, not just on verbally expressed objections. If in doubt, clinicians should assume the service user is objecting (MHA Code of Practice 13.51/14.20).

7.12.5 Chapters 13&14 of the Code of Practice to the MHA (DH, 2015) contain detailed guidance for practitioners on the appropriate use of MHA and MCA, in relation to service users who have a mental disorder (including the use of guardianship) and are assessed to lack capacity. Practitioners are recommended to refer to the Code for guidance on individual cases.

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Table 2: Mental Health Act or Mental Capacity Act?

	MENTAL CAPACITY ACT 2005	MENTAL HEALTH ACT 1983
AGE	Must be over 16 years old For LPA, Advance Decisions and DoLS, over 18 years old	No age limits (except for Guardianship: over 16 years old)
CAPACITY	Applies only to those who lack capacity as defined by the Standard Test – although can plan ahead for loss of capacity.	Does not require lack of capacity.
BEST INTERESTS	Decisions must be made in the best interests of the incapacitated service user. Protection of others is **not** part of best interests	Detention in hospital on the grounds of the service user's health, safety or for the protection of others.
MEDICAL TREATMENT	Treatment decisions made in service user 's best interests (except for excluded decisions).	Treatment for mental disorder only – governed by Part IV of the Act.
RESTRICTION OF LIBERTY	Allows care and treatment including restraint when necessary to protect the service user from harm, proportionate and not a deprivation of liberty. Deprivation of Liberty can be authorised using DoLS.	Broad range of compulsory powers to detain and treat without consent and in the face of resistance. Least restriction principle must be applied.
ADVANCE DECISIONS	Advance decisions that are "valid and applicable" are legally binding.	Part IV powers allow advance decisions to be overridden (NB except ECT).
POWERS OF ATTORNEY	POA can make proxy decisions.	POA have no authority over treatment of detained service users
SAFEGUARDS	No formal safeguards. Requires consultation with relatives, carers and IMCAs. DoLS has some safeguards (Personal Representative). Can apply to Court of Protection in disputed cases.	Formal independent appeals procedures (MHRT & Hospital Managers). Second Opinion Appointed Doctors.

7.13 The Use of Restraint (CoP 6.39 – 6.48)

7.13.1 The MCA defines restraint as the

- use of force or threat to use force, to make someone do something they are resisting, or
- restriction of a person's freedom of movement, whether they are resisting or not, including the use of sedating medication.

Acts of restraint can range from prompts and gentle verbal persuasion to physical force (hands-on and / or mechanical restraint) and medication (sedation).

7.13.2 Objections to particular actions can take many different forms, from physical resistance to verbal objections, passive resistance and other non-verbal responses. Clear communication and sensitive responses from the member of staff may still enable appropriate care to be given.

7.13.3 The effect of not providing the particular intervention will vary with the nature of the care or treatment. In some circumstances (e.g. cleaning or washing), the effect will be gradual and/or restricted to reducing the service user's quality of life. In other situations the refusal will have a faster and more drastic effect (such as declining food, drink or medication).

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7.13.4 Whenever an incapacitated service user is refusing or resisting care or treatment, and specific risks to their health or welfare are identified, discussions must be held with senior staff to consider how to ensure the appropriate care is delivered.

7.13.5 The protection from liability under section 5 (see 7.11) extends to the use of restraint, provided the following conditions are met:

- the act is in the person's best interests;
- restraint is necessary to prevent harm to the person being restrained; and
- the force used is proportionate to the likelihood and seriousness of the harm being prevented.

MCA 2005, Section 6

7.13.6 Ultimately a balance has to be struck between a number of competing rights and duties, such as the person's civil liberties and staff's duty of care, with the key factor being the protection and enhancement of the vulnerable person's dignity.

7.14 Restriction of Movement and Deprivation of Liberty (CoP 6.49 – 6.53)

7.14.1 Section 6 of the MCA permits restriction of movement that does not amount to a deprivation of liberty. Restrictions amounting to a deprivation of liberty requires a formal legal authorisation process (Mental Health Act, MCA Deprivation of Liberty Safeguards (DoLS) or Court Order).

7.14.2 A *restriction of movement* (restraint) will become a *deprivation of liberty* when the restraint results in the service user being ***" under continuous supervision and control and not free to leave".***

7.14.3 Service users who are receiving critical care (care without which they would die or suffer a severe deterioration in their condition) are **not** deprived of liberty and a DoLS Authorisation is **not** required provided they are being treated in the same way as a service user who has given consent. A DoLS Authorisation **will** be required if:

- the service user or anyone on their behalf is objecting to admission and/or treatment
- the service user is attempting to leave or subject to specific restrictions to prevent them leaving
- the service user is being sedated to manage their behaviour
- discharge of a medically fit service user is being delayed due to concerns about their safety on discharge

7.15 Avoiding Deprivation of Liberty

7.15.1 Principle 5 of the MCA requires that any best interests intervention should involve no more interference with the service user's freedoms than is necessary. The following elements of good practice will assist in avoiding 'deprivation of liberty':

- Ensuring that decisions are taken, reviewed and recorded in a structured way, including a proper assessment of the service user's capacity to consent to the proposed care;
- appropriate and documented involvement of servce user, family, friends, carers and others interested in their welfare;
- ensuring that alternatives to admission to hospital or residential care are considered;

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- ensuring that any restrictions placed on the service user while in hospital or residential care are kept to the minimum necessary – meeting needs effectively and enhancing opportunities for choice and activity will often reduce the need for restraint;
- ensuring appropriate information is given to service users themselves and to family, friends and carers, including information about the purpose and reasons for the service user's admission, proposals to review the care plan and the outcome of such reviews, and the way in which they can challenge decisions (e.g. through the relevant complaints procedure);
- Ensuring both the assessment of capacity and the care plan are kept under regular review. It may well be helpful to include an independent element in the review. Such a second opinion will be particularly important where family members, carers or friends do not agree with the authority's decisions.

7.16 Authorisations under the Deprivation of Liberty Safeguards

7.16.1 Whenever a hospital in-patient is identified to be deprived of their liberty, a request for an authorisation under the Deprivation of Liberty safeguards must be made, unless there is already a formal authority to detain in place (e.g. under the Mental Health Act or a Court Order). The request will normally be made by the ward sister or nurse in charge.

7.16.2 If the need for deprivation of liberty is immediate the person in charge of care or treatment will complete an Urgent Authorisation, valid for seven days at the same time as requesting a Standard Authorisation. A request for a Standard Authorisation is made by completing pages 1-5 of DoLS Form 1 and an Urgent Authorisation is made on page 6 of Form 1.
http://intranet.iow.nhs.uk/Deprivation-of-Liberty-Safeguards

7.16.3 An urgent authorisation can only be given if all ten criteria set out on page 6 of form 1 apply. Each box must be ticked to confirm that the statement applies. A medical diagnosis is not required to confirm presence of a mental disorder, which may be based on observed symptoms and points 5, 6 and 9 only require you to confirm that you are not aware of any contrary decision.

7.16.4 An urgent Authorisation is valid for a maximum of seven days, with the day it is completed counting as day one and it will expire on the preceding day of the following week. An extension of up to seven days can be given by the Supervisory Body (The Isle of Wight Council).

7.16.5 The completed DoLS request must be saved to the service user record and be emailed to the Supervisory Body at DOLS@iow.gov.uk

7.16.6 Detailed guidance on completing a request is also included on the above link.

7.16.7 Once a DoLS Authorisation has been requested the DoLS Office must be notified of any changes in the service user's circumstances, in particular if an authorisation is no longer needed, the service user is discharged or dies.

7.16.8 An urgent Authorisation will expire after 7 days, unless extended by the Supervisory Body. If the Standard Authorisation request has not been resolved during that time, the service user may potentially be unlawfully deprived of liberty. Provided that all the required procedures have been followed by the Trust, any legal liability for such unlawful deprivation of liberty is likely to fall on the responsible Council rather than the Trust.

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7.16.9 When this occurs the MHA & MCA Lead for the Trust will liaise with the detaining ward and the Council's DoLS Team. The following must be kept under review by the Ward with support from the MHA & MCA Lead:

1. If the service user, or anyone on their behalf is objecting to the admission;
2. If there is any doubt as to whether it is in the service user's best interests to remain in hospital;

In either of these situations – an application to the Court of Protection to determine the service user's best interests must be considered;

3. There is any change in the service user's mental capacity;
4. The service user requires treatment for a mental disorder and is objecting, in which case an assessment for detention under the MHA must be requested.

7.17 Criminal Offence (CoP 14.23 – 14.26)

7.17.1 Under the MCA it is a criminal offence to ill-treat or wilfully neglect a person who lacks capacity. The offence may apply to:

- anyone caring for a person who lacks capacity – this includes family carers, healthcare and social care staff;
- an attorney appointed under an LPA or an EPA;
- a deputy appointed for the person by the court.

7.17.2 To be guilty of ill-treatment the ill-treatment must have been deliberate or reckless and the perpetrator must have known, or should have known, that the person lacked capacity. Neglect usually means the person deliberately failed to carry out an act they had a duty to do.

7.17.3 Penalties range from a fine to up to 5 years imprisonment.

7.18 Independent Mental Capacity Advocates (IMCAs) (CoP Chapter 10)

7.18.1 The purpose of the IMCA service is to support particularly vulnerable service user who lack the capacity to make certain far-reaching decisions. It is available to those service user who have no family or friends whom it would be appropriate to consult about those decisions.

7.18.2 In cases where a service user who lacks capacity does not have friends or relatives to consult, you must consult an IMCA where the decision is about:

- serious medical treatment;
- a long term change in accommodation arranged by the NHS or a local authority
- a care plan under Safeguarding Vulnerable Adult procedures;
- a proposed deprivation of liberty under DoLS.

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

- there is a fine balance between the likely benefits and the burdens to the service user and the risks involved; or
- a decision between a choice of treatments is finely balanced; or
- what is proposed is likely to have serious consequences for the service user.

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If the treatment is urgent, you do not need to instruct an IMCA.

7.18.4 A long-term change of accommodation is defined as being for more than 28 days in hospital or more than 8 weeks in a care home. If the arrangements need to be made as a matter of urgency the move can proceed before an IMCA is instructed. However, if the service user is then expected to be more than 28 days in hospital or 8 weeks in a care home or its equivalent then an IMCA must be instructed as soon as possible after the move.

7.18.5 When protective measures are being put in place to protect a vulnerable adult from abuse an IMCA should be instructed even if there are friends or family members to consult. An IMCA must be instructed in the following situations:

- There is a reasonable belief that it is inappropriate to consult family or friends because they may not have the service user‘s best interests at heart;
- The proposed protection plan involves a serious life-changing decision or a serious exposure to risk which should not be agreed without consulting an independent advocate;
- The decision that the responsible body needs to make involves a potential conflict of interests between the responsible body and the vulnerable service user and/or their family.

7.18.6 Once an IMCA has been instructed and until a best interests decision is taken the decision maker must follow the Act’s five principles in relation to that decision making process. NHS bodies and LAs must take into account any information given, or submissions made, by the IMCA. Any decision taken before proceeding with serious medical treatment or a move must also be made in the service user’s ‘best interests’.

7.18.7 IMCAs have the following powers to enable them to carry out their role:

- to see the service user concerned in private
- to examine and take copies of any records that are relevant to the decision. They must apply to see records using the form in Appendix C.

7.18.9 Details of the locally commissioned IMCA service can be found on the Trust’s MCA/DoLS Intranet pages.

8 Consultation

The draft policy has been made available on the Trust Intranet site and comments invited via the Trust e-Bulletin. It has been reviewed by the following committees prior to approval:

- Trust Dementia Steering Group
- Trust Joint Safeguarding Steering Group
- MH&LD Document Control Group
- Trust Clinical Standards Committee

9 Training

9.1 This Mental Capacity Act Policy has a mandatory training requirement which is detailed in the Trusts mandatory training matrix and is reviewed on a yearly basis.

9.2 This policy will be cascaded via senior staff / team leaders in all areas and highlighted in all MCA Training.

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9.3 MCA training is available to all staff free of charge at three levels:

- e-learning modules on ESR (MCA and DoLS).
- MCA and DoLS introductory sessions tailored to each division (1 – 1.5 hours)
- MCA and DoLS: half day session for all specialist staff.

Training can also be delivered to individual teams and departments – contact the MHA/MCA Lead.

10 Monitoring Compliance and Effectiveness

Implementation of the MCA and DoLS is subject to a number of key performance indicators monitored quarterly and reported to the Joint Safeguarding Steering Group:

- Compliance with mandatory training requirement
- Quarterly audit of a sample of service users in relation to requests for DoLS Authorisations
- Periodic staff survey of MCA knowledge and training needs.
- Audit of medical and nursing records in relation to MCA and DoLS.

11 Links to other Organisational Documents

Advance Decisions to Refuse Treatment Policy

Consent to Examination or Treatment Policy

Health and Care Records Policy

Safeguarding Adults Local Policy

12 References

Department of Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice

Department of Constitutional Affairs (2009) Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice

Department of Health (2015) Code of Practice to the Mental Health Act

Jones, R. (2018) Mental Capacity Act Manual. (8th Edition)

Letts, P. (ed) (2010) Assessment of Capacity – A Practical Guide for Doctors and Lawyers. British Medical Association and the Law Society

Office of the Public Guardian (2009) Mental Capacity Act Booklets:

OPG601 Making Decisions …..about your health, welfare or finances. Who decides when you can't?

OPG602 Making Decisions – A guide for family, friends and other unpaid carers.

OPG603 Making Decisions – A guide for people who work in health and social care.

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OPG604 Making Decisions – A guide for advice workers
OPG605 Making Decisions – An easy read guide
OPG606 Making Decisions – The IMCA service
OPG607 Deprivation of Liberty Safeguards – A guide for primary care trusts and local authorities
OPG608 Deprivation of Liberty safeguards – A guide for hospitals and care homes
OPG609 Deprivation of Liberty Safeguards – A guide for relevant person's representatives

http://www.scie.org.uk/mca/

https://www.gov.uk/government/organisations/office-of-the-public-guardian

NICE Guideline NG108 (2018) Decision-making and Mental Capacity

13 Appendices

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Download Form here

5
Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

4
An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

3
A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

2
A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been undertaken without success.

1
A person must be assumed to have capacity unless it is established that they lack capacity.

Hampshire Mental Capacity Toolkit

Part A – Assessment of Capacity

January 2014

Tool to assess whether an individual lacks mental capacity in relation to a specific decision.

Person's name ______________________________

Address ______________________________

Client Ref - AIS/NHS number ______________________________

What is the decision that needs to be made? (See guidance notes)

What steps have been taken to help the person take the decision for themselves?
(Explain how you have followed statutory principles 1 & 2)

What is the key information the person needs to understand in order to make this decision?

ASSESSMENT QUESTIONS

1. Is there evidence of an impairment of or disturbance in the functioning of the mind or brain (permanent or temporary) that may affect the person's ability to make the above decision?	**YES Impairment is present** — record symptoms /behaviours or any relevant diagnoses that lead to your belief, (see guidance notes) **If YES Proceed to Q.2 below**	**NO Impairment is not present** — record evidence for this belief. **If NO the person is deemed to have capacity -assessment is ended now.**

Questions (2a)-(2d) concern the impact of the above impairment/disturbance upon the individual and whether it prevents them from making this specific decision at the time of assessment.

2a) With all possible help given is the person able to understand the information relevant to the decision? E.g.What is their understanding of decision in question? Can they tell you why they think the decision needs to be made? What do they think the consequences of the decision will be? See guidance notes.	**YES - able to understand info.** Record views/evidence to show they understood it.	**NO - unable to understand info.** Record steps taken to explain info and views/evidence why they did not understand it.
b) Are they able to retain the information long enough to make the decision? See Guidance notes.	**YES - able to retain info.** record evidence.	**NO - unable to retain information**, record any help given and evidence.
c) Are they able to weigh the information as part of the decision making process? Are they able to understand the consequences of making or not making the decision? See guidance notes.	**YES - able to weigh information**, record evidence.	**NO - unable to weigh info** record evidence.
d) Are they able to communicate the decision in any way? There may be many methods to communicate and assistance may be required.	**YES - able to communicate**, record evidence.	**NO - unable to communicate**, record evidence.

Date of assessment	
How was the assessment completed? Who was present, where did it happen?	

What is your professional relationship to the person being assessed?
Please indicate professional qualifications and/or the reason why you are the appropriate person to assess capacity in this instance

Conclusion - If the answer to question 1. is YES and the answer to any part of question 2. a) - d) is NO then the person lacks capacity under the Mental Capacity Act (2005). **Fluctuating capacity:** Always consider whether the person has fluctuating capacity and whether the decision can wait until capacity returns. If this is the case, explain and enter reassessment date in outcome below.
Outcome:
Decision maker/ assessor signature:

Download Form here

Person's name ______________________________

Address ______________________________

Client Ref - AIS/NHS number ______________________________

Decision being consulted upon

Details of the assessment of capacity in relation to the above decision (Date carried out/ assessor/where a copy of the assessment can be found)

Specify the different options that are being considered
1.
2.
3.

Best Interests Consultation - Service User

Consultation with the person lacking capacity	Supporting evidence (record here or note here where the information is recorded on their case file/AIS etc)
What are the issues that are most relevant to the person who lacks capacity?	
Specify their past and present wishes, feelings and concerns in relation to this decision.	
What are the person's values and beliefs (eg. religious, cultural, moral) in relation to this decision?	
Does the person have any previously held instructions (eg. advance decisions) relevant to this decision? Give details	
Are there any other " relevant circumstances" that should be taken into account in this case?	

Best Interests Consultation - Relevant parties

Checklist of persons	Details
Anyone named by the person lacking capacity as someone to be consulted (state name and relationship)	
Anyone engaged in caring for the person or interested in their welfare (state name and relationship)	
Any attorney appointed under an enduring or lasting power of attorney (state name and what kind of power has been donated i.e. EPA; LPA Property and Affairs; LPA Health and Welfare)	
Any deputy appointed by the Court of Protection (state name and the nature of the Court Order)	
Independent Mental Capacity Advocate (IMCA) Where the person lacking capacity has nobody in the above 4 categories other than paid carers, and faces a decision about serious medical treatment or a change of residence, you will need to refer the person to the IMCA service in the area where they are currently residing (state name and which IMCA service)	

Best Interests Consultation - Relevant parties (1)

Name:	**Date:**
Views:	

Best Interests Consultation - Relevant parties (2)

Name:	Date:
Views:	

Best Interests Consultation - Relevant parties (3)

Name:	Date:
Views:	

Best Interests Consultation - Other relevant parties

Name(s)/Date(s)/Views (please list and explain if you have excluded any family or other relevant parties):

Best Interests Decision

Specify the option that is considered to be in the individual's best interests.	
Specify why this is the preferred option, including key benefits to the individual.	
Please give details of why other options listed were not considered to be in the individual's best interests. Please include details of any option that was not chosen because it was unlikely it could be successfully implemented.	

If your decision is at odds with anybody who was consulted please give details. Please include details of any interim decision(s) and what action will be taken to try and resolve the dispute. The decision maker to consider if an application to the Court of Protection is appropriate and proportionate in this circumstance.

Decision maker:	**Date:**
Manager: (if appropriate)	**Date:**

Appendix C

IMCA Application for Access to Health Records

Application Form for Access to Health / Social Care Records as required under the Mental Capacity Act 2005.
This form is intended for use by the appointed Independent Mental Capacity Advocate (IMCA)

Please fully complete all relevant sections and return to the relevant address below, ensuring that you have enclosed the necessary evidence confirming your status as IMCA (ID and IMCA Instruction).

For Health records - Trust staff receiving this application must forward it immediately to:
Information Governance, IOW NHS Trust, St Marys Hospital, Newport, Isle of Wight. PO30 5TG
Telephone 01983 822099 Ex 2078/5677
Or:
Information Governance, Isle of Wight Clinical Commissioning Group, Building A, The APEX, St Cross Business Park, Monks Brook, Newport, Isle of Wight, PO30 5XW
Telephone 01983 552470

For Social Care records please either apply to the Manager of the relevant service or to:
Corporate Information Unit, Legal Services, Isle of Wight Council, County Hall, **Newport, Isle of Wight. PO30 1UD**

Tel 01983 821000 Ex 6329

Section A – Whose records are being requested?	
Surname	
Forename(s)	
Previous Names	
Date of Birth	
Address	
Postcode	

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Previous Addresses	
Section B – Your details	
Surname	
Forename(s)	
Address where the records are to be sent to	
Telephone Number	
Section C – Records Required and Justification	
Please indicate which records you are requesting including dates where possible.	
Please explain the purpose you require the records.	
Section D – How do you wish to access the records?	
Please tick the appropriate box.	☐ I would like copies of the records ☐ I would like to view the records
Section E – Authority to Release Records and Declaration. **To be completed by the individual named in Section B.**	
I declare that the information I have provided on this application form is true and that I am authorised to apply for access to the health / social care records under the Data Protection Act 1998/ Mental Capacity Act 2005. I attach copy of my ID and evidence of my appointment as IMCA – please tick box ☐	
Signed	
Print Name	
Date	

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Mental Capacity Act 2005 (Section 35)
Appointment of independent mental capacity advocates

(1) The appropriate authority must make such arrangements as it considers reasonable to enable persons ("independent mental capacity advocates") to be available to represent and support persons to whom acts or decisions proposed under sections 37, 38 and 39 relate.

(2) The appropriate authority may make regulations as to the appointment of independent mental capacity advocates.

(3) The regulations may, in particular, provide-

- (a) that a person may act as an independent mental capacity advocate only in such circumstances, or only subject to such conditions, as may be prescribed;
- (b) for the appointment of a person as an independent mental capacity advocate to be subject to approval in accordance with the regulations.

(4) In making arrangements under subsection (1), the appropriate authority must have regard to the principle that a person to whom a proposed act or decision relates should, so far as practicable, be represented and supported by a person who is independent of any person who will be responsible for the act or decision.

(5) The arrangements may include provision for payments to be made to, or in relation to, persons carrying out functions in accordance with the arrangements.

(6) For the purpose of enabling him to carry out his functions, an independent mental capacity advocate-

- (a) may interview in private the person whom he has been instructed to represent, and
- (b) may, at all reasonable times, examine and take copies of-
  - (i) any health record,
  - (ii) any record of, or held by, a local authority and compiled in connection with a social services function, and
  - (iii) any record held by a person registered under Part 2 of the Care Standards Act 2000 (c. 14),

If you have any queries in relation to access to records by IMCAs please contact Stephen Ward, Mental Capacity Act Lead, IOW NHS Trust, St Marys Hospital, Newport, Isle of Wight. PO30 5TG. Tel 01983 534098.

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Equality Impact Assessment

Appendix D

This Equality Analysis is a written record that demonstrates that you have shown *due regard* to the need to **eliminate unlawful discrimination**, **advance equality of opportunity** and **foster good relations** with respect to the characteristics protected by the Equality Act 2010.

Name of policy/procedure	Mental Capacity Act Policy
Date of assessment:	2/8/2021
Responsible department:	MH&LD
EIA Author:	Stephen Ward, MHA & MCA Lead
Intended equality outcomes:	To provides a framework for managing decision making for service users with cognitive impairments. It sets out how service users should be supported to make decisions for themselves, how to identify service users who are unable to make decisions for themselves and how to make decisions for those service users.

Who was involved in the consultation of this document?

Date	**Forum**
05/03/2021	Chief Nurse
30/07/2021	Clinical Standards Group

Please describe the positive and any potential negative impact of the policy on service users or staff.

In the case of negative impact, please indicate any actions to mitigate against this by completing stage 2. Supporting Information can be found be following the link: www.legislation.gov.uk/ukpga/2010/15/contents

Protected Characteristic	**Equality Analysis**	**EIA Impact (Positive/Negative)**
Age		
Disability	The purpose of the MCA is to empower and protect vulnerable adults who have impaired ability to make decisions for themselves.	Positive
Gender reassignment		
Marriage & civil partnership		
Pregnancy & maternity		
Race		
Religion/Belief		
Sex		
Sexual orientation		

<u>Stage 2: Full impact assessment</u>

What is the impact?	**Mitigating actions**	**Monitoring of actions**
None		

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