Document Control

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Mental Capacity Act Policy			
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1.0	28 Jul 2009	Final	Amend requested by Trust Board to show positive impact for disability in Equality Impact Assessment. Final amends by Corporate Affairs to update version number and formatting. Hyperlinks to Appendices. References and associated documents details revised.
1.1	Feb 2011	Revision	Minor amendments made to update document. Approved by Director of Nursing at Op Group meeting on 15th February. Minor amendments by Corporate Affairs to update document control report, formatting, correcting review date to 3 years, and renumbered contents pages.
1.2	July 2012	Review	Major review, separating Mental Capacity Act and Deprivation of Liberty Safeguards into separate Policies. Revised documentation and guidance to support policies in practice
1.3	Oct 2012	Review	Addition of consultation feedback and final editing
1.4	Oct 2017	Review	Minor amendments for approval at SAB 26/10/2017. Extension granted for 3 months for final approval.
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Summary of key differences and main changes in this harmonised policy compared to the Northern and Eastern policies

Staff are expected to review the complete policy's contents.

Section Ref.	Key Differences / Changes
8	A distinction has been made between day to day decisions and more complex serious decisions, which aligns with the consent policy
9	More details and clarity on when and how to involve and IMCA including checklist in appendix D.
10	Clarifies how the MCA protects staff from liability
11	Provides information regarding people that may have planned ahead i.e. Advance Decision, Lasting Powers of Attorney, statements wishes etc.
Appendices	Key changes to supporting tools and guidance. New flowchart, revised mental capacity assessment form with examples, IMCA SMT checklist.

CONTENTS

2. Introduction

2.1. The Mental Capacity Act (MCA) 2005 provides a statutory and quality framework to empower and protect some of the most vulnerable people in society. It makes it clear who can take decisions, in which situations and how they should go about this in respect of people who lack capacity to make particular decisions for themselves. This document sets out Northern Devon Healthcare NHS Trust's system for applying the MCA in practice and ensuring staff are aware of their responsibilities as defined by the Act.

3. Purpose

3.1. The purpose of this document is to ensure that the Trust meets nationally recognised and regionally agreed best practice for working with patients that may lack capacity. This policy is in line with and should be read in conjunction with the MCA Code of Practice and Devon's Multi agency MCA Practice Guidance. and professional codes of practice.

3.2. There could be up to 6 million people every year who are caring for a person who lacks capacity and around 2 million requiring the Mental Capacity Act's protections.

3.3. The Act will generally only affect people aged 16 and over, and provides a statutory framework for the protection of people who may lack capacity to make some decisions themselves, based on current best practice and common law principles. It also makes it clear who can take decisions in which situations and enables people to plan ahead (Advance Decisions & Lasting Powers of Attorney) for a time when they may lack capacity.

3.4. The policy applies to all patient facing Trust staff.

3.5. Implementation of this policy will ensure that:

- All clinical staff are able to recognise when there is a need to assess a patient/client's ability to make decisions based on their mental capacity and can act on this assessment.
- All clinical staff are aware of how to assess or undertake a Mental Capacity Assessment and Best Interest Decision and integrate these assessments into their work.
- Clinical staff are aware of and acknowledge Advance Decisions to Refuse Treatment and act on these.
- Independent Mental Capacity Advocates are appointed appropriately
- There is consistency of reporting and procedures across health, social care and other partner agencies locally.
- The Trust is compliant with the CQC essential standards relating to Mental Capacity

4. Definitions

Advance Decision:

4.1. This is a 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.

Best Interests

4.2. Any decisions made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out someone's best interests. These are set out in section 4 of the MCA, and in the non-exhaustive checklist in 5.13.

Capacity

4.3. The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is set out in section 2 of the MCA

Consent

4.4. Agreeing to a course of action – specifically in this document, to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.

Court of Protection

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

Decision Maker

4.6. Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout the Code, as the 'decision maker', and it is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.

Deprivation of liberty Safeguards (DoLS)

4.7. The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.

Independent Mental Capacity Advocate (IMCA)

4.8. 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):

4.9. 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/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.

Restraint:

4.10. 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.

Statement of wishes and feelings:

4.11. 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 non-binding but should be used by relevant professionals for consideration when making Best Interests decisions for a person who lacks capacity.

5. Responsibilities

Role of Safeguarding Adults Executive Lead

5.1. The Safeguarding Adults Executive Lead is responsible for:

- Ensuring the Trust fulfils its responsibilities in protecting vulnerable adults within NDHT.

- Ensuring that the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 are fully implemented within the Trust, to ensure that the rights of persons lacking capacity are respected.

Role of Non-executive and elected leads

5.2. The Non-executive and elected leads are responsible for:

- Champion & maintain focus on Mental Capacity
- Provide independent scrutiny
- Hold executive directors and Boards to account

Role of Safeguarding Adults Lead

5.3. The Safeguarding Adults Lead is responsible for:

- Ensuring the process and procedures are consistent for recording mental capacity and applying the Act.
- Attending local and regional Mental Capacity Act Groups and Networks.
- Developing internal structures to provide assurance to the organisation that Mental Capacity issues are considered and dealt with in a consistent and effective way.
- Provide systems and structures to support MCA implementation e.g. procedures, training

Role of all staff in managerial positions

5.4. All staff in managerial positions are responsible for:

- The implementation of this policy within their department. They are responsible for ensuring all staff are aware of the policy guidelines at staff inductions.
- They should ensure that all staff involved in supporting patients who may lack mental capacity have access to appropriate training.

Role of the Clinicians/Health professionals and Healthcare Assistants

- The member of staff carrying out the procedure or intervention is responsible for ensuring that consent to treatment is valid and that full discussions are recorded in the patient record.
- Where the patient may lack mental capacity for that treatment decision the health professional must carry out a mental capacity assessment and subsequent best interest decision before carrying out the intervention.

6. Key Messages of the Mental Capacity Act (MCA) 2005

- 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

- Designed to protect and restore power to those vulnerable people who lack capacity
- Supports those who have capacity and choose to plan for their future – this is everyone in the general population who is over the age of 18 (note whilst 16/17 year olds cannot make an Advance Decision or Lasting Power of Attorney they can make an Advance Statement of wishes and preferences)
- Provides legal protection in practice for health and social care staff and support and guidance for carers
- Provides a Code of Practice which all professionals have a duty to comply with
- **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:**
    - **A person must be assumed to have capacity UNLESS it is proved otherwise.**
    - **Until all practical steps have been taken to help someone make a decision without success they cannot be treated as lacking capacity.**
    - **An unwise decision does NOT in itself indicate a lack of capacity.**
    - **Any act or decision made must be in the person's Best Interests.**
    - **Any act or decision should aim to be the least restrictive option to the person in terms of their rights and freedom of action.**
- Provides a capacity assessment test designed to support and empower those in health and social care to assess capacity themselves in relation to the provision of health and social care treatment
- Provides a Best Interests checklist to direct those making Best Interests decisions for people who lack capacity including the requirement to consult with families, carers and close friends
- Emphasises that assessment of capacity and Best Interests decision making is integral to day to day practice
- Highlights the importance of the decision making processes around capacity assessments and Best Interest decisions which are as important as the outcomes of the decision making processes
- Underlines the importance of the appropriate involvement of carers and families in capacity assessments and Best Interest decision making.

7. Assessing Mental Capacity and Best Interests

7.1. The Mental Capacity Act requires that specific consideration be given to the assessment process

Defining a lack of capacity

- A person lacks capacity in relation to a matter if at that particular time s/he is unable to make a decision for him/herself in relation to the matter because of an impairment, or a disturbance in the functioning, of the mind or brain.
- It does not matter whether the impairment or disturbance is permanent or temporary.
- A lack of capacity cannot be established merely by reference to:

  (a) A person's age or appearance, or

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

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

7.3. Mental Capacity should not be confused with patient non-compliance with care/treatment. A patient who is non-compliant may be doing so with consent or without understanding the risks, therefore possibly lacking capacity. See section 10.4 of this policy for risks arising from self-neglect or a person's own behaviour or lifestyle.

How is Capacity Assessed?

7.4. Capacity is the ability to make an informed decision. Consequently, there are two basic questions for staff to consider:

7.5. ***Is there an impairment of or disturbance in the person's mind or brain?*** (Code of Practice 4.11)

7.6. Examples of an impairment or disturbance include Brain Injury, Learning Disability, Dementia, Physical or Medical conditions that cause confusion, drowsiness, or loss of consciousness etc. (Please see Code of Practice 4.12)

If so:

Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision? (Code of Practice 4.13)

A person is unable to make a decision if they cannot:-

- Understand information relevant to the decision.
- Retain information related to the decision to be made.
- Use or weigh up that information as part of the process of making the decision.
- Or communicate the decision, whether by talking, using sign language or any other means.(Code of Practice 4.14)

Who assesses capacity and best interests?

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. Often the multi-disciplinary team will make the decision together, 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 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:

- Where the decision involves medical treatment, the doctor proposing the treatment is the decision-maker
- Where nursing care is provided, the nurse is the decision-maker
- A health care assistant may need to assess if the person can agree to be bathed.
- Where a physiotherapy intervention is being proposed the therapist will be the decision-maker.
- 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
- 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
- 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.

Types of decision – when to assess capacity

7.8. Informed consent applies when a person can be said to have given consent based on a clear appreciation and understanding of the facts, and the implications and consequences of an action. English law necessitates that before any medical professional can examine or treat a patient, they must obtain informed consent to do so. Further information can be found in the Consent Policy.

If a patient is unable to give informed consent due to a mental disorder or impairment this is a good prompt to consider mental capacity. The Mental Capacity Act (2005) formalises the area assessing whether the patient is mentally capable of making the decision.

7.9. The kinds of decision which are covered by the MCA 2005 range from day-to-day decisions to significant decisions. Day-to-day assessments of capacity may be relatively informal and may be documented within the person's case notes. More serious decisions have greater consequences for the person who, it is thought, may lack capacity and justify a more formal assessment of capacity using an Assessment Form (See Appendix B).

Day-to-day Decisions

7.10. Assessments of capacity in this context may be made solely by the decision-maker. When assessing capacity for day-to-day decisions, you do not need to be an expert. But you do need to have what is called a 'reasonable belief' that the person lacks the capacity to make the decision. This means you must give your reason for thinking a person can't make a decision. The capacity assessment/Best Interests decision may be recorded within the person's case notes/electronic records and or the capacity assessment included in the care planning/support plan and treatment process. You may only need to make short notes in daily records or care plans to show why you decided that a person could or could not choose for themselves.

7.11. Section 6.34 of the MCA Code of Practice states that healthcare and social care staff can be said to have 'reasonable grounds for believing' that a person lacks capacity if:

- They are working to a person's care/support plan and
- The care planning process involved an assessment of the person's capacity to make a decision about actions in the care/support plan.

Significant Decisions

7.12. A formal assessment of capacity must be carried out when a service user/patient faces an important decision, whether in relation to care and treatment or something arising from it or in relation to their financial affairs and there are any doubts about the ability of the service user to give a valid consent to the decision. Some examples include;

- Consent to 'Serious Medical Treatment' (SMT - see section 6.15 – 6.19, MCA Code of Practice) Real examples of SMT include; smear tests, hip replacements, any treatment requiring a general anaesthetic, someone with breast cancer refusing treatment, a blood test with serious implications, operation for cataract removal etc
- Consent to an informal admission (to hospital, nursing or care home)
- Consent to a change of accommodation
- Decision in relation to the management of finances, property or affairs
- Any situation where consideration is being given to a referral under DoLS.

- Request a Tribunal Hearing when detained under the Mental Health Act MHA (1983)
- Consent to their confidentiality being breached – e.g. during a Safeguarding Adults investigation.
- There may be a dispute with the person, their family or the care team, as to the capacity of the individual.
- The person's capacity may be subject to challenge.
- There may be legal consequences of a finding of capacity (e.g. as a result of a claim for personal injury).
- The person is making decisions that put him/her or others at risk or that result in preventable suffering or damage.

7.13. **The above list is not exhaustive and professional judgement must be used. In these types of decision a formal assessment of capacity should be carried out and recorded using the Mental Capacity Assessment form (See Appendix B).**

7.14. Depending on the level and seriousness of the decision, specialist or expert opinion may be requested where the decision is major or complex. Please see Mental Capacity Act Code of Practice 4.60 – 4.62.

7.15. Any assessment of capacity is decision specific e.g. an individual may have the capacity to choose where they live, but not have the capacity to make a decision regarding serious medical treatment.

7.16. 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.

7.17. **Each professional group has responsibility to plan and undertake their own MCA assessments, if they are responsible for providing the necessary treatment or action**.

7.18. A patient's capacity may change over time, therefore it is import to review any assessments if the patients circumstances or care/treatment plan changes. The outcome of the capacity assessment should be clearly documented in the patient's notes.

Best Interests

7.19. The Mental Capacity 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 in a specific area, one of the key principles of the Act is that any act done for, or any decision made on behalf of that person, must be done or made in the person's best interest. This will ensure the care giver is protected from liability in the law relation to consent.

7.20. Factors to be considered: (Mental Capacity Code of Practice 5.13)

- No decision is made solely on the basis of a person's age, appearance or other aspect of behaviour that might lead others to make unjustified assumptions.
- All relevant circumstances should be considered.
- Likelihood of regaining capacity – if possible could the decision be delayed?
- As far as possible encourage the person to participate.
- If life-sustaining treatment then the decision must not be motivated by a desire to bring about their death.
- Is it possible to ascertain the person's past and present wishes and feelings?
- Is it possible to ascertain their beliefs and values?
- The views of other people, in particular anyone formerly named by the person to be consulted, those involved in caring for the person, those interested in their welfare, donees of a lasting Power of Attorney or any Court Deputy.
- Consultation with Independent Mental Capacity Advocate (IMCA) if one is required.

7.21. Decisions must be clearly recorded in the case notes or designated forms.

What happens in emergency situations?

7.22. Sometimes people who lack capacity to consent will require emergency medical treatment to save their life or prevent them from serious harm. In these situations, what steps are 'reasonable' will differ to those in non-urgent cases. In emergencies, it will almost always be in the person's best interests to give urgent treatment without delay. One exception to this is when the healthcare staff giving treatment are satisfied that an Advance Decision to refuse treatment exists, for example a Do not Attempt to Resuscitate (DNAR) Instruction.

8. Independent Mental Capacity Advocate (IMCA)

8.1. The aim of the IMCA service is to provide independent safeguards for people who **lack capacity** to make certain important decisions and, at the same time as such decisions need to be made, **have no-one else (other than paid staff) to support or represent them or be consulted**.

When to Involve an IMCA

An IMCA ***must*** be instructed, by the Local Authority or an NHS body, and then consulted, for people aged over 16 lacking capacity who are unbefriended (i.e. have no-one else other than paid staff to support them) whenever:

- The Trust is proposing to provide serious medical treatment,
  Or
- An NHS body or Local Authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and
  - The person will stay in hospital longer than 28 days or
  - They will stay in the care home for more than eight weeks.

8.2. See Mental Capacity Act Code of Practice 10.3 for further guidance. Within the Devon and Torbay Health and Social Care community, practitioners are advised to consider instructing an IMCA to support someone who lacks capacity;

- In adult protection cases, whether or not family, friends or others are involved.
- For care reviews when no-one else is available to be consulted.

The Role of the IMCA

8.3. The IMCA's role is to support and represent the person who lacks capacity. Because of this, IMCAs have the right to be provided with access to relevant healthcare and social care records. (Mental Capacity Act Code of Practice 10.20)

8.4. Any information or reports provided by an IMCA must be taken into account as part of the process of determining whether a proposed decision is in the person's best interests.

8.5. **A written copy of the final decision, and the decision maker's reasons for it, must be sent to the IMCA Service as soon as possible after the decision is made.**

8.6. It is vital that clear, accurate and timely identification of the need for an IMCA is made in all cases. Delay in identifying the need for an IMCA is likely to cause delays in medical treatment, discharge from hospital or placement in care homes.

Serious Medical Treatment

NHS bodies must instruct and then take into account information from an IMCA where decisions are proposed about 'Serious Medical Treatment' (SMT) 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. Detailed guidance on involving IMCAs in SMT decisions can be found here. A Checklist for instructing an IMCA in SMT decisions is available in Appendix D.

Serious medical treatment is that which involves:

- Giving new treatment
- Stopping treatment that has already started

- Withholding treatment that could be offered.

And where there is either:

a) a fine balance between the benefits and the burdens & risks of a single treatment.

b) a choice of treatments which are finely balanced,

c) what is proposed would be likely to involve serious consequences for the patient.

8.7. Serious consequences refer to those which could have a serious impact on the person. It could include treatments which:

- Cause serious and prolonged pain, distress or side-effects.
- Have potentially major consequences for the patient e.g. major surgery.
- Have a serious impact on the patient's future life choices (e.g. interventions for ovarian cancer).

Which treatments are 'Serious Medical Treatments?'

8.8. The MCA Code of Practice (10.45) offers some examples of treatments, which may be considered as serious medical treatment; however, it is impossible to provide a definitive list of all serious medical treatments. It is for the clinician responsible for the person's treatment to consider the implications of what is proposed and to decide if the consequences are serious *for that individual*. Examples of treatments where IMCAs have been involved include surgery, treatment for cancer, insertion of a PEG, amputation, dental treatment, blood tests, cataract operation, withdrawal of antibiotic treatment and Do Not Attempt Resuscitation (DNAR) orders.

8.9. A minor treatment may not in itself be considered as serious medical treatment but depending on the persons circumstances, as well as the impact on them of providing or withholding treatment and potential degree of invasiveness, it could still be considered SMT. Examples are minor treatment for an eye infection where the person only has one eye or prescribing laxative, which may be routine but could become SMT if it's part of initial treatment for bowel obstruction

Emergency decisions

8.10. The only exception for the need to instruct an IMCA is if there is an emergency situation requiring an urgent decision to be made, for example, to save a person's life. However, once the emergency has passed, there is a duty to instruct an IMCA for any subsequent serious medical treatment decisions.

When an IMCA cannot be instructed

8.11. An IMCA cannot be instructed in the following situations:

- A person who lacks capacity previously named a person who should be consulted and that person is available and willing to be involved.
- A person who lacks capacity has appointed an attorney under a Lasting Power of Attorney (LPA) who has the appropriate decision-making authority. The relevant LPA for treatment decisions is a Health and Welfare LPA.
- An IMCA cannot be involved if the proposed treatment is for a mental disorder and that treatment is authorized under Part IV of the Mental Health Act 1983. However, if a person is being treated under the Mental Health Act and the proposed treatment is for physical illness e.g. cancer, an IMCA would represent the patient in the decision-making process for this treatment. In such circumstances the IMCA would be expected to work closely with the Independent Mental Health Advocate (IMHA).

Requirement for instructing an IMCA for hospital stays over 28 days.

8.12. When unplanned admissions to acute general hospital care occur it is often the case that the decision to treat and the decision to admit are made as urgent decisions and therefore exempt from instruction at that time but may turn out to be a sustained admission. However, if it is likely that a person will be in hospital for more than 28 days, there will also be a duty to instruct an IMCA for an accommodation decision. The Code of Practice advises that the **'responsible body should involve an IMCA as soon as they realise the stay will be longer than 28 days**.

8.13. However, for others it may be less evident, as the course of a patient's recovery or deterioration is not foreseeable. The progression through hospital services may also incur changes in ward or place of care. It is important that NHS bodies have systems in place to recognise those patients who meet IMCA criteria and follow their overall length of stay, so that instruction can be made to meet this statutory duty in a timely manner before the admission extends past 28 days. Instruction should be made regardless of whether the person is still recovering from treatment, due to receive further treatment or if a decision about whether they are fit to be discharged is yet to be determined. The IMCA's work in such cases will be focused on whether or not it is in the person's best interests to remain in hospital.

8.14. ***The majority of IMCA instructions for a change of accommodation occur when the person is in hospital and they lack capacity to make a decision about accommodation at that time. It is highly possible that those same people lack capacity to make a decision about Serious Medical Treatment.***

Instructing an IMCA

8.15. It is vital that accurate and timely information about the need for an IMCA is made in every case. Delay in instructing an IMCA may result in delays in medical treatment.

8.16. Each NHS Trust is responsible for authorising staff within its organisation who can instruct an IMCA. Instruction will therefore be made by a range of healthcare staff. The following staff within Northern Devon Healthcare Trust could, for example, instruct an IMCA: Consultants, Staff Nurses/pre-admission nurses, Occupational Therapists, Physiotherapists, Matrons, Ward Managers, Learning Disability nurses, Clinical Nurse Specialists.

8.17. Initial instruction can be made either by telephone or by sending an instruction form to the IMCA service. If instruction is made by phone, the IMCA service will ask for relevant information pertinent to the decision to be made, including;

- details of the decision
- how it is has been established that the person lacks capacity
- whether the person has family or friends who are appropriate to consult
- what support the person has received to enable them to make the decision for themselves
- timescales for the decision-making process

8.18. A record must be made in the patient's notes of the decision to instruct an IMCA and the people involved in making that decision.

8.19. If there is uncertainty about whether a patient is eligible for IMCA and a discussion is held where the outcome is not to instruct IMCA, this must also be recorded in the patient's notes.

8.20. Devon County Council commissions the IMCA service through Age UK.

8.21. IMCA Service (Devon & Torbay) Age UK Devon, **Tel: 0845 231 1900**

Follow the link on www.AgeUKDevon.co.uk for the IMCA referral page where you will find the referral form and referral guidance

Please email referral forms to imca.devon@nhs.net or fax to 01392 829594

Example:

Lisa is an adult with severe learning disabilities and both her parents have recently died.

Lisa needs heart bypass surgery. This is the first time since her parents died that a decision needs to be made in relation to Lisa and she has no other family and friends or anyone else to represent or support her.

Although she is able to make decisions about her day to day life she lacks capacity to consent to the operation.

An IMCA will therefore be instructed to find out as far as possible Lisa's views and represent them to the doctor who will then decide whether or not it is in Lisa's best interests to go ahead with the operation.

9. Providing care or treatment to people who lack capacity

How does the MCA protect you if you work in health and social care?

9.1. The MCA provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity to consent, provided that:

- you have observed the principles of the MCA;
- you have carried out an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in question (part 6); and
- you reasonably believe the action you have taken is in the best interests of the person (part 7).

9.2. Some decisions that you make could result in major life changes or have significant consequences for the person concerned and these need particularly careful consideration. For example, a change of residence, perhaps into a care home or nursing home; or major decisions about healthcare and medical treatment.

9.3. Providing you have complied with the MCA in assessing a person's capacity and have acted in the person's best interests you will be able to diagnose and treat patients who do not have the capacity to give their consent.

9.4. It is important to keep a full record of what has happened. The protection from liability will only be available if you can demonstrate that you have assessed capacity (see section 8), reasonably believe it to be lacking and then acted in what you reasonably believe to be in the person's best interests (see section 8).

In emergencies, it will often be in a person's best interests for you to provide urgent treatment without delay.

There are some decisions about medical treatment that are so serious that each case should go to the Court of Protection. For more detailed information you should refer to the Code of Practice.

The Trusts Consent policy and consent forms are available on Bob

The Use of Restraint

9.5. Restraint covers a wide range of actions, Section 6(4) of the Act states that someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or

- restrict a person's freedom of movement, whether they are resisting or not.

9.6. Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

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

See paragraphs 6.44–6.48 for more explanation of the terms necessary, harm and a proportionate response. Trust staff should also refer to the Restraint Policy:

9.7. In addition to the requirements of the Act, the common law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

9.8. However, within this context, the common law would not provide sufficient grounds for an action that would have the effect of depriving someone of their liberty (see 10.3 below and paragraphs 6.49–6.53 of the MCA CoP).

9.9. Using excessive restraint could leave you liable to a range of civil and criminal penalties. For instance, it may be necessary to accompany someone when going out because they cannot cross roads safely, but it may be unreasonable for you to stop them from going outdoors all together.

Deprivation of Liberty Safeguards

9.10. These safeguards are designed to protect people lacking capacity who need to be deprived of their liberty for their own safety and who are not capable of making decisions themselves about arrangements that should be made for their care and treatment. The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS), which came into force in England on 1 April 2009, provides a legal framework to prevent unlawful deprivation of liberty occurring. The safeguards protect vulnerable people in hospitals or care homes who lack the capacity to consent to the arrangements made for their care and/or treatment but who need to be deprived of their liberty in their own best interests to protect them from harm.

9.11. Further information can be found in the Trusts Deprivation of Liberty Safeguards Policy and the Deprivation of Liberty Safeguards Code of Practice.

9.12. If you think there are a number of restrictions in place for a particular patient you should complete a DoLS risk assessment tool and if you identify a potential DoL then follow the steps on the tool, making an application to the Devon County Council DoLS service.

Risks arising from self-neglect or a person's own behaviour or lifestyle

9.13. A vulnerable adult may be considered under the Safeguarding Adults procedure where they are unable to provide adequate care for themselves and one or more of the following situations apply:

- They are unable to obtain necessary care to meet their needs.
- They are unable to make reasonable or informed decisions because of their state of mental health or because they lack the mental capacity to understand the risks and consequences associated with their behaviour.
- They are unable to protect themselves adequately against potential exploitation or abuse.
- They have refused essential services without which their health and safety needs cannot be met.

9.14. Often, the cases which give rise to the most concern are those where a vulnerable adult refuses help and services and is seen to be at significant risk as a result. If Trust staff are satisfied that the vulnerable adult has the mental capacity to make an informed decision and they are not being subjected to coercion or intimidation, then that person has the right to refuse services/ treatment/ intervention.

9.15. Although there should always be a presumption of capacity, in these high risk cases it is recommended a mental capacity assessment is undertaken to establish that the vulnerable adult does have capacity to understand the risks and consequences of their actions. This should be clearly evidenced and documented within the patient's notes.

9.16. Where the vulnerable adult (with capacity) continues to refuse all assistance, this decision, together with any reasons, should be fully recorded and maintained on the person's file, with a full record of the efforts and actions taken by the agencies to assist the vulnerable adult and to understand the basis of refusal. If the vulnerable adult lacks capacity to understand the risks and consequences of refusal then the Mental Capacity Act should be followed and a best interest decision made (in complex situations this is likely to be in the form of a multi-agency meeting).

9.17. Appropriate communication should be forwarded to the vulnerable adult concerned, setting out what services were offered and why and the fact of the person's refusal to accept them. This needs to make clear that the person can contact the relevant agency for services at any time in the future. In cases of high risk, consideration should be given to arrangements for monitoring the case to ensure that circumstances do not deteriorate to an unacceptable degree. It may also be necessary for agencies to discuss their concerns at a safeguarding strategy meeting in order to share concerns and consider multi-agency protection plans to safeguarding the vulnerable adult.

10. Providing care or treatment for people who have planned ahead

10.1. The MCA has far reaching effects for people who work in health and social care because it extends the ways in which people using services can plan ahead for the time when they may lack capacity. These are Lasting Powers of Attorney (LPAs), Advance Decisions to refuse treatment, and written statements of wishes and feelings.

10.2. If you are providing care or treatment for someone who lacks capacity these may be very helpful in deciding what to do. If you are working with people who have capacity, or who have fluctuating capacity (such as people with mental health problems) it may be helpful for you to explain to them these ways of planning ahead for a time when they may lack capacity.

10.3. Providing care or treatment for people who have planned ahead is a very complex area and it is advisable to refer to the Code of Practice for more detailed guidance.

Lasting Powers of Attorney

10.4. The MCA introduces a new form of Power of Attorney which allows people over the age of 18 to formally appoint one or more people to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. The person making an LPA is called the Donor. The power that is given to someone else is called a Lasting Power of Attorney (LPA) and the person(s) appointed are known as an attorney(s). The LPA gives the Attorney authority to make decisions on behalf of the Donor and the Attorney has a duty to act or make decisions in the best interests (principle 4) of the person who has made the LPA.

10.5. There are two different types of LPA:

1) A Personal Welfare LPA is for decisions about both health and personal welfare; and

2) A Property and Affairs LPA is for decision about financial matters.

Important facts about LPAs

- The introduction of LPAs for property and affairs means that no more Enduring Powers of Attorney (EPA) can be made, but the MCA makes transitional provisions for existing EPAs to continue whether they are registered or not. This means that pre-existing EPAs can continue to be used (whether registered or not) and can continue to be registered.
- When a person makes an LPA they must have the capacity to understand the importance of the document and the power they are giving to another person.
- Before an LPA can be used it must be registered with the Office of the Public Guardian (part 12). This is vital because **without registration an LPA cannot be used at all.**
- An LPA for property and affairs can be used when the Donor still has capacity unless the Donor specifies otherwise.
- A Personal Welfare Attorney has no power to consent to, or refuse treatment, at any time or about any matter when the person has the capacity to make the decision for himself or herself.
- If the person in your care lacks capacity and has created a Personal Welfare LPA, the Attorney is the decision-maker on all matters relating to the person's care and treatment. Unless the LPA specifies limits to the Attorney's authority the Attorney has the authority to make personal welfare decisions and consent to or refuse treatment (except life-sustaining treatment) on the Donor's behalf. The Attorney must make these decisions in the best interests of the person lacking capacity (principle 4) and if there is a dispute that cannot be resolved, for example, between the attorney and a doctor, it may have to be referred to the Court of Protection.
- If the decision is about life-sustaining treatment, the Attorney only has the authority to make the decision if the LPA specifies this.
- If you are directly involved in the care or treatment of a person who lacks capacity, you should not agree to act as their Attorney other than in exceptional circumstances, for instance, if you are the only close relative of the person.
- It is important to read the LPA if it is available to understand the extent of the Attorney's power.

Example:

Martin has recently been diagnosed as being in the very early stages of Alzheimer's disease. He wants to make sure that if he lacks capacity in the future his personal values and preferences are taken into account when a decision is made on his behalf. He decides to appoint his daughter as a Personal Welfare Attorney to make any personal welfare decisions if he loses capacity to make himself.

He talks through things that are important to him, such as wanting to stay near his friends, and to be able to go into a care home that allows pets. His daughter then registers the LPA. If in the future Martin lacks capacity to decide where he should live,

his daughter will have the authority to make this decision as his Personal Welfare Attorney. She will be able to take account of the things that her father has stated when considering what would be in his best interests.

Advance Decisions to refuse treatment

10.6. Sometimes people have clear views about what types of treatment they don't want to have and would not consent to. An Advance Decision allows them to express these views clearly, before they lose capacity. Advance Decisions, also called Advance Directives or 'Living Wills' can currently be made under common law and the Mental Capacity Act puts them on a statutory footing. It also explains what is required in law for an Advance Decision to be valid and applicable and introduces new safeguards.

10.7. An Advance Decision is where a person aged 18 or over may set out what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent to this treatment for themselves in the future. It can be about any treatment even if it may result in the person's death, and if it is valid and applicable it must be followed as it is legally binding and has the same force as when a person with capacity refuses treatment (see below for the requirements for Advance Decisions). An Advance Decision does not need to be in writing; except for decisions relating to life-sustaining treatment (see below) but it is helpful if it is.

What are the requirements for Advance Decisions?

10.8. The MCA introduces a number of rules people must follow when making an Advance Decision. If you are making a decision about treatment for someone who is unable to consent to it, you must be satisfied that the Advance Decision exists and is valid and applicable to the particular treatment in question.

- The following list gives a very brief summary of some of the main requirements for Advance Decisions (if you are involved in such a decision you should consult the Code of Practice).
- It must be valid. The person must not have withdrawn it, or overridden it by making an LPA that relates to the treatment in the Advance Decision (see part 10), or acted in a way that is clearly inconsistent with the Advance Decision.
- It must be applicable to the treatment in question. It should clearly refer to the treatment in question (detailed medical terms do not have to be used) and it should explain which circumstances the refusal refers to. If there have been changes in circumstances which there are reasonable grounds for believing would have affected a person's Advance Decision when they made it, then it may not be applicable.

You should also note the following.

- Where people are detained under the Mental Health Act 1983 and can therefore be treated for mental disorder without their consent, they can also be given such treatment despite having an Advance Decision to refuse the treatment.
- People cannot make an Advance Decision to ask for medical treatment - they can only say what types of treatment they would refuse.
- People cannot make an Advance Decision to ask for their life to be ended.

10.9. If you are satisfied that the decision is both valid and applicable then you will have to abide by that decision.

Advance Decisions to refuse life-sustaining treatment

10.10. The MCA sets out additional formalities for Advance Decisions that refuse life-sustaining treatment. An Advance Decision to refuse life-sustaining treatment must fulfill the following additional requirements:

- It must be in writing, which includes being written on the person's behalf or recorded in their medical notes.
- It must be signed by the maker in the presence of a witness who must also sign the document. It can also be signed on the maker's behalf at their direction if they are unable to sign it for themselves.
- It must be verified by a specific statement made by the maker, either included in the document or a separate statement that says that the Advance Decision is to apply to the specified treatment, even if life is at risk. If there is a separate statement this must also be signed and witnessed.

Example:

George has witnessed a friend die of cancer. He decides that he would not wish to receive chemotherapy or radiotherapy if he became seriously ill and was close to dying. George is concerned that if he is unable to make a decision, the doctors may make it for him.

So he makes an Advance Decision stating that in the future if he becomes ill he does not want to receive chemotherapy or radiotherapy. His Advance Decision includes a written statement confirming that he does not want chemotherapy or radiotherapy even if his life is at risk. George signs the Advance Decision and his close friend witnesses the signature.

The Advance Decision must be followed if and when it becomes relevant and the doctor is satisfied that it is valid and applicable.

Providing care or treatment for people who have made Advance Decisions is a complex area and it is advisable to refer to the MCA Code of Practice for more detailed guidance.

Conscientious objection

10.11. You will not have to act on an Advance Decision if you object to it on religious or moral grounds.

10.12. You must make this known as soon as possible and arrangements must be made for the management of the patient's care to be transferred to another health professional.

Liability of people who work in health and social care

10.13. You will not incur liability for providing treatment in a patient's best interests if, having taken reasonable steps, you do not know or are not satisfied that a valid and applicable Advance Decision exists. If you are satisfied that an Advance Decision exists which is valid and applicable, then not to abide by it could lead to a legal claim for damages or a criminal prosecution for assault.

10.14. If you reasonably believe that there is a valid and applicable Advance Decision then you will not be held liable for the consequences of abiding by it and not providing treatment. You should clearly record how you came to your conclusions.

Disputes and disagreements about Advance Decisions

10.15. You will have to form a view about whether or not an Advance Decision is valid and applicable and you should refer to the Code of Practice for more detailed guidance particularly if there is a disagreement.

10.16. If there is a dispute or difficulty, then you should consider mediation or the matter could be referred to the Court of Protection by you or a relative, carer or a close friend of the patient.

Dealing with Advance Decisions that were made before October 2007

10.17. If any of the people you provide care or treatment for had an Advance Decision (sometimes known as a 'Living Will') before the MCA came into force then it may still be valid. However, you should check that it meets the new rules, particularly if it deals with life-sustaining treatment. More detailed guidance on this is available at www.dh.gov.uk/consent

Statements of wishes, feelings, beliefs and values

10.18. Sometimes people will want be able to write down or tell people about their wishes and preferences about future treatment and care and explain their feelings or values that govern how they make decisions.

10.19. These statements can be about anything, including personal preferences such as having a shower rather than a bath, or wanting to sleep with the light on. Such statements can request certain types of treatment, which you must consider carefully, in particular if they have been written down.

Example:

Kieran is vegetarian and has a degenerative condition. He wants to make sure that if he lacks mental capacity and needs people to help him with daily tasks they take into account his personal beliefs. He therefore writes down a statement explaining that he only wishes to receive vegetarian food.

Kieran asks for the statement to be filed with his health records so that in the future, if he can no longer make and communicate his own decisions, he receives food in line with his wishes.

10.20. When you are assessing what treatment or care is in a person's best interests you will have to take these statements into account. However, your final decision must always be based on your assessment of what is in the person's best interests and your professional judgment of what is clinically necessary or appropriate. If this is different to what they have said in their statement of wishes and feelings you should keep a record of this and be prepare to justify your decision if challenged.

Court Appointed Deputies

10.21. The Court of Protection was established under the Mental Capacity Act 2005, to make a decision or to appoint a decision-maker on someone's behalf in cases where there is no other way of resolving a matter affecting a person who lacks capacity to make the decision in question.

10.22. The Court of Protection has powers to:

- Decide whether a person has capacity to make a particular decision for themselves
- Make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions
- Appoint deputies to make decisions for people lacking capacity to make those decisions
- Decide whether an LPA or EPA is valid, and remove deputies or attorneys who fail to carry out their duties
- Serious healthcare and treatment decisions, such as withdrawing artificial nutrition, bone marrow or organ donation, non-therapeutic sterilisation or other instances where there is doubt about whether a particular treatment is in the person's best interest should be put to the Court of Protection for approval

10.23. For more information see Chapter 8 of the Mental Capacity Act 2005 Code of Practice

11. Further Support and Advice

11.1. If you are unable to find the answer to a question in this Policy or the MCA Code of Practice, and having discussed the matter with your line manager there are several routes for further support.

- The Trust Safeguarding Adult Lead – Direct Dial 01392 356917
- The Devon County Council DoLS and MCA service – 01392 381676
- Out of hours you will need to contact out of hours on call.

12. Training Requirements

12.1. All staff who are required to undertake Safeguarding Adults training will be identified through the Trust's training matrix available via BOB under 'What training do I need?'. The training matrix will detail:

- Staff groups requiring training
- Frequency of training
- Mode of deliver i.e. e-learning or taught
- Course titles

12.2. Face to face safeguarding training is multi-agency and delivered through Devon County Council, Course availability and booking should be made in the same way as all internal training through Workforce development

12.3. As this training is delivered via Devon County Council it is important that the Trust's Workforce and Development team are notified of any attendance to ensure the Electronic Staff Record is kept up to date. Signed records must be kept of all training undertaken in the Trust. These records will be held centrally and reported Trust wide through ESR records. Individuals are encouraged to keep a copy of this in their portfolio.

12.4. On updating the Electronic Staff Record, line managers will be notified of all non-attendees. Further detail on booking and reporting processes are contained within Risk Management (Statutory and Mandatory) Training Policy.

13. The Development of the Policy

Prioritisation of Work

13.1. This is the harmonised Safeguarding Adults policy reflecting the incorporation of the community services in Exeter, East and Mid Devon policy with Northern Devon Healthcare NHS Trust policy in April 2011.

Document Development Process

13.2. As the author, the Safeguarding Adults Lead is responsible for developing the policy and for ensuring stakeholders were consulted with. The advice of the Equality and Diversity lead must be sought. For NHS Litigation Authority (NHSLA) policies, the author must seek the advice of the Compliance Manager.

13.3. Draft copies were circulated for comment before approval was sought from the relevant committees.

Equality Impact Assessment

13.4. The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. An Equality Impact Assessment Screening has been undertaken and there are no adverse or positive impacts (Appendix E).

14. Consultation, Approval and Ratification Process

Consultation Process

The author consulted widely with stakeholders, including:

- Clinical Audit lead
- Head of Learning & Development
- Equality & Diversity Lead
- Health & Safety Advisor
- Users of this document
- Director of Nursing
- Director of Medicine
- Head of Professional Practice – Assistant Director of Nursing
- Head of Quality and Patient Safety
- Head of Corporate Governance
- Health and Social Care Cluster Managers
- Devon County Council Safeguarding Adult Team
- NDHT Safeguarding Adult Board
- Community Matrons

- Professional Practice team
- Investigations Lead
- Datix and Incident Manager
- Compliance Manager

14.1. Consultation took the form of a request for comments and feedback via email. Hard copies were available on request.

Policy Approval Process

14.2. Approval of the policy will be sought from the Safeguarding Adults Board.

15. Review and Revision Arrangements including Document Control

Process for Reviewing the Policy

15.1. The policy will be reviewed every three years. The author will be sent a reminder by the Corporate Governance Manager four months before the due review date. The author will be responsible for ensuring the policy is reviewed in a timely manner.

15.2. The reviewed policy will be approved by the Trust's Safeguarding Adults Board. The author must update the Document Control Report each time the policy is reviewed. Details of what has changed between versions should be recorded in the Document Control Report.

Process for Revising the Policy

15.3. In order to ensure the policy is up-to-date, the author may be required to make a number of revisions, e.g. committee changes or amendments to individuals' responsibilities. Where the revisions are minor and do not change the overall policy, the author will make the amendments, record these in the document control report and send to the Corporate Governance Manager for publishing. Significant revisions will require approval by the Trusts Safeguarding Adults Board. The author must update the Document Control Report each time the policy is revised.

Document Control

15.4. The author will comply with the Trust's agreed version control process, as described in the organisation-wide Guidance for Document Control.

16. Dissemination of the Policy

Dissemination of the Policy

16.1. After approval by the Safeguarding Adults Board, the author will provide a copy of the policy to the Corporate Governance Manager to have it placed on the Trust's Intranet (Bob). The policy will be referenced on the home page as a latest news release and staff will be informed that this policy replaces any previous versions.

16.2. Information will also be included in the weekly Chief Executive's Bulletin which is circulated electronically to all staff.

16.3. An email will be sent to senior management to make them aware of the policy and they will be responsible for cascading the information to their teams and staff. In addition, staff will be informed that this policy replaces any previous versions. The policy will be presented to a variety of forums, e.g. Senior Nurse Forum, Community Nurse Team Leaders Forum, and Divisional Management Meeting.

Implementation of the Policy

16.4. Line managers are responsible for ensuring this policy is implemented across their area of work. Support for the implementation of this policy will be provided by the Safeguarding Adults Lead, supported by the training pathway.

17. Document Control including Archiving Arrangements

Library of Procedural Documents

17.1. The author is responsible for recording, storing and controlling this policy.

17.2. Once the final version has been approved, the author will provide a copy of the current policy to the Corporate Governance Manager so that it can be placed on the Trust's Intranet site (Bob). Any future revised copies will be provided to ensure the most up-to-date version is available on the Trust's Intranet site (Bob).

Archiving Arrangements

17.3. Once the final version has been ratified, the author will provide a copy of the current policy to the Bob Support Officer so that it can be placed on Bob. All versions of this policy will be archived in electronic format within the Nursing Directorate policy archive. Archiving will take place by the Safeguarding Adults Lead once the final version of the policy has been issued.

17.4. Revisions to the final document will be recorded on the document control report. Revised versions will be added to the policy archive held by the Nursing Directorate.

Process for Retrieving Archived Policy

17.5. To obtain a copy of the archived policy, contact should be made with the Nursing Directorate.

18. Monitoring Compliance with and the Effectiveness of the Policy

Standards/ Key Performance Indicators

18.1. Key performance indicators comprise:

- Percentage of staff completing Mental Capacity training
- Percentage of mental capacity assessments completed for patients who lack capacity
- Number of SMT IMCA referrals

18.2. Process for Monitoring Compliance and Effectiveness

18.3. This policy and its implementation will be monitored through the Safeguarding Adults Board (Terms of Reference agreed). This group is chaired by the Executive Lead for Safeguarding Adults.

18.4. Within Northern Devon Healthcare Trust, the Director of Nursing has executive responsibility for Safeguarding Adults and reports to the Quality Assurance Committee and the Trust Board. The Director of Nursing chairs the Safeguarding Adults Board. The Safeguarding Adults Lead reports to the Director of Nursing and is a member of the Safeguarding Adults Board, the Devon MCA sub group and also the Devon Safeguarding Adults Board. All line managers have a responsibility to ensure the MCA Policy is followed by staff that they directly manage. The Safeguarding Adults Board will undertake case file audits to ensure consistency of compliance with the policy and reporting procedures. In addition to a questionnaire audit of staff awareness of guidelines, processes where to seek advice and support. Where non-compliance is identified, support and advice will be provided to improve practice.

19. References

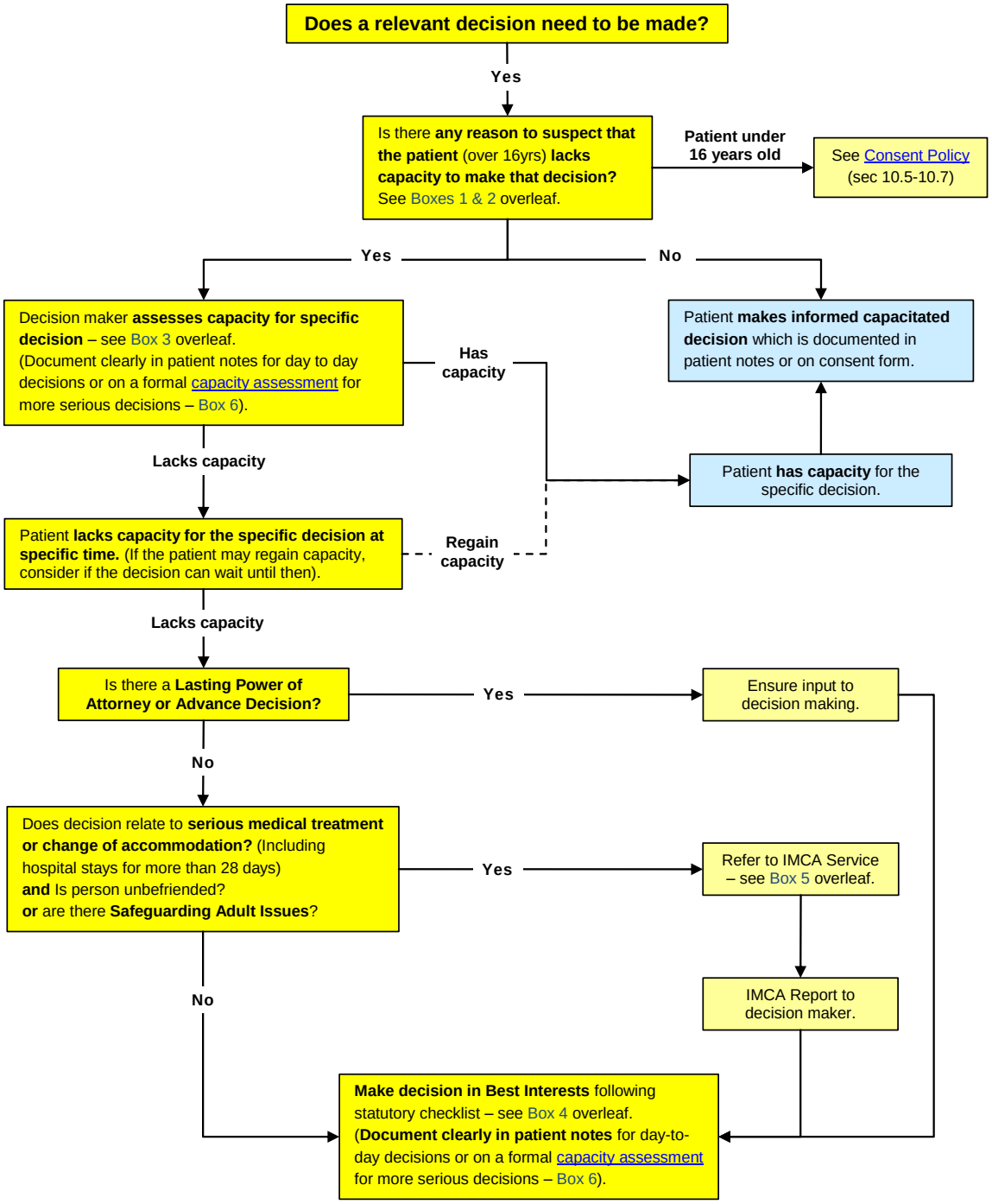
- Mental Capacity Act code of Practice (2005)
- The Care Quality Commissions Essential Standards
- Making decisions: A guide for people who work in health and social care

20. Associated Documentation (Optional)

- Devon County Council MCA practice guidance

- Safeguarding Adults Policy
- Consent Policy
- Incident Reporting policy
- Dignity, Privacy and Respect policy
- Professional Codes of Conduct (E.g. GMC, NMC, HPC)

Appendix A: Mental Capacity Act Decision Making Flowchart



Box 1: Five principles of capacity

1. A person must be assumed to have capacity unless it is proved otherwise
2. Until all practicable steps have been taken to help someone make a decision without success, they cannot be treated as lacking capacity
3. An unwise decision is NOT to be taken as a lack of capacity
4. Any act should aim to be the least restrictive option to the person in terms of their rights and freedom of action
5. Any act or decision taken on behalf of someone lacking capacity must be in the persons best interest

Box 2: Two Stage Test

Is there an impairment of, or disturbance in the functioning of the persons mind or brain?
If so,
Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision? (See Box 3 for test of capacity)

Box 3: Test for Capacity

The person must be able to:

- Understand the information relevant to the decision
- Retain the information
- Use or weigh the information as part of the decision making process
- Communicate the decision

Box 4: Best Interests

1. Involve the person who lacks capacity
2. Be aware of the person's past and present wishes and feelings
3. Consult others who are involved in the care of the person
4. Do not make assumptions based solely on the person's age appearance, condition or behaviour
5. Is the person likely to regain capacity to make the decision in the future

Box 5: IMCA

The IMCA instruction form and referral guidance can be downloaded from the IMCA service website *www.AgeUKDevon.co.uk*
Devon County Council commissions the IMCA service through Age UK.
IMCA Service (Devon & Torbay) Age UK Devon, Unit 1 Manaton Court, Matford Business Park, Exeter. EX2 8PF **Tel: 0845 231 1900**
Please email referral forms to imca.devon@nhs.net or fax to 01392 829594

Box 6: Record keeping and Documentation

Good record keeping is essential to the provision of safe and effective care. It is not an optional extra to be fitted in is circumstances allow.

The kinds of decision which are covered by the MCA 2005 range from day-to-day decisions to significant decisions. Day to day assessments of capacity may be relatively informal and may be documented within the person's case notes. More serious decisions have greater consequences for the person who, it is thought, may lack capacity and justify a more formal assessment of capacity using an Assessment form.

Appendix B: Mental Capacity and Best Interests Assessment Form

Name: **Location:** **D.O.B:** Patient Identification Label	Northern Devon Healthcare NHS Trust Incorporating community services in Exeter, East and Mid Devon **MENTAL CAPACITY AND BEST INTERESTS ASSESSMENT**

I am completing this assessment form on (date)…….. because the patient named above appears to lack capacity at this time
(Assessment context *-Remember assessment of Mental Capacity must be decision and time specific***)**

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

Determination of Capacity *(This is specific, not general determination*) See Decision Making flow chart in the Mental Capacity policy

Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?	Permanent impairment ☐	Temporary impairment ☐	None ☐
Details:			

Can the decision be delayed because the person is likely to regain capacity in the near future?	Yes ☐	Not likely to regain capacity ☐	Not appropriate to delay ☐
Details:			

1. Is the patient able to understand information related to the decision?	Yes ☐	No ☐
Comments/Evidence:		
2. Is the patient able to retain information related to the decision?	Yes ☐	No ☐
Comments/Evidence:		
3. Has the patient been able to use and weigh that information? Do they understand the risks and benefits of making or not making the decision?	Yes ☐	No ☐
Comments/Evidence:		
4. Person has ability to communicate their decision by any means?	Yes ☐	No ☐
Comments/Evidence: state what steps have been taken to achieve communication?		

If you have ticked any of the above questions 1 to 4 as NO then this person lacks capacity at this time

What steps have been taken to enable or assist the person to make or be involved in this decision?
e.g. using non-verbal means of communication.

Mental Capacity Assessment Outcome			
If the patient has capacity, what is their decision? Use patients own words **OR** If the patient does not have capacity, they cannot consent, therefore, decisions must be made in their best interests and the decision recorded on the Best Interests form overleaf.			
Advance Decisions *(Refer to the MCA policy or Code of practice chapter 9 for further guidance on ADs)*			
Is there an Advance Decision relevant to the proposed treatment?	No ☐ Yes ☐	If yes verbal ☐ *(Detail below)*	Written ☐ *(Detail below)*
Details: (Remember: an AD refusing life sustaining treatment MUST be in writing, signed and witnessed and clearly state that the decision applies even if life is at risk).			
Best Interest Decision Making: Step 1: who are you going to consult?			
Has the patient appointed a Lasting Power of Attorney? No ☐ Yes ☐ *Name*……..			
Does the person have a Next of Kin/ Person who can inform decision making? No ☐ Yes ☐ *Name*……..			
If there is no (unpaid) person who can help inform the decision making process and this decision relates to Serious Medical Treatment, an accommodation move or a Safeguarding Adults concern, you must appoint an Independent Mental Capacity Advocate(IMCA) Person appointing IMCA: *Name*…… *Role*…… *Date*……..			
Determination of Best Interest Decision: Step 2: views of patient, professionals and interested others			
What are the patients past and present wishes and feelings? E.g. written statements.			
What are the views of significant others, including family, friends, IMCA, carers, LPA etc, identify those consulted and their relationship? If no-one consulted give reason why.			
What are the views of the professionals?			
Are there any conflicts or disagreements? If so what steps can be taken to resolve this disagreement?			
Best Interest Decision Summary: Step 3: Final decision			
In consideration of the above and all relevant factors what is the final decision? Summarise the reasoning behind the decision and why this decision would be in the patient's best interests:			

Decision Maker Name……Role……..Signature……..Date……

Appendix C: Mental Capacity and Best Interests Assessment Example

Name: Mr Jimmy Jam

Location: NDDH

D.O.B: 04/08/1984
Patient Identification Label

Northern Devon Healthcare NHS
NHS Trust

Incorporating community services in Exeter, East and Mid Devon

MENTAL CAPACITY AND BEST INTERESTS ASSESSMENT

ACUTE HOSPITAL SMT EXAMPLE

I am completing this assessment form on (date) 01/09/2012.... because the patient named above appears to lack capacity at this time **(Assessment context** - *assessment of Mental Capacity must be decision and time specific)*

Details of treatment decision(s) or other specific issue(s) in relation to which capacity is being assessed:
Jimmy has been living in residential accommodation in a group home for adults with severe learning difficulties for two years. He requires one-to-one support to complete most activities of daily living. Jimmy has some receptive language skills and uses his limited expressive language skills and behaviour to communicate with staff. Jimmy collapsed with shortness of breath clenching his chest and was taken to A+E where it was established he had suffered a heart attack. Jimmy has had a history of heart problems, however he always resists any form of intervention. The consultant would like to carry out further examination, including a heart biopsy to accurately diagnose and treat Jimmy. This may require general anaesthetic due to his lack of compliance with care.

This assessment is being conducted to assess if Jimmy has capacity to consent to the heart biopsy procedure and associated interventions.

Determination of Capacity *(This is specific, not general determination*) See Decision Making flow chart in the Mental Capacity policy

Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?	Permanent impairment ☐X	Temporary impairment ☐	None ☐
Details: **Jimmy has a learning disability**			
Can the decision be delayed because the person is likely to regain capacity in the near future?	Yes ☐	Not likely to regain capacity ☐	Not appropriate to delay ☐ X
Details: **Due to Jimmy learning disability his capacity will not improve with time and it would not be appropriate to delay decision due to the risk of harm if he were not to have the procedure**.			

1. Is the patient able to understand information related to the decision?	Yes ☐	No ☐X
Comments/Evidence: **Jimmy did not appear to understand the information relevant to the decision, despite the use of pictograms and makaton in communicating, which he sometimes uses when in the residential home.**		
2. Is the patient able to retain information related to the decision?	Yes ☐	No ☐X
Comments/Evidence: **He was unable to understand the information therefore was not retained.**		
3. Has the patient been able to use and weigh that information? Do they understand the risks and benefits of making or not making the decision?	Yes ☐	No ☐X
Comments/Evidence: **Jimmy was not able to evidence any understanding of the risks or benefits form having the procedure or by not having it.**		
4. Person has ability to communicate their decision by any means?	Yes ☐	No ☐X
Comments/Evidence: state what steps have been taken to achieve communication? **Jimmy has some receptive language skills and uses his limited expressive language skills and behaviour to communicate with staff, but was unable to understand the reason for the decision in question.**		

If you have ticked any of the above questions 1 to 4 as NO then this person lacks capacity at this time

What steps have been taken to enable or assist the person to make or be involved in this decision?
e.g. using non-verbal means of communication. **A referral was made to the learning disability liaison nurses who have expertise with people with a LD. Jimmy's mother, sister and usual carers were also consulted in order to establish the best means of communication but despite all attempts Jimmy was unable to understand the decision that needed to be made.**

Mental Capacity Assessment Outcome

If the patient has capacity, what is their decision? Use patients own words **OR**
If the patient does not have capacity, they cannot consent, therefore, decisions must be made in their best interests and the decision recorded on the Best Interests form overleaf.
We concluded Jimmy's assessment as it appeared to both assessors that Jimmy had not understood the information provided and was unsettled by our visit. It was evident that Jimmy would not be able to retain the information, nor weigh up the pros and cons or reach a decision about whether to consent to the heart

If the patient has capacity, what is their decision? Use patients own words **OR**
If the patient does not have capacity, they cannot consent, therefore, decisions must be made in their best interests and the decision recorded on the Best Interests form overleaf.
We concluded Jimmy's assessment as it appeared to both assessors that Jimmy had not understood the information provided and was unsettled by our visit. It was evident that Jimmy would not be able to retain the information, nor weigh up the pros and cons or reach a decision about whether to consent to the heart biopsy. It was therefore evident that Jimmy did not have the capacity to understand the need for the treatment nor the ability to consent to heart biopsy.

Advance Decisions *(Refer to the MCA policy or Code of practice chapter 9 for further guidance on ADs)*

Is there an advance decision relevant to the proposed treatment?	No ☐X Yes ☐	If yes verbal ☐ *(Detail below)*	Written ☐ *(Detail below)*

Details: (Remember: an AD refusing life sustaining treatment MUST be in writing, signed and witnessed and clearly state that the decision applies even if life is at risk).

Best Interest Decision Making: Step 1: who are you going to consult?

Has the patient appointed a Lasting Power of Attorney? No ☐X Yes ☐ *Name*……..

Does the person have a Next of Kin/ Person who can inform decision making? No ☐ Yes ☐X N*ame* **Janine Jam (Mother)**

If there is no (unpaid) person who can help inform the decision making process and this decision relates to Serious Medical Treatment, an accommodation move or a Safeguarding Adults concern, you must appoint an Independent Mental Capacity Advocate(IMCA)

Person appointing IMCA: ***Name Dr Doolittle***… *Role* ***Consultant*** ……. *Date* **01/09/2012**…..

Determination of Best Interest Decision: Step 2: views of patient, professionals and interested others

What are the patients past and present wishes and feelings? E.g written statements.
Jimmy has not ever had capacity to make a written statement but does not seem to like being in hospital or medical intervention as evidenced by his behavior.

What are the views of significant others, including family, friends, IMCA, carers, LPA etc, identify those consulted and their relationship? If no-one consulted give reason why.
A best interest meeting was held involved Jimmy's mother and sister, his key worker, the ward sister that has built up a good rapport with Jimmy, a LD liaison nurse and the consultant proposing the procedure. Jimmy's mother and sister both agree that Jimmy should be provided with the procedure. Jimmy's mother is applying to the Court of Protection to be appointed as a Deputy for Jimmy (this application is in progress and not finalised) and she believes the procedure is essential. Jimmy's father died 6 years ago. Jimmy's mum states that if she was appointed as a Deputy today, she would consent to the procedure and to the use of a general anaesthetic as she believes this is the best option

What are the views of the professionals?
The consultant is of the opinion that the risks associated with Jimmy not having the procedure is greater than having it. Despite the risks of the general anesthetic, on the balance of probabilities it would be in Jimmy's best interest to have the heart biopsy. The key worker, ward sister and LD nurse have no reason to disagree that this would be best course of action for Jimmy.

Are there any conflicts or disagreements? If so what steps can be taken to resolve this disagreement?
NO

Best Interest Decision Summary: Step 3: Final decision

In consideration of the above and all relevant factors what is the final decision? Summarise the reasoning behind the decision and why this decision would be in the patient's best interests:
All those present agreed that the heart biopsy is in Jimmy's best interests. The meeting considered the options regarding how the procedure can best be given including use of full or general anaesthetic or sedation and oral sedation. Jimmy has previously been quite distressed and difficult to manage when he required medical intervention, trying to climb out of his bed, lashing out and risking further damage to himself and others.

After weighing up all the risks, professionals and Jimmy's mother all agree that although there is always a risk in giving anyone a general anaesthetic, it would be in Jimmy's best interests if he did received a general anaesthetic on this occasion before his procedure commenced. This approach would be on balance less restrictive and less distressing for Jimmy than any other alternatives that would allow the consultant to examine his mouth and carry out necessary procedure. It is agreed that it is in Jimmy's best interests to undertake this operation at the earliest opportunity and the consultant (Dr Doolittle) advises that this will be possible the following day. Everyone agrees that a general anaesthetic (a restraint) will be proportionate to the likelihood of significant harm if a diagnosis and subsequent treatment does not urgently occur and the the use of the anesthetic and the heart biopsy are in Jimmy's best interests.

Name: Ms Tina Turner

Location: Tiverton Community Hospital

D.O.B: 26/11/1939
Patient Identification Label

Northern Devon Healthcare NHS
NHS Trust
Incorporating community services in Exeter, East and Mid Devon

MENTAL CAPACITY AND BEST INTERESTS ASSESSMENT

COMMUNITY HOSPITAL SAFEGUARDING EXAMPLE

I am completing this assessment form on (date) 01/09/2012.... because the patient named above appears to lack capacity at this time **(Assessment context** - *assessment of Mental Capacity must be decision and time specific**)***

Details of treatment decision(s) or other specific issue(s) in relation to which capacity is being assessed:
Tina is currently an inpatient on a Ward at Tiverton Hospital. She wants to go home to her brother, who's been charged with physically assaulting her. He is out on bail at the moment. Tina does not understand the consequences of going home to her brother and the ward staff are questioning her capacity to make this decision.

Determination of Capacity *(This is specific, not general determination)* See Decision Making flow chart in the Mental Capacity policy

Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?	Permanent impairment ☐X	Temporary impairment ☐	None ☐

Details: **Tina has a diagnosis of Alzheimer's Disease, therefore her ability to make capacitated decisions is likely to decrease with time**

Can the decision be delayed because the person is likely to regain capacity in the near future?	Yes ☐	Not likely to regain capacity ☐	Not appropriate to delay ☐ X

Details: **Due to Tina's condition she is unlikely to regain capacity and it would not be appropriate to delay decision due to the risk of harm if she were to be discharged into her brothers care**.

1. Is the patient able to understand information related to the decision?	Yes ☐	No ☐X

Comments/Evidence:
Tina did not understand our concerns about her going home. She admitted that her brother hits her when she has been "naughty", but did not understand that this was wrong. She also did not understand that her poor physical health would prevent her from doing her normal housework, which will aggravate her brother and lead to further assaults.

2. Is the patient able to retain information related to the decision?	Yes ☐	No ☐ X

Comments/Evidence:
When asked to explain her understanding of why we were assessing her, she talked about many other things, jumping from one topic to the next. She could not retain the information we gave her about the risks of going home for long enough to make an informed decision.

3. Has the patient been able to use and weigh that information? Do they understand the risks and benefits of making or not making the decision?	Yes ☐	No ☐ X

Comments/Evidence:
We explained to Tina why we think it would be in her best interest to stay in hospital and what risks there would be if she went home to her brother, i.e. abuse, risk of self neglect, risk of falling etc. Tina could not see this information to weigh up the advantages and disadvantages and showed no insight or understanding into the risks of going home today.

4. Person has ability to communicate their decision by any means?	Yes ☐ X	No ☐

Comments/Evidence: state what steps have been taken to achieve communication?
Tina was able to communicate, but her speech was incoherent and at times hard to understand. She could however communicate efficiently for us to establish that she truly did lack capacity to understand, retain and weigh up the information to make a decision about go home today.

If you have ticked any of the above questions 1 to 4 as NO then this person lacks capacity at this time

What steps have been taken to enable or assist the person to make or be involved in this decision?
e.g. using non-verbal means of communication. **Yes - Spoke to Tina at length about the decision regarding going home to her brother who is abusing her. Two nurses who know her well were involved throughout the assessment to help her with this.**

Mental Capacity Assessment Outcome

If the patient has capacity, what is their decision? Use patients own words
OR
If the patient does not have capacity, they cannot consent, therefore, decisions must be made in their best interests

If the patient has capacity, what is their decision? Use patients own words
OR
If the patient does not have capacity, they cannot consent, therefore, decisions must be made in their best interests and the decision recorded on the Best Interests form overleaf.
Tina lacks capacity to make a decision about going home to stay with her brother. Long term residential care should be considered, but her capacity will need to be re-assessed for that decision.

Advance Decisions *(Refer to the MCA policy or Code of practice chapter 9 for further guidance on ADs)*

Is there an advance decision relevant to the proposed treatment?	No ☐X Yes ☐	If yes verbal ☐ *(Detail below)*	Written ☐ *(Detail below)*

Details: (Remember: an AD refusing life sustaining treatment MUST be in writing, signed and witnessed and clearly state that the decision applies even if life is at risk).

Best Interest Decision Making: Step 1: who are you going to consult?

Has the patient appointed a Lasting Power of Attorney? No ☐X Yes ☐ *Name*……..

Does the person have a Next of Kin/ Person who can inform decision making? No ☐X Yes ☐ N*ame*……...
Tina has a brother who is abusing her and he has been charged by the police. He should thus NOT be consulted in their best interests and as she has no other friends or family to support her, a request for an IMCA should be made as soon as it is practicable to do so.

If there is no (unpaid) person who can help inform the decision making process and this decision relates to Serious Medical Treatment, an accommodation move or a Safeguarding Adults concern, you must appoint an Independent Mental Capacity Advocate(IMCA)

Person appointing IMCA: ***Name Johnny Depp***…… *Role* ***Discharge Facilitator***……. *Date* **01/09/2012**…..

Determination of Best Interest Decision: Step 2: views of patient, professionals and interested others

What are the patients past and present wishes and feelings? E.g written statements.
Tina has always lived with her brother and still wants to go home, which she has clearly expressed throughout the assessment.

What are the views of significant others, including family, friends, IMCA, carers, LPA etc, identify those consulted and their relationship? If no-one consulted give reason why.
Not appropriate to consult with brother as he has been charged with assaulting her, No other family or friends to consult. No IMCA involved, but referral to IMCA service will be made following this assessment of her capacity.

What are the views of the professionals?
Ward Manager agreed Tina lacks capacity and that it would be in her best interests not to go home to her brother. Staff nurse agreed with above.

Are there any conflicts or disagreements? If so what steps can be taken to resolve this disagreement?
The brother does not agree with the decision and as part of the safeguarding meeting planned later this week his objections will be considered. There may be grounds to take this case to the court of protection, in order to make a definitive decision on Tina's Long term accommodation.

Best Interest Decision Summary: Step 3: Final decision

In consideration of the above and all relevant factors what is the final decision? Summarise the reasoning behind the decision and why this decision would be in the patient's best interests:
Based on the above it was agreed that it would not be in Tina's best interests to return home to her brother's care. It would be Tina best interests to move into to temporary care while arrangements for long-term care are made would be in her best interest and permissible under the MCA.

There is a Safeguarding meeting planned in the next couple of days in regards to the abuse, as part of that Tina's ongoing care and accommodation will be considered. This assessment will form part of the discussion. If decisions about long term care need to be made, the involvement of an IMCA should be a high priority and no best interest decision should be made before the IMCA is involved. If there is a risk of depriving her of her liberty, a DOLS authorisation needs to be requested. If her brother insists on discharge back into his care and this is refused, she would be at risk of a deprivation of her liberty, in which case the managing authority (care home or hospital) would have to request authorization under the DoLS procedures.

Decision Maker Name **Johnny Depp**……Role ***Discharge Facilitator*** ..Signature…*J. Depp*…...Date **01/09/2012**

Appendix D: Checklist for IMCA Instruction

Independent Mental Capacity Advocacy Service

When to instruct an IMCA for a patient with regard to Serious Medical Treatment decisions

Some patients (aged 16+) have a right under the Mental Capacity Act to the support and representation of an **Independent Mental Capacity Advocate.**

✓	**A decision needs to be made about Serious Medical Treatment**	Serious Medical Treatment can be providing treatment, stopping treatment already being provided or deciding not to start treatment that could be offered and one or more of the following apply: • Where a single treatment is proposed, there is a fine balance between the benefits, burdens and risks to the patient • Where there is a choice of treatments, a decision as to which one to use is finely balanced • What is involved is likely to have serious consequences for the patient *For more information see MCA Code of Practice 10.42*
✓	**The patient has an impairment, disability or illness which is affecting their ability to make the decision**	For example, dementia, a brain injury or learning disability. It can also be a temporary condition such as unconsciousness or a person who is under the influence of alcohol or drugs.
✓	**The patient lacks capacity to make the specific decision at the time it needs to be made**	Patients should be supported to make the decision, for example, by simplifying information about a particular procedure. If, after this support is given, there are reasons to believe the patient may lack capacity to make the particular decision, an assessment of their capacity should be done,
✓	**There are no family or friends who can be appropriately involved in the discussions about the decision**	IMCA is primarily intended for people who have nobody who can be consulted about the decision. However, if there *are* family and friends but they have limited contact with the patient or know little about their wishes and views or do not want to be involved in the decision making process, a referral to IMCA should be made.

4 ticks means there is a duty to instruct an IMCA for the patient.
Emergency treatment should not be delayed.

The local IMCA service details are below.

IMCA Service (Devon & Torbay) Age UK Devon,
Unit 1 Manaton Court, Matford Business Park, Exeter EX2 8PF
Tel: 0845 231 1900

Follow the link on www.AgeUKDevon.co.uk for the IMCA referral page
Please email referral forms to imca.devon@nhs.net or fax to 01392 829594.

This checklist is part of the Action for Advocacy involving IMCAs in Serious Medical Treatment Decisions guidance.
Further copies can be obtained from www.actionforadvocacy.org.uk or telephone 0207 921 4395.
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Appendix E: Equality Impact Assessment Screening Form

Equality Impact Assessment Screening Form			
Title	Mental Capacity Act policy		
Author	Leigh Skelton		
Directorate	Nursing & Therapies Professional Advice		
Team/ Dept.	Professional Practice		
Document Class Policy	**Document Status** Review	**Issue Date** Oct 2017	**Review Date** Oct 2020

1	**What are the aims of the document?** The aim of this document is to ensure that the Trust meets nationally recognised and regionally agreed best practice for working with patients that may lack capacity.
2	**What are the objectives of the document?** • All clinical staff are able to recognise when there is a need to assess a patient/client's ability to make decisions based on their mental capacity. • All clinical staff are aware of how to access or undertake a Mental Capacity Assessment and Best Interest Decision. • Clinical staff are aware of and acknowledge Advance Decisions to Refuse Treatment • Independent Mental Capacity Advocates are appointed appropriately • There is consistency of reporting and procedures across health, social care and other partner agencies locally. • The Trust is compliant with the CQC essential standards relating to Mental Capacity
3	**How will the document be implemented?** Line managers are responsible for ensuring this policy is implemented across their area of work. Support for the implementation of this policy will be provided by the Safeguarding Adult Lead, supported by the training pathway. After approval by the Safeguarding Adult Board, the author will provide a copy of the policy to the Corporate Governance Manager to have it placed on the Trust's intranet. The policy will be referenced on the home page as a latest news release and staff will be informed that this policy replaces any previous versions. Information will also be included in the weekly Chief Executive's Bulletin which is circulated electronically to all staff. An email will be sent to senior management to make them aware of the policy and they will be responsible for cascading the information to their teams and staff. In addition, staff will be informed that this policy replaces any previous versions. The policy will be presented to a variety of forums, e.g. Senior Nurse Forum, Community Nurse Team Leaders Forum, Divisional Management Meeting
4	**How will the effectiveness of the document be monitored?** This policy and its implementation will be monitored through the Safeguarding Adults Board (terms of reference agreed). This Board is chaired by the Executive Lead for Safeguarding Adults. Mental Capacity will become part of regular audits to evidence compliance. Where non-compliance is identified, support and advice will be provided to improve practice.
5	**Who is the target audience of the document?** All clinical staff

6	**Is consultation required with stakeholders, e.g. Trust committees and equality groups?** Yes
7	**Which stakeholders have been consulted with?** • Clinical Audit lead • Head of Learning & Development • Equality & Diversity Lead • Health & Safety Advisor • All users of this document/ • Director of Nursing • Head of Professional Practice • Head of Quality and Patient Safety • Health and Social Care Cluster Managers • Devon County Council Safeguarding Adult Team • NDHT Safeguarding Adult Board
8	**Equality Impact Assessment** Please complete the following table using a cross, i.e. **X**. Please refer to the document "A Practical Guide to Equality Impact Assessment", Appendix 3, on the Trust's Intranet site (Bob) for areas of possible impact. • Where you think that the policy could have a **positive** impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, cross the 'Positive impact' box. • Where you think that the policy could have a **negative** impact on any of the equality group(s) i.e. it could disadvantage them, cross the 'Negative impact' box. • Where you think that the policy has **no impact** on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, cross the 'No impact'

Equality Group	Positive Impact	Negative Impact	No Impact	Comments
Age	X			This policy will ensure all patients, regardless of age are involved in decision making about their care. When they are unable to make decisions themselves due to a lack of capacity, decisions will be made in their best interests in line with the MCA
Disability	X			This policy will ensure all patients, regardless of disability are involved in decision making about their care. When they are unable to make decisions themselves due to a lack of capacity, decisions will be made in their best interests in line with the MCA
Gender			X	
Gender reassignment			X	

Human Rights (rights to privacy, dignity, liberty and non-degrading treatment)	X			The policy supports article 5 of the Human Rights Act, regarding restrictions and deprivation of liberty.
Marriage and civil partnership			X	
Pregnancy, maternity and breastfeeding			X	
Race / Ethnic Origins			X	
Religion or Belief			X	
Sexual Orientation			X	
	If you have identified a negative discriminatory impact of this procedural document, ensure you detail the action taken to avoid/reduce this impact in the Comments column. If you have identified a **high** negative impact, you will need to do a Full Equality Impact Assessment, please refer to the document "A Practical Guide to Equality Impact Assessments", Appendix 3, on the Trust's Intranet site (Bob).For advice in respect of answering the above questions, please contact the Equality and Diversity Lead.			
9	**If there is no evidence that the document promotes equality, equal opportunities or improved relations, could it be adapted so that it does? If so, how? N/A**			

Completed by:

Name	Leigh Skelton
Designation	Safeguarding Adults Lead
Trust	Northern Devon Healthcare NHS Trust
Date	October 2017