South Central Ambulance Service NHS
NHS Foundation Trust

Mental Capacity Act 2005 Policy
CLINICAL SERVICES POLICY & PROCEDURE
(CSPP No. 16)

DOCUMENT INFORMATION	
Author:	Sue Putman. Clinical Lead, Mental Health and Learning Disability.
Ratifying committee/group:	Patient Safety Group.
Date of ratification:	13th October 2016
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Version:	**7**

Contents

1. Introduction

The Mental Capacity Act 2005 (MCA) provides a statutory framework to empower and protect vulnerable people (aged 16 years and over), who may not be able to make their own decisions. The Act makes it clear who can take decisions, in which situations and how they should go about this. It also allows for people with capacity to plan ahead for a time when they may lose capacity.

For the purposes of the Act, "A person lacks capacity in relation to a matter if at the material time he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain". It does not matter whether the impairment is temporary or permanent.

A national Code of Practice has been drawn up and forms the basis for this guidance.

2. Scope

The Mental Capacity Act provides a legal basis for determining an individual's capacity to make decisions at the time they need to be made.

This guidance is for all staff working within South Central Ambulance NHS Trust who are involved in the care, treatment and support of people over the age of 16 (living in England or Wales) who are unable to make some - or all - decisions for themselves.

All NHS Trusts and Local Authorities are required to ensure that practices and procedures relating to patients, carers and members of the public who lack capacity are compliant with the MCA; and all staff receive training relevant to their role within the organisation.

All ambulance clinicians have a duty to be aware of, and act in accordance with, the Code of Practice.

3. Aim

The aim of this policy is to ensure that the Trust complies with the statutory requirements of the Mental Capacity Act 2005, and all staff are aware of the procedures pertaining to this (relevant to their role).

4. Roles and Responsibilities

4.1 Trust Board

The Trust Board has responsibility and accountability for ensuring the provision of the appropriate resources required to implement this policy. The Board, Committee and Meeting structure is at Appendix 1.

4.2 Chief Executive

The Chief Executive has overall responsibility for ensuring that systems for the safe and appropriate use of the Mental Capacity Act 2005 are followed.

4.3 Executive Director

The Executive Director of Patient Care is the board member responsible for the Mental Capacity Act 2005.

4.4 Managers and Supervisors

The Clinical Lead for Mental Health and Learning Disability is responsible for managing the process for the safe and appropriate use of the Mental Capacity Act 2005 within the Trust, and reports through the Executive Director of Patient Care to the Trust Board for this purpose.

The Operations Directors and Area Managers are responsible and accountable for the day to day safe and appropriate use of the Mental Capacity Act 2005 and must ensure that copies of the Mental Capacity Act 2005 Policy and SOPs are available to their staff.

4.5 All staff

All staff have a responsibility to understand the Mental Capacity Act 2005, relevant to their role.

All patient facing staff should understand the Mental Capacity Act 2005 and be competent to carry out the duties described in this policy.

Clinical staff have a responsibility to maintain their competency and to ensure their familiarity with changes to legislation/therapeutic guidelines as they are adopted by the Trust.

5. Definitions

"Mental capacity" is the ability of an individual to make decisions regarding specific elements of their life - *at the time a decision needs to be made*. It is also sometimes referred to as 'competence'. Capacity is not an absolute concept. Different degrees of capacity are required for different decisions, with the level of competence required increasing with the complexity of the decision.

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

"Personal Welfare" Lasting Powers of Attorney enable appointed attorneys to make a number of decisions about a person's life, when they have lost the capacity to make those decisions. This may include the power to give or refuse consent to medical examination and/or treatment.

"Deprivation of Liberty Safeguards". If restrictions of movement, or restraint, are in the best interest of a person who lacks capacity to consent to them, extra safeguards are needed if the restrictions and/or restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards. Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.

6. Abbreviations

Mental Capacity Act 2005 (MCA)

Advance Decisions to Refuse Treatment (ADRT)

Deprivation of Liberty Safeguards (DoLS)

National Health Service (NHS)

Standard Operating Procedures (SOPs)

7. MCA Key Principles

Five key principles are laid out in Section 1 of the MCA. They underpin every action/intervention and should always be considered.

Assumption of capacity:
A person must be assumed to have capacity unless it is established that he/she lacks capacity.

Assisted decision-making:
A person is not to be treated as unable to make a decision unless all practical steps to help him/her to do so have been taken without success.

Unwise decisions:
A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision.

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

Least restrictive alternative:
Before the decision is made, regard must be taken as to whether there is an alternative which is less restrictive.

7.1. Assessing capacity

The Act sets out a single clear test for assessing whether a person lacks capacity to make a particular decision at a particular time. It is always "decision and time specific" and is known as the Diagnostic Test (it is intended that anyone involved in the care of an individual should be able to use the test to determine whether there is capacity in relation to the decision in question).

Diagnostic Test

Capacity is the ability to make an informed decision *at the time that decision needs to be mad*e. Consequently, there are two basic questions for staff to consider:

- Is there an impairment of or disturbance in the person's mind or brain (this covers a range of problems such as psychiatric illness; emotional distress, learning disability; dementia; brain damage, neurological conditions, the effects of hypoxia, pain or toxic confusional state)?

If so:

- Is the impairment or disturbance sufficient that the person lacks

the capacity to make that particular decision?

Balance of probabilities

Any question as to whether a person lacks capacity must be decided on the balance of probabilities (i.e. being more likely than not).

Emergency situations

It is recognised that in an emergency/life threatening situation, staff may have to act without being able to gain consent from the patient.

Existing conditions

No one can simply be labelled 'incapable' as a result of a particular medical condition or diagnosis.

Functional Test

A person is unable to make a decision for him/herself if he/she is unable to meet *any one* of the following criteria:

- Understand the information relevant to the decision.
- Retain that information.
- Use or weigh that information as part of the process of making the decision.
- Communicate their decision (whether by talking, using sign language or any other means).

7.2 Recording an assessment.

Assessments must always be clearly recorded, in the relevant Trust clinical records in use at the time.

Compliance with Functional Test

Staff should document all attempts to help the person to make the decision themselves, and provide evidence of:

- How the person is able/unable to understand the information relating to the decision in question.
- Whether the person is able to retain the information and, if their retention is limited, whether they are able to hold the information long enough to make a decision.
- How well the person is able to weigh up the information in the balance (weigh up the pros and cons) in order to come to a decision.
- The ability of the person to communicate the decision.

7.3 Best Interests

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 applies to whoever is making the decision.

Information

All decisions can only be made based on the information available at the time.

Non urgent decisions

For significant, non-urgent, decisions consultation with other people involved in the care and support of the patient will be required (e.g. doctors, social workers, nurses, occupational, speech and language therapists, residential and care home managers, care staff, support workers and family).

Others lawfully authorised to act on behalf of a person who lacks capacity.

The views of other people - in particular anyone formerly named by the person to be consulted, (where applicable) those holding Lasting Power of Attorney, an Independent Mental Capacity Advocate, or a Court appointed Deputy.

7.4 Advance Decisions to Refuse Treatment (ADRT)

An ADRT made by a person with capacity should be respected.

Concerns about validity of ADRT

In a pre-hospital emergency environment there may be situations in which there is doubt about the validity of an ADRT. If ambulance clinicians are not satisfied that the patient had made a prior and specific request to refuse treatment, they should continue to provide clinical care in the normal way.

7.5 Deprivation of Liberty Safeguards (DoLS)

DoLS apply to people over the age of 18 only.

Purpose

DoLS aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

The MCA DoLS were introduced to prevent deprivations of liberty without proper safeguards including independent consideration and authorisation. Deprivations of liberty in hospitals or care homes, other than under the Mental Health Act 1983, should now follow the MCA DoLS process, and all affected patients and residents should benefit from these safeguards.

Levels

Sometimes restrictions have to be placed on people for their own safety. There are different levels of restriction ranging from a locked door to physical restraint. At some point the degree and intensity of these restrictions become what is legally known as a deprivation of liberty.

Examples

Some examples that are likely to be a deprivation of liberty (and therefore will require DoLS assessment) include:

- Force being used to prevent a person leaving hospital where they persistently try to leave.
- Severely restricting access to the patient by relatives & carers.
- Decision to admit being opposed by relatives / carers who live with the patient.
- Severely restricting movement within the setting or access to the wider community.

Responsibilities

When attending a patient who has a DoLS order in place the attending staff must ensure that the order is valid and request to see a copy of the order (or formal record of the Best Interest assessment relating to this) to confirm this. If neither of these are present:

- In hours - contact the Safeguarding Team via Clinical Contact Centre.
- Out of hours - contact your local on call duty manager.

Ambulance Transport

Transporting a person who lacks capacity from their home (with or without the use of force), to another location, i.e. to a hospital or care home will not usually amount to a deprivation of liberty (e.g. to take them to hospital by ambulance in an emergency). Even where there is an expectation that the person will be deprived of their freedom within the care home or hospital, it is unlikely that the journey itself will constitute a deprivation of liberty.

When transporting a patient subject to DoLS a request to take a copy of the order with the patient to hospital must be made to the senior manager responsible for ensuring the compliance of the order. If this is refused then the refusal must be documented and the name of the refusing manager recorded.

An ambulance may be requested to assist in transporting a patient subject to a DoLS order, to return the patient to the location specified in the DoLS order.

Death of person subject to a DoLS order

The police must always be called to the death of a person subject to a DoLS order, as the Coroner will treat this as a 'death in custody'.

For further information about DoLS, please follow this link. http://www.scie.org.uk/publications/ataglance/ataglance43.asp

8. Training

Any training that is required for this policy is included in the organisation's mandatory training schedule.

9. Equality and Diversity

9.1 An impact assessment form must be completed for all policies. This form must be included in the Appendices (see Appendix 3). Full assessment maybe required dependant on the screening results. The level of impact assessment must be included in this section and any actions that have been taken to minimise any forms of discrimination due to the policy.

9.2 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marriage and civil partnership, disability, race, gender, religion/belief, sexual orientation, gender reassignment and pregnancy/maternity or any other basis not justified by law or relevant to the requirements of the post. The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of the afore mentioned protected characteristics, whether full or part time or employed under a permanent or a fixed term contract or any other irrelevant factor.

9.3 By committing to a policy encouraging equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

9.4 Where there are barriers to understanding; for example, an employee has difficulty in reading or writing, or where English is not their first language, additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the HR Department.

9.5 Employees exercising their rights and entitlements under these regulations will suffer no detriment as a result.

10. Monitoring

This policy will be monitored by review of training records and staff surveys.

Standard / process / issue	Monitoring and audit			
	Method	By	Committee	Frequency
MCA training compliance.	Figures and details reported.	Education Department.	Patient Safety Group.	Quarterly.
Staff knowledge review.	Staff survey.	Clinical Lead, Mental Health & Learning Disability	Patient Safety Group.	Annually.

11. Consultation and Review

This policy will be reviewed every three years or sooner if there are any relevant changes to legislation or best practice. A consultation exercise on the policy will be carried out with the stakeholders listed below.

Stakeholder or Group Title	Consultation Period (From-to)	Comments received (Yes/No)
All managers and staff	29th July to 19th August 2016	Yes
Patient Safety Group	29th July to 19th August 2016	Yes

The changes made from the previous version are detailed in the review table in Appendix 1.

12. Implementation (including raising awareness)

Education on this policy will be provided by the Education Department, in line with the statutory training plan.

A Hot News will be produced for all front line staff to update them on the latest DoLS elements contained within this policy.

13. References

Mental Capacity Act 2005; The Stationery Office

Mental Capacity Act Code of Practice 2007; The Stationery Office

14. Associated documentation

CSPP 21 Consent Policy; July 2016.

15. Appendix 1: Review Table

Version	Reason for change	Overview of change
V7	Transferred into new Trust template	New headings used in line with Trust template.
V7	Change in underpinning guidance about Deprivation of Liberty Safeguards.	Deprivation of Liberty Safeguards section completely rewritten to reflect changes.

16. Appendix 2: Responsibility Matrix – Policies, Procedures and Strategies

Policy Group	Lead Director / Officer	Working Group	Committee	Board Ratification
Strategies	As appropriate	As appropriate	As appropriate	Required
Standing Orders & Standing Financial Instructions	Chief Executive + Director of Finance	Not applicable	Audit Committee	Required
Corporate Policies	Chief Executive +Director of Patient Care	As appropriate	Quality and Safety Committee	Required/ Committee decision
Health and Safety Policies and Procedures	Director of Patient Care	Strategic Health, Safety and Risk Group	Quality and Safety Committee	Health and Safety Policy – Required H&S Appendices – Committee decision
Control of Infection Policy and Procedures	Director of Patient Care	Clinical Review Group	Quality and Safety Committee	Required
Personnel Policies and Procedures	HR Director	Staff Consultation Group	Quality and Safety Committee	Required for new policies. Committee decision for revisions
Financial Policies and Procedures.	Director of Finance	Not applicable	Audit Committee	Required for new Policies. Committee decision for procedural changes.
Operational Policies and Procedures	Director Operations	As appropriate or through Team Meeting	Quality and Safety Committee	Committee decision
Information and IT Policies and Procedures	Director of IT	Information Governance Steering Group	Quality and Safety Committee	Committee decision
Emergency Operational Centre Policies and Procedures	Director Operations	As appropriate	Quality and Safety Committee	Committee decision
Clinical Policies and Procedures	Director of Clinical Services	Clinical Review Group	Quality and Safety Committee	Committee decision

17. Appendix 3: Equality Impact Assessment Form Section One – Screening

Name of Function, Policy or Strategy: Mental Capacity Act 2005 Policy v7

Officer completing assessment: Clinical Lead, Mental Health & Learning Disability.

Telephone: 07825 680414

1. What is the main purpose of the strategy, function or policy?
This policy is for staff working within South Central Ambulance NHS Trust who are involved in the care, treatment and support of people over the age of 16 (living in England or Wales) who are unable to make some - or all - decisions for themselves.
2. List the main activities of the function or policy? (for strategies list the main policy areas)
The Mental Capacity Act 2005 (MCA) provides a statutory framework to empower and protect vulnerable people (aged 16 years and over), who may not be able to make their own decisions. The Act makes it clear who can take decisions, in which situations and how they should go about this. It also allows for people with capacity to plan ahead for a time when they may lose capacity. This policy provides guidance for SCAS staff to ensure these statutory requirements are met.
3. Who will be the main beneficiaries of the strategy/function/policy?
Patients (aged over 16) who may lack capacity to make some decisions. This is most likely to include people who have mental illness, dementia, learning difficulty, stroke/head injury, or a temporary impairment due to medication, intoxication, injury or illness. Staff – this policy provides guidance to ensure compliance with the statutory requirements.
1. Use the table overleaf to indicate the following:- a. Where do you think that the strategy/function/policy could have an adverse impact on any equality group, i.e. it could disadvantage them? b. Where do you think that there could be a positive impact on any of the groups or contribute to promoting equality, equal opportunities or improving relations within equality target groups?

[Assessment completed August 25th 2016].

		Positive Impact	Negative Impact	Reasons
GENDER	Women	N/A	N/A	The policy is designed to ensure that care is delivered by highly trained clinicians, and benefits all who may lack capacity to make certain decisions, without prejudice or discrimination.
	Men	N/A	N/A	
RACE	Asian or Asian British People	N/A	N/A	Beliefs and cultures may differ and necessary clinical interventions inevitably can result in compromise. All clinicians are trained to respect beliefs, discuss procedures with patients and to deliver the best possible care.
	Black or Black British People	N/A	N/A	
	Chinese people and other people	N/A	N/A	
	People of Mixed Race	N/A	N/A	
	White/white other	N/A	N/A	
DISABILITY	**Disabled People**	YES	NO	This policy is specifically for people who may lack capacity to make certain decisions
SEXUAL ORIENTATION	**Lesbians, gay men and bisexuals**	N/A	N/A	
AGE	Older People (60+)	N/A	N/A	The policy is designed to ensure that care is delivered by highly trained clinicians, and benefits all who may lack capacity to make certain decisions without prejudice or discrimination.
	Younger People (18 and under)	N/A	N/A	The Mental Capacity Act 2005 is for people aged 16 years and over.
RELIGION/BELIEF	**Faith Groups**	N/A	N/A	Beliefs and cultures may differ and necessary clinical interventions inevitably can result in compromise. All clinicians are trained to respect beliefs, discuss procedures with patients and to deliver the best possible care.

	Positive Impact	Negative Impact	Reasons
Equal Opportunities and/or improved relations	N/A	N/A	Yes – ensuring that a fair and consistent process is followed for all patients aged over 16 years.

Notes: Faith groups cover a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus. Consider faith categories individually and collectively when considering positive and negative impacts. The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and to the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

5.	If you have indicated that there is a negative impact, is that impact:		
		Yes	**No**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			
Level of Impact		**High**	**Low**
If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.			

6(a).	Could you minimise or remove any negative impact that is of low significance? Explain how below:
	No negative impact identified
6(b).	Could you improve the strategy, function or policy positive impact? Explain how below:
7.	If there is no evidence that the strategy, function or policy promotes equality, equal opportunities or improves relations – could it be adopted so it does? How?

Please sign and date this form, keep one copy and send one copy to the Trust's Equality Lead.	
Signed:	S. Putman
Name:	Sue Putman
Date:	17 October 2016

Appendix 4

Section 1: To be completed by Author prior to submission for ratification

Policy Title	Mental Capacity Act 2005
Author's Name and Job Title	Sue Putman. Clinical Lead, Mental Health & Learning Disability.
Review Deadline	September 30th 2016.
Consultation From – To (dates)	July 29th 2016 to August 19th 2016
Comments Received? (Y/N)	YES
All Comments Incorporated? (Y/N)	YES
If No, please list comments not included along with reasons	
Equality Impact Assessment completed (date)	August 25th 2016
Name of Accountable Group	Patient Safety Group/Clinical Revie Group.
Date of Submission for Ratification	13th October 2016

Section 2: To be completed by Accountable Group

Template Policy Used (Y/N)	Yes
All Sections Completed (Y/N)	Yes
Monitoring Section Completed (Y/N)	Yes
Date of Ratification	October 14th 2016 (Sept. meeting re-scheduled to this date).

Date Policy is Active	October 2016
Date Next Review Due	October 2019
Signature of Accountable Group Chair (or Deputy)	
Name of Accountable Group Chair (or Deputy)	Deidre Thompson, Director of Quality and Patient Care, Chair of Patient Safety Group