South East Coast Ambulance Service NHS
NHS Foundation Trust

Mental Capacity Act Policy

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Manager Responsible

Name:	
Job Title:	Nurse Consultant for Safeguarding
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Approval

Person/ Committee	Comments	Version	Date
Safeguarding Lead	New policy to replace previous Consent and Capacity Guidelines	V0.01	Nov 2017
West Sussex CCG MCA Lead	For review	V0.01	Nov 2017
West Sussex CCG MCA Lead	For review	V0.01	Nov 2017
SECAmb Legal team	Updated following input	V0.04	May 2018
West Sussex Designated nurses	Updated following input	V0.03	April 2018
Safeguarding Lead	Update following MCA lead input	V0.02	April 2018
Surrey Safeguarding Designated Nurses	Updated following input	V1.01	May 2021
End of Life Care Lead	Updated following input	V1.02	May 2021
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Safeguarding Specialist Practitioners/Safeguarding Lead/Safeguarding Nurse Consultant	Updated following Input	V1.04	December 2021
Specialist Safeguarding Practitioner	Updated re change of Director of Quality and Nursing	V2	September 2022
Specialist Safeguarding Practitioner Safeguarding Lead Safeguarding Nurse Consultant	Update following Trust wide consultation	V3	November 2022
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Manager		
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Supports Standard(s)/KLOE

	Care Quality Commission (CQC)	**IG Toolkit**	**Other**
Criteria/KLOE:	Name core service area and CREWS elements		

Contents

1. Introduction

1.1. *The Mental Capacity Act 2005* (MCA) Mental Capacity Act 2005 (legislation.gov.uk) provides a statutory framework to empower and protect 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.

1.2. 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

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

2.2. This guidance is for all staff working within South East Coast Ambulance Service NHS Foundation Trust (SECAmb) 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.

2.3. Throughout this policy SECAmb may be referred to as ‘The Trust’

2.4. 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.

2.5. This policy is designed primarily for all staff who have direct patient contact; however, all staff have a duty to act in accordance with the MCA.

3. Aim

3.1. The aim of this policy is to ensure that the Trust complies with the statutory requirements of the MCA, 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.

4.2. **Chief Executive**
The Chief Executive has overall responsibility for ensuring that systems for the safe and appropriate use of the MCA are followed.

4.3. **Director of Quality and Safety**
The Director of Quality and Safety is the board member responsible for the MCA.

4.4. **Executive Director for Quality and Nursing**
The Executive Director for Quality and Nursing is the board member responsible for the implementation of the MCA in practice.

4.5. **Managers and Supervisors**

The operational managers are responsible and accountable for the day to day safe and appropriate use of the MCA and must ensure that copies of this Policy are available to their staff.

4.6. **All staff**

For the avoidance of doubt and for the purposes of this policy, staff include all employees, volunteers, apprentices, students, and contractors.

4.6.1. All staff have a responsibility to understand the MCA, relevant to their role.

4.6.2. All staff should understand the MCA and be competent to carry out the duties described in this policy.

4.6.3. 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

5.1. **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. 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.

5.2. **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.

5.3. **Lasting Powers of Attorney** (LPA) (health and welfare) - enable appointed attorneys to make a number of decisions about a person's life when they the capacity to make those decisions. This may include the power to give or refuse consent to medical examination and/or treatment.

6. MCA Key Principles

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

- **Principle 1:** Assume a person has capacity unless proved otherwise. This enshrines the starting presumption of capacity and ensures that people are not discriminated against due to diagnosis, age, disability, or impairment.

- **Principle 2:** Individuals should be supported to make decisions for themselves before concluding that they may lack the capacity to do so. This requires staff to be familiar with 'reasonable adjustments' such as easy read information, additional time and staff support, use of augmentative communication (picture/non-verbal) and interpreters.

- **Principle 3:** A person should not be treated as incapable of deciding because their decision may seem unwise. Staff will ensure that these are upheld even if they are contrary to advice being given. If people make repeated unwise decisions or the decisions made are out of character, then it may be appropriate to seek further advice from a senior colleague or a specialist practitioner.
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- **Principle 4:** An Act done, or a decision made under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests. Staff will ensure that a capacity assessment using the Trusts Mental Capacity Act assessment (Appendix A) Mental Capacity Assessment Form.pdf documentation has been undertaken before making a best interest decision. This must also be clearly documented on the best interest assessment form (Appendix B) Best Interest Plan Form v1 0.pdf

- **Principle 5:** Before the Act is done, or a decision is made, regard must be taken to whether the purpose for which it is needed can be achieved in a way that is less restrictive of the person's rights and freedom of action. When acting in someone's best interest, the practitioner must ensure that there is no alternative that would interfere less on the person's basic rights and freedoms. This should include considering whether the decision is required at all. As any decision is made in a person's best interest must be the least restrictive option.

7. Assessing capacity

7.1. 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 2-step test.

7.2. 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.

7.3. The 2-step test consists of the Diagnostic test and the Functional test.

7.3.1. **Diagnostic Test**
Capacity is the ability to make an informed decision at the time that a decision needs to be made. 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. Including but not limited to; emotional distress, learning disability, dementia, brain damage, neurological conditions, pain, intoxication and psychiatric illness.

If so:

- Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

- If the answer to the diagnostic test is no, then that person has capacity. If the answer is yes, then the functional test should be applied.

7.3.2. **Functional Test**
A person is unable to decide for themselves if they are 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 by any appropriate means.

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

7.5. No one can simply be labelled "incapable" or "lacking capacity" as a result of a particular medical condition or diagnosis. The 2-step test must be completed and documented on the MCA form.

8. Recording an Assessment.

8.1. It is essential that when an MCA assessment is undertaken that appropriate recording takes place. Either using the ePCR system or Trust issued paper documentation. Assessments must always be clearly recorded and completed as fully as possible.

8.2. In order to demonstrate compliance with the Functional Test, staff must 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 (pros and cons) in order to come to a decision.
- The ability of the person to communicate the decision.

9. Best Interests

9.1. If, following a capacity assessment, the crew believe that on balance the patient lacks capacity, Staff will need to make a best interest decision on behalf of the person. Best interest decisions can only be applied to a patient who lacks capacity.

9.2. The MCA does not define the term “best interest” as there are too many different decisions which could be covered by the term. A best interest decision must be based on what the decision maker believes the person would agree was the best course of action for them, if they had capacity.

9.3. Best interest decisions must be sympathetic to the culture, beliefs, or any known wishes (particularly written statements) the patient held prior to loss of their capacity, wherever practical.

9.4. If time allows, consideration must be made to consulting with family/friends/carers/other health-care professional involved with the patient before making a best interest decision.

9.5. If there is a chance that the person could regain capacity, and if it is safe to do so, consideration must be given to delaying treatment until this might happen. If capacity is regained, then no best interest decision is required.

9.6. If the decision cannot be delayed, the clinician who undertakes the capacity assessment will become the decision maker for the patient. Provided the patient does not have anyone who they have appointed as their Lasting Power of Attorney. The decision maker must:

- Have taken reasonable steps to assess the person's capacity to consent to the act in question.

- Reasonably believe that the person lacks the capacity to consent.

Reasonably believe that the act they are carrying out is in the person's best interest**.** The process used to work out the best interest decision must be clearly recorded on the Patient electronic Patient Clinical Record (ePCR), or paper PCR, setting out:

- How the decision was reached?

- What was the reason for the decision?

- Who was consulted?

- Any other factors considered.

9.7. Staff are protected under section 5 of the MCA Mental Capacity Act 2005 (legislation.gov.uk)when carrying out acts of care or treatment in the best interest of a patient who they believe lacks capacity.

9.8. In cases where a patient appears to have a disturbance or impairment of mind or brain but there is no time to undertake a capacity assessment – e.g., a patient attempting to run into traffic, staff may intervene using the doctrine of necessity under Common Law (a common law principle is a legal concept which is established by case law that is accepted as legal). This allows staff to do what is immediately necessary.

9.9. (Where safe to do so) to prevent a serious deterioration in physical or mental well-being but does not allow intervention beyond the point of crisis. Once the patient is safe, any further interventions would need to be undertaken using a capacity assessment and best interest decision as appropriate. Ensuring this is well documented with the reasoning as to why the best interest decision is the least restrictive option.

10. Restraint

10.1. Section 6(4) Mental Capacity Act 2005 (legislation.gov.uk)of the MCA 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.

The list below covers some of the common forms of restraint used by ambulance staff. The list is not exhaustive but includes:

- Placing an arm around the patient and 'steering' them towards the vehicle.
- Placing a blanket around the patient and using this to manoeuvre the patient towards the vehicle.
- Securely blanketing a patient and placing a strap across them on a carry chair.
- Using straps on the vehicle stretcher (i.e., five-point harness).

10.2. Anybody considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used.

10.3. A carer or professional must not use restraint just so they can do something more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible. In these circumstances, staff using minimum restraint required to protect a patient who lacks capacity will be supported by the Trust providing comprehensive and contemporaneous information around the decision to apply restraint has been documented on the PCR.

10.4. Any use of restraint for a patient who lacks capacity must be clearly documented on the PCR. This must include what form of restraint was required, and how long the patient was subject to restraint. It must be limited and proportionate to the risk of harm and be the least restrictive method possible.

10.5. If the patient is violent, threatening violence, or there is a possibility that there may be a breach of the peace or other crime committed then police must be called to assist with restraint of the patient. This may create a delay in being able to treat the patient. However, the safety of the patient, carers and staff must be considered. Any delay in being able to deliver treatment safely must be risk assessed and noted on the PCR.

10.6. Action under the MCA regarding escalation to police for assistance as outlined above, must be for this incident only and not for any prior occasion of violent behaviour.

10.7. In some circumstances it is necessary to provide sedation or anxiolysis Anxiolytic - Wikipediato a patient to facilitate emergency treatment or safe transport, and all other alternatives have been explored and documented. This will be conducted utilising a defined procedure as detailed Governance - C414 V1 - Management of Acute Behavioural Disturbance - 14 Sept 21.pdf (sharepoint.com). This will be undertaken by a specialist practitioner with appropriate training and supervision. This will utilise the least restrictive option, for the shortest period of time deemed necessary to complete the procedure safely and will include ongoing re-assessment of the patients'

ability to consent and what actions are in their best interest. All other alternatives must have been explored and documented.

10.8. These actions only receive protection from liability if the person is reasonably believed to lack capacity to give permission for the action. The action must also be in the person's best interests and follow the MCA principles. Restraint or treatment of a patient without lawful justification may amount to the offences of assault and/or false imprisonment.

11. Involving Others

11.1. There are only two types of people who are lawfully authorised to act on behalf of a person who lacks capacity and make decisions of their behalf. Namely a court appointed deputy or someone holding Lasting Power of Attorney (LPA)

11.2. Court appointed deputies are appointed by the Court of Protection to make specific decisions on behalf of someone who does not have capacity. If there is a known court appointed deputy for health and welfare, then they are the decision maker regarding the person's care and treatment.

11.3. Deputies are required to follow principle 4 of the Act Mental Capacity Act 2005 (legislation.gov.uk)in that they must act in the person's best interest and consider their wishes and beliefs prior to losing capacity. Any concern that Deputies are not acting in the person's best interest should be reported to the Court of Protection.

11.4. People over the age of 18 can give statutory authority, whilst they still have capacity, for other people to make decisions on their behalf. Usually once they have lost capacity to do so for themselves. This is known as Lasting Power of Attorney.

11.5. There are two types of LPA:

- Health and Welfare
- Property and Finance

For the purpose of assessment, treatment and conveying, if it is known that a person who lacks capacity has an LPA for health and welfare, then this person should be consulted, if it is possible to do so.

11.6. LPAs are required to follow principle 4 of the MCA in that they must act in the person's best interest and consider their wishes and beliefs prior to losing capacity. Any concern that LPAs are not acting in the person's best interest should be escalated. Following the Safeguarding Policy and Procedure Safeguarding Policy and Procedures for Children, Young People and Adults (sharepoint.com)to Safeguarding on Call. If staff are concerned that there is a criminal element, call the Police. Consider escalating concerns via a Safeguarding Referral for onward processing by the Safeguarding Team safeguarding@secamb.nhs.uk.

12. Advance Decisions to Refuse Treatment (ADRT)

12.1. An ADRT is legally binding and allows someone aged 18 and over, who has capacity at the time of making the ADRT, to refuse specified medical treatment at a time in the future, should they lose capacity.

12.2. ADRT's are valid when:

- They are made when the patient had capacity, (Health practitioners must assume this decision was made when the person had capacity until proven otherwise)
- The person who made it has not subsequently withdrawn it.
- An ADRT **cannot** be overridden by an LPA or Court Deputy
- The patient has continued to act in a way consistent with the ADRT, i.e., has a valid ADRT that **must** be respected, and that decision should be treated by staff in the same way they would treat the decision of a patient who **has** capacity.

12.3. 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 best interests of the patient.

12.4. If an ADRT involves refusing life-sustaining treatment it must be written down, and:

- Signed and dated by the person in the presence of a witness.
- Signed and dated by the witness.
- Must contain the statement 'I refuse this treatment even if my life is at risk as a result.'

12.5. ADRTs not relating to life sustaining treatment do not need to be written down, these can be verbal. However, it can be difficult for ambulance staff to act on these, and as stated above, can only do so if they are satisfied that there is reasonable evidence of existence. The patient should be encouraged to write it down and try to have a person to witness the statement where possible. All decisions regarding the verbal ADRT should be document on the EPCR.

13. Deprivation of Liberty Safeguards (DoLS) / Liberty Protection Safeguards

13.1. DoLS is a legal framework to ensure that people who lack capacity to consent to their accommodation for the purposes of treatment or care can be lawfully deprived of their liberty where this treatment is in their best interest and will protect them from harm.

13.2. A deprivation of liberty can occur in a care home, hospital, or domestic setting such as supported living or a person's own home.

13.3. DoLS apply to people over the age of 18 only, and do not apply to people who have capacity.

13.4. DoLS will be replaced by Liberty Protection Safeguards in April 2022, which will provide protection for people aged over 16 who need to be deprived of their liberty. The LPS will continue to apply to individuals in hospital and care home settings but have been extended to include those residing in all domestic settings who need to be deprived of their liberty. This change ensures that all individuals who need to be deprived of their liberty will be protected under LPS.

14. Wilful Neglect

14.1. The MCA 2005 created a criminal offence of wilful neglect or ill treatment of a person who lacks capacity. This is punishable by a fine or a sentence of up to five years imprisonment or both.

14.2. These offences may apply to anyone caring for a person who lacks capacity. This includes family members, carers, health or social care staff in hospital, care homes and those providing care or support in a person's home.

14.3. The MCA introduced the role of Independent Mental Capacity Advocates (IMCA) and clarified the need to involve them. They are a legal safeguard for people who lack capacity to make important decisions such as where to live or decisions about serious medical treatment when there is no family or friends independent of services to represent them.

15. Training

15.1. Staff will complete MCA training in line with the Safeguarding Training Needs Analysis (TNA) Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing (rcn.org.uk)

15.2. Staff are required to undertake training commensurate to their roles and are responsible for ensuring that their training is up to date and completed.

16. Monitoring

16.1. This policy will be monitored by the Safeguarding Sub-Group, and monitoring may include:

- Review of training records
- Staff surveys and knowledge review
- MCA training compliance, figures and details reported to Learning and development.

17 Financial Checkpoint

17.1. To ensure that any financial implications of changes in policy or procedure are considered in advance of document approval, document authors are required to seek approval from the Finance Team before submitting their document for final approval.

17.2. This document has been confirmed by Finance to have no unbudgeted financial implications.

18 Equality Analysis

18.1. The Trust believes in fairness and equality, and values diversity in its role as both a provider of services and as an employer. The Trust aims to provide accessible services that respect the needs of each individual and exclude no-one. It is committed to comply with the *Human Rights Act* and to meeting the *Equality Act 2010*, which identifies the following nine protected characteristics: Age, Disability, Race, Religion and Belief, Gender Reassignment, Sexual Orientation, Sex, Marriage and Civil Partnership and Pregnancy and Maternity.

18.2. Compliance with the Public Sector Equality Duty: If a contractor carries out functions of a public nature, then for the duration of the contract, the contractor or supplier would itself be considered a public authority and have the duty to comply with the equalities duties when carrying out those functions.

17. Associated documentation.

a. Safeguarding Policy and Procedures for Children, Young People and Adults Safeguarding Policy and Procedures for Children, Young People and Adults (sharepoint.com)
b. End of Life Care Policy - End of Life Care Policy

18. References

- Mental Capacity Act (2005) Mental Capacity Act 2005 (legislation.gov.uk)

- MCA: Code of Practice (2007) Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)
- Human Rights Act Human Rights Act 1998 (legislation.gov.uk)
- Care Act 2014 Care Act 2014 (legislation.gov.uk)
- Safeguarding vulnerable groups Act 2006 Safeguarding Vulnerable Groups Act 2006 (legislation.gov.uk)
- Liberty Protection Safeguards: what they are - GOV.UK (www.gov.uk)
- Safeguarding | Topic | NICE

Appendix A

MCA Assessment form
Mental Capacity Assessment Form.pdf

Appendix B

BI assessment form
Best Interest Plan Form v1 0.pdf