



English  
Community Care  
Association

# **The Mental Capacity Act 2005**

**What you need to do to ensure compliance**

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# The Mental Capacity Act 2005

## 1. Introduction

This document is designed to help Care Homes understand the new Mental Capacity Act 2005 (MCA or Act) and their consequent new responsibilities. It also contains advice on documentation you will need to put into place to ensure that you can manage various aspects of the Act. Some of the advice will already be considered good practice in homes and may already be in place. In other cases, you may wish to incorporate the advice into your existing documentation. Please remember the advice is to help you comply with the Act and as an individual home you may wish to develop your own approach.

*Warning: This document contains generic advice only. No legal liability is accepted by ECCA. In any specific case you should always obtain legal advice from an appropriately qualified person.*

## 2. Outline of the Act

*Note: We recommend that you obtain the booklets, six in all, about the Mental Capacity Act, each pre-fixed "Making decision" available online at [www.dca.gov.uk/legal-policy/mental-capacity/publications.htm](http://www.dca.gov.uk/legal-policy/mental-capacity/publications.htm) and the Code of Practice.*

The Act came fully into force in England and Wales on 1<sup>st</sup> October 2007. Its implementation was phased with part of the act coming into force in April 2007.

The Act will help people to make their own decisions and protect those who lack the capacity.

The new law will affect everyone aged 16 years and older who is unable to make some or all decisions whatever those decisions may be about.

The lack of ability to make a decision could be because of:-

- a learning disability
- mental health problems
- brain injury
- dementia
- alcohol or drug use and/or misuse
- side effects of medical treatment or any other illness or disability
- Alternatively, it may be because at the time the decision needs to be made, they are unconscious or barely conscious whether due to an accident or being under anaesthetic.

This is important because in determining capacity :-

- You must start from the assumption that a service user can make his or her own decisions and the help and support to enable them to do so
- If a resident, with capacity, makes a decision that you think is unwise this has to be accepted
- If you feel that a resident lacks capacity you need to test the resident's capacity to make decisions and record the evidence
- You cannot assume that individuals do not have capacity just because they have a particular diagnosis or because of their age or how they look or because they have

- a particular disability. They may be able to make some decisions but not others
- If a decision is to be made for an individual, who lacks capacity, it must be made in the individual's best interests.

*Note: The issue of mental capacity is "decision specific"; you must not assess a person's capacity and conclude that the person can or cannot make all decisions. Each decision will need to be separately considered.*

The Act also introduces new processes:

- A new Lasting Power of Attorney
- A new role of Deputy
- A new Court of Protection
- A new Office of the Public Guardian
- A new criminal offence
- A new Independent Mental Capacity Advocate service
- New rules on research

These processes are detailed in appendix 1.

The Lord Chancellor in April 2007 issued a Code of Practice to support the Act. This is available on the Public Guardianship Office site [http://www.publicguardian.gov.uk/docs/Code\\_of\\_Practice\\_OPG.pdf](http://www.publicguardian.gov.uk/docs/Code_of_Practice_OPG.pdf). This guidance draws on the Code of Practice but it is important that **all staff who work with residents have access and training on this Code of Practice**. Whilst the first five chapters of the Code of Practice deal with the day to day decision making required in many care homes, the new processes of the Act and related issues are dealt with in detail in the subsequent chapters. Chapter 15 deals with situations when there are disagreements and disputes about issues covered in the Act.

This document has been developed to help care homes implement the Act in their organisations. It is not intended to replace the Code of Practice and any points of detailed interpretation should be referred to a legal professional if a careful reading of the Act and the Code of Practice does not provide the answer.

The Code of Practice contains many practical examples and we have therefore deliberately not included examples in this document.

### 3. Working With The Act

In practice residents need to either make decisions or have decisions made for them numerous times every day. These might be quite regular and ordinary decisions such as what clothes to wear or they might be more complex decisions about, for example, their health care. The process for making decisions is outlined in the diagram (Fig 1).

The important points are that the staff working with residents should:-

- Be able to assess if someone has the capacity to make a particular decision
- Be able to help residents make their own decisions where they need help and support to do so
- Know what to do if someone cannot make decisions and they are required to act in their best interests

## **How to Help Someone in Their Decision Making.**

All residents are different and the skill of staff is paramount to helping someone make a decision.

The MCA Code of Practice (Chapter 3) details how residents should be supported in their decision-making and details the skills required by staff to help residents in the process. It requires staff to:

- Provide the relevant information including all potential choices
- Communicate in an appropriate way - this may require unconventional communication processes
- Make the person at ease and give them time to consider the information provided and to reach the decision
- Support them in their decision

All staff that care for residents should be trained in this process.

## **How to Assess if Someone Has the Capacity to Make a Decision**

If it is thought that someone may not be able to make a decision the emphasis is on you to demonstrate, on the balance of probabilities, that the resident cannot make the particular decision.

The minimum required is a 2 point test:

- Does the resident have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.)
- If so, does that impairment or disturbance mean that the resident is unable to make the decision in question at the time it needs to be made?

The outcomes of the testing should be recorded in the resident's record and/or care plans. Such testing is key to the implementation of the act and all your staff working with residents should be conversant with the varying techniques for testing decision making. These are detailed in the Code of Practice Chapter 4.

You are required to show that the resident was given the information to make the decision and that either they did not understand the consequences of not making the decision or they were not able to weigh up the information or they could not communicate their decision.

*Note: If a resident is sometimes better able to make decisions at certain times rather than other times try to ensure that is when he/she is generally asked to make decision.*

*Note: If a resident is not able to make a decision consider whether the decision can be delayed and made at a later date.*

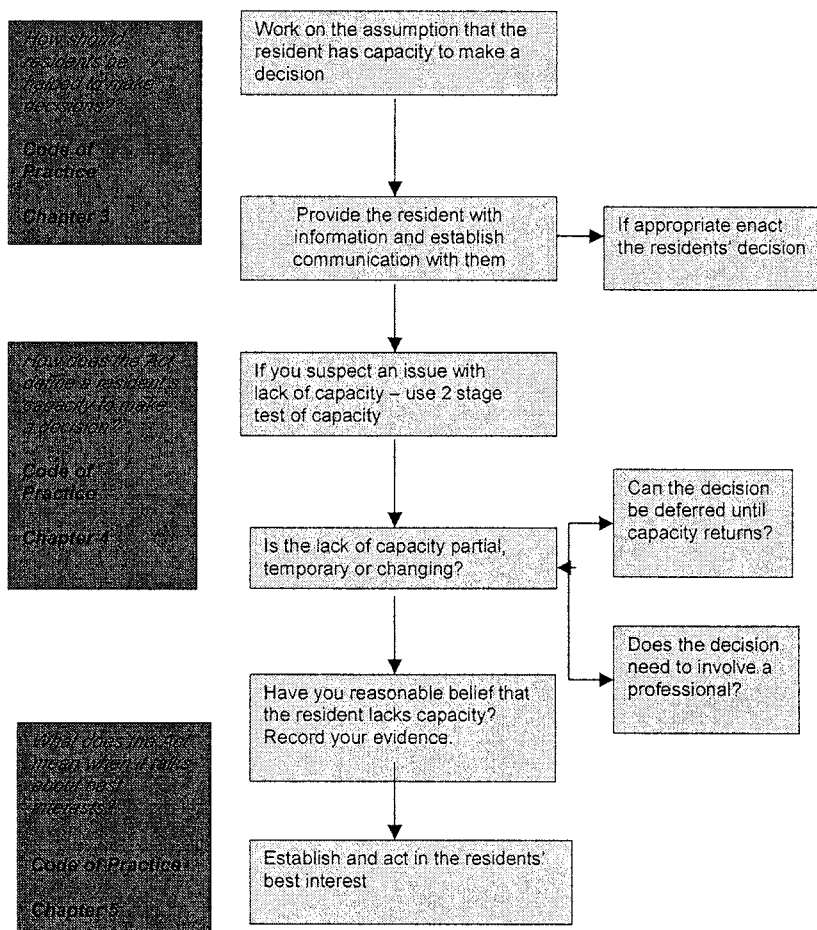
## How to Act in Someone's Best Interests

The Act is very specific about this – if you are making a decision on behalf of a resident who lacks capacity you must act in that resident's best interests, the only exception being if there is an advance decision indicating otherwise.<sup>1</sup>

As long as the decision is taken in the best interests of the resident who lacks capacity to make the decision for themselves, or to consent to acts concerned with their care or treatment, then the decision-maker will be protected from legal liability. This means you have to be able to demonstrate that you have acted in the resident's best interests.

The first step is to establish that you have been through the process to establish capacity (Figure 1).

Figure 1 Making Decisions with Residents



This flow chart is a distillation of the process detailed in the Code of Practice as indicated in the red boxes. For points of details refer to the Code of Practice.

<sup>1</sup> An advance decision made when somebody has capacity to refuse treatment will if valid and applicable mean that treatment cannot be given to that person at a time when they lack capacity. An advance decision can not be made by a person aged under 18 years. Advance decisions to refuse life sustaining treatment have to be in writing and witnessed.

If you have evidence that the resident lacks capacity then you need to establish what is in the resident's best interests. The following checklist can be used to help establish the best interests.

1. Is there other relevant information to be taken into account? In particular the resident's past behaviour and habits should be taken into consideration when making small day to day decisions
2. Have the resident's wishes, feelings, values and beliefs been considered?
3. Have the views of the resident's family members, parents, carers and other people interested in the resident's welfare been considered, if this is practical and appropriate? Family members with Lasting Power of Attorney or Court appointed Deputies must be consulted on any significant decision and may have the authority to make the decision on behalf of the resident
4. Have you been influenced in the decision by the resident's appearance, age, medical condition, or behaviour? If so, reconsider the decision and eliminate this influence.
5. Is anyone involved in the decision being motivated by a desire to bring about the resident's death or are they making assumptions about the resident's quality of life if decisions are about life sustaining treatment?

Checklist items 1 and 2 above can be supported by the gathering of good information about the resident on admission. Good recording of this information will help to ensure continuity of support for the resident's decisions and it will be useful evidence when you are challenged. An outline admission data document can be found in Appendix 2.

Checklist item 3 (*whether the views of the resident's family members, parents, carers and other people interested in the resident's welfare have been considered, if this is practical and appropriate*) means that communication between the home and residents' families is critical. It is recommended that a "Shared Decision Record" is put into place where the home can record decisions made by residents and families and carers who visit can record their observations. It should be emphasised that such a document is to support the normal channels of oral communication which should still be maintained and enhanced where possible. The nature of the decision recorded will be dependent on the relationship that develops between the home and the resident and their families/friends. It is recommended that all decisions on health care and significant events are recorded in this log. Such a log could become critical if you are challenged under the Act. An outline "Shared Decision Record" can be found in Appendix 3.

If there are carers or family members with a Lasting Power of Attorney (or Court appointed deputies) you will need to establish and argue processes for making decisions about the resident prior to admission. It is proposed that this process should be recorded and an admission document for such residents can be found in Appendix 4.

If there is disagreement about significant decisions being made on behalf of a resident then the new Court of Protection, that commenced its work on 1<sup>st</sup> October 2007, will be available to resolve such difficulties. It expects that other channels will have been used to resolve disputes prior to the court's involvement. (See chapter 15 Code of Practice)

It will be important for family members and carers to be aware of the Act and that care homes and their staff are obliged to comply with the Act. A brief example leaflet has been produced that should support you in any discussions with the resident's family. This is shown in Appendix 5.

Checklist item 4 (*whether any decisions have been based merely on the residents appearance, age, medical condition, or behaviour*) will need a degree of staff training but is self evident.

If you have any concerns about Checklist item 5 (*whether people are being motivated by a desire to bring about the resident's death or making assumptions about the resident's quality of life if decisions are being made about treatment that is needed to keep the resident alive*) we recommend that you contact the Office of the Public Guardian. That office has the responsibility to work with police and social services to look into such matters.

### **If You Still Feel Unable to Act in the Persons Best Interests**

If a resident has an important decision to make, a trained person should go through the check process and record the outcomes of their assessment.

If the decision could not be made by the individual you need to check:

1. Has the resident made a Lasting Power of Attorney (LPA), in which case you should contact the person (s) having power under the LPA
2. Have they an advance decision which might affect the decision in question?
3. Has the Court of Protection appointed a deputy in which case they should be contacted

In the event of none of these being in place you should contact the relatives and apply to the Court of Protection who may consider the best interests of the case. The Court may make the decision on that particular issue (a single order of the court) or may appoint a deputy to make the decision and future decisions.

In an emergency situation the Act requires life sustaining treatment or treatment to prevent serious deterioration of the resident's condition, whilst the Court is reaching its determination.

### **4. Next Steps**

#### **Training**

All your operational staff who have contact with residents will require training. You will therefore need to develop a **staff-training plan and commission the training required.**

Every member of staff employed will need basic awareness training. Some training may be available from your local council. Always check the intended training outcomes to be satisfied that the training will meet the needs of your staff.

It is advisable that all staff that care for residents are trained to a level where they can test a resident's ability to make decisions and they are familiar with the Code of Practice. The process is standard for all decisions but in practice there are 2 levels of decision making that may influence the training required:

- The decision making required on a day-to-day basis when you are caring for someone e.g. what clothes to wear, food to eat
- The decision making required on more fundamental issues which might lead to life changing events

You may wish to get your training provider to tailor your training according to your organisation's needs.

## **Documentation**

All homes are advised to **carry out a thorough review of their existing documentation** to ensure that it is fully compliant with the Act. At a minimum, you should consider:

- That all residents should have the basic data on their current life style collected. This provides the home with a solid benchmark should that individual lack capacity at any time to make decisions on their own behalf. An example is shown in Appendix 2
- All residents who have LPA's or deputies should have documents outlining the administration of those duties in the care home setting. An example of this is shown in Appendix 4
- All advance decisions to refuse treatment should be recorded in detail so that the home knows what to do in an emergency. Have a copy available too
- A shared decision record should be developed and policy as to when such documents are introduced. (Appendix 3).

## **Information for Families**

As a minimum, you should indicate to the families of your existing residents that there is a significant change in the legislation that affects the management of residents in your care. If this information is given to all future residents and their families it should support actions that you may be obliged to take to comply with the legislation. An example leaflet is shown in appendix 5

## **Contacts**

You will need to have available procedures for contacting The Office of the Public Guardian

## **Induction**

Not that the system is up and running you will have a responsibility for ensuring that all new staff are trained in the application of the Act. Your induction process consequently will need to be modified to ensure all new staff are trained.

## **5. Summary**

The Mental Capacity Act came fully into force on 1<sup>st</sup> October 2007. All homes are obliged to abide by the terms of the Act. Training of staff on decision-making is crucial to the application of the Act at resident level. Hopefully you will never be challenged. If you are, your documentation will be critical for your defence.

## Appendix 1

### *Lasting Power of Attorney (LPA)*

Replaces the enduring power of attorney. Allows for the appointment of people to make decisions for the resident. There can be more than one attorney. Those appointed as property and affairs attorneys must be over 18 and not bankrupt. They must act in the best interests of the resident lacking capacity. The new powers create two types of LPA. One for property and affairs and another for personal welfare matters including healthcare and medical treatment matters. They can be combined.

### *The Court of Protection*

This is a new court replacing the 'old' Court of Protection. The court has been set up to deal with any rulings under the Act, including whether a resident has capacity or not. The Court of Protection will be available to resolve disagreements about what is in the best interests of a resident. For example, if doctors advise one course and the family disagree then the court can be asked to make the decision. It can also appoint Deputies to make decisions for any resident who has not the capacity to decide.

### *The Office of the Public Guardian*

Applications for LPA's will come through this office, and attorneys will be monitored by this office, which will also supervise Deputies appointed by the Court of Protection. It will work with the police and social services if it thinks someone has been abused. The Office will function alongside the Court of Protection. It will provide administrative support to the Court of Protection

### *The Role of Deputy*

The Court of Protection can appoint deputies. A deputy will be able to make certain decisions for a person who is unable to make a decision. The court will be able to limit the powers of the deputy. The deputy must act in the best interests of the person lacking capacity.

### *Independent Mental Capacity Advocate (IMCA)*

The Act has set up a new service the IMCA. An IMCA will help residents who have no family or friends when they lack the capacity to make decisions in specified circumstances. They have been operational since April 2007 in England and commenced in Wales on 1<sup>st</sup> October 2007.

### *Criminal offence*

There has been a new criminal offence of "ill-treatment and / or willful neglect" in place since April 2007 to provide additional safeguards to those lacking capacity. A number of cases are currently within the criminal justice system.

### *New rules on research.*

There are new rules about carrying out research on people who do not have the capacity to consent to the research. Any research should follow certain rules. These rules will be scrutinised by a local Research Ethics Committee. Any research must be safe, appropriate and focused and must be stopped if the person indicates they are not happy to participate any further. Family and carers must agree to research being carried out. In certain circumstances where a client is unable to consent to research it may be carried out without their consent. This is not considered a major concern for care homes but if you are involved in research you should consider chapter 11 of the Code of Practice

**Appendix 2**

An example of a data gathering sheet to give a profile of a resident's preferences

**Information About the Resident**

*Diet*

Does the resident have any special dietary requirements?.....

Is there any particular food the resident dislikes?  
.....

Regular meal times for this home are ..... Does the resident prefer to eat outside these hours?

Does the resident drink alcohol? Never, Sometimes, Regularly.

Any general observations about the residents diet  
.....  
.....  
.....  
.....

*Dress*

Describe the style of dress the resident usually wears:-

Around Home  
.....

When going out to the shops  
.....

When going out on a special occasion  
.....

When going to bed  
.....

Any general observations about the resident's dress  
.....  
.....  
.....

*Grooming*

How often does the resident have their hair cut or styled?.

Does the resident wear makeup? yes/no - if yes describe the type and style  
.....  
.....

Does the resident have any professional help with their nails? – Hands? .....  
Feet?.....

Does the resident wear glasses? if so please give relevant details  
.....  
.....

*Hygiene*

Does the resident prefer to shower or  
bath?.....

Frequency with which they bath/shower  
.....

Males only -

Does the resident shave? - daily, 3 times a week, weekly, not at all

Does the resident shave with an electric razor or a wet  
razor?.....

*Health care*

Does the resident attend the dentist  
regularly?.....

Details of dental care  
.....  
.....  
.....

Who is the resident's regular  
doctor?.....

Does the resident have any preference to the gender of the doctor treating  
them?.....

Does the resident have a flu vaccination annually? if not why not?  
.....  
.....

Does the resident have any fears/phobias about their health  
care?.....  
.....

*Religion*

Does the resident have any predominant religious  
beliefs?.....

If so, have they regularly attended a place of worship?

Where? .....

Do they have pastoral visits from their place of worship?.....

Do they have any religious practices which the home needs to cater for?.....

Whilst in our care the XXX Care Home and any other person involved in your care (This includes family and friends) are obliged to comply with the terms of the Mental Capacity Act 2005.

Has a Power of Attorney been executed by [name of resident]? If so, please request a copy.

Has an Advance Decision been executed by [name of resident]? If so, request a copy.

This document should be signed if possible by the resident or by a person holding an LPA for the resident or a deputy appointed by the Court of Protection.

Signed ..... Print  
Name.....Date.....

This document must be signed by the person compiling this form on behalf of the XXX care home.

Signed ..... Print  
Name.....Date.....

## Appendix 3

### An Example of a Shared Decision Record

<i>Date</i>	<i>Decisions Recorded by Home Staff</i>	<i>Date</i>	<i>Decisions Recorded by Relatives/friends</i>
20 <sup>th</sup> February 2007	When Mr Smith was admitted he recorded that he only wore his suit and tie on Sundays when he went out. He is now requesting that he wears it every day around the home. Could you please provide more shirts and ties as he only has one appropriate shirt and tie and it is difficult to meet his requests? Care Assistant Jones	23 <sup>rd</sup> February 2007	We will call in at Asda and bring him some in next time.  Mrs June Smith
25 <sup>th</sup> February	Podiatrist attended, cut toe nails and trimmed corns.		
3 <sup>rd</sup> March	Mr Smith is refusing to wear the T shirts you bought him yesterday and is asking for a proper shirt and tie. Can you discuss this with us next time you are in?  Care Assistant Jones	10 <sup>th</sup> March	Called. You weren't around. The family don't see why we need to buy expensive shirts when he has worn T shirts for many years.  Mrs June Smith
5 <sup>th</sup> March	Repeat prescription ordered and delivered.		
11 <sup>th</sup> March	Mr Smith does require shirts with a collar and at least one other tie. I am sorry. We are not being awkward but we are obliged to comply with the Mental Capacity Act and carry out Mr Smith's wishes. I will phone you to discuss this.  Josie White, Head of Home		

## Appendix 4

### Admission Documentation where a Resident has Persons holding an LPA

Although this Agreement has been designed for persons holding an LPA it can readily be adapted for use where the Court of Protection has appointed a Deputy. A person may hold an LPA which has not yet become 'operative' because the resident is still able to make decisions. In these circumstances the Agreement should be brought to the attention of the holder of the LPA with an indication that it will be required when the LPA becomes operative.

#### Agreement under the Mental Capacity Act 2005

This is an agreement between the XXX Nursing Home and Mrs A (*If there is more than one holder of the LPA name all holders at this point*) who hold lasting power of attorney over the property, affairs and / or personal welfare of Mr B, resident of XXX Nursing Home.

The purpose of this Agreement is to ensure that the roles of the respective parties are clarified such that the best interests of Mr B can be served.

This Agreement will become operative if Mr B lacks capacity to make a decision or decisions.

The staff of the nursing home will maintain a log of decisions that Mrs A will have access to.

We the XXX Nursing Home and Mrs A agree to the following detailed working policies for the handling of Mr B's property, affairs and personal welfare whilst he is resident in the XXX Nursing Home :

- Minor Day to Day expenses – a budget of £X per week is agreed for XXX Nursing Home to meet the small day to day expenses of Mr B. This will be administered by the nursing home and included on Mr B's monthly invoice. Minor day to day expenses include, papers, tobacco and ..... (Add items relevant to this resident)
- Mrs A will provide all items of clothing required by Mr B. If the staff of the XXX Nursing Home identify a need for an item of clothing this will be written in the log of decisions and should be provided within a reasonable time. The type of clothing will be for Mr B to determine whilst he is able. If he is unable to make such decisions Mrs A should determine the style of clothes but these should be in line with Mr B's previous expressed views
- In exceptional circumstances the home may provide items to Mr B and these will be included in the monthly invoice. Where possible such exceptional items will be discussed with Mrs A prior to purchase; however, it is accepted that time constraints may not allow such discussion in every circumstance
- Disposal – the staff of XXX Nursing Home may dispose of items that are stale, soiled or in any way detrimental to maintaining an appropriate level of hygiene for Mr B and/or the home
- Calling the GP – the Staff of XXX Nursing Home may call the GP to attend Mr B at

any time they consider it is in Mr B's best interests. Mrs A can be present at such GP attendances if she considers it is in Mr B's interests and if the GP agrees. The Home will endeavour to inform by telephone when the GP has been called

- Routine GP calls for such items as repeat prescriptions and influenza vaccination will not be telephoned to Mrs A but will be written into the decision log
- Routine attention by other health professionals (e.g. Podiatrists) will be recorded in the decisions' log
- Mrs A should indicate any interventions provided as a normal part of health care that Mr B would not want to be given (e.g. blood transfusion)  
.....  
.....  
.....  
.....
- When practised, Mrs A will be advised of any interventions recommended by a GP prior to that intervention being carried out
- Routine hospital attendances – Mrs A will be informed by telephone of any proposed hospital attendances when the appointment is made. Mrs A should inform the home if she wishes to attend the hospital with Mr B when she is informed of the appointment. Repeat appointments for follow up of routine conditions will not normally be informed by telephone but will be written in the decisions log
- Emergency attendances at hospital –. Such treatment cannot usually be provided by the XXX Nursing Home and transfer to hospital will usually be required. You will be informed of such a transfer as soon as possible. If Mr B has made any advance decisions to refuse treatment, copy of the document, if written, should be attached to this agreement. (..... is attached).  
Please provide a certified copy and permit us to have sight of the original from time to time when it may be requested
- Whilst in our care the staff of XXX Care Home and any other person involved in Mr B's care (this may include family and friends) are obliged to comply with the terms of the Mental Capacity Act
- Communication

Mrs A can normally be contacted as follows:

Mobile .....Home phone .....

and will normally visit ..... times per month  
(Repeat if more than one person holds the LPA)

In the event of Mrs A leaving the vicinity for holidays, business etc. and not being contactable, any decisions normally requiring contact will be made in writing to Mrs A's home address. (If more than one person holds the LPA this section may be changed accordingly)

Signed .....Mrs A

Address

.....

Print name .....

Date .....

Signed ..... on behalf of XXX Nursing Home

Print Name.....

Date .....