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Cardiff & Vale UHB Mental Capacity Act (MCA) Policy

Policy Statement

To ensure that Cardiff and Vale UHB (the UHB) delivers its aims, objectives, responsibilities and legal requirements transparently and consistently. The UHB is committed to ensuring that adult patients are supported to make decisions and where they are found to have impaired mental capacity the appropriate process is followed, in accordance with the Mental Capacity Act 2005.

Policy Commitment

We are committed to ensuring that the Mental Capacity Act 2005 is understood and adhered to by our staff.

We support staff in this by

- Publishing this policy and keeping it updated
- Providing intranet pages containing useful information on mental capacity issues
- Providing training for staff on mental capacity
- Providing support to staff with queries on capacity issues

Supporting Procedures and Written Control Documents

This policy and the supporting procedures describe the following with regard to supporting adults with impaired capacity to make decisions.

- The process to follow when there are doubts regarding a person's ability to make decisions, including relevant documentation.
- Who to consult when decisions need to be made for a person who lacks mental capacity to decide
- When to consider the Deprivation of Liberties Safeguards (DoLS)

Relevant legislation and guidance to read alongside this policy include:

- Social Services and Wellbeing (Wales) Act 2014
- Mental Capacity Act 2005
- Mental Health Act 1983
- Mental Health (Wales) Measure 2010
- Deprivation of Liberty Safeguards 2009
- The All Wales Safeguarding Procedures for Children and Adults at Risk or abuse and Neglect 2020.

• Domestic Abuse (Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015). **Other supporting documents are:** • Department for Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice, TSO London • Ministry of Justice (2008) Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice HMSO (2005) • Mental Capacity Act 2005, HMSO London • Cardiff and Vale UHB, Consent to Examination or Treatment Policy, UHB 100 • Consent to Examination or Treatment Under the Mental Health Act 1983 (UHB 491) • Independent Mental Capacity Advocacy Procedure (Mental Capacity Act 2005), UHB 186 • Restraint in the care management of patients aged 16 years and over with impaired mental capacity – Policy and procedure UHB 044 • Lasting Power of Attorney and Court Appointed Deputy Procedure (Mental Capacity Act 2005) UHB 113 • Research Consent and Capacity: Standard Operating Procedure, UHB 147 • Accessing Legal Advice Procedure UHB 469 • Restraint in the care management of patients aged 16 years and over with impaired mental capacity – Policy and Procedure (UHB 044) • Jones, R. (2018) *Mental Capacity Act Manual* (8th Edition)
Scope This policy applies to all of our staff in all locations including those with honorary contracts.

Equality and Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has been completed and this found there to be a positive impact. Key actions have been identified and these can be found in the EHIA.

Policy Approved by	Mental Health Committee
Group with authority to approve procedures written to explain how this policy will be implemented	
Accountable Executive or Clinical Board Director	Executive Nurse Director

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date Review Approved**	**Date Published**	**Summary of Amendments**
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CONTENTS

1. EXECUTIVE SUMMARY 6
2. INTRODUCTION 6
3. DEFINITIONS 7
4. SCOPE 9
5. PURPOSE 10
5.1. Overview 10
5.2. Principles 10
6. ROLES AND RESPONSIBILITIES 10
6.1. The Health Board 10
6.2. Designated Executive Director with responsibility for MCA 11
6.3. The Health Board Lead for the Mental Capacity Act 11
6.4. Clinical Boards /Line Managers / Service Leads 11
6.5. Responsible Clinicians 11
6.6. Ward Sisters and Senior Nurses on duty in inpatient wards 11
6.7. All Healthcare Staff and Volunteers 12
7. POLICY DETAIL / COURSE OF ACTION 12
7.1 The Statutory Principles 12
7.2. Principle 1 - Presumption of capacity: 12
7.3. Principle 2 - Supported decision-making: 12
7.4. Principle 3 - An unwise decision does not prove a lack of mental capacity: 13
7.5. Principle 4 - Best interests: 13
7.6. Principle 5 - Less restrictive alternative: 14
7.7. Who can make decisions? 14
Table 1: Identifying the Decision Maker 15
7.8. Lasting Power of Attorney (LPA) 15
7.9. Court-Appointed Deputies 16
7.10. Advance Decisions to Refuse Treatment (ADRTs) 16
7.11. Assessment of Capacity – General points 17
7.12. The Test of Capacity 18
7.14. Recording assessments of capacity 20
7.15. Making a Best Interests Decision 20
7.16. Consultation 21
7.17. Best Interests Meetings: 22

7.18. Recording a Best Interests Decision: 22
7.19. Protection from Liability for Acts in Connection with Care and Treatment 24
7.20. Care and Treatment of Mental Disorder 24
Table 2: Mental Health Act or Mental Capacity Act? 25
7.21. The Use of Restraint 26
7.22. Restriction of Movement and Deprivation of Liberty 27
7.23. Avoiding Deprivation of Liberty 27
7.24. Criminal Offence 28
7.25. Independent Mental Capacity Advocates (IMCAs) 28
8. OBTAINING LEGAL ADVICE 29
9. CONSULTATION 30
10. TRAINING 30
11. MONITORING COMPLIANCE AND EFFECTIVENESS 30
12. LINKS TO USEFUL TEMPLATES AND OTHER ORGANISATIONAL DOCUMENTS 30
13. REFERENCES 32
APPENDIX A IMCA Referral Form 33

1. EXECUTIVE SUMMARY

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

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

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

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

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

The policy helps staff to identify when restraint of a person results in a Deprivation of Liberty, which requires additional procedural safeguards under the Mental Health Act or the Deprivation of Liberty Safeguards (DoLS).

2. INTRODUCTION

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

This guidance should be read alongside the Cardiff & Vale University Health Board's Consent and Adult Safeguarding policies and DoLS procedure. This policy is not intended to replace the Code of Practice to the Mental Capacity Act, which should be referred to for more detailed guidance.

3. DEFINITIONS

Advance Decision to Refuse Medical Treatment (ADRT)	Decision made by a person, which remains valid and binding after they lose the mental capacity to make decisions. An ADRT does not have to be in a specific format, but if it concerns life-sustaining treatment it must be in writing, include a statement that the person is aware their life is at risk and be signed and witnessed.
Advance Statement	Statement made by someone who has capacity setting out their views on aspects of lifestyle, care or treatment. If they later lack capacity for the decisions that they have discussed in their advanced statement, then the wishes set out in their statement should be followed as a guide.
Cognitive function/Cognition	The American Psychological Society defines cognition as "*all forms of knowing and awareness, such as perceiving, conceiving, remembering, reasoning, judging, imagining and problem-solving. The SAMPLE model outlines involved cognitive processes - Speed of processing, Attention, Memory, Perception, Language and Executive processing. These processes interact so an impairment in one area may affect another*." American Psychology Society 2018, SAMPLE Model of cognition. Measurement of impairment of cognitive functions involves assessment of the following elements of mental performance: orientation, registration, attention and calculation, recall, and language. Some forms of cognitive impairment affect other elements of a person's personality, while leaving the elements mentioned above, relatively intact. It may be less apparent that the person's decision making is impaired and careful assessment will be required to ascertain whether the impairment amounts to a lack of capacity to make specific decisions
Consent	The voluntary and continuing permission of the person to the intervention in question, based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.

Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions
Critical Care / a vital act	Care that is needed to save someone's life or prevent a serious deterioration of their condition.
Carer	Person who provides unpaid care to an adult or disabled child.
Decision Maker	The person who makes a decision on behalf of a person who lacks mental capacity to make that decision. In the absence of any formally appointed authority (Lasting Power of Attorney or Court Appointed Deputy) this is usually the person who is requiring a decision to be made, for example the clinician proposing care and/or treatment for the person.
Deprivation of liberty	Being under continuous supervision and control and not free to leave
The Deprivation of Liberty Safeguards (DoLS)	Procedure which provides a legal framework where a person is detained within a hospital or care home for the purposes of receiving care and/or treatment. The safeguards provide protection for the individual by ensuring scrutiny of the care arrangements and the right of appeal.
DoLS Supervisory Body	The authority responsible for assessing and authorising requests for DoLS Authorisations, which is the Local Authority in whose area the person subject to deprivation of liberty resides or the Health Board if the person is in a hospital setting.
DoLs Managing Authority	the Care Home provider if person is a resident or the responsible Clinical Board if the person is in a hospital setting
Court Appointed Deputy	Person appointed by the Court of Protection to manage the affairs of a person who lacks the mental capacity to make decisions about such matters. Deputies can be appointed for financial matters and/or health and welfare matters
Donor of a Lasting Power of Attorney (LPA)	Person who has made the LPA to appoint a decision maker on their behalf
Lasting Power of Attorney (LPA)	This transfers decision making authority from the donor to the attorney. This can be for decisions relating to health and welfare and/or property and finance.
Enduring Powers of Attorney (EPA)	Made before the MCA came into force and cover financial decisions only (superseded by LPA)
The Office of the Public Guardian	Body that supervises deputies, keeps a register of deputies, Lasting Powers of Attorney and Enduring Powers of Attorney, checks on what attorneys are

	doing, and investigates any complaints about attorneys or deputies
Independent Mental Capacity Advocate (IMCA)	Qualified advocate who is appointed to represent the views of a person who lacks capacity in the decision-making process
Mental Capacity	The ability of an individual to make decisions about specific issues in their life. It is also sometimes referred to as 'competence'. Capacity is not an absolute concept: the level of understanding required will increase with the complexity of the decision and capacity can vary over time
Restraint	The use, or threatened use of force, to make someone do something, or prevent them from doing something, against their wish, or to restrict their movement, whether they resist or not.
Persons, People	Used in this policy to cover all patients, whether inpatients, outpatients and those receiving short-term or emergency contact, whether face-to-face, by phone or video link.
You	In this policy means any person, whether staff member or volunteer, who interacts with patients.

4. SCOPE

This guidance applies to all staff, including temporary staff (bank), agency and volunteers in the Cardiff & Vale University Health Board who have direct or indirect contact with people and/or their family or carers, who may have impaired mental capacity to make decisions.

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

- Decisions concerning family relationships, including marriage, sexual relationships etc. A person may have their capacity to make these decisions assessed, and you may be asked to contribute to this assessment. If the person is found to lack capacity for any of these decisions then the case must be referred to court rather than following the usual Best Interests process, so that what is in their best interests can be decided by a judge.
- Treatment under the Mental Health Act.
- Unlawful killing or assisted suicide.

5. PURPOSE

5.1. Overview

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

5.2. Principles

All staff who may come into contact with people who have impaired decision making and their family and/or carers must comply with this policy and in particular be aware of and follow the statutory principles of the MCA;

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

***(Section 1, MCA 2005*)**

This policy is designed to support staff it finding the balance between protecting and empowering the people that we care for, by ensuring that they are involved in decisions about their care so far as they are able. Where a person is found to be unable to make a particular decision for themselves, it is important that those who know them best are consulted to enable staff to better understand the individual and their views.

6. ROLES AND RESPONSIBILITIES

6.1. The Health Board

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

6.2. Designated Executive Director with responsibility for MCA

The Designated Executive Director for Cardiff & Vale University Health Board is the Executive Director of Nursing who is responsible for oversight of the MCA, executive leadership and reporting to the Board.

6.3. The Health Board Lead for the Mental Capacity Act

The Health Board Lead for the Mental Capacity Act will be responsible for the provision of expert guidance and leadership to support members of staff, and the organisation, to fulfil their obligations to people and their families and carers in relation to the MCA.

The Health Board Lead for the Mental Capacity Act is responsible for developing policies and monitoring practice relating to the MCA.

The Health Board Lead for the Mental Capacity Act will be responsible for the provision of training to support Health Board compliance with the mandatory training relating to the MCA.

The Health Board Lead for the Mental Capacity Act will monitor the use of the Deprivation of Liberty Safeguards and liaise with the Supervisory Body to ensure effective reporting and to resolve any issues.

6.4. Clinical Boards /Line Managers / Service Leads

The Clinical Boards /Line Managers/Service Leads are responsible for ensuring that staff are aware of the Health Board's policy.

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

They should ensure that each staff member is able to access mandatory MCA training as appropriate to their role.

6.5. Responsible Clinicians

The Responsible Clinician must ensure that they are familiar with this policy and that appropriate steps are taken to establish a person's mental capacity to consent where there is any reason to doubt their ability to do so.

6.6. Ward Sisters and Senior Nurses on duty in inpatient wards

Nurses in charge of an inpatient unit must ensure that Mental Capacity and DoLS screening is undertaken for all inpatients.

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

6.7. All Healthcare Staff and Volunteers

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

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

When discussing any intervention with a person staff must:

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

7. POLICY DETAIL / COURSE OF ACTION

7.1 The Statutory Principles

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

7.2. Principle 1 - Presumption of capacity:

All adults over the age of 16 have the right to make their own decisions and you must assume that a person has the mental capacity to make a particular decision unless:

1) You have reason to doubt their decision-making ability
2) You have then assessed their capacity and can show that they lack the mental capacity to make the decision in question.

People do not have to prove that they have mental capacity.

If you conclude that a person lacks mental capacity you must provide evidence that the individual lacks mental capacity to make the decision in question at the time it needs to be made.

7.3. Principle 2 - Supported decision-making:

Before you conclude that a person lacks mental capacity for a decision, you must take all practicable steps, to help them make their own decision. You must explain

all the relevant information to the person and strike a balance between giving sufficient information to enable them to decide and giving too much information or too great detail, which could be confusing.

You must identify the most effective method of communication to help the person to understand the nature of the decision and the choices available:

- Use simple language avoiding jargon or technical language;
- Use pictures or diagrams to help the person visualise what you are explaining;
- Involve family, carers and others who know the person well, to advise on the most effective methods of communication;
- The presence of relatives, friends or other people who know the person, may reassure them and assist communication;
- Use communication aids such as an interpreter or professional with specific skills (e.g. Speech and Language Therapist) if the person has impaired communication;
- Consider the most appropriate location for the discussion to put the person at ease. If possible avoid noisy, busy environments;
- Consider the timing of the decision, as some people's functioning may vary between different times of the day, or may be affected by particular medication;
- The person may benefit from having the support of another person in making their decision;
- You must address any cultural and ethical issues that may affect communication.
- Where practicable, treat any ongoing medical issues that may be affecting their decision making
- Consider any therapeutic intervention needed to support the person's decision-making ability (for example, supporting a person with a learning disability to learn new skills)

7.4. Principle 3 - An unwise decision does not prove a lack of mental capacity:

You must not conclude that a person lacks mental capacity simply because they have made what you consider to be a bad or unwise decision that you disagree with.

An unwise decision or series of unwise decisions may be a warning sign that you need to assess whether the person does in fact have the mental capacity to make a decision, particularly if the decision involves significant risks or is new 'out of character' behaviour.

7.5. Principle 4 - Best interests:

When making a decision or acting for, or on behalf of a person who lacks the mental capacity to make a decision you must do so in their best interests.

You must consider the statutory "Best Interests Checklist" (see section 7.15) in deciding in the person's best interests.

7.6. Principle 5 - Less restrictive alternative:

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

7.7. Who can make decisions?

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

For decision making relating to children under the age of 16 years please refer to the Health Board's *Consent to Examination or Treatment Policy*.

The decision maker:

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

For social care decisions, the decision maker may be a care manager or a staff member in day services or a care home or person/persons who hold relevant LPA.

- For medical treatment issues, a doctor, nurse or AHP will be the decision maker, or person/persons who hold relevant LPA
- For care and residence decisions, a social worker, person/persons who hold relevant LPA, family or clinical team; depending on the decision to be made
- For day-to-day decisions, a family member, friend or formal or informal carer may assist the individual to make a decision, or person/persons who hold relevant LPA.

If you are proposing or providing care or treatment for the person, you are likely to be the decision maker in respect of that care or treatment, unless someone has been given a formal authority to act on behalf of the person. See Table 1.

Where a person lacks capacity to make a decision for themselves, no one can give consent on their behalf except for:

- A valid and applicable Lasting Power of Attorney
- A valid and applicable Court Appointed Deputy
- A judge

Table 1: Identifying the Decision Maker

Decision level	Who should be involved in the assessment & decision-making process?	Recording
Simple e.g. day to day decisions about what to wear, what to eat, where to go during the day	**Decision maker –** paid carer whether formal (e.g. domiciliary or residential care staff member, support worker) or unpaid carer (family/friend)	With formal relationships, the person's care plan should be completed to show how the decision is made.
Procedures & Investigations e.g. scans, surgical procedures or medical investigations.	See section 20-22 within the consent to examination or treatment policy: Consent Policy	Welsh Risk Pool Consent Forms
Significant e.g. longer-term decisions involving care plans, arranging and reviewing packages of care.	**Decision Maker –** Allocated Worker (e.g. Care Manager, Nurse, OT, GP, Care Co-ordinator) who is managing the care. The decision maker must consult with relevant others (e.g. other involved professionals and family/friends).	**Use Forms at Appendices A and B to record:** Evidence that the person lacks capacity and outline who was consulted in making the decision. Factors considered in making the best interests decision.
Complex, high risk or contentious e.g. decisions about long term treatment, situations where risk levels are high, adult protection cases where there are disagreements between those involved.	**Decision maker** –Allocated Worker e.g. Care Manager, Nurse, Doctor) using a Multi-Disciplinary approach and consulting relevant others family/friends, and possibly an advocate. A team or Care Home Manager may be appropriate to chair a planning meeting if required. The Adult Protection framework should be used where relevant.	**Use Forms at Appendices A and B to record:** Evidence that the person lacks capacity and outline who was consulted in making the decision. Factors considered in making the best interests' decision. Additional reports/second opinions may also be required.

7.8. Lasting Power of Attorney (LPA)

Adults over the age of 18 years can authorise another adult over the age of 18 years to make decisions on their behalf in the event of a loss of capacity. Lasting Powers of Attorney (LPA) can be made for property and finances and / or for health and welfare matters.

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

The LPA document will specify what powers the attorney holds and any exceptions. If the attorney is asked to make any decisions about life sustaining treatment the LPA document must specify that they have this power, it is not automatically granted.

Sometimes people will make an Advance Decision to Refuse Treatment (ADRT) and also register to donate LPA. If the donor made an ADRT after they registered an LPA

then the LPA cannot overrule the ADRT. If the donor made an ADRT before they registered an LPA, the LPA's decision would overrule this ADRT although they should be expected to evidence why they are overruling the persons previously expressed wishes.

Professionals must ask to see evidence of any LPA, to check that the power has been registered and that the relevant decision falls within the scope of the power. A copy of the LPA should be taken and maintained in the medical record. The attorney must act in the donor's best interests and if professionals have concerns about an attorney's actions, the matter must be referred to the Office of the Public Guardian.

LPAs registered on or after 1st January 2016 in England and Wales can be accessed online with an access code provided by the LPA.

LPAs must formally request access to the person's notes via information governance.

For further guidance please see the UHB's Information Governance Policy

7.9. Court-Appointed Deputies

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

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

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

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

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

A deputy cannot refuse consent to life sustaining treatment.

7.10. Advance Decisions to Refuse Treatment (ADRTs)

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

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

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

Clinicians must comply with an advance decision unless they have evidence that the decision is not valid or applicable in which case they should seek advice.

For further details see the Health Board's Advance Decision to Refuse Treatment policy and MCA Code of Practice.

Useful documents and guidance can be found on the MCA Team's SharePoint pages: Advance Decisions, Lasting Powers of Attorney (LPA) and Court Appointed Deputies

7.11. Assessment of Capacity – General points

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

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

You must consider the need to assess a person's capacity whenever a decision needs to be made and you have reason to doubt their ability to make this decision. Doubt may arise because:

- The person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision.
- Somebody else says they are concerned about the person's capacity.
- The person has been previously diagnosed with an impairment or disturbance that affects the way their mind or brain works and it has already been shown they lack capacity to make other decisions in their life.
- Someone repeatedly makes unwise decisions that put them at significant risk of harm.
- Someone makes unwise decisions that are new and out of character.

The following is a non-exhaustive list of decisions or situations where you must assess and record a person's mental capacity if their decision-making is in doubt:

- at any clinical consultation in respect of care or treatment;

- on admission to hospital in respect of consent to admission and proposed treatment;
- on admission, in relation to the nursing needs assessment and care plan;
- whenever there is a significant change in the person's cognitive functioning;
- for any subsequent significant decision, such as additional or change in treatment;
- the provision of treatment or care in the community;
- whenever a patient disengages or is non-compliant with care or treatment;
- issues arising from a lack of mental capacity for decisions relating to day-to-day care interventions, including administration of regular medication, personal care, food and you must be aware of changes in the person's functioning and presentation that suggest that they may have re-gained mental capacity and reassess mental capacity whenever there is a change in the person's cognitive functioning.

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

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

7.12. The Test of Capacity

MCA Section 2:

'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time they are unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

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

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

There are three elements to the test for capacity:

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

A person will be unable to make a decision if they are unable to do **any one** of the following:

- **understand** the information relevant to the decision, the reason it needs to be made, the options and consequences including the consequences of not making a decision at all;
- **remember** that information long enough to make a decision;
- **use or weigh** that information as part of the process of making a decision, or
- **communicate** that decision, by talking, sign language or any other means.

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

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

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

The impairment or disturbance does not need to be 'formally diagnosed', you just need to have reasonable belief that one is present and be able to evidence why you think this is the case.

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

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

7.13. Vulnerable Adults and Capacity

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

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

You must consider what steps you can take to promote a person's decision making, including considering the effect of your and other's influence and the person's social

situation. This is particularly important where vulnerable adults may be in abusive relationships.

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

7.14. Recording assessments of capacity

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

To benefit from the protection from liability provided by Section 5 of the MCA you must record sufficient evidence to support a reasonable belief that the person lacked mental capacity.

The evidence should include:

- the decision and why it needs to be made;
- the relevant information that you have given the person, including the options and consequences;
- the help you have provided to them to make a decision;
- your decision 'on balance' as to whether they do, or do not, have the capacity to make this decision the evidence that they are able, or unable to make a decision;
- the evidence of the mental impairment and how it causes the inability to make the decision. See Appendix A for UHB form.

7.15. Making a Best Interests Decision

Once you have concluded that a person lacks the mental capacity to make a decision you must first check for the presence of a valid and applicable ADRT, LPA or Court Appointed Deputy. (Figure 2).

If the person has made an ADRT that is valid and applicable to the current decision for which they lack capacity, then this must be followed.

In any other circumstance if the person has appointed an LPA or Deputy that is valid and applicable to the current decision, then they will act as the decision maker.

If none of the above are in place, the clinician responsible for carrying out the act or intervention will be the decision maker.

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

- **Avoid discrimination:** Your decision about the person's best interests must be based on assessment, consultation and the establishment of information about them and their circumstances, not on assumptions about their age, appearance, condition or behaviour, although all of these will be relevant considerations.
- **Encourage participation:** do whatever you can to support and encourage the person to take part in making the decision.
- **Consider all relevant circumstances relating to the decision:** the decision that needs to be made, why it needs to be made, what the options are, the outcomes, risks and benefits of each option, the impact it will have on the person etc.

You must also:

- **Consider the person's views:** their past and present wishes, values and beliefs and how these would influence their decision if they were able to make it.
- **Consult others** including anyone named by the person, anyone involved in their care or interested in their welfare, including family and friends and anyone with a Lasting Power of Attorney or Deputyship.
- **Assess whether the person may regain capacity:** can you delay the decision to enable the person to make their own decision?
- **Less restriction:** Any interference with the person's freedom of choice must be kept to a minimum consistent with achieving what is in their best interests

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

7.16. Consultation

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

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

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

7.17. Best Interests Meetings:

If your consultation establishes that there is a clear consensus as to what is in the person's best interests, you do not need to arrange a best interest meeting. However, it is deemed best practice to arrange a meeting when there is a range of different views or any uncertainty or disagreement about what is in the person's best interests. The outcome of the meeting must be clearly recorded in all relevant documentation. You must consider whether it is appropriate to invite the person to this meeting or whether they should be represented by an advocate (for example an IMCA). All consultees listed above must be invited.

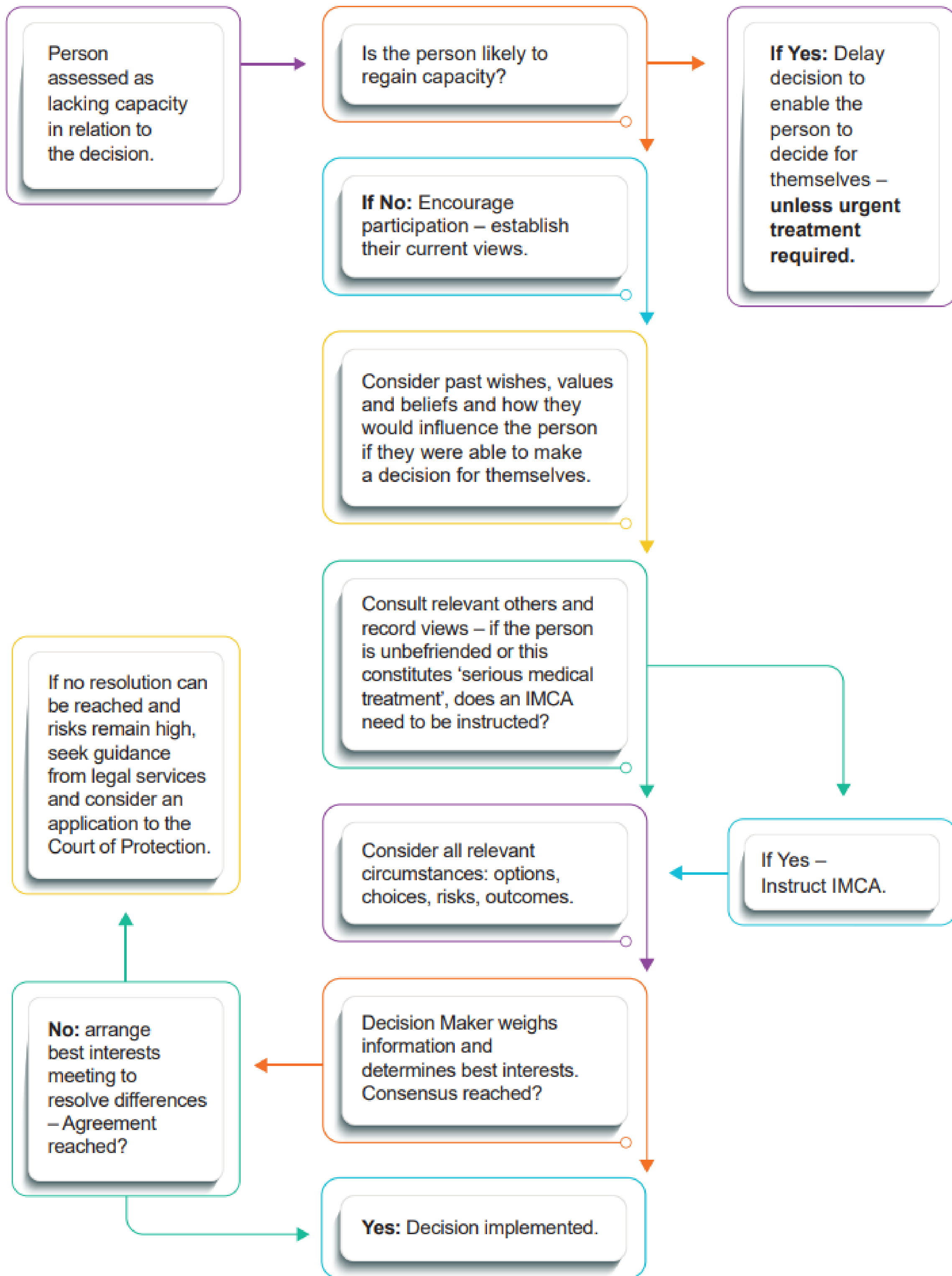
7.18. Recording a Best Interests Decision:

You must record the best interests decision making process and consultation, including any conflicting opinions in relation to any major decision or decision with potentially serious or significant consequences on the Best Interests Form. This form is also available

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

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

Figure 2: Best Interests Flowchart



7.19. Protection from Liability for Acts in Connection with Care and Treatment

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

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

Resources are available on the MCA Team Sharepoint which are designed to help you record the required evidence to support the above.

However, see Sections 7.20 of this policy in relation to additional requirements should an action involve restraint.

7.20. Care and Treatment of Mental Disorder

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

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

The Mental Health Act 1983 only deals with treatment "for mental disorder". However, a person detained under the Mental Health Act may lack capacity in relation to some other form of medical treatment or some other issues. The MCA will apply to all decisions that are not the treatment and care of a mental disorder.

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

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

Table 2: Mental Health Act or Mental Capacity Act?

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

7.21. The Use of Restraint

The MCA defines restraint as the;

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

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

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

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

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

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

- the person has been judged as lacking capacity to agree to the restraint and the restraint is in the person's best interests;
- restraint is necessary to prevent harm to the person being restrained; and
- the force used is proportionate to the likelihood and seriousness of the harm being prevented. *MCA 2005, Section 6*

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

Please see the UHB policy 'Restraint in the Care Management of Patients Aged 16 Years and Over with Impaired Mental Capacity' available on SharePoint.

7.22. Restriction of Movement and Deprivation of Liberty

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

This only applies to people over 18 who are in a hospital or living in a registered care home. If the inpatient is 16 -17 years old or resident in any other setting but you believe that they are being deprived of their liberty seek legal advice.

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

See guidance on DOLS Sharepoint:
[Deprivation of Liberty Safeguards (DoLS) - Home (sharepoint.com)]

7.23. Avoiding Deprivation of Liberty

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

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

7.24. Criminal Offence

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

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

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

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

If there is an indication of the above then please seek further advice from the MCA Team in the first instance.

7.25. Independent Mental Capacity Advocates (IMCAs)

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

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

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

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

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

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

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

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

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

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

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

- to see the person concerned in private;
- to examine and take copies of any records that are relevant to the decision; however, they must apply to see records using the appropriate form: Independent Mental Capacity Advocate (IMCA) - AS Cymru

Details of the locally commissioned IMCA service can be found on the Health Board's MCA/DoLS Intranet pages (IMCA Procedure.pdf (SharePoint.com).

8. OBTAINING LEGAL ADVICE

If you need advice about a mental capacity issue and/or you think a court application may be required, you should in the first instance contact your line manager.

Guidance on how to access legal advice can be found here.

9. CONSULTATION

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

- Health Board Dementia Steering Group
- Health Board Safeguarding Steering Group
- Editorial Panel via Patient Experience
- MCA Focus Group
- Mental Health Legislation and Mental Capacity Act Committee

10. TRAINING

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

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

MCA training is available to all staff, including;

- E-learning modules on ESR (MCA Level 1 + 2 and DoLS).
- Face to Face sessions offered for Level 2 MCA and DoLS
- Additional sessions devised by the MCA team for specialist training.

Training can be delivered to individual teams and departments – contact the MCA Team to discuss training requirements.

11. MONITORING COMPLIANCE AND EFFECTIVENESS

Implementation of the MCA and DoLS is subject to a number of key performance indicators monitored quarterly and reported to the Mental Health Legislation and Mental Capacity Act Committee:

- Compliance with Mandatory Training requirements.
- Collation and monitoring of feedback from face to face training sessions.
- Annual Audit of Medical and Nursing records in relation to MCA and DoLS.

12. LINKS TO USEFUL TEMPLATES AND OTHER ORGANISATIONAL DOCUMENTS

Please note the latest templates for documenting assessments of mental capacity and making best interest decisions can be found on the ‘Forms’ section of the MCA Team SharePoint page.

All Wales DNACPR policy – “Sharing and Involving” A Clinical Policy for Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) for Adults (18+) in Wales

Consent to Examination and Treatment Policy

Lasting Power of Attorney and Court Appointed Deputy Procedure

Information Governance Policy

All Wales Safeguarding Procedures

Restraint in Care Management of Patients Aged 16 Years and Over with Impaired Mental Capacity Policy and Procedure

13. REFERENCES

American Psychology Society 2018 [Accessed online 29.12.23] APA Dictionary of Psychology

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

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

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

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

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

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

- OPG601 Making Decisions about your health, welfare or finances. Who decides when you can't?
- OPG602 Making Decisions – A guide for family, friends and other unpaid carers.
- OPG603 Making Decisions – A guide for people who work in health and social care.
- OPG604 Making Decisions – A guide for advice workers.
- OPG605 Making Decisions – An easy read guide.
- OPG606 Making Decisions – The IMCA service.
- OPG607 Deprivation of Liberty Safeguards – A guide for primary care Health Boards and Local Authorities
- OPG608 Deprivation of Liberty safeguards – A guide for hospitals and care homes
- OPG609 Deprivation of Liberty Safeguards – A guide for relevant person's representatives

SAMPLE Model of cognition, referenced in Swansea University Masters Course 2023

Useful Links

Mental Capacity Act 2005 (sharepoint.com)

Consent (sharepoint.com)

Deprivation of Liberty Safeguards (sharepoint.com)

Accessing legal advice - CAV UHB

APPENDIX A IMCA Referral Form

SOUTH EAST WALES IMCA REFERRAL FORM

Please return completed form to :
Advocacy Support Cymru, Charterhouse 1, Links Business Park, Fortran Road,
St Mellons, Cardiff CF3 0LT

☏ 029 2054 0444   🖷 029 2073 5620   ✉ info@ascymru.org.uk

Reason For Referral (please only tick one box per form)	
Serious medical treatment [ ] **Safeguarding Vulnerable Adults [ ]** **Move of accommodation [ ]** **Care Review:** New **[ ]** Monitoring **[ ]**	**Deprivation of Liberty Safeguards (DoLs)** 39A **[ ]** 39C **[ ]** 39D **[ ]** **Relevant Person Representative (RPR)** \` Relevant Person **[ ]** Relevant Persons representative **[ ]** Relevant Persons and Relevant Persons Representative **[ ]**

Are there any family/friends? Yes [ ] No [ ] Have they been informed that an IMCA has been instructed? Yes [ ] No [ ] Why are they not appropriate to consult with:	Are they available/appropriate to consult with Yes [ ] No [ ]

Do you consider the person to lack capacity? Yes [ ] No [ ] Has a capacity assessment been completed? Yes [ ] No [ ] Date of Assessment: .... Name of Assessor: .... Is the person's capacity likely to change? Yes [ ] No [ ]

CLIENT NAME		Male [ ] Female [ ] Date of Birth:
Current Address (where client is now)	Home Address	

Postcode	Tel	Postcode	Tel

REFERRER	
Name:	Position:
Organisation:	
NHS Request [ ]	
Local Authority Request [ ]	Email:
Telephone number for confirmation of receipt of referral:	

DECISION MAKER (if not the referrer)	
Name:	Position:
Organisation:	
Address:	
Telephone:	Email:

CONTACT PERSON FOR ACCESS TO RECORDS	
Name:	Position:
Organisation:	
Address:	
Telephone:	Email:

Is the client in:

Hospital [ ] Name of Hospital .... Ward ....

Independent Hospital [ ] Name of Hospital .... Ward ....

Residential Home [ ] Nursing Home [ ] EMI Residential Home [ ] EMI Nursing Home [ ]

Supportive Living [ ] Care Home [ ] Own Home [ ]

Other: ....

Are there any risk issues that the IMCA should be aware of (e.g. risk to lone worker, infection control etc) ?

Client Group

Mental Health [ ] Learning Disability [ ] Older People [ ]

PSNI (Physical sensory neurological impairment) [ ] SPI (Serious/severe physical illness) [ ]

ASD (Autistic Spectrum Disorder) [ ] Dementia [ ] Combination [ ]

Brain Injury [ ] Cognitive Impairment [ ]

Other: ....

What is their primary communication method? (please tick the most appropriate box)
English [ ] Welsh [ ] Other spoken language [ ] No obvious means of communication [ ]
Words/Pictures/Makaton [ ] Gestures/vocalisations/facial expressions [ ] Sign language (e.g. BSL) [ ]
Sign Supported Makaton [ ]

Other: ....

Ethnicity

White British [ ] White Irish [ ] White (other) [ ] Chinese [ ] Caribbean [ ]

Black African [ ] Black (other) [ ] Bangladeshi [ ] Indian [ ] Pakistani [ ]

Asian (other) [ ] Mixed Race [ ] Other: ....

Known religious/cultural beliefs

Additional Contacts – Relevant people to obtain information from.
Other people involved e.g. friends, family, LPA (Lasting Power of Attorney), GP, care home staff, lead nurse who may be able to indicate the wishes of the person being referred.

Name		Name	
Relationship		Relationship	
Address		Address	
Tel		Tel	

Name		Name	
Relationship		Relationship	
Address		Address	
Tel		Tel	

Case overview:

Is there a date by which the decision must be made? YES [ ] NO [ ]

If 'YES', what is the date ....

Is there a deadline for a course of action? (Best interest or MDT meeting outcome) YES [ ] NO [ ]

If 'YES', what is the date, time and venue?

Is there a deadline for the required report? YES [ ] NO [ ]

If 'YES', what is the deadline date?

Has Serious Medical Treatment in an emergency already been carried out? YES [ ] NO [ ]

Details

I confirm that the IMCA has permission to access appropriate medical/social care records

I confirm that I am the Decision Maker/Person appointed by the Decision Maker on behalf of:

NHS body or local authority ....

Name (print) ....

Signature .... Date ....

For decisions regarding (Client name) ____

For any **MCA related queries** contact the MCA Team at **mca-lps.cav@wales.nhs.uk**

PRESUMPTION OF CAPACITY

SUPPORT TO MAKE DECISIONS

UNWISE DECISIONS

BEST INTERESTS

LESS RESTRICTIVE INTERVENTION

GIVE ME FIVE