

Mental Capacity Assessment and Best Interest Forms

Note:

Top copy: filed in the patients notes

Second Copy: send to Governance Department Kendrick Wing Warrington Hospital

Third copy: remains in pad

Information surrounding the Mental Capacity Act and Assessment of Capacity can be found within the Governance,
Risk and Patient Safety Community within The Hub - Mental Capacity
Telephone advice can be sought from the Governance Dept ext 2484/2191
Safeguarding Matron ext 5313
Matrons within the Specialties

DO NOT FILE THIS SECTION IN THE NOTES FOR REFERENCE ONLY

ASSESSMENT OF MENTAL CAPACITY-GUIDANCE NOTES

(GUIDANCE MUST BE READ AND UNDERSTOOD BEFORE MAKING ASSESSMENT)

Core principles

The Mental Capacity Act applies in England and Wales to everyone who works in health and social care and is involved in care.

- A person is assumed to have capacity. A lack of capacity has to be clearly demonstrated.
- No one should be treated as unable to make a decision unless all practicable (reasonable) steps to help them have been exhausted and shown not to work.
- A person can make an unwise decision. This does not necessarily mean they lack capacity.
- If it is decided a person lacks capacity then any decisions taken on their behalf must be in their best interests.

Any decision taken on the behalf of a person who lacks capacity must taken into account their rights and freedom of action. Any decision should show that the least restrictive option or intervention is achieved.

Who is a relevant advocate?

As far as possible you must consult other people if it is appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity, especially:

- Anyone previously named by the person lacking capacity as someone to be consulted e.g. in an advance statement
- Carers, close relatives or close friends or anyone else interested in the person's welfare
- Any attorney appointed under a Lasting Power of Attorney
- Someone with the person's Enduring Power of Attorney (financial matters)
- Any deputy appointed by the Court of Protection to make decisions for the person.

For decisions about serious medical treatment, significant financial decisions or certain changes of accommodation and where there is no one who fits into any of the above categories, you may need to instruct an Independent Mental Capacity Advocate (IMCA).

Best Interests- the 7 statutory checklist points:

- Don't make assumptions about person's best interests.
- All relevant circumstances must be considered.
- Is the person likely to regain capacity, if so, can decision wait?
- Involve person as fully as possible.
- Decisions concerning the provision or withdrawal of life sustaining treatment must not be motivated by a desire to bring about a persons death.
- Past and present wishes and feelings together with and any relevant beliefs or values. These may be written in an advance decision (refusal of treatment) and / or and advance statement (advance care planning).
- Must consult other people if appropriate and take account of views especially: anyone previously named by the person as someone to be consulted, carers, close relatives or close friends or anyone else interested in the persons welfare, any attorney appointed under a Lasting Power of Attorney and any deputy appointed by the Court of Protection to make decisions for the person.

The "Decision maker" weighs up all the information in order to determine what decision is in the person's best interests. Clear record keeping of the above is crucial.

Can the decision be delayed because the person is likely to regain capacity in the near future?

Careful consideration needs to be given to whether a person is likely to regain capacity with the time limits required by a decision. For example, is the person's understanding better at different times of the day or in particular contexts? Are they able to make decisions when they are in a comfortable environment, perhaps with loved ones in attendance? Consider the effects of medication over the course of the day.

Independent Mental Capacity Advocate (IMCA)

An IMCA is a specific type of advocate that will only have to be involved if there are no family or friends who can be consulted.

An IMCA will not be the decision-maker, but you will have a duty to take into account the information given by the IMCA.

An IMCA will only be involved if:

- The decision is about serious medical treatment provided by the NHS
- It is proposed that the person be moved into long-term care of more than 28 days in a hospital or 8 weeks in a care home
- A long-term move (8 weeks or more) to different accommodation is being considered, for example, to a different hospital or care home.

Lasting Power of Attorney (LPA)

In October 2007 the MCA introduces Lasting Power of Attorney (LPA) which will allow people over the age of 18 to formally appoint someone to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. The person appointed will be known as an attorney. The LPA will give the attorney authority to make decisions on behalf of the donor and the attorney will have a duty to act or make decisions in the best interests of the person

- A personal welfare LPA is for decisions about both health and personal welfare
- A property and affairs LPA is for decision about financial matters

The attorney will be the decision-maker on all matters relating to the person's care and treatment. Unless the LPA specifies limits to the attorney's authority the attorney will have the authority to make personal welfare decisions and refuse treatment (except life-sustaining treatment unless the LPA specifies this) on the donor's behalf. If there is a dispute that cannot be resolved, e.g. between the attorney and a doctor, it may have to be referred to the Court of Protection who may appoint a deputy to have ongoing authority to make decisions

It is important to read the LPA if it is available to understand the extent of the attorney's power.

Deputy appointed by Court of Protection

A deputy appointed by the Court of Protection makes ongoing decisions about a person who lacks capacity. The Court of Protection will have defined the remit of their powers.

General Advocate

A general advocate is a person from an independent Advocacy Project or Service who listens to service users and gives them support to express their views. General advocates can help service users in a range of ways for example: by ensuring they have access to information to make choices; by attending meetings to support service users and to ensure they are listened to; discovering what service user's choices are.

Decision-maker

The decision-maker is the person who is deciding whether to take action in connection with the care or treatment of an adult who lacks capacity or who is contemplating making a decision on their behalf:

- Where the decision involves medical treatment – the doctor proposing the treatment is the decision maker.
- Where nursing care is provided, the nurse is the decision-maker.
- For most day-to-day actions or decisions, the decision-maker will be the person must directly involved with the person at the time.

Outside hospital, the decision maker is likely to be care workers and family members concerning day to day actions.

If there is a dispute then it should be clearly identified. If there is a dispute then the following things can assist the decision maker:

- Involve an advocate who is independent of all parties involved.
- Get a second opinion.
- Hold a formal or informal case conference.
- Go to mediation.
- Consider and discuss with line manager an application can be made to the Court of Protection for a ruling.

ASSESSMENT OF CAPACITY AND BEST INTERESTS: RECORDING GUIDANCE

In working towards demonstrating compliance with the provisions of the Mental Capacity Act and yet keep bureaucracy to a minimum Warrington and Halton Hospitals NHS Foundation Trust propose two levels of recording by staff:

- A capacity and best interest form required to be completed only in situations of specific life changing decisions regarding a client for whom capacity is an issue.
- In relation to more general care for all staff to start recording assessments of capacity and best interest decisions in regard to their own professional intervention within the recording system they currently use i.e. at initial assessment and reviews.

ASSESSMENT AND BEST INTEREST REVIEW OF PATIENTS WHO LACK CAPACITY TO MAKE A SPECIFIC DECISION

If the person has been confirmed to lack Capacity and has no family or friends other than paid carers then an Independent Mental Capacity Advocate (IMCA) must be contacted via the Matron for the Specialty.

First Name(s):		Surname:	
Hospital Number:	D.O.B:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Division:		Ward/Department:	

Examples of Specific Decision: Cancer treatment, Change of accommodation, Hip/leg operation, DNAR, Medical investigations, Serious dental work, Termination of pregnancy, Treatment that may lead to loss of hearing or sight, Major surgery, Major amputations (arm or leg), Nutritional Support	Document below the Decision to be made
---	---

Diagnostic Test: Is there an impairment of, or disturbance in, the functioning of the person's mind or brain (temporary or permanent)	Yes <input type="checkbox"/> Details:	No <input type="checkbox"/>
If yes, does the impairment or disturbance affect the person's ability to make a specific decision?		Yes <input type="checkbox"/> No <input type="checkbox"/>

Functional Test - Is the person able to:	1.	Understand the information	Relevant to the decision being made?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	2.	Retain the information	Long enough to make a decision	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	3.	Use & weigh up the information	To arrive at a choice	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	4.	Communicate the decision	e.g. by talking, signing, use of Trust Communication Tool etc? Note: Assessor must assist communication with practical steps	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Does the person lack Capacity to make the decision?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
--	------------------------------	-----------------------------

Can the decision be delayed because the person is likely to regain capacity in the near future?	Yes (no further action) <input type="checkbox"/> Details:
	Not likely to regain capacity <input type="checkbox"/> Details:
	Not appropriate to delay <input type="checkbox"/> Details:

Is a Welfare Lasting Power of Attorney in place?	Yes (consider consultation) <input type="checkbox"/>	No <input type="checkbox"/>
Is a Financial Lasting Power of Attorney (or EPA) in place?	Yes (consider consultation) <input type="checkbox"/>	No <input type="checkbox"/>
Has the person made an advanced decision to refuse treatment?	Yes <input type="checkbox"/> Details:	No <input type="checkbox"/>
Has the person made an advanced statement or request?	Yes <input type="checkbox"/> Details:	No <input type="checkbox"/>

Consultation Who has been involved about the Specific Decision (names and signatures to be provide)	Please print and full signature of those involved	
	Doctor (s)	
	Nurse / Midwife	
	Social Worker	
	Therapist / Dietician	
	Family	
	Friends	
	IMCA (Independent Mental Capacity Advocate) if no family and only Carers)	
Other		

What is the persons Primary means of communication?			
English <input type="checkbox"/>	Gestures / Facial expressions / vocalisations <input type="checkbox"/>		
Other spoken language <input type="checkbox"/>	No obvious means of communication <input type="checkbox"/>		
British Sign Language <input type="checkbox"/>	Other (please state) <input type="checkbox"/>		
Words / pictures / Makaton <input type="checkbox"/>	Use of the Trust Communication Book was used <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Best Interests - the 7 Statutory Checklists points:	
1.	Don't make assumptions about person's best interests.
2.	All relevant circumstances must be considered.
3.	Is the person likely to regain capacity, if so, can decision wait?
4.	Involve person as fully as possible.
5.	Decisions concerning the provision or withdrawal of life sustaining treatment must not be motivated by a desire to bring about a persons death.
6.	Past and present wishes and feelings together with and any relevant beliefs or values. These may be written in an advance decision (refusal of treatment) and / or and advance statement (advance care planning).
7.	Must consult other people if appropriate and take account of views especially: anyone previously named by the person as someone to be consulted, carers, close relatives or close friends or anyone else interested in the persons welfare, any attorney appointed under a Lasting Power of Attorney and any deputy appointed by the Court of Protection to make decisions for the person.
The Decision Maker weighs up all the information in order to determine what decision is in the person's best interests. Clear record keeping of the above is crucial.	

I have reasonable belief that I have:		
• I have considered all relevant circumstances listed in the document	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I have ensured that the decision recommendation is not based on assumptions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
• I have considered that the decisions concerning the provision or withdrawal of life sustaining treatment have not been motivated by a desire to bring about a person's death	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Title of the person completing the assessment:	Date of assessment:	
Print Name:	Sign Name:	

WHEN SHOULD THE FORM BE FILLED IN?

The Assessment of Capacity and Best Interest form should be filled in for clients without capacity or for whom capacity for a decision or course of care or treatment is in doubt who are confronted with life changing decisions/events and specifically for clients without capacity where:

- There is conflict with family.
- There are adult or public protection issues.
- Accommodation change e.g. to long term care, hospital admission, respite care Change of tenancy.
- Any case conference convened around a serious issue.

SPECIFICALLY WHEN SHOULD HOSPITAL STAFF COMPLETE THE FORM?

- Where a patient's admission is "informal" (ie the person is not detained under the Mental Health Act 1983) and there is an issue around a clients capacity. This area is important given that from 1 October 2007 best interest actions under common law no longer applies so that actions such as physical care intervention by nurses, medication giving etc will need to be justified against and consistent with the Capacity Act.
- Where there are restrictions of liberty issues in relation to a client with capacity issues eg high level observations.
- Where a patient is in hospital and there is conflict with family, adult protection issues or case conference convened in regard to a serious issue (ie as above).

Unless there are major changes in capacity or proposed interventions only one form should be completed per admission (with minor changes being recorded in routine clinical notes).

WHO SHOULD FILL IN THE ASSESSMENT FORM?

Many of these assessments will clearly be multidisciplinary given that they refer to life changing decision/ events where typically a number of professionals will be involved.

The final responsibility of co-ordinating a capacity or best interest assessment will rest with the "decision maker". The decision maker will be the main professional involved around the proposed decision/care and treatment and it will (see guidance attached to best interests form).

WHAT GRADE OF STAFF SHOULD COMPLETE THE FORM?

The form can be completed by F2 and above medical staff, Divisional Heads of Nursing, Matrons, Band 6 Nurses and above, Ward Managers, Senior Radiographers, Senior Heads of Therapy Services, Governance Compliance Manager and the Associate Director of Governance who will be expected to be leading on pulling together a formal capacity assessment and best interest determination.

WHAT IS EXPECTED OF GENERAL RECORDING FOR STAFF?

The level of detail in general recording around capacity and best interests will depend upon the specific intervention being proposed by a professional and in particular on the degree of potential impact on the client. In most interventions of a routine nature staffs merely need to demonstrate that they are taking account of capacity and best interests at key points within their professional practice.

If the client clearly has capacity recording could be as brief as to indicate that the client "impairment" or "disturbance" does not affect the clients cognitions in regard to the intervention being proposed ie does not "make the person unable to make the decision". If this is unchanged at review then this capacity would merely be noted as being unchanged from that recorded in the original assessment.

For clients without capacity for a particular decision/intervention there would be the need to include an assessment summary of capacity, who will be consulted and a summary of why a course of action is decided to be in the best interests of the client.

For routine interventions such recording need not be extensive and staff can choose whether to record such briefly in case notes or whether they wish to use the more detailed form. Such **recording is not expected for all decisions but around significant changes** only.

WHAT SHOULD BE RECORDED FOR CLIENTS WHOSE CAPACITY FLUCTUATES?

Fluctuating capacity will an issue for many clients. In such cases staff should record in their initial assessments that this could be the case stating how their practice would change in such an event eg postponing therapy, liaising with key carers, recording the change in capacity and how continued intervention confers with the best interest checklist. The best client centred practice will clearly be to agree the response with the client and family in advance whilst the client still has capacity.

WHEN SHOULD THE FORM BE FILLED IN?

The Assessment of Capacity and Best Interest form should be filled in for clients without capacity or for whom capacity for a decision or course of care or treatment is in doubt who are confronted with life changing decisions/events and specifically for clients without capacity where:

- There is conflict with family.
- There are adult or public protection issues.
- Accommodation change e.g. to long term care, hospital admission, respite care Change of tenancy.
- Any case conference convened around a serious issue.

SPECIFICALLY WHEN SHOULD HOSPITAL STAFF COMPLETE THE FORM?

- Where a patient's admission is "informal" (ie the person is not detained under the Mental Health Act 1983) and there is an issue around a clients capacity. This area is important given that from 1 October 2007 best interest actions under common law no longer applies so that actions such as physical care intervention by nurses, medication giving etc will need to be justified against and consistent with the Capacity Act.
- Where there are restrictions of liberty issues in relation to a client with capacity issues eg high level observations.
- Where a patient is in hospital and there is conflict with family, adult protection issues or case conference convened in regard to a serious issue (ie as above).

Unless there are major changes in capacity or proposed interventions only one form should be completed per admission (with minor changes being recorded in routine clinical notes).

WHO SHOULD FILL IN THE ASSESSMENT FORM?

Many of these assessments will clearly be multidisciplinary given that they refer to life changing decision/ events where typically a number of professionals will be involved.

The final responsibility of co-ordinating a capacity or best interest assessment will rest with the "decision maker". The decision maker will be the main professional involved around the proposed decision/care and treatment and it will (see guidance attached to best interests form).

WHAT GRADE OF STAFF SHOULD COMPLETE THE FORM?

The form can be completed by F2 and above medical staff, Divisional Heads of Nursing, Matrons, Band 6 Nurses and above, Ward Managers, Senior Radiographers, Senior Heads of Therapy Services, Governance Compliance Manager and the Associate Director of Governance who will be expected to be leading on pulling together a formal capacity assessment and best interest determination.

WHAT IS EXPECTED OF GENERAL RECORDING FOR STAFF?

The level of detail in general recording around capacity and best interests will depend upon the specific intervention being proposed by a professional and in particular on the degree of potential impact on the client. In most interventions of a routine nature staffs merely need to demonstrate that they are taking account of capacity and best interests at key points within their professional practice.

If the client clearly has capacity recording could be as brief as to indicate that the client "impairment" or "disturbance" does not affect the clients cognitions in regard to the intervention being proposed ie does not "make the person unable to make the decision". If this is unchanged at review then this capacity would merely be noted as being unchanged from that recorded in the original assessment.

For clients without capacity for a particular decision/intervention there would be the need to include an assessment summary of capacity, who will be consulted and a summary of why a course of action is decided to be in the best interests of the client.

For routine interventions such recording need not be extensive and staff can choose whether to record such briefly in case notes or whether they wish to use the more detailed form. Such **recording is not expected for all decisions but around significant changes** only.

WHAT SHOULD BE RECORDED FOR CLIENTS WHOSE CAPACITY FLUCTUATES?

Fluctuating capacity will an issue for many clients. In such cases staff should record in their initial assessments that this could be the case stating how their practice would change in such an event eg postponing therapy, liaising with key carers, recording the change in capacity and how continued intervention confers with the best interest checklist. The best client centred practice will clearly be to agree the response with the client and family in advance whilst the client still has capacity.