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The Mental Capacity Act (MCA) and care planning



The report contains examples of evidence to illustrate what MCA-compliant care planning might look like.

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Foreword



The Mental Capacity Act 2005 (MCA) is widely recognised by those who work in health, social care and beyond as a positive and potentially transformative piece of legislation. Yet there is some way to go before it is widely understood and implemented.

Many of those who lack or have fluctuating capacity miss out on their fundamental rights to make, or influence, important decisions about their own care. That isn't right. The House of Lords Select Committee on the Act set out a clear challenge to government to re-commit to implementing the Act in practice. This report, commissioned by the Department of Health, represents part of this re-commitment.

Good, person-centred, care and support planning is a vital part of protecting our freedom, choices and rights when we are at our most vulnerable.

Plans should be flexible tools that maximise people's freedom to make decisions about their own care, lives and deaths. They should also clearly document how, when a person lacks capacity, decisions are made in their best interests and how their rights would be protected even when they are deprived of their liberty.

This report shows commissioners and providers of care how to embed the principles of the Mental Capacity Act into care and support planning right across the board.

I welcome the publication of SCIE's report and its contribution to the important work of making the Mental Capacity Act a reality.

Baroness Liz Barker

House of Lords Select Committee on the Mental Capacity Act 2005

Key messages

- The Mental Capacity Act (MCA) 2005 is vital to ensuring person-centred care that respects people's rights.
- Local authorities and paid staff who provide care and support to people over 16 years of age are legally required to work within the framework of the MCA and have regard to the MCA Code of Practice (the Code).
- Care planning is a key mechanism for ensuring that the MCA is implemented in social care. Care planning should reflect the principles of the MCA.
- Care and support plans should promote people's liberty – the freedom to make decisions about their care and support as far as they are able.
- Care planning should show how people and their chosen representatives are supported to be involved in developing and reviewing their care and support.
- Care plans must provide evidence of consent, or, where people lack capacity to consent to their care and support plan, there must be a clearly recorded assessment of capacity with supporting evidence.
- Care planning documents must demonstrate how any decisions made on behalf of a person who lacks capacity are made in their best interests.
- Care and support plans must be regularly reviewed to make sure they continue to meet people's changing needs and choices.
- Care planning documents must demonstrate how people who are deprived of their liberty have their rights protected.

Introduction

Purpose of this report

A human being is a human being. Behaviours may be erratic, chaotic or self-sabotaging, but people still retain their human rights [1]

The MCA protects people's basic human right to live the lives that they choose as far as they are able. Integrating the principles of the MCA into care planning and practice can transform the experience of adults with care and support needs.

This report is not intended as a guide to care planning, commissioning or the MCA. There are already excellent resources available on each of these topics. What it does offer is a starting point for both commissioners and providers to understand and demonstrate how care and support plans can **comply with the principles** of the MCA.

Despite examples of good practice, there is still considerable uncertainty about what the MCA means for care planning.

Care and support plans can and should:

- consider questions of autonomy and liberty
- reflect the efforts staff have made to maximise people's capacity to be involved and to make decisions
- reflect the right of people, who have capacity, to make unwise decisions.

Commissioners must check that providers are aware of this, and are implementing it – for all people, including those with challenging behaviour or complex needs.

This report aims to encourage and challenge providers to perform care planning differently and better; to think about promoting rights and liberty, promoting people's capacity to make decisions about their life and their care, and supporting people to be involved in every decision about their care. It also encourages commissioners of residential and domiciliary care services to question and scrutinise care planning to ensure that it meets the requirements of the MCA and delivers human rights.

The report will also be of interest to people who use care services, their families or other caregivers. By setting out the principles of good quality care planning under the MCA, this report tells people what they can expect and what can be achieved.

A note on terminology

The terms 'capacity' or 'lack of capacity' are used throughout this report to refer to capacity that is specific to each decision **at the time that it needs to be made**.

How this report was produced

This report was commissioned by the Department of Health (DH) as part of its programme to implement the MCA 2005. The Social Care Institute for Excellence (SCIE) carried out a scope of available research on care planning and the MCA, which forms the basis of this report. Members of an advisory group of users and stakeholders from across the social care sector have also contributed to the content by drawing on their experiences.

The report was reviewed in September 2017.

What to look for in care and support planning

The report contains examples of evidence to illustrate what MCA-compliant care planning might look like. These examples are intended to be used as prompts. Not all of these prompts will be relevant to every situation, so you will need to pick and mix. Some of the evidence will be found in the care and support plan itself; other evidence may be in the care planning assessment documentation or may be gleaned from conversations with staff, users and/or their relatives/carers.

Promoting human rights, choice and control

This section sets out the responsibilities of providers and commissioners. It introduces the MCA as a framework for promoting human rights, choice and control.

Understand your legal obligations

Where do human rights begin?

In small places, close to home – so close and so small that they cannot be seen on any map of the world. Yet they are the world of the individual person ... (Eleanor Roosevelt, 1958)

Embedding the principles of the MCA within care planning means the world of the individual person is one in which their rights are respected. The MCA provides a framework for empowering people to make their own decisions and for others to make decisions that are in their best interests when they are unable to do so. These decisions may range from small everyday matters such as what to wear and what to eat, to more complex decisions such as where to live or what medical treatment to receive. The MCA safeguards people's human rights and the choices they wish to make.

The MCA makes it clear who can make decisions on behalf of a person who lacks capacity to do so, when they can do this, and the safeguards that must be followed. It also enables people with capacity to plan for a time in the future when they may lack capacity.

Everyone working with, or providing care and support for, a person over 16 years of age, who may lack capacity to make decisions for themselves, is required by law to understand and use the MCA. They must also have regard to the MCA Code of Practice (the Code), [2] and the Deprivation of Liberty Safeguards (DoLS), an amendment to the MCA introduced in 2009 via the Mental Health Act 2007. [3]

Providers should be able to demonstrate to commissioners how they are meeting these statutory obligations through their care planning processes and practice.

Around two million people are thought to lack capacity to make decisions about their care and support. [4] Despite the fact that the MCA was implemented many years ago, evidence from research tells us that it is still not well understood by staff working in health and social care.

The MCA 2005 Select Committee

The House of Lords Select Committee, established to scrutinise how the MCA is working in practice, published a report in March 2014. [5] It found that although the MCA 'continues to be held in high regard', it has not met the 'high expectations it raised', due to a lack of awareness and understanding, a persistent culture of paternalism in health services, and aversion to risk in social care.

The Care Quality Commission's report on the use of the Deprivation of Liberty Safeguards

Similarly, the Care Quality Commission (CQC) found in 2014 that the MCA was not well understood across all sectors. [6] The Commission's evidence showed that in some care homes (and hospitals), people's freedom to make decisions for themselves was restricted without proper consideration of their ability to consent or refuse. The Commission called upon both providers and commissioners to improve in this area.

The Care Act 2014

The statutory obligation contained in the Care Act 2014, to promote individual wellbeing, sets the future direction of social care. This means that care planning must focus on achieving change for people and not just their safety.

The Care Act recognises the importance of 'beginning with the assumption that the person is best-placed to judge their situation'. It places a duty on local authorities to make sure that:

- the person participates as fully as possible in decisions and is given the information and support necessary to enable them to participate
- decisions are made having regard to all the individual's circumstances (and are not based only on the individual's age or appearance or other condition or behaviour)
- any restriction on the individual's rights or freedom of action is kept to the minimum necessary for achieving the purpose.

The principles that underpin the MCA mirror these duties. The MCA places the person at the heart of decision-making. Providers must show through their care plans and associated records how people are supported to stay in control of their lives and to make their own decisions about how their care and support is provided as far as they are able.

The five principles of the MCA

The law recognises that each person is unique and will have a different lifestyle and aspirations for their care and support. To reflect this diversity, the MCA is underpinned by five key principles which enable a flexible approach to decision-making. When staff use these principles well, they empower people to make their own decisions and protect and empower those who lack capacity to do so. The five principles are:

- a person must be assumed to have capacity unless there is evidence to establish that they lack capacity
- a person is not to be treated as unable to make a decision for themselves unless all practical steps have been taken to help them make it, without success

- a person is not to be treated as unable to make a decision merely because they make an unwise or eccentric decision
- an act done, or decision made, for or on behalf of a person who lacks capacity must be done, or made, in their best interests
- options should be sought that are the least restrictive of the person's rights and freedoms and that will meet their need.

The principles applied to care and support planning

Principle 1: assume capacity unless there is evidence otherwise. A person who has capacity has a right to make their own decisions without interference from others. Assuming capacity, therefore, means starting from the premise that a person has capacity to make their own decisions about their care and support. It should never be assumed that a person lacks capacity solely because of their age or medical condition.

Mental capacity is 'decision-specific'. A person may have capacity to make decisions about some aspects of their care and support and not others. Care providers must obtain consent to each element of the care plan where the person is able to give it (consent is considered in more detail in the section **Care planning, liberty and autonomy**). For example, the person may be able to make their own decisions in relation to their personal care, but not about their finances.

When providing care and support, staff should consider whether the person has the capacity to make the specific decision at the time that it needs to be made. Asking this question protects the person from blanket assumptions of a lack of capacity.

What to look for in the care and support plan and other records

- Evidence of the person's informed consent to their care and support
- Evidence of why the person was assessed as lacking the capacity to consent.

Principle 2: do not treat a person as unable to make a decision unless you have done all you practically can to help them reach that decision. It would be unlawful to say that a person lacks capacity if you have not tried to support them to make a given decision. We all need advice and support at different times of our lives, for example, when buying a house or making complex financial decisions. If we seek advice we want information conveyed to us in a way that we are able to understand to help us reach our own decision. This applies equally to people in need of care and support.

Before concluding that a person lacks capacity, care staff must do all they reasonably can to help them understand the choices they have about their care and support (this is discussed further in the section **Care planning, involvement and person-centred care**). By maximising a person's capacity, they are empowered to maintain control as far as they are able, and unnecessary interventions in their lives can be avoided.

What to look for in the care and support plan and other records

- A description of any special communication needs.
- How the person is supported to understand and be involved in decisions about their care and support. This includes the nature of the decision, the options available and the consequences of each decision.

Principle 3: unwise or eccentric decisions don't of themselves prove lack of capacity. Choices are influenced by an individual's values, preferences and lifestyle. Staff must not impose their values on people for whom they provide care and support. Everyone has a right to pursue choices that others may consider unwise – for example, eating unhealthy foods, engaging in dangerous sports, buying lottery tickets, etc. This right does not diminish simply because a person uses care services. A person is not to be treated as unable to make a decision merely because this decision is considered unwise.

What to look for in the care and support plan and other records

- Information about what is important to that person, their wishes and preferences.
- What the person would like to achieve from their care and support.
- A person's social history, including any key events or achievements.
- If the person appears to lack capacity to make a specific decision for themselves at the time it needs to be made, an assessment of capacity should be made in relation to that particular decision.

Principle 4: if you are making a decision for, or acting on behalf of, a person who lacks capacity, you must do so in their best interests. The 'best interests' principle only applies if the person is unable to make the decision after being given all necessary support (see Principle 2). With the best intentions, care providers may on occasion act or make a decision that they consider to be in a person's best interests before establishing whether or not that person has capacity to make their own choices. This is unlawful and deprives a person of their basic human right to freedom and autonomy.

Any decision made on behalf of someone who lacks capacity to make it for themselves has to have regard to the 'best interests' checklist (set out in Section 4 of the MCA). This applies to all decisions about care, treatment and support, except where there is an advanced decision to refuse treatment (see chapter 9 of the Code) or in cases of research (see chapter 11 of the Code).

Social and health care professionals sometimes make the mistake of conflating their 'duty of care' with a paternalistic approach of doing what they believe to be in a person's best interests. Yet we know that putting people in the driving seat of their care and support dramatically improves outcomes. [7] In practice, this means paying attention to what the person wants from their care and support plan rather than the professional taking control. Care staff should always question whether their own value judgements are influencing the decision-making process. [8]

What to look for in the care and support plan and other records

- How the person's liberty and choices about their care and support are promoted.
- Information about the person's views.
- How the person was supported to be involved in the decision about their care and support. This includes keeping them informed about any decisions made about them.
- Information against each element of the 'best interests' checklist (see the section in this report on [Demonstrating best-interests decision-making](#)).

Principle 5: look for the least restrictive option that will meet the need. When making a best-interests decision about a person's care and support plan, providers must consider all of the options and then choose the one that meets the need and is the least restrictive of the person's rights and freedoms. Staff should always challenge themselves to consider whether there could be an alternative option that is less restrictive, but nevertheless meets the identified need.

What to look for in the care and support plan and other records

- Details of the options that were considered together with the associated risks and benefits of each.
- A clear explanation of why a particular option was decided upon.
- If restrictions are imposed, when these will be reviewed and how.

Care planning, involvement and person-centred care

This section explores two key themes that are central to care planning within the MCA framework: involvement, and keeping the wishes of the person at the centre of their care and support. It emphasises that building relationships and good communication are critical to meaningful involvement.

Involving people in decisions about them

Involving people in decisions about their care is intrinsic to the principles of the MCA and should be evident in every care and support plan. Research on mental health and wellbeing demonstrates that involvement leads to improved service outcomes and enhances mental wellbeing. [9] People who use services and their carers are experts by experience. By bringing their knowledge and ideas, they give a fresh perspective on how their particular needs for care and support can best be met.

Providers and commissioners must challenge assumptions about how care plans are developed that limit the level of active involvement by the user. Supporting people to be involved in decisions about their care and treatment should be reflected in the ethos, management, policies and care practice of each service. All services should be able to show how they do this.

Meaningful involvement is based on a sharing of power between the person using the service and the provider. Involving people in designing their care plans means:

- having a conversation among equals who are working together to help one of them make a decision about their care and support
- that the person is considered as a whole in all aspects of their life
- that the plan belongs to the person, keeping them in control
- that the plan is only implemented or shared with others if the person gives consent (where they have capacity to do so).

These are identified [10] as key elements in person-centred care planning for people with long-term conditions. They are, however, equally applicable to care planning for all adults in need of care and support:

... care planning is a conversation between the person and the healthcare practitioner about the impact their condition has on their life, and how they can be supported to best meet their health and wellbeing needs in a whole-life way. The care plan is owned by the individual, and shared with others with their consent. It is important that a discussion takes place, there is a record of it, and people know they have a plan.

Producing a shared written record of how the person will be supported tells them (and others whom they wish to involve) what to expect. Giving this information clearly maintains the accountability of the service provider and enables people to raise any concerns about the care plan or its delivery.

What to look for

- The person or their family/friends are able to tell you how they were involved in developing the care and support plan and that they felt (and feel) listened to.
- The person and their chosen representative are aware of the care and support plan and have seen a copy.
- The care and support plan clearly explains how care and support will be delivered.

The next section considers how to create a care and support plan that follows the MCA principles.

Person-centred care and support plans

Each person's needs and choices will be unique to them. This means that staff must do all they can to help the person convey their personal aspirations and goals, and the support they need. Creating the care plan with the person or their chosen representative will keep the focus on what is important to that individual and will enable their care and support to reflect this.

Designing an MCA-compliant care and support plan requires a cultural shift from traditional models of care planning to **person-centred care planning**. The key differences between the two are summarised in the table below (Table 1).

Table 1 Key differences between ‘traditional’ and person-centred care

Traditional care planning	Person-centred, MCA-compliant care planning
The professional assesses the person’s needs.	Care and support plans are developed with the person. The conversation is led by the person who knows best about their needs and preferences.
Care planning follows a medical model of disability.	Care planning follows a social model of disability.
There is a focus on what the person is unable to do.	There is a focus on goals and aspirations, what the person would like to achieve with their care and support.
There is a static view of the person’s ability or capacity.	Care planning explores potential for change, opportunities to develop capacity and ability.
The professional writes the care plan with little or no input from the person or their representative.	The person is supported to express how they would like their care and support to be delivered. The professional provides information about what the service can offer. They agree what will be in the care and support plan. A copy of the plan is made available to the person and/or their representative.
The emphasis is on protecting the person from risk.	The emphasis is on safe care that respects a person’s right to take risks that they understand.
The process takes place when it is convenient for the professional.	The care planning conversation takes place at a time when the person is most or more likely to have capacity.
Power is with the professionals.	Power is equally shared.

Promoting involvement may mean, for example, helping to orientate a person with dementia to the time and place relevant to the decision and filling in the gaps of their understanding. It might also include orientating a person's beliefs concerning a decision. For example, helping someone who is depressed to hold onto positive values that were important to them when they were not so depressed. Ongoing work to reduce the effects of mental health conditions and maintain independence and control is vital to maximising a person's capacity to make a decision.

Actively involving other people who are part of the person's life will usually improve their care and support. Linking into a person's existing support network will bring together all the information about them, so that their care and support are tailored to meet their specific needs and preferences. This will help to improve the user's experience and promote their wellbeing, rather than merely responding to problems as they arise: 'Being truly person centred is about recognising people within the full context of their lives and how they live them and not just focusing on their health conditions'. [10] The person's wishes, thoughts and feelings should be routinely prioritised together with input from families and carers.

What to look for in the care and support plan and other records

- What the person would like to achieve with their care and support, their goals and aspirations for the future.
- What is important to the person about how they live their life now: what they enjoy doing, their interests, likes and dislikes, who is important to them, who they like to see, and their preferred routines (such as when they like to get up and go to bed, whether they like a bath or a shower).
- Details of key life events and dates to assist with chronological orientation.
- How best to support and involve the person in decision-making.
- Essential information for continuity of care and for use in emergencies.
- Roles and responsibilities so that the person receives coordinated care and support to meet their needs.
- Where a person lacks capacity to express their choices, how their families and others who are interested in their welfare have been consulted.
- What outcome the person wants and any other options considered.
- The associated benefits and risks of each option.

The case of M, [11] from the Court of Protection, clearly illustrates the importance of care planning that takes account of the full context of a person's life.

Practice example: the case of M

M, a 67-year-old woman, had a mild mental health problem and lacked capacity to decide where to live. She had substantial medical needs including diabetes, which was not well controlled. M was placed in a care home by the clinical commissioning group (CCG). It considered this to be in her best interests because of the significant risks to her health if she returned home. However, M hated living in the care home and said that she wanted to leave or she would take her own life. While acknowledging these risks, the Court of Protection said that if M remained in the care home, she was entitled to ask, what for? The right to life and the state's obligation to protect it is not absolute and the Court must have regard to the person's own assessment of their quality of life. In M's case, there was little to be said for a solution that attempted to preserve her daily life without meaning or happiness.

Involvement in the cycle of care and support planning



Involvement is not an isolated activity. Ongoing communication between commissioners, providers, users and their families/carers is fundamental to taking the right decisions at the right time. It enables decisions to be altered over time to reflect people's changing needs.

Services must make sure that their staff have the knowledge and skills to **maximise involvement** as part of an ongoing conversation that takes place at all stages of the care and support planning process. For example:

- at the outset, when developing the plan of care for each person
- as part of the risk management process, including safeguarding
- each and every time care and support are provided
- when carrying out reviews
- through regular feedback about people's experience of the service they receive.

What to look for

- Evidence that staff ask people about their preferences each time they provide care or support – for example, whether they want to take their medicines now, whether they would like a cup of tea, coffee or a cold drink.
- Evidence that staff regularly ask the views of people using the service and/or their families about the care and support they receive and listen to what they say.
- Evidence of systems for reviewing care and support plans and obtaining feedback.

Relationships

Involvement in the care and support planning cycle is underpinned by the quality of the relationship between the person using the service and the social care professional: [12] 'People who use services have emphasized the support that they gain from relationships based on warmth, empathy, reliability and respect'. [13]

Having the right care staff with sufficient time and the right training in communication skills is critical to building effective relationships. [5]

What to look for

- Care staff talk to people in a respectful way.
- People say that staff are caring towards them and always treat them with respect.

Communication

Assumptions are often made about the capacity of people who have limited communication skills or sensory impairments. Yet we know that it is quite possible to discern what a person feels or wants from their gestures and facial expressions, tone and volume of voice, or body language and behaviours. Care staff may need to observe a person's responses over a period of time to understand these non-verbal signals.

A **communication chart** is a good example of a person-centred approach that carefully looks for what each individual is trying to communicate, rather than making blanket assumptions. The authors of 'Person centred thinking with older people' [14] provide a useful worked example about eating, based on four questions:

- **What is happening?** Food is being prepared.
- **What is the person doing?** Shutting their lips tightly.
- **What do we think this means?** Best guess – the person does not want food at the moment or wants a drink first.
- **What should we do?** Offer a drink, gently encourage the person to eat, try shifting their mealtime to later in the day, maintain a record of food consumed and monitor.

Other ways to help a person communicate include the following:

- Making time to listen, to ask enough questions, to create opportunities for the person to tell their story in their own time, in their own way.
- Researching their previous wishes and finding out about their values.
- Providing all the relevant information in an accessible way – for example, in plain English, in clear writing, in Braille, in alternative languages, in pictures or in photographs, or a combination of these.
- Using a translator or other person/professional who understands the person's communication style best.
- Addressing any sensory needs – does the person use a hearing aid, glasses, dentures; do they understand sign language?
- Involving family, friends or an advocate to provide support and reassurance.
- Choosing the right setting and time of day, considering whether the person may gain or regain capacity at a later date.
- Meeting with the person informally to explain the options and possible outcomes.
- Talking clearly, slowly, using straightforward, jargon-free language.

In order for care staff to successfully support people's dignity and choices, they must do all they practically can to understand the meaning that users are trying to convey: 'Having the power to communicate and to be understood is central to older people being able to have choice and control in their life – in fact, to have any quality of life at all'. [14]

What to look for in the care and support plan and other records

- A description of any communication needs and how these will be met.
- Where the person has limited communication ability, other non-verbal communication methods that the person may use.
- How the person was supported to be involved in decisions about their care and support.

What else to look for

- Users have clean spectacles, dentures are fitted and hearing aids are working.
- Staff use different communication tools to meet people's needs.
- Staff explain what is happening each time they offer care and support.
- Staff take time to listen to what people are trying to convey.

Care planning, liberty and autonomy

This section highlights the importance of liberty and autonomy within care and support planning, and the frequent tensions between liberty and risk-taking. It considers the evidence required to demonstrate that additional safeguards are in place when a person is either restrained or deprived of their liberty.

Liberty and care planning

Liberty is important – it is a human right. Liberty is what allows us to live fulfilling lives. We all have a right to live a life that is free from abuse or harm, but we also have the right to live our lives autonomously. The challenge for providers and commissioners is to manage the tension between, on the one hand, promoting people's rights, and on the other, the duty to protect them from risk. Too much emphasis on rights can lead to a lack of safety. Conversely, a risk-adverse approach can impose unnecessary restrictions on people's freedom.

The MCA supports a move from a model of protection and paternalism to one of enablement and empowerment. Respecting people's rights to choose how they live their lives (as far as they are able) goes beyond the 'duty of care' (meaning that social care professionals must do what a reasonable person with their knowledge, skills and training can be expected to do). It represents a key principle of good care planning.

What to look for in the care and support plan and other records

- How the person's rights will be promoted – i.e. their rights to liberty, autonomy and family life.
- The steps taken to maximise capacity.

The case of DE and the NHS

The recent case of DE provides a striking example of how valuing autonomy and liberty can transform people's lives. [16]

Practice example: the case of DE and the NHS

This case is the first time that a court in England and Wales has made an order permitting the sterilisation of a man who was unable to consent to this, for non-therapeutic reasons. This case is summarised here not because of the sterilisation, but because of the reasoning that led to the decision.

DE was aged 37 and had learning disabilities. He lived with his parents who had worked hard to help him attain a degree of autonomy: travelling alone on the bus, attending a day centre alone, going for walks in the centre of town with a friend, participating in two swimming clubs and having a longstanding and close relationship with a girlfriend, with whom he had a sexual relationship. His girlfriend became pregnant and gave birth to a child.

This prompted a decision that DE lacked capacity to consent to a sexual relationship with his girlfriend, and from there a safeguarding intervention and protective measures to prevent it happening again. The protective measures included stopping DE and his girlfriend being alone together and preventing them visiting each other's homes. The measures led eventually to the end of their relationship. They also led to DE being supervised at all times and eventually he lost confidence. The Court of Protection summed it up: 'DE's life was turned upside down'.

The impact of the protection plan on DE was summarised by the Court as experiencing:

- the loss of engaging with the community without supervision/staff support
- the loss of being able to walk through town from one venue to another with a friend
- the loss of the ability to go alone to shops, make purchases and interact with traders and passers-by
- the loss of the use of the local gym and facilities on the same terms as any other participant
- the loss of privacy, the loss of a long-term relationship and the loss of liberty.

The order allowing the sterilisation was made because it would mean that he would be able to see his girlfriend and resume his sexual relationship with her, without the risk of another child that neither of them wanted being born. DE and his girlfriend therefore began their relationship again, and DE regained much of his former liberty to engage with the community, alone or with friends.

Consent: who gives it and when?

The duty to obtain consent

Where people have capacity the care and support plan can only be delivered with their consent. **Consent is critically important: it is the difference between care that is lawful and care that is not.** To enable a person to give their informed consent they need to:

- have been given all of the relevant information about their care, treatment or support
- understand the different options available and the possible consequences of each
- be free from any duress and understand that they have the right to refuse
- be able to weigh up the options and use this information to make a decision and communicate this.

Consent may be communicated in a number of ways – for example, verbally, or by blinking, by squeezing a person’s hand. It may also be implied through actions – for example, a person holding their arms up so that they can be undressed, reaching out their hand to accept their medication or opening their mouth to accept food.

If a person with capacity to understand a proposed plan of care refuses to give their consent, their decision must be respected. Without consent, a care provider could be committing a civil offence such as trespass to the person or their property, or even a criminal offence such as assault. If there is reason to believe that a person may lack capacity to consent to their care and support plan, there should always be an assessment of their capacity and if necessary a best-interests decision. Where there is no evidence that a person lacks capacity, then even if what they want may put them at risk, our legal duty is to protect their right to autonomy.

Legal protection for care staff

The MCA gives protection from civil and criminal liability to staff who follow the five principles of the MCA (Sections 5.1 and 5.2) when providing care, treatment or support. However, protection from liability only applies where the person and their family/carer have been listened to and where risk-adverse practices are challenged.

What to look for in the care and support plan and other records

- Evidence of the person’s consent to their care and support
- Evidence of why the person lacked capacity to consent
- Why the person refused to give consent.

Who can give consent to the care and support plan when a person lacks capacity to do so?

Health and social care professionals sometimes make the mistake of asking the next of kin or a relative to give consent to care and treatment when the person lacks capacity to do so for themselves. Families can never give consent to the care and treatment of a relative without statutory authority to do so.

It is important to distinguish between seeking the views of people who know the person well to inform care planning, and actual consent. Families may, and usually should, be consulted about the proposed care and support, and their views taken into account, but **this is not the same as consent**. They do not have automatic legal authority to provide permission for the proposed care or treatment. Only people who have a lasting power of attorney (LPA), or have been appointed by the Court of Protection as a deputy, have legal authority to give consent on behalf of a person who lacks capacity to do so. It should be noted that attorneys and deputies are also legally required to act in a person's best interests and in line with the principles of the MCA. Their legal authority may be revoked if they fail to do this.

What to look for in the care and support plan

- Information about who has legal authority to make decisions about the person on their behalf.

Lasting power of attorney

Creating a lasting power of attorney enables people over 18, who have capacity, to give authority to others to make decisions on their behalf. The lasting power of attorney must be on the prescribed form set out in the regulations, and must be registered with the Office of the Public Guardian (OPG) before it can be used.

Under the MCA, there are two types of attorney (refer to the Code, Chapter 7 for a full explanation):

- property and affairs; and/or
- personal welfare.

A person may give power of attorney to more than one named person for either property and affairs and/or personal welfare. An attorney for property and affairs may be registered to make decisions at any time, whereas a personal welfare attorney can only make decisions on behalf of a person when that person lacks capacity to do so.

As part of care and support planning it is important to know whether the person using services has created a power of attorney. Care providers must record details of anyone who has power of attorney in the care and support plan, together with any attached conditions. It is a good idea for the manager to see a copy of the order so that they are clear about the scope of the attorney's decision-making powers. For example, a personal welfare lasting power of attorney may state that: 'My son, Mr Mariani, can make decisions about my welfare, but this does not include decisions about medical treatment or whom I may have contact with'.

If the person lacks capacity to make a specific decision and their attorney has been given authority to do so, the decision of the attorney will be as valid as if the person had made the decision themselves. This means that where a person lacks capacity and they have an attorney for personal welfare, the attorney must be involved in designing the care and support plan and must give their consent on behalf of the person.

Service providers have an important role in supporting people who have capacity to donate (give) a lasting power of attorney. This provides an opportunity to appoint a trusted person to make decisions on their behalf should they lack capacity to do so in the future.

What to look for in the care and support plan

- Information about attorneys and the extent of their decision-making powers.
- If a person lacks capacity to make decisions about their care and support plan or financial matters, evidence that registered personal welfare or financial affairs attorneys are involved.
- People with capacity are supported to create a lasting power of attorney if they wish to.

Enduring power of attorney

Under the Enduring Powers of Attorney Act 1985 a person could appoint an enduring power of attorney (EPA) to handle their property and financial affairs, this could continue after that person lost capacity to make these decisions for themselves. From 2007, the MCA replaced EPAs with the two forms of LPAs (personal welfare and property and affairs). Existing EPAs that are registered and valid can still be used. Details should be noted in the care and support plan.

What to look for in the care and support plan

- Information about those holding enduring power of attorney and the extent of their decision-making powers.
- If a person lacks capacity to make decisions about their property or financial affairs, that the attorney is involved if they have appointed one.

Court-appointed deputies

In some instances a person may have a court-appointed deputy to make decisions on their behalf (refer to the Code, Chapter 8 for a full explanation). This may occur where a person lacks capacity, does not have an attorney, and requires ongoing health and welfare decisions which the court considers require a deputy. Often the deputy may be a relative of the person.

What to look for in the care and support plan

- Details of any court-appointed deputies and the extent of their decision-making powers.
- Where appropriate how they have been involved in developing the care and support plan.

Advance decisions to refuse treatment

Advance decisions to refuse treatment (ADRTs) (refer to the Code, Chapter 9 for a full explanation) provide another way that a person can plan for a future time when they may lack capacity to make decisions. As part of the care and support planning process, care providers need to find out whether the person has made an advance decision to refuse any particular type of medical treatment. It is essential that this is recorded in the care and support plan. Information can then be shared with health professionals when necessary so that the person's choices are respected. In most cases, a valid advance decision that is applicable to the situation cannot be overridden.

To maximise a person's involvement in their medical treatment, they may need support to make an advance decision. It is especially important for a person who has fluctuating capacity to record their views about any clinical intervention while they have capacity to do so.

What to look for in the care and support plan and other records

- Details of any advance decisions to refuse specific medical treatment and the circumstances in which these apply.
- Evidence that the advance decisions have been regularly reviewed.

Statements of preferences and wishes

Care and support plans should include statements that the person may make regarding their preferences or wishes. These do not carry the same legal weight as an advance decision to refuse treatment, but they do provide critical information for decision-makers about what is important to the person. These statements must be taken into account when determining what is in the person's best interests.

What to look for in the care and support plan and other records

- Statements of preferences and wishes and how these have been taken into account when making best-interests decisions.
- A detailed explanation of any incidents of a statement of wishes being over-riden, with a clear justification of why that was thought to be in the person's best interests,

Assessing capacity to consent

Capacity assessments are important

Capacity enables people to make their own decisions about their care and support. Assessing capacity in the right way at the right time is vital in care planning. Determining whether or not someone has capacity to make a decision has significant consequences. A person assessed as lacking capacity may be denied their rights. Conversely, a person who lacks capacity to make specific decisions could be put at significant risk if they are making decisions that they do not really understand. Capacity assessments should not only take place because a person is resisting care and support.

Evidence that a person may lack capacity to consent to their care and support should always lead to an assessment.

People's capacity may change over time, and this needs to be taken into account when creating and reviewing a care plan. For example:

- delaying a decision may provide an opportunity for a person to acquire new skills so that they can make their own decision (as in the case of DE above)
- a person may have fluctuating capacity – for example, someone with dementia
- a person may regain capacity – for example, someone recovering from a brain injury or an infection.

Who carries out a capacity assessment and how?

A capacity assessment can be thought of as a supported decision-making process. The assessor needs to build a rapport with the person so they can give them the support they need to make their own decisions about their care plan.

The person responsible for carrying out the capacity assessment is usually the 'person who is directly concerned with the individual at the time of the decision' (the Code, Chapter 4.38). Depending on the type of decision, this could be the local authority or the care provider. It is often the case that capacity assessments are a collaborative process between the person, their family, the local authority, the provider and health care practitioners.

The local authority may carry out an assessment of a person's capacity to consent to their care plan as part of a care and support needs assessment. The provider can use this to inform its own care planning about how care and support will be given on a day-to-day basis. The provider may also need to carry out its own capacity assessment to see if the person is able to understand and make decisions about particular aspects of how their care is given.

Capacity assessments for everyday care planning do not usually require a set of skills separate from those widely used in existing practice. However, there may be some cases where people have conditions or circumstances that make it particularly difficult to assess their capacity to make a decision. For example, some people with a brain injury may retain a lot of their previous abilities, but find it difficult to use and weigh information due to a strong tendency to make impulsive choices. In such cases, specialist expertise will be needed to carry out the assessment. Most times, however, the assessment of capacity forms part of routine support and decision-making. The key point is not to judge a person's capacity to make decisions about their care and support solely on the basis of their age, appearance, behaviour or other condition (such as an illness, disability or intoxication).

A person may have varying levels of capacity in relation to the different areas of their care and support. They may, for example, be able to make decisions about their personal care, but not about their medication. An assessment of capacity therefore needs to be made for each aspect of their care and support using the MCA framework. This uses a two-stage functional test for assessing capacity:

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works?
- If so, does that impairment or disturbance mean that the person is **unable to make the decision in question at the time it needs to be made?**

It is not necessary to have a formal diagnosis of the condition causing the impairment, but there does need to be evidence. The person carrying out the assessment must have a reasonable belief that the person either has, or lacks, capacity. This means that they do not need to be 100 per cent certain, but must believe that it is more likely than not. If there is a disagreement about the outcome of the assessment, either with the person or their family, this should be discussed with the person and, where appropriate, their family. If no agreement can be reached, it may be necessary for the local authority to refer the matter to the Court of Protection.

The law says that, to have capacity to make a certain decision, a person must be able to carry out **all** of the following four steps:

- **understand** the information relating to the decision
- **retain** the information for long enough
- **use and weigh it** to reach a decision
- **communicate** that decision, by any means that is understood.

If the assessment concludes that even with support the person lacks capacity, this should be recorded in the care and support plan.

The care plan is likely to be drawn up by a senior manager in the care home or domiciliary care agency. The care worker needs to be familiar with each person's care and support plan so that they can deliver care in the agreed manner. The care worker will also need to explain to the person what they are doing each time they provide care and support, and check that the person is comfortable with this. This will not necessarily be recorded in each care plan – however, staff should understand that this is how they should routinely give care and support.

What to look for in the care and support plan and other records

- Either consent to each aspect of the care and support plan or an assessment of capacity stating that the person lacks capacity in relation to specific aspects of the care and support plan.
- Evidence of an impairment or disturbance in the mind or brain and how this affects the person's ability to make a decision about their care and support.
- Diagnosis and prognosis where these are available.
- A capacity assessment that follows the MCA framework and principles and provides evidence of whether the person is able to:
 - Understand the information relating to the decision – what decision they need to make, why they need to make it, the likely consequences of making, or not making, this decision
 - Retain the information for long enough; not forever, or for a set period, just long enough to use
 - Weigh the information in order to reach a decision. (Is there a need for a more thorough assessment perhaps involving a doctor or other professional expert?)
 - Communicate that decision, by any means that is understood, such as sign language, use of a language board, hand gestures and/or facial expressions. (Would the services of a professional such as a speech and language therapist be helpful?)
- The evidence in the capacity assessment fits with the conclusion.
- The person has been given support, including specialist support where necessary, to help them make their own decision.
- Where appropriate, the person's family has been involved.
- Evidence that the timing of the assessment took account of whether the person might have more capacity at another time.
- If there was a disagreement over the assessment, what efforts were made to reach an agreement, whether the local authority was informed, and whether a referral was made to the Court of Protection if appropriate.

Demonstrating best-interests decision-making

When a person has been assessed as lacking capacity to make a decision, then that decision needs to be made in the person's best interests. There are two exceptions to this: situations involving research and where there is a valid and applicable advance decision to refuse a particular medical treatment. For example, the person may have made an advance decision to refuse antibiotics in the event that they suffer from a chest infection.

Creating a care and support plan that is in a person's best interests requires a collaborative approach with other significant people. Even though a person has been assessed as lacking capacity to decide about their care and support, they should still be involved in the best-interests decision-making process as much as possible. Any

knowledge about their beliefs and values should be taken into account. The decision-maker needs to consider what the person might have wanted if they had been able to make the decision for themselves, and case law increasingly emphasises the importance of factoring in what is known about a person's wishes. While the decision may not always be able to reflect what the person would have wanted, the impact of not carrying out their wishes may have serious consequences for their wellbeing and so must be carefully considered.

The Code provides a detailed checklist for deciding what would be in the person's best interests (Chapter 5). A balance sheet approach to weighing up different options is helpful for more significant decisions – i.e. listing the certain or potential benefits and drawbacks of each option and the likelihood that these will occur.

What to look for in the care and support plan and other records

This list has been adapted from the Thirty Nine Essex Chambers checklists [17] for best interests assessments, care planning and transition planning, together with the MCA Code.

- How any decisions made on behalf of a person who lacks capacity are made in their best interests.
- A summary of the person's care and support needs.
- The person's wishes past or present (obtained from the person, an advance statement or others such as family members or paid carers).
- How the person was supported to understand the nature of the decision and the options available.
- How the person was supported to express their views.
- Other factors that the person would be likely to consider if they were making the decision for themselves.
- Who else was consulted (e.g. family, close relatives, anyone previously named by the person as someone to be consulted, or other people involved in the person's welfare), and their views.
- A record of any family members who were not consulted and why.
- The options for care and support that were considered. This includes the option of doing nothing and options suggested by family members, even though these may have been discounted.
- The risks and benefits of each option.
- The likelihood of each risk occurring and the seriousness of impact if they did occur.
- The care and support that is being proposed and why this option was decided upon as being in the person's best interests.

Promoting least restrictive care

Any intervention without a person's consent must consider whether there are options that would meet a person's need in a **less restrictive** way. For instance, if changes can be made to a care plan that means cot sides on a person's bed are not needed, or that medication does not have to be administered covertly, these should be explored.

What to look for in the care and support plan and other records

- Consideration of whether there is another option that is less restrictive and will meet the need.
- If this option was not chosen, the reason why.
- How and when the care and support plan will be reviewed to see if a less restrictive option can be applied in the future.

Care planning and the use of restraint

The MCA (Section 6.4) defines restraint as:

- using force – or threatening to use force – to make someone do something that they are resisting, or
- restricting a person's freedom of movement, whether they are resisting or not.

Good care planning can often avoid the need for restraint or restrictions on a person's movements. It can challenge institutional practices which may normalise restrictive interventions.

In some cases, a person may have capacity to consent to the use of restraint (e.g. the use of a lap belt to stop someone falling out of a wheelchair). If the person lacks capacity to consent, then the restraint can only be used lawfully to prevent harm to the person. In these cases, the amount or type of restraint and the time it lasts must be proportionate to the likelihood and seriousness of harm. Staff who use restraint without meeting these conditions are acting unlawfully.

What to look for in the care and support plan and other records

- How the person was assessed as lacking capacity to decide upon the use of the restriction or the restraint.
- Identification of the harm that needed to be prevented.
- Options that were considered.
- Consideration of whether there was another option that was less restrictive and would meet the need.
- If this option was not chosen, the reason why.
- How the restriction or restraint was in the person's best interests.
- Evidence that the restraint used was proportionate to the likelihood and seriousness of harm.

- How and when the care and support plan will be reviewed to see if a less restrictive option can be applied in the future.

Depriving a person of their liberty: additional safeguards

The Code of Practice on deprivation of liberty (the Deprivation of Liberty Safeguards) provides additional measures to protect people's human rights if the care and support plan so restricts their freedom that it amounts to a deprivation of liberty, either in a care home or in a hospital. These safeguards do not apply to people who are detained under the Mental Health Act (MHA) 1983 or people who receive care in their own homes.

The MCA Deprivation of Liberty Safeguards were introduced to make sure that a person may only be deprived of their liberty when:

- there is evidence that they lack the capacity to make decisions about the restrictions or restraint that are being applied or planned; and
- the restriction on their liberty is necessary to prevent harm and is proportionate to the likelihood and seriousness of any harm to the person; and
- it is in their best interests and the least restrictive option to meet the need; and
- the deprivation of liberty has been authorised by the local authority as the supervisory body (except in urgent circumstances where the managing authority – the care home – may give the authorisation for a maximum of seven days. In these cases the managing authority must submit an urgent *and* standard application for authorisation to the supervisory body).

The safeguards give legal protection to the relevant person (i.e. the person who may be deprived of their liberty). This includes the right to:

- an independent representative to act on their behalf
- the support of an independent mental capacity advocate (IMCA)
- have their deprivation of liberty reviewed and monitored on a regular basis
- challenge their deprivation of liberty in the Court of Protection.

A care home or a hospital (managing authority) will need to apply to the supervisory body for an authorisation to deprive a person of their liberty when:

- a person needs to remain in a care home in order to receive necessary care or treatment to prevent harm occurring
- there are reasons to believe that the person may be deprived of their liberty in the next 28 days or is being deprived of their liberty.

The guidance from case law shows that determining when restrictions amount to a deprivation of liberty is often a complex issue and that many factors need to be taken into account.

In a March 2014 Supreme Court judgement, Lady Hale said that it was axiomatic that people with disabilities, both mental and physical, had the same human rights as the rest of the human race. She emphasised that 'the right to physical liberty contained in

Article 5 of the European Convention on Human Rights, must be the same for everyone, whether or not they have physical or mental disabilities'. [18]

Lady Hale went on to state that the 'acid test' for determining whether or not a care and support plan creates a deprivation of liberty is whether it provides 'continuous supervision and control', and whether the person 'is not free to leave' the placement irrespective of any desire to do so. Support can be offered rather than control; choices can be explained to the person instead of decisions being made by staff and managers. For example, people can be supported to manage their money, choose their leisure pursuits and engage with wider society.

The purpose of this report is not to explore how to recognise a deprivation of liberty nor to explain the process of seeking authorisation. Providers of care services and commissioners need to refer to other sources to make sure that they understand when the safeguards may apply and the steps they need to take. The Deprivation of Liberty Safeguards offer guidance on how to identify when a person is, or is at risk of, being deprived of their liberty, how deprivation of liberty may be avoided, and the process for protecting people who are deprived of their liberty.

The important point to note here is that **people who have been deprived of their liberty are among the most vulnerable, and therefore care planning must demonstrate how their rights are being protected**. There must be a continuous process of review to make sure that the deprivation of liberty is still necessary and that there are no other less restrictive interventions that could meet the need.

What to look for in the care and support plan

- How a person's liberty is being promoted. This might be anything from going out to the local pub occasionally, to eating their preferred foods or shopping for their own clothes.
- Attempts to take account of the person's wishes and views as far as possible.
- How the relevant person and their representative are being assisted to be involved in their care and support.
- How the person is supported to maintain contact with family and friends.
- That conditions attached to the authorisation are being complied with.
- That there are arrangements for regular review of the care and support in order to give the person more liberty and choice and see if the authorisation is still needed.

Monitoring MCA implementation

This section sets out the role of providers and commissioners in monitoring and assessing quality. It offers a set of standards against which evidence gathered about care planning can be measured.

Example quality standards and prompts

A set of standards is produced below for monitoring officers to use with either domiciliary care agencies or care homes. Providers may also wish to use these as part of their own quality management processes. Beneath each standard is a list of the types of evidence that would demonstrate whether or not that standard is being achieved. These prompts are not designed to be used as a tick-box set of criteria. They represent suggested areas for enquiry, and the monitoring officer or provider may choose to use them to build their own tools.

Person-centred care and support

Quality standard: care and support plans promote people's liberty – the freedom to make decisions about their care and support.

People's choices are recorded including:

- the person's preferred style of address
- what the person would like to achieve from their care and support, their goals and aspirations for the future
- what is important to the person about their lifestyle, what they enjoy, dislike, etc.
- any other specific lifestyle choices that may affect the way their care and support are provided – for example, sexual orientation, spiritual rituals, special diets, etc.
- historical and social information to help staff get to know the person better, such as their family circumstances, social situation, significant events past and present, key achievements
- any statement of wishes or future preferences for their care and support should they lose capacity to express these (including end of life wishes)
- any advance decision to refuse treatment.

Involvement

Quality standard: people and their chosen representatives are supported to be involved in their care planning and to make decisions about their care and support.

How people are supported to be involved in their care and support planning is recorded, including:

- how to communicate well, whether the person has any special communication needs, and how these can be understood and met

- information about who is important to the person and the level of their involvement – for example, family member or a friend who helps with shopping.
- details of any attorneys (lasting or enduring)
- anyone else the person wants to be involved in decisions about their care and support and the information that can be shared with each named person
- how the person and their chosen representative are involved
- the person's informed consent to their care and support plan or, where they lack capacity to do so, and they have a personal welfare attorney or court-appointed deputy, that person's consent.

Assessment of mental capacity

Quality standard: there is a clearly recorded assessment of capacity with supporting evidence for people who lack capacity to consent to their care and support plan.

The evidence includes:

- the decision to be made
- how the person was assisted to understand the decision about their care and support
- the impairment or disturbance in the functioning of the mind or brain
- how this affects the person's capacity to make the decision about their care and support (see [Assessing capacity to consent](#) for details about what evidence is required in the capacity assessment)
- whether the decision can be delayed
- a reasonable belief (i.e. more likely than not) that the person lacks capacity to make a decision about this specific aspect of their care and support plan
- a referral to the commissioning body if there is a dispute about the capacity assessment.

Best-interests decision-making process

Quality standard: care planning documents demonstrate that any act performed for, or any decisions made on behalf of, people who lack capacity is performed, or made, in their best interests.

Documents should show:

- that it has been checked whether there is an LPA or a valid ADRT
- how the decision was in the person's best interests
- the person's health, care and support needs
- if the decision is about medical treatment, whether the person made an advance decision to refuse this treatment while they had capacity to do so
- how the person and their family were encouraged to be involved

- what attempts were made to find out about the person's past and present wishes and feelings (e.g. any relevant religious, cultural or moral beliefs and values)
- who was consulted
- options considered and risk assessment of each option
- reason for choosing a particular option and whether there were other less restrictive options that were discounted, and why
- if restraint is included in the plan, evidence that this is necessary to prevent harm to the person, that the amount and type is proportionate to the likelihood and seriousness of harm, and that there is the minimum amount of force for the shortest time possible
- how the best-interests decision was shared with the person and their significant others where appropriate.

Reviews

Quality standard: care and support plans are regularly reviewed to make sure that they continue to meet people's changing needs and choices.

Reviews should ensure that:

- the person is involved in the review of their care and support plan as far as they are able
- the person receives the necessary support to take part in the review and their wishes are taken into account in future planning
- the person's chosen representatives are involved in the review
- changes to the person's capacity and best-interests decision are considered
- any less restrictive options to meet the need have been considered.

Deprivation of Liberty Safeguards

Quality standard: people who are deprived of their liberty have their rights protected.

The following questions should be asked:

- Has the care home or hospital taken all practical steps to avoid depriving the person of their liberty? Is there a less restrictive option that will meet the person's needs?
- Has the deprivation been authorised by the supervisory body?
- If not, has the care home or hospital requested authorisation?
- Have they notified the Care Quality Commission that they have requested an authorisation and the outcome?
- Is information about the relevant person's representative recorded in the care and support plan?

- Does the care and support plan take account of any conditions attached to the authorisation?
- Does the care and support plan clearly record the purpose of the restrictions, how they are to be used, by whom and when?
- Do the care and support plan or case notes describe the steps that the care home has taken to help the relevant person understand the effects of the authorisation and their rights?
- Does the care and support plan include a mechanism for keeping the measures under regular review and who will be involved?
- Does the care and support plan clearly state when the Deprivation of Liberty Safeguards authorisation will expire and a review date to assess whether a further application will need to be made?
- If the request for authorisation to deprive the person of their liberty was refused, does the care and support plan take account of the best-interests' assessor's recommendations?

A monitoring checklist

This checklist will help commissioners and contract monitoring staff to easily identify if services are developing Mental Capacity Act compliant care and support plans. Staff might consider incorporating elements of the checklist into their own monitoring forms.

Consent

- Evidence of the person's informed consent to their care and support.
- Evidence of why the person was assessed as lacking the capacity to consent.

Communication and control

- A description of any special communication needs.
- Where the person has limited communication ability, other non-verbal communication methods that the person may use.
- How the person is supported to understand and be involved in decisions about their care and support. This includes the nature of the decision, the options available and the consequences of each decision.
- Information about what is important to that person, their wishes and preferences.
- What the person would like to achieve from their care and support.
- A person's social history, including any key events or achievements.
- If the person appears to lack capacity to make a specific decision for themselves at the time it needs to be made, an assessment of capacity should be made in relation to that particular decision.
- How the person's liberty and choices about their care and support are promoted.
- Information about the person's views.
- How the person was supported to be involved in the decision about their care and support. This includes keeping them informed about any decisions made about them.

Decisions

- Information against each element of the 'best interests' checklist (see the section in this report on **Demonstrating best-interests decision-making**).
- Details of the options that were considered together with the associated risks and benefits of each.
- A clear explanation of why a particular option was decided upon.
- If restrictions are imposed, when these will be reviewed and how.

Involvement

- The person or their family/friends are able to tell you how they were involved in developing the care and support plan and that they felt (and feel) listened to.
- The person and their chosen representative are aware of the care and support plan and have seen a copy.
- The care and support plan clearly explains how care and support will be delivered.

Person-centred planning

- What the person would like to achieve with their care and support, their goals and aspirations for the future.
- What is important to the person about how they live their lives now. For example, what they enjoy doing, their interests, likes and dislikes, who is important to them, who they like to see, where they like to go, their preferred routines (such as when they like to get up and go to bed, whether they like a bath or a shower).
- Details of key life events and dates to assist with chronological orientation.
- How best to support and involve the person in decision-making.
- Essential information for continuity of care and for use in emergencies.
- Roles and responsibilities so that the person receives coordinated care support to meet their needs.
- Where a person lacks capacity to express their choices, how their families and others who are interested in their welfare have been consulted.
- What outcome the person wants and any other options considered.
- The associated benefits and risks of each option.

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The Mental Capacity Act (MCA) and care planning

A human being is a human being. Behaviours may be erratic, chaotic or self-sabotaging, but people still retain their human rights [1]

The MCA protects people's basic human right to live the lives that they choose as far as they are able. Integrating the principles of the MCA into care planning and practice can transform the experience of adults with care and support needs.

This report is not intended as a guide to care planning, commissioning or the MCA. What it does offer is a starting point for both commissioners and providers to understand and demonstrate how care and support plans can comply with the principles of the MCA. The report will also be of interest to people who use care services, their families or other caregivers.

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