Royal Devon University Healthcare NHS Foundation Trust

Informed Consent

Reference Number: RDF1857-23
Date of Response: 09/10/23

Further to your Freedom of Information Act request, please find the Trust's response(s) below:

Please be aware that the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) has existed since 1st April 2022 following the integration of the Northern Devon Healthcare NHS Trust (known as Northern Services) and the Royal Devon and Exeter NHS Foundation Trust (known as Eastern Services).

Dear Freedom of Information Team,

We are exploring the availability of training in informed consent for doctors working within a hospital setting. In accordance with the Freedom of Information Act 2000, please can you disclose any policies and/or guidance and/or any other documentation you hold relating to training in informed consent for doctors working at your hospital.

In particular, we are interested in any policies/guidance/documentation which address the following:

1. *Whether training in informed consent is mandatory for doctors working within your hospital.*
   Answer: All doctors get training around capacity & consent within the induction programme. Specific consent around individual procedures sits at departmental level. The consent policy 'Advanced Decision to refuse treatment' and a 'Mental Capacity Policy' are available on the intranet for doctors to refer to at any time, please find both attached.

2. *Who provides/funds training in informed consent for doctors working at your hospital.*
   Answer: Training around capacity & informed consent related to safeguarding concerns is covered by the safeguarding team at induction & then reinforced at F1/2 teaching around MCA capacity assessment. Specific consent around individual procedures sits at departmental level.

3. *What a doctor must do to fulfil any training requirements relating to informed consent*
   Answer: This would be down to individual clinical teams & specialties. Mental capacity training around informed consent is part of induction. All clinical staff have to complete MCA training. All doctors have to complete e-learning for Safeguarding Adults prior to starting in the Trust.

Advance Decision to Refuse Treatment Policy

Post holder responsible for Procedural Document	[redacted] Medical Director
Author of Policy	[redacted] Nurse Consultant Safeguarding
Division/ Department responsible for Procedural Document	Corporate Affairs
Contact details	x[redacted]
Date of original document	01/06/2008
Impact Assessment performed	**Yes**/No
Ratifying body and date ratified	Clinical Effectiveness Committee: 7 March 2019
Review date (and frequency of further reviews)	Sept 2021 (every 2 ½ years)
Expiry date	March 2022
Date document becomes live	11 March 2019

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience	✓	Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards Regulation No.1, 2,3 ,	✓	Infection Control	
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author (Title)	Reason
1.0	June 2008	Medical Director	New Policy, entitled Living Wills
2.0	March 2011	Medical Director	Revision to replace Living Wills policy
3.0	August 2015	Medical Director	Routine revision
4.0	16 May 2016	Medical Director	Section paragraph 6.20, first bullet-point: Removal of requirement of "distinguishing features", as agreed at IGSG on 12-06-16/ CEC Chair.
5.0	December 2018	Nurse and Doctor Safeguarding	Policy updated and new template used. Repetition removed and sections simplified.

Associated Trust Policies/ Procedural documents:	Cardiopulmonary Resuscitation Policy Assessing Mental Capacity Policy
Key Words	Advanced decision to refuse treatment, living will,
In consultation with and date: Governance Managers 19 December 2018 Divisional Directors 19 December 2018 Associate Medical Directors 19 December 2018 Assistant Directors of Nursing, Senior Nurses 19 December 2018 Quality Assured- 17 January 2019 Clinical Effectiveness Committee: 7 March 2019	
Contact for Review:	Nurse Consultant Safeguarding
Executive Lead Signature:	[redacted] [redacted] Medical Director

CONTENTS

KEY POINTS

- An advance decision to refuse treatment (ADRT) can only be made when a person has capacity to make the decisions about treatment choices.
- A person with capacity should always be consulted about treatment choices regardless of whether an ADRT exists or not.
- All staff have a legal responsibility to respect and comply with ADRT when the person lacks capacity.
- ADRT should be recorded in paper and electronic heath record systems and communicated to the professionals providing care to the person.

1. INTRODUCTION

1.1 People have a right to consent to or refuse treatment. The courts have recognised that adults have the right to say in advance that they want to refuse treatment if they lose capacity in the future, even if this results in their death. A valid and applicable Advanced Decision to Refuse Treatment (ADRT) has the same force as a contemporaneous decision. This is set out in the Mental Capacity Act Code of Practice.

2. PURPOSE

2.1 The purpose of this policy is to help to all health professionals employed by the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) to understand and implement the law relating to Advance Decisions to Refuse Treatment (ADRT) in the event that they are aware that a patient either has made an advance decision or requests to write one.

2.2 **Failure to comply with this policy could result in disciplinary action.**

3. DEFINITIONS

3.1 **Advance Decision to Refuse Treatment** is a statement made by a mentally capacitous person aged over 18 years, which defines in advance their refusal of medical treatment should they become mentally or physically incapable of making their wishes known. The Mental [redacted] Act outlines that Advance Decisions to Refuse Treatment are legally binding provided they fulfil the legal requirements of being valid and are applicable to the particular treatment in question.

3.2 **Advance Statements** may be made to express patient's wishes, feelings, beliefs and values about future care. Unlike an advance decision, an advance statement is not legally binding but must be taken into account if the person loses capacity. Advance statements may be made verbally or in writing. It allows a person to set out what they would like or not like to happen in terms of their care.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 **The Medical Director** has overall responsibility for ensuring processes are in place to provide patients with their legal and fundamental rights and for ensuring that this policy is reviewed and that there are appropriate quality assurance mechanisms in place in relation to this policy.

4.2 **The Clinical Effectiveness Committee** is responsible for the review and ratification of this policy.

4.3 **Legal Department** - where there is a major difference of opinion relating to Advance Decision to Refuse Treatment legal advice must be sought. The matter may be referred to the Court of Protection.

4.4 **The Patient Record Manager** is responsible for ensuring that where the patient has an ADRT this is contained within the patient's health record and

within electronic patient record systems.

4.5 **All Staff** have a responsibility for taking reasonable steps to ascertain whether an ADRT exists, to comply with it, and to ensure that it is recorded in the notes and shared with the rest of the team providing care to the person. This should be done as early in the admission as possible. Some healthcare professionals may disagree in principle with patients' rights to refuse life-sustaining treatment or find the decision a person makes difficult to accept. Staff should seek support from their line manager or staff support services if this is the case.

5. MAKING AN ADVANCE DECISION TO REFUSE TREATMENT

5.1 Adults have the right to say in advance that they want to refuse treatment if they lose capacity in the future, even if this results in their death. People can only make advance decisions to refuse treatment. Nobody has the legal right to demand specific treatment, either at the time or in advance. Nobody can ask for and receive procedures that are against the law.

5.2 A valid and applicable advance decision to refuse treatment has the same force as a contemporaneous decision.

5.3 A person can make an advance decision to refuse treatment if:

- they are 18 or older, and,
- they have the capacity to make an advance decision about treatment.

5.4 To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:

- has done anything that clearly goes against their advance decision
- has withdrawn their decision
- has subsequently conferred the power to make that decision on an attorney, or
- would have changed their decision if they had known more about the current circumstances.

5.5 An advance decision to refuse treatment:

- must state precisely what treatment is to be refused – a statement giving a general desire not to be treated is not enough
- may set out the circumstances when the refusal should apply – it is helpful to include as much detail as possible
- will only apply at a time when the person lacks capacity to consent to or refuse the specific treatment.

5.6 If the advance decision refuses life-sustaining treatment, see section 6.

5.7 Advance decisions made before the Mental Capacity Act comes into force may still be valid and applicable.

5.8 If a person or their friend/relative tells any health professional that an ADRT exists, a copy should be requested. Their GP may have a copy of the document.

5.9 To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person:

- has done anything that clearly goes against their advance decision
- has withdrawn their decision
- has subsequently conferred the power to make that decision on an attorney, or
- would have changed their decision if they had known more about the current circumstances.

5.10 Advance decisions to refuse treatment for a mental disorder may not apply if the person is detained under the Mental Health Act 1983.

5.11 Healthcare professionals must follow an ADRT if it is valid and applies to the particular circumstances. If they do not, they could face prosecution.

5.12 It is good practice to encourage the person to involve family and friends in the discussions about the ADRT.

5.13 There is no set format for recording advance decisions. If a person informs a healthcare professional of their decision to refuse treatment in the future, they should record a verbal advance decision to refuse treatment in a person's healthcare record. The record should include:

- a note that the decision should apply if the person lacks capacity to make treatment decisions in the future
- a clear note of the decision, the treatment to be refused and the circumstances in which the decision will apply
- details of someone who was present when the oral advance decision was recorded and the role in which they were present (e.g. healthcare professional or family member), and
- inform the Records Manager to ensure that the ADRT is recorded on clinical systems

5.14 It is possible that a professional acting as a witness to an ADRT will also be the person who assesses the person's capacity. If so, the professional should also make a record of the assessment, because acting as a witness does not prove that there has been an assessment.

5.15 The advance decision must also apply to the proposed treatment. It is not applicable to the treatment in question if:

- the proposed treatment is not the treatment specified in the advance decision
- the circumstances are different from those that may have been set out in the advance decision, or
- there are reasonable grounds for believing that there have been changes in circumstance, which would have affected the decision if the person had known about them at the time they made the advance decision.

5.16 A valid and applicable advance decision to refuse treatment is as effective as a refusal made when a person has capacity. Therefore, an advance decision overrules:

- the decision of any Lasting Power of Attorney (LPA) for health and welfare made before the advance decision was made. So an attorney cannot give consent to treatment that has been refused in an advance decision made

after the LPA was signed

- the decision of any court-appointed deputy (so a deputy cannot give consent to treatment that has been refused in an advance decision which is valid and applicable)
- any decision healthcare professionals make that they believe is in a person's best interests.
- an LPA made after an advance decision will make the advance decision invalid, if the LPA gives the attorney the authority to make decisions about the same treatment.

5.17 Anyone who has made an advance decision is advised to regularly review and update it as necessary. Decisions made a long time in advance are not automatically invalid or inapplicable, but they may raise doubts when deciding whether they are valid and applicable. A written decision that is regularly reviewed is more likely to be valid and applicable to current circumstances, particularly for progressive illnesses. A new stage in a person's illness, the development of new treatments or a major change in personal circumstances may be appropriate times to review and update an advance decision.

5.18 A person can cancel or alter an advance decision at any time while they still have capacity to do so. There are no formal processes to follow. People can cancel their decision verbally or in writing, and they can destroy any original written document. Where possible, the person who made the advance decision should tell anybody who knew about their advance decision that it has been cancelled. Healthcare professionals should record a verbal cancellation in healthcare records and inform the Records Manager. This then forms a written record for future reference.

6. ADVANCE DECISIONS TO REFUSE LIFE-SUSTAINING TREATMENT

6.1 Life-sustaining treatment is treatment including artificial nutrition and hydration (ANH) which a healthcare professional who is providing care to the person regards as necessary to sustain life.

6.2 The ADRT to refuse life sustaining treatment must be put in writing. If the person is unable to write, someone else should write it down for them. It must include a clear, specific written statement from the person making the advance decision that the advance decision is to apply to the specific treatment even if life is at risk.

6.3 The person making the decision must sign in the presence of a witness to the signature. The witness must then sign the document in the presence of the person making the advance decision. If the person making the advance decision is unable to sign, the witness can witness them directing someone else to sign on their behalf. The witness must then sign to indicate that they have witnessed the nominated person signing the document in front of the person making the advance decision.

7. DECIDING ON THE EXISTENCE, VALIDITY AND APPLICABILITY OF ADVANCE DECISIONS

7.1 If healthcare professionals are not satisfied that an advance decision exists that

is both valid and applicable, treatment must be in the person's best interests. They should make clear notes explaining why they have not followed an advance decision which they consider to be invalid or not applicable. Staff should discuss any concerns with a senior staff member or the Trust legal team.

7.2 Sometimes professionals can give or continue treatment while they resolve doubts over an advance decision. It may be useful to get information from someone who can provide information about the person's capacity when they made the advance decision. The Court of Protection can settle disagreements about the existence, validity or applicability of an advance decision. Section 26 of the Act allows healthcare professionals to give necessary treatment, including life-sustaining treatment, to stop a person's condition getting seriously worse while the court decides.

7.3 Healthcare professionals should not delay emergency treatment to look for an advance decision if there is no clear indication that one exists. But if it is clear that a person has made an advance decision that is likely to be relevant, healthcare professionals should assess its validity and applicability as soon as possible. Sometimes the urgency of treatment decisions will make this difficult.

7.4 Some situations might be enough in themselves to raise concern about the existence, validity or applicability of an advance decision to refuse treatment. These could include situations when:

- a disagreement between relatives and healthcare professionals about whether verbal comments were really an advance decision
- evidence about the person's state of mind raises questions about their capacity at the time they made the decision
- evidence of important changes in the person's behaviour before they lost capacity that might suggest a change of mind.

7.5 It is ultimately the responsibility of the healthcare professional who is in charge of the person's care when the treatment is required to decide whether there is an advance decision which is valid and applicable in the circumstances. In the event of disagreement about an advance decision between healthcare professionals, or between healthcare professionals and family members or others close to the person, the decision maker must consider all the available evidence.

7.6 Where there is genuine doubt or disagreement about an advance decision's existence, validity or applicability, contact the Trust legal team who will be able to assist if an application to the Court of Protection is necessary. The Court of Protection can make a decision but does not have the power to overturn a valid and applicable advance decision.

7.7 While the court decides, healthcare professionals can provide life-sustaining treatment or treatment to stop a serious deterioration in their condition. The court has emergency procedures which operate 24 hours a day to deal with urgent cases quickly.

8. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author The Medical Director. An electronic copy will be maintained on the Trust Intranet P – Policies – A –

Advance Decision to Refuse Treatment. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years

9. PROCESS FOR MONITORING COMPLIANCE WITH AND FFECTIVENESS OF THE POLICY

9.1 To monitor compliance with this policy, the auditable standards will be monitored as follows:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
Patients have the right under the MCA to develop ADRTs and for these to be honoured	An audit of ADRTs that have been honoured	Clinical Effectiveness Committee. Associate Medical Director
The Advanced Decision to Refuse Treatment document filed immediately behind patient ID sheet	An audit of patient's case notes	Clinical Effectiveness Committee. Head of Records Management

10. REFERENCES

The Office of Public Guardian
https://www.gov.uk/government/organisations/office-of-the-public-guardian

Mental Capacity Act Code of Practice 2007
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Advance decisions to refuse treatment: A guide for health and social care professionals. NHSE
https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Advance-Decisions-to-Refuse-Treatment-Guide.pdf

Royal Devon and Exeter NHS
NHS Foundation Trust

APPENDIX 1: SAMPLE ADRT

Advance Decision to Refuse Treatment (ADRT)

My name	Date of Birth
Address	NHS no. (if known) Hospital no. (if known)
	Telephone number

What is this document for?

This advance decision to refuse treatment has been written by me to specify in advance which treatments I don't want in the future

These are my decisions about my healthcare, in the event that I have lost mental capacity and cannot give consent to or refuse treatment.

This advance decision replaces any previous decisions I have made.

Advice to the carer reading this document:

Please check

- Please do not assume that I have lost mental capacity before any actions are taken, I might need help and time to communicate when the time comes to make a decision.
- If I have lost mental capacity for a particular decision check that my advance decision is valid and applicable to the circumstances that exist at the time
- If the professionals are satisfied that this advanced decision is valid and applicable this decision becomes legally binding and must be followed, including checking that it has not been varied or revoked by me either verbally or in writing since it was made.
- Please share this information with people who are involved in my treatment and need to know about it.
- Please also check if I have made an advance statement about my preferences, wishes, beliefs, values and feeling that might be relevant to this advance decision.

This advance decision does not refuse the offer or provision of basic care, support and comfort

Important note to the person making this advance decision:

If you wish to refuse a treatment that is (or may be) life-sustaining you must state in the boxes

"I am refusing this treatment even if my life is at risk as a result"

My Name	

My advance decision to refuse treatment

I wish to refuse the following treatments:	**In these circumstances**
My signature (or nominated person)	Date of signature

Witness	
Witness signature	Name of witness
Address of witness	Telephone number of witness Date
Person to be contacted to discuss my wishes	
Name	Relationship
Address	Telephone number
I have discussed this with (e.g. name of healthcare professional)	
Contact details	Profession / Job Title: Date
I give my permission for this document to be discussed with my relatives / carers	
Yes	No (Please circle one)
My General practitioner is:	
Name Telephone:	Address:
Optional review Comment	Date / Time
Signature of person named on Page 1	Witness signature

The following list identifies which people have a copy and have been told about this advance decision to refuse treatment (ADRT)

Name	Relationship	Telephone number

Further Information (Optional)

I have written the following information that is important to me.

It describes my hopes, fears and expectations of life and any potential health and social care problems. It does not directly affect my advance decision to refuse treatment, but the reader may find it useful, for example to inform any clinical assessment if it becomes necessary to decide what is in my best interests.

Original source: Advance decision to Refuse Treatment: a Guide for Health and Social Care Staff (2008)

APPENDIX 2: THE PROCESS FOR MAKING BEST INTERESTS DECISIONS IN CARE CRISES

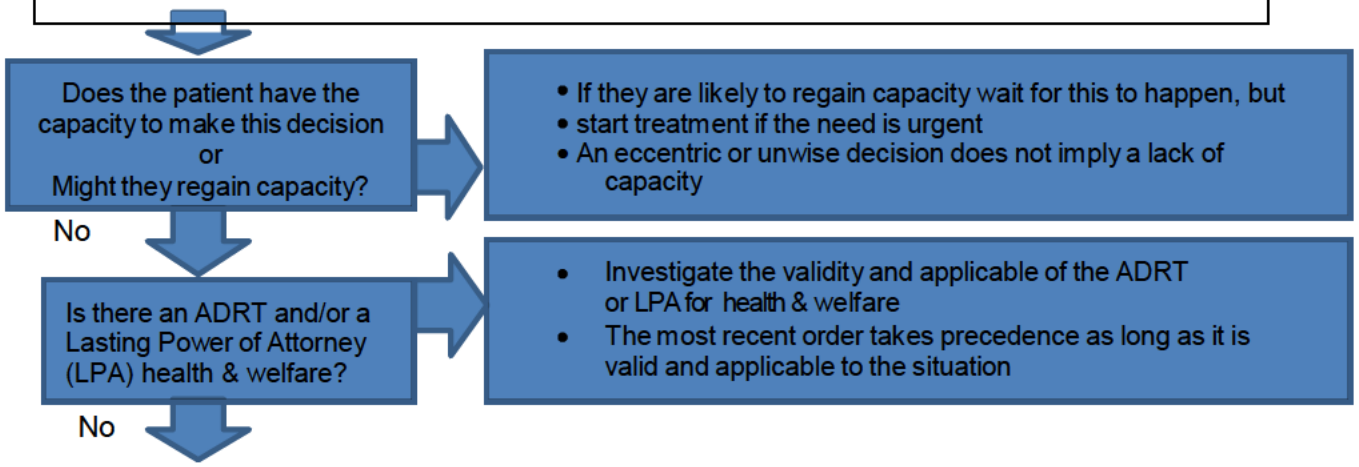
In an emergency treat if this is likely to succeed and benefit the patient

Assume the person has capacity for this specific decision

If the person has an impairment of, or a disturbance of their brain or mind, this may indicate they lack capacity to make a specific decision. In this situation, test their capacity as follows

1) Can they understand the information? Every effort must be made to make this information clear and accessible.
2) Can they retain the information? This only needs to be long enough to use and weigh the information
3) Can they weigh up that information? The person must demonstrate that they are able to consider the benefits and burdens of the proposed treatment and the alternatives available
4) Can they communicate their decision? Every effort must be made to make this possible

If the person can do all of the above they have the capacity to make this specific decision at this time. Document the result of each of the above, ideally by quoting the patient



The Decision Maker should:

- Set up a best interests meeting to plan for the future
- Encourage the participation of the patient if possible
- If there is no one who can be consulted about their previous views consider appointing an Independent Mental Capacity Advocate (IMCA)
- Find out and consider the person's views (i.e. wishes and feelings, beliefs and values): these may have been expressed verbally previously to family or friends, or exist in an Advance Statement or ADRT made when the patient had capacity for these decisions
- Identify all the relevant circumstances (clinical, social, financial, psychological, spiritual)
- Consult others (within the limits of confidentiality): this will include all relevant professionals, and may include a LPA, an IMCA or Court Appointed Deputy
- Weigh up all these facts in order to make the decision the patient would have made if they had capacity. Avoid assumptions about quality of life and choose the least restrictive option
- Record the decisions and agree the next review dates

If there are unresolved conflicts, consider involving the local ethics committee. If a solution is proving difficult consider the Court of Protection, possible through a Court Appointed Deputy (CAD)

APPENDIX 3: STANDARD OPERATING PROCEDURE FOR ADRT

Should any member of staff receive an Advanced Decision to Refuse Treatment document from either a patient or a relative then they should forward this to the Patient Record Manager immediately who will take the following steps:

1. Date stamp the document the day it is received.

2. Establish if the patient is registered at the Trust by searching the Patient Administration System (PAS). If the patient is not registered there will be no case notes. In this event the document should be returned immediately to the patient suggesting that the GP should hold a copy. **Case notes will not be created solely for the purpose of filing the Advance Decision to Refuse Treatment document.**

3. If the patient is registered on PAS send an acknowledging letter (Appendix 4) to the patient. The letter should stress that the Advanced Decision document will not be placed immediately on the patient's health record until it has been checked by clinical staff.

4. Establish from the attendance history on PAS whose care the patient is currently under. If the patient is under more than one Consultant, identify who saw the patient most recently.

5. Request and retrieve the patient case notes. Send a letter to the Consultant whose care the patient is under (Appendix 5). If the patient is not currently under the care of a Consultant it will be forwarded to the Associate Medical Director. The letter is asking the Consultant to check the Advanced Decision document for clarity. The case notes should accompany the letter to the Consultant.

6. If the Consultant has agreed that the Advanced Decision document is clear then the document should be filed within the patient's health record without further delay.

7. The Advanced Decision document should be filed immediately behind the Patient ID sheet in front of the case notes. The clinical alert box should be completed to read the following; "Advanced Decision to Refuse Treatment document filed immediately behind patient ID sheet" - print the patient's name with your name alongside (Patient Record Manager).

8. A letter should be sent to the patient confirming the above (Appendix 6)

9. If the Consultant does not agree that the Advanced Decisions Document is clear then this needs to be communicated back to the patient with the reason why. It may be that further clarification is required or that indeed the patient has completed the document incorrectly (by ticking contradictory boxes). Suggest to the patient that they may wish to discuss / take advice regarding the contents of the document with their GP. Make it clear to the patient that no copy has been placed on their health records and that you await their further advice.

10. The hospital case notes should be returned to prefile.

11. A copy of all the correspondence should not be placed on the patient's health record but held within the Advanced Decision file within the Patient Record Manager's office.

APPENDIX 4: LETTER TO ACKNOWLEDGE RECEIPT OF ADRT DOCUMENT

Royal Devon and Exeter
NHS Foundation Trust

Royal Devon and Exeter NHS Foundation Trust
Barrack Road
Exeter
EX2 5DW
Tel: 01392 411611
Health Records Department [redacted]
Fax [redacted]

Dear

I acknowledge receipt of your Advanced Decision to Refuse Treatment Document, which was received by myself on…….. I hope that you will understand that the clinical staff will need to look carefully at the document to be sure that your wishes are clearly understood. I will write to you again when a senior doctor has had the opportunity to read your document, either to confirm there are issues that require further clarification or to confirm that it has been placed on your medical records. Thereafter, I can confirm that we will place the document within your medical records, but I cannot guarantee that the document would be immediately available to all staff attending you on any subsequent admission and, certainly, if you are admitted as an emergency, the notes themselves may not be immediately available. You may, therefore, wish to keep a copy on your person at all times.

Yours sincerely

Head of Records Management

APPENDIX 5: LETTER TO CONSULTANT TO CHECK ADRT

Royal Devon and Exeter NHS Foundation Trust

Royal Devon and Exeter NHS Foundation Trust
Barrack Road
Exeter
EX2 2DW

Tel: 01392 411611
Health Records Department [redacted]
Fax [redacted]

Dear

NAME OF PATIENT- Hospital Number

Please find attached copy of Advanced Decision to Refuse Treatment document which was received by the Trust on…… and my response to Mrs/Mr……..

I note from Mrs/Mr……health record that she/he is currently under your care.

I would therefore be grateful if you could carefully check through the document to ensure these instructions are clear and appropriate. You may wish to refer to the Trust policy on Advanced Decisions to Refuse Treatment which is attached.

I look forward to receiving your

response.

Yours sincerely

Head of Records Management

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APPENDIX 6: LETTER TO PATIENT CONFIRMING ADRT

Royal Devon and Exeter
NHS Foundation Trust

Royal Devon and Exeter NHS Foundation Trust
Barrack Road
Exeter EX2 5DW
Tel: 01392 411611
Health Records Department [redacted]
Fax [redacted]

Dear

Further to my letter of …… I am pleased to confirm that your Advanced Decision to Refuse Treatment document has now been checked by a Consultant and has been placed in your Health Record.

It is important that you review your Advanced Decision to Refuse Treatment regularly to ensure your decision is still valid.

As previously mentioned, I cannot guarantee that the document would be immediately available to all staff attending you on any subsequent admission and, certainly, if you are admitted as an emergency the notes themselves may not be immediately available. I therefore advise that you may wish to keep a copy on your person at all times.

Yours sincerely

Head of Records Management

APPENDIX 7: COMMUNICATION PLAN

Royal Devon and Exeter NHS
NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	All Clinical staff
The key changes if a revised policy	Policy updated and new template used. Repetition removed and sections simplified.
The key objectives	The purpose of this policy is to help to all Health Professionals to understand and implement the law relating to Advance Decisions to Refuse Treatment (ADRT) in the event that they are aware that a patient either has made an Advance Decision or requests to write one.
How new staff will be made aware of the policy and manager action	Cascade by email from ANDs and Must Read on Trust Intranet
Specific Issues to be raised with staff	Staff should be made aware of the policy.
Training available to staff	None
Any other requirements	
Issues following Equality Impact Assessment (if any)	3 relevant impacts for age, disability and religion
Location of hard / electronic copy of the document etc.	The original of this policy will remain with the author. An electronic copy will be maintained on the Trust Intranet. Archived electronic copies will be stored on the Trust's “archived policies” shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years

APPENDIX 8: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Advance Decision to Refuse Treatment
Division/Directorate and service area	Corporate Services
Name, job title and contact details of person completing the assessment	[redacted] Nurse Consultant Safeguarding [redacted]
Date completed:	13/12/18

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

The purpose of this policy is to help ~~to~~ all Health Professionals employed by the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) to understand and implement the law relating to Advance Decisions to Refuse Treatment (ADRT) in the event that they are aware that a patient either has made an Advance Decision or requests to write one.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☐ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box (x)

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	☒	☐
Sex - *including: Transgender, and Pregnancy / Maternity*	☐	☒
Race	☐	☒
Religion / belief	☒	☐
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

3. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to…** (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Please specify any groups you think may be affected in any significant way: End of Life patients, Patients with degenerative conditions or lacking mental capacity

5. **Do you think the document meets our human rights obligations?** ☒

A quick guide to human rights:
• ***Fairness*** *– how have you made sure it treat everyone justly?* • ***Respect*** *– how have you made sure it respects everyone as a person?* • ***Equality*** *– how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity*** *– have you made sure it treats everyone with dignity?* • ***Autonomy*** *– Does it enable people to make decisions for themselves?*

6. **Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?**

N/A

If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	None
Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Mental Capacity Act (MCA) Policy	
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Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

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Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards - Regulation: **SAFE**		Infection Control	

Other *(please specify)*:		
Note: This document has been assessed for any equality, diversity or human rights implications		

Controlled document

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History

Version	Date	Author	Reason
0.1	27 May 2022	Draft	New Policy due to the joining of RDE and NDHT to form Royal Devon University Healthcare NHS Foundation Trust. New policy aligning previous MCA policies for respective Trusts

Associated Trust Policies/ Procedural documents:	RDE: Advance Decision to Refuse Treatment Policy NDHT: Advance Care Planning Policy Deprivation of liberty safeguards policy Restraint and Restrictive Practice Policies NDHT RDE: Violence Prevention and Reduction Policy
AKey Words	Safeguarding Adults, Restraint, Restriction, Mental Capacity Act, Best Interests, IMCA,

	DoLS, Deprivation of Liberty, Lasting Power of Attorney, Advance Decision, Consent
In consultation with and date: •	
Contact for Review:	[redacted] [redacted] Mental Capacity Act /Liberty Protection Safeguards Leads RDUH
Executive Lead Signature: *(Applicable only to Trust Strategies & Policies)*	**To be added by Policies Administrator when uploading to Intranet**

CONTENTS

1. INTRODUCTION

1.1. The Mental Capacity Act (MCA) 2005 provides a statutory and quality framework to empower and protect some of the most vulnerable people in society. It makes it clear who can take decisions, in which situations and how they should go about this in respect of people who lack capacity to make particular decisions for themselves. This document sets out the Royal Devon University HealthCare NHS Foundation Trust (hereafter referred to as the Trust) policy for applying the MCA (also referred to as the Act) in practice and ensuring staff are aware of their responsibilities as defined by the Act.

2. PURPOSE

2.1. The purpose of this document is to ensure that the Trust meets nationally recognised and regionally agreed best practice for working with patients that may lack capacity. This policy is in line with and should be read in conjunction with the MCA Code of Practice, Devon's Multi-agency MCA Practice Guidance, and professional codes of practice and NICE Guidelines.

2.2. The Act provides a statutory framework for the protection of people who may lack capacity to make some decisions themselves, based on current best practice and common law principles. It also makes it clear who can take decisions in which situations and enables people to plan ahead (Advance Decisions & Lasting Powers of Attorney) for a time when they may lack capacity.

2.3. The policy applies to all patient facing Trust staff.

2.4. Implementation of this policy will ensure that:

- All clinical staff are able to recognise when there is a need to assess a patient's ability to make decisions based on their mental capacity and can act on this assessment.
- All clinical staff are aware of how to assess or undertake a Mental Capacity Assessment and Best Interest Decision and integrate these assessments into their work.
- Clinical staff are aware of and acknowledge Advance Decisions to Refuse Treatment and act on these.
- Independent Mental Capacity Advocates are appointed appropriately.
- There is consistency of reporting and procedures across health, social care and other partner agencies locally.
- The Trust is compliant with the CQC essential standards relating to Mental Capacity.

3. DEFINITIONS

3.1 Best Interests

Any decisions made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out someone's best interests. These are set out in section 4 of the MCA, and in the non-exhaustive checklist in section 5.13 of the MCA Code of Practice.

3.2 Capacity

The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is set out in section 2 of the MCA.

3.3 Consent

Agreeing to a course of action – specifically in this document, to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.

3.4 Court of Protection

The specialist Court for all issues relating to people who lack capacity to make specific decisions.

3.5 Decision Maker

Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout the Code as the 'decision maker', and it is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.

3.6 Deprivation of Liberty Safeguards (DoLS)

The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.

3.7 Independent Mental Capacity Advocate (IMCA)

This is a person who supports and represents a person who lacks capacity to make a specific decision, where that person has no one else who can support them. They make sure that major decisions for a person who lacks capacity are made in accordance with the Mental Capacity Act 2005.

3.8 Lasting Power of Attorney (LPA):

This is a power of attorney created under the Mental Capacity Act 2005. It enables a person initially with capacity to appoint another person to act on their behalf in relation to decisions about the donor's financial and/or personal welfare (including healthcare)

at a time when they no longer have capacity or enact the LPA. An LPA must be registered with the Office of the Public Guardian before it can be used.

3.9 Restraint:

The use or threat of force to undertake an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm. The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of that harm. If the restraint or restrictive practices meets the criteria for a deprivation of liberty (see DoLS Policy) please consider the appropriate legal framework.

3.10 Statement of wishes and feelings:

A person with capacity may express their wishes and feelings about their future medical treatment, where they would choose to live, how they would wish to be cared for, in the event they lose capacity in the future. These are non-binding but should be used by relevant professionals for consideration when making Best Interests decisions for a person who lacks capacity.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The **Board of Directors and Non-Executive Directors and elected leads** are responsible for:

- Holding Executive Directors and Boards to account and providing independent scrutiny.
- Ensuring that the Trusts' duty under the Mental Capacity Act 2005 Code of Practice (2007) and the Mental Capacity (amendment) Act 2019 is discharged effectively across the whole of the Trust.
- Identifying an Executive Lead person at Board level with responsibility for safeguarding vulnerable adults.
- Championing & maintaining focus on Mental Capacity.

4.2 The Joint **Integrated Safeguarding Committee (ISC)** is responsible for:

- Assuring the Governance Committee that the effective implementation of the infrastructure and processes for safeguarding is embedded within Corporate and Divisional structures.
- Producing a yearly report to the Governance Committee detailing the Trusts' performance in relation to MCA.
- Providing a focus for performance management of the delivery of the safeguarding agenda through Corporate and Divisional infrastructures and escalating via the Performance Assurance Framework process where necessary.
- Overseeing and monitoring Trust responses and action plan to the findings of serious case reviews, serious incidents or complaints relating to MCA.
- Agreeing an annual audits programme both internally and externally.

- Receiving reports from the Joint MCA/LPS Operational Group in accordance with the ISC schedule of reports.

4.3 The **Safeguarding Adults Leads and the Safeguarding Adults Operational Group** are responsible for:

- Ensuring processes and procedures are consistent for implementing the MCA.
- Advising the Chief Executive and senior managers of the Trust on MCA matters.
- Developing internal structures to provide assurance to the organisation that Mental Capacity issues are considered and dealt with in a consistent and effective way.
- Ensuring the regular development and review of this policy.

4.4 The **Joint Mental Capacity Act/Liberty Protection Safeguards (MCA/LPS) Operational Group** is responsible for:

- Providing assurance to the Joint Integrated Safeguarding Committee that effective processes and policies are in place to ensure compliance with the MCA.
- Monitoring compliance with the MCA through investigation and management of actions of any such issue raised via Datix.
- Defining and monitoring key performance indicators for quarterly review by the ISC.
- Reviewing and overseeing implementation of any actions from serious case reviews.
- Implementing an on-going system of audit in relation to compliance with this policy and reviewing those results.
- Identifying themes from review of incidents and complaints.
- Providing a report to the ISC after each meeting.

4.5 The **Integrated Safeguarding and MCA/LPS teams** are responsible for:

- Monitoring and ensuring effective implementation of the MCA Policy across the Trust.
- Developing and implementing a training strategy to support MCA competence across the Trust.
- Developing training, guidance, and resources for practitioners, that support practical application of the MCA across the Trust.
- Attending all local and regional groups and networks relating to MCA.
- Developing internal structures and providing assurance to the organisation that MCA issues are considered and dealt with in a consistent and effective way.
- Offering advice and support to staff on any aspects of the MCA.
- Auditing, reviewing practice and developing processes and procedures to improve performance.
- Expanding professional knowledge and skills in relation to the Mental Capacity Act by keeping abreast of current trends/initiatives and related developments and disseminating them to practitioners.

4.6 **All staff in managerial positions** are responsible for:

- Ensuring all staff are aware of this policy and their role around MCA.
- Ensuring staff access MCA training appropriate to their responsibilities.

- Ensuring staff make comprehensive and accurate healthcare records when documenting Mental Capacity.

4.7 **Clinical staff** are responsible for:

- Being familiar with and following the Trust MCA Policy.
- Knowing who to contact in the Trust to get advice about MCA processes.
- Ensuring that they receive MCA training and maintain their knowledge.
- Ensuring that they share relevant information with the MCA/LPS team.
- The member of staff carrying out the procedure or intervention is responsible for ensuring that consent to treatment is valid and that full discussions are recorded in the patient record.
- Where the patient may lack mental capacity for that treatment decision the health professional must carry out a mental capacity assessment and subsequent best interest decision before carrying out the intervention.

5. KEY MESSAGES OF THE MENTAL CAPACITY ACT (MCA) 2005

- Applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves.
- Designed to protect and restore power to those vulnerable people who lack capacity.
- Supports those who have capacity and choose to plan for their future – this is everyone in the general population who is over the age of 18 (note whilst 16/17 year olds cannot make an Advance Decision or Lasting Power of Attorney they can make an Advance Statement of wishes and preferences).
- Provides legal protection in practice for health and social care staff and support and guidance for carers.
- Provides a Code of Practice which all professionals have a duty to comply with.
- Provides **five statutory principles** which are the benchmark of the MCA and must underpin all acts carried out and decisions taken in relation to the Act. They are as follows:

  - **A person must be assumed to have capacity UNLESS it is proved otherwise.**

  - **Until all practical steps have been taken to help someone make a decision without success they cannot be treated as lacking capacity.**

  - **An unwise decision does NOT in itself indicate a lack of capacity.**

  - **Any act or decision made must be in the person's Best Interests.**

  - **Any act or decision should aim to be the least restrictive option to the person in terms of their rights and freedom of action.**

- Provides a capacity assessment test designed to support and empower those in health and social care to assess capacity themselves in relation to the provision of health and social care treatment.

- Provides a Best Interests checklist to direct those making Best Interests decisions for people who lack capacity including the requirement to consult with families, carers and close friends.

- Emphasises that assessment of capacity and Best Interests decision making is integral to day to day practice.

- Highlights the importance of the decision-making processes around capacity assessments and Best Interest decisions which are as important as the outcomes of the decision-making processes.

- Underlines the importance of the appropriate involvement of carers and families in capacity assessments and Best Interest decision making.

6. ASSESSING MENTAL CAPACITY AND BEST INTERESTS

6.1. The Mental Capacity Act requires that specific consideration be given to the assessment process.

Defining a lack of capacity

- A person lacks capacity in relation to a matter if at that particular time s/he is unable to make a decision for him/herself in relation to the matter because of an impairment, or a disturbance in the functioning, of the mind or brain.
- It does not matter whether the impairment or disturbance is permanent or temporary.
- A lack of capacity cannot be established merely by reference to:

  (a) A person's age or appearance, or
  (b) A condition or an aspect of their behaviour, which might lead others to make unjustified assumptions about their capacity.

6.2. Any question as to whether a person lacks capacity must be decided on the balance of probabilities.

6.3. Mental Capacity should not be confused with patient non-compliance with care/treatment. A patient who is non-compliant may be doing so with consent, or without understanding the risks, therefore possibly lacking capacity. See section 10.4 of this policy for risks arising from self-neglect or a person's own behaviour or lifestyle.

How is Capacity Assessed?

6.4. Capacity is the ability to make an informed decision. Consequently, there are three basic questions for staff to consider: All three must be met for a conclusion of a lack of capacity to be reached.

1. ***Does the person lack the capacity to make a particular decision?*** (Code of Practice 4.13.)

   A person is unable to make a decision if they cannot do any ONE of the following four things:

   - Understand the information relevant to the decision.
   - Retain the information long enough to make a decision.
   - Use or weigh up that information as part of the process of making the decision.
   - Communicate their decision, whether by talking, using sign language or any other means. (Code of Practice 4.14.)

If so:

2. ***Is there an impairment of, or disturbance in, the person's mind or brain?*** (Code of Practice 4.11.)

   Examples of an impairment or disturbance include Brain Injury, Learning Disability, Dementia, Physical or Medical conditions that cause confusion, drowsiness, or loss of consciousness etc. (Please see Code of Practice 4.12.)

   If so:

3. **Is there evidence to suggest this inability to make a particularly decision (1.) is caused by the impairment of, or disturbance in, the person's mind or brain (2.)? (the causative nexus)**

Who assesses capacity and best interests?

6.5. Most assessments of capacity should be conducted by the decision-maker, who is the person responsible for deciding what is in the Best Interests of the person who lacks capacity. The decision-maker can only delegate the assessment of capacity to another on the basis that; they will still review the assessment and agree with its conclusions before making a Best Interest decision. There are times when a number of people may be involved in making recommendations in relation to a decision. Often the multi-disciplinary team will make the decision together. It is the decision-maker's responsibility to work out what would be in the Best Interests of the person who lacks capacity. The decision–maker is the person who is deciding whether to take action in

connection with the care or treatment of an adult who lacks capacity or who is contemplating making a decision on their behalf:

 Where the decision involves medical treatment, the doctor proposing the treatment is the decision-maker.

 Where nursing care is provided, the nurse is the decision-maker.

 A health care assistant may need to assess if the person can agree to be bathed.

 Where a physiotherapy intervention is being proposed the therapist will be the decision-maker.

 Where the decision involves social care or accommodation, the Social Worker or other professional proposing and responsible for the arrangements will be the decision-maker.

 For more day-to-day decisions, the decision-maker will be the person most directly involved with the person at the time usually a family member, paid carer, carer or friend.

 The holder of a valid Lasting Power of Attorney or a deputy will be the decision-maker for decisions within the scope of their authority.

Types of decision – when to assess capacity

6.6. Informed consent applies when a person can be said to have given consent based on a clear appreciation and understanding of the facts, and the implications and consequences of an action. English law necessitates that before any medical professional can examine or treat a patient, they must obtain informed consent to do so. Further information can be found in the Consent Policy. If a patient is unable to give informed consent due to a mental disorder or impairment this is a good prompt to consider mental capacity. The Mental Capacity Act (2005) formalises the area assessing whether the patient is mentally capable of making the decision.

6.7. The kinds of decision which are covered by the MCA 2005 range from day-to-day decisions to significant decisions. Day-to-day assessments of capacity may be relatively informal and may be documented within the person's case notes. More serious decisions have greater consequences for the person who, it is thought, may lack capacity and justify a more formal assessment of capacity using an Assessment Form (See Appendix B).

Day-to-day Decisions

6.8. Assessments of capacity in this context may be made solely by the decision-maker. When assessing capacity for day-to-day decisions, you do not need to be an expert. But you do need to have what is called a 'reasonable belief' that the person lacks the capacity to make the decision. This means you must give your reason for thinking a person can, or can't, make a decision. The capacity assessment/Best Interests decision may be recorded within the person's case notes/electronic records and/or the

capacity assessment included in the care planning/support plan and treatment process. You may only need to make short notes in daily records or care plans to show why you decided that a person could or could not choose for themselves.

6.9. Section 6.34 of the MCA Code of Practice states that healthcare and social care staff can be said to have 'reasonable grounds for believing' that a person lacks capacity if:

 They are working to a person's care/support plan and

 The care planning process involved an assessment of the person's capacity to make a decision about actions in the care/support plan.

Significant Decisions

6.10. A formal assessment of capacity must be carried out when a service user/patient faces an important decision, whether in relation to care and treatment or something arising from it, or in relation to their financial affairs and there are any doubts about the ability of the service user to give a valid consent to the decision. Some examples include:

 Consent to 'Serious Medical Treatment' (SMT - see section 6.15 - 6.19, MCA Code of Practice). Real examples of SMT include: smear tests, hip replacements, any treatment requiring a general anaesthetic, someone with breast cancer refusing treatment, a blood test with serious implications, operation for cataract removal etc.

 Consent to an informal admission (to hospital, nursing or care home).

 Consent to a change of accommodation.

 Decision in relation to the management of finances, property or affairs.

 Any situation where consideration is being given to a referral under DoLS.

 Request a Tribunal Hearing when detained under the Mental Health Act MHA (1983).

 Consent to their confidentiality being breached – e.g. during a Safeguarding Adults investigation.

 There may be a dispute with the person, their family or the care team, as to the capacity of the individual.

 The person's capacity may be subject to challenge.

 There may be legal consequences of a finding of capacity (e.g. as a result of a claim for personal injury).

 The person is making decisions that put him/her or others at risk or that result in preventable suffering or damage.

6.11. The above list is not exhaustive and professional judgement must be used. In these types of decision a formal assessment of capacity should be carried out and recorded using the Mental Capacity Assessment form (See Appendix B).

6.12. Depending on the level and seriousness of the decision, specialist or expert opinion may be requested where the decision is major or complex. Please see Mental Capacity Act Code of Practice 4.60 – 4.62.

6.13. Any assessment of capacity is decision specific e.g. an individual may have the capacity to choose where they live, but not have the capacity to make a decision regarding serious medical treatment.

6.14. An individual's capacity may fluctuate during the day or over the course of time. It is important to allow for this in any assessment.

6.15. Each professional group has responsibility to plan and undertake their own MCA assessments if they are responsible for providing the necessary treatment or action.

6.16. A patient's capacity may change over time, therefore it is import to review any assessments if the patients circumstances or care/treatment plan changes. The outcome of the capacity assessment should be clearly documented in the patient's notes.

Relevant Information

In order to assess someone's capacity in relation to a particular decision, professionals need to provide the person with all the 'relevant information' in relation to that decision. This information is specific to the decision in question and the holistic situation in question. In relation to areas such as medical treatment, care and accommodation, case law around mental capacity provides a guide to what information should be considered. An overview for this guidance has been summarised by 39 Essex Chambers and can be accessed HERE.

Best Interests

6.17. The Mental Capacity Act (2005) sets out a checklist of factors to be considered by the decision maker whilst considering the best interests of the person. If an individual is assessed as lacking capacity in a specific area, one of the key principles of the Act is that any act done for, or any decision made on behalf of that person, must be done or made in the person's best interest.

6.18. Factors to be considered: (Mental Capacity Code of Practice 5.13)

- No decision is made solely on the basis of a person's age, appearance or other aspect of behaviour that might lead others to make unjustified assumptions.
- All relevant circumstances should be considered.
- Likelihood of regaining capacity – if possible could the decision be delayed?

- As far as possible encourage the person to participate.
- If life-sustaining treatment then the decision must not be motivated by a desire to bring about their death.
- Is it possible to ascertain the person's past and present wishes and feelings?
- Is it possible to ascertain their beliefs and values?
- The views of other people, in particular anyone formerly named by the person to be consulted, those involved in caring for the person, those interested in their welfare, donees of a lasting Power of Attorney or any Court Deputy.
- Consultation with Independent Mental Capacity Advocate (IMCA) if one is required.

6.19. Decisions must be clearly recorded in the case notes or designated forms.

If best interests cannot be agreed e.g there is a disagreement between family and medical team, or different family as to what constitutes a patient's best interests, then further advice should be sought from the MCA/LPS or legal team.

6.20. What happens in emergency situations?

Sometimes people who lack capacity to consent will require emergency medical treatment to save their life or prevent them from coming to serious harm. In these situations, what steps are 'reasonable' will differ to those in non-urgent cases. In emergencies, it will almost always be in the person's best interests to give urgent treatment without delay. In these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions, or to consult with any known attorneys or deputies. However, even in emergency situations, healthcare staff should try to communicate with the patient and keep them informed of what is happening.

One exception to this is when the healthcare staff giving treatment are satisfied that an Advance Decision to refuse treatment exists, for example a Do not Attempt to Resuscitate (DNAR) Instruction.

7. INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)

7.1. The aim of the IMCA service is to provide independent safeguards for people who **lack capacity** and are **unbefriended** (have no-one else other than paid staff to represent them). **Their role is to provide support, be consulted or represent them when they need** to make certain important decisions.

When to Involve an IMCA

An IMCA ***must*** be instructed and then consulted by an NHS Trust, for people aged over 16 lacking capacity who are unbefriended whenever:

The Trust is proposing to **provide serious medical treatment,**
Or
 An NHS body or Local Authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, **and**
The person will stay in hospital longer than 28 days or
They will stay in the care home for more than eight weeks.
See Mental Capacity Act Code of Practice 10.3 for further guidance.

7.2. Within the Devon and Torbay Health and Social Care community, practitioners are advised to consider instructing an IMCA to support someone who lacks capacity:
 In adult protection cases, whether or not family, friends or others are involved.
 For care reviews when no-one else is available to be consulted.

The Role of the IMCA

7.3. The IMCA's role is to support and represent the person who lacks capacity. Because of this, IMCAs have the right to be provided with access to relevant healthcare and social care records. (Mental Capacity Act Code of Practice 10.20)

7.4. Any information or reports provided by an IMCA must be taken into account as part of the process of determining whether a proposed decision is in the person's best interests.

7.5. A written copy of the final decision, and the decision maker's reasons for it, must be sent to the IMCA Service as soon as possible after the decision is made.

7.6. It is vital that clear, accurate and timely identification of the need for an IMCA is made in all cases. Delay in identifying the need for an IMCA is likely to cause delays in medical treatment and discharges from hospital.

For further details on specific IMCA criteria in relation to serious medical treatment and accommodation, please refer to the relevant pages on the Trust intranet or through the IMCA service:

IMCA Service (Devon & Torbay) Age UK Devon, **Tel:** [redacted]
Follow the link on www.AgeUKDevon.co.uk for the IMCA referral page where you will find the referral form and referral guidance
Please email referral forms to [redacted]**.**

8. PROVIDING CARE OR TREATMENT TO PEOPLE WHO LACK CAPACITY - How does the MCA protect you if you work in health and social care?

8.1. The MCA provides legal protection from liability for carrying out certain actions in connection with the care and treatment of people who lack capacity to consent, provided that:

- you have observed the principles of the MCA;
- you have carried out an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in question (part 6); and
- you reasonably believe the action you have taken is in the best interests of the person (part 7); and
- there is no disagreement as to what constitutes a patient's best interests.

8.2. Some decisions that you make could result in major life changes or have significant consequences for the person concerned and these need particularly careful consideration. For example, a change of residence, perhaps into a care home or nursing home; or major decisions about healthcare and medical treatment.

8.3. It is important to keep a full record of what has happened. The protection from liability will only be available if you can demonstrate that you have assessed capacity (see section 8), reasonably believe it to be lacking and then acted in what you reasonably believe to be in the person's best interests (see section 8).

In emergencies, it will often be in a person's best interests for you to provide urgent treatment without delay.

There are some decisions about medical treatment that are so serious that each case should go to the Court of Protection. Please seek advice from the MCA/LPS or legal team.

The Trusts Consent policy and consent forms are available on the Trust intranet.

The Use of Restraint

8.4 Section 6(4) of the Act states that someone is using restraint if they:

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

8.5. Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and

- the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

This use of restraint will usually require DOLS authorisation – please see DOLS policy

Trust staff should also refer to the Violence Prevention and Reduction Policy RDE in respect of the management of violence and aggression, and the Restraint Policy NDHT in regards to restraint.

8.6. In addition to the requirements of the Act, common law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore, if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in way which may cause harm to others, staff may, under common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

8.7. However, within this context, the common law would not provide sufficient grounds for an action that would have the effect of depriving someone of their liberty. In these circumstances please refer to the DoLS Policy for further guidance around appropriate legal frameworks. The Royal College of Emergency Medicine has provided this guidance for considering the use of the Mental Capacity Act in Emergency medicine.

Deprivation of Liberty Safeguards

8.8. These safeguards are designed to protect people lacking capacity who need to be deprived of their liberty for their own safety and who are not capable of making decisions themselves about arrangements that should be made for their care and treatment. The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS), which came into force in England on 1 April 2009, provides a legal framework to prevent unlawful deprivation of liberty occurring.

8.9 Further information can be found in the Trusts Deprivation of Liberty Safeguards Policy and the Deprivation of Liberty Safeguards Code of Practice.

Risks arising from self-neglect or a person's own behaviour or lifestyle

8.10 Please read this in conjunction with the Safeguarding Adult policy.

Please read this in conjunction with the Safeguarding Adult policy. There may be situations where a safeguarding adult concern referral will need to be considered in regard to self neglect. This would be when a vulnerable adult is unable to provide adequate care for themselves; and one or more of the following situations apply:

- They are unable to obtain necessary care to meet their needs.

- They are unable to make reasonable or informed decisions because of their state of mental health or because they lack the mental capacity to understand the risks and consequences associated with their behaviour.
- They are unable to protect themselves adequately against potential exploitation or abuse.
- They have refused essential services without which their health and safety needs cannot be met.

8.12. Often, the cases which give rise to the most concern are those where a vulnerable adult refuses help and services and is seen to be at significant risk as a result. If Trust staff are satisfied that the vulnerable adult has the mental capacity to make an informed decision and they are not being subjected to coercion or intimidation, then that person has the right to refuse services/ treatment/ intervention.

8.13. Although there should always be a presumption of capacity, in high risk cases it is recommended a mental capacity assessment is undertaken to establish that the vulnerable adult does have capacity to understand the risks and consequences of their actions. This should be clearly evidenced and documented within the patient's records together with a full record of the efforts and actions taken by the agencies to assist the vulnerable adult and to understand the basis of refusal.

8.14. If the vulnerable adult lacks capacity to understand the risks and consequences of refusal then the Mental Capacity Act should be followed and a best interest decision made (in complex situations this is likely to be in the form of a multi-agency meeting).

8.15. If they have capacity, appropriate communication should be forwarded to the vulnerable adult concerned, setting out what services were offered and why and the fact of the person's refusal to accept them. This needs to make clear that the person can contact the relevant agency for services at any time in the future.

8.16. In cases of high risk, consideration should be given to arrangements for monitoring the case to ensure that circumstances do not deteriorate to an unacceptable degree. It may also be necessary for staff to consider raising a safeguarding adult concern referral to consider multi-agency protection plans to safeguard the vulnerable adult.

9. PROVIDING CARE OR TREATMENT FOR PEOPLE WHO HAVE PLANNED AHEAD

9.1. The MCA has far reaching effects for people who work in health and social care because it extends the ways in which people using services can plan ahead for the time when they may lack capacity. These are Lasting Powers of Attorney (LPAs), Advance Decisions to refuse treatment, and written statements of wishes and feelings.

9.2. If you are providing care or treatment for someone who lacks capacity these may be very helpful in deciding what to do. If you are working with people who have capacity, or who have fluctuating capacity (such as people with mental health problems) it may be helpful for you to explain to them these ways of planning ahead for a time when they may lack capacity.

9.3. Providing care or treatment for people who have planned ahead is a very complex area and it is advisable to refer to the Code of Practice for more detailed guidance.

Lasting Powers of Attorney

9.4. The MCA introduces a new form of Power of Attorney which allows people over the age of 18 to formally appoint one or more people to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. The person making an LPA is called the Donor. The power that is given to someone else is called a Lasting Power of Attorney (LPA) and the person(s) appointed are known as an attorney(s). The LPA gives the Attorney authority to make decisions on behalf of the Donor and the Attorney has a duty to act or make decisions in the best interests (principle 4) of the person who has made the LPA.

9.5. There are two different types of LPA:
1) A Personal Welfare LPA is for decisions about both health and personal welfare; and
2) A Property and Affairs LPA is for decision about financial matters.

Important facts about LPAs

- The introduction of LPAs for property and affairs means that no more Enduring Powers of Attorney (EPA) can be made, but the MCA makes transitional provisions for existing EPAs to continue whether they are registered or not. This means that pre-existing EPAs can continue to be used (whether registered or not) and can continue to be registered.

- When a person makes an LPA they must have the capacity to understand the importance of the document and the power they are giving to another person.

- Before an LPA can be used it must be registered with the Office of the Public Guardian (part 12). This is vital because **without registration an LPA cannot be used at all.**

- An LPA for property and affairs can be used when the Donor still has capacity unless the Donor specifies otherwise.

- A Personal Welfare Attorney has no power to consent to, or refuse treatment, at any time or about any matter when the person has the capacity to make the decision for himself or herself.

- If the person in your care lacks capacity and has created a Personal Welfare LPA, the Attorney is the decision-maker on all matters relating to the person's care and treatment. Unless the LPA specifies limits to the Attorney's authority the Attorney has the authority to make personal welfare decisions and consent to or refuse treatment (except life-sustaining treatment) on the Donor's behalf. The Attorney must make these decisions in the best interests of the person lacking capacity (principle 4) and if there is a dispute that cannot be resolved, for example, between the attorney and a doctor, it may have to be referred to the Court of Protection.

- If the decision is about life-sustaining treatment, the Attorney only has the authority to make the decision if the LPA specifies this.

- If you are directly involved in the care or treatment of a person who lacks capacity, you should not agree to act as their Attorney other than in exceptional circumstances, for instance, if you are the only close relative of the person.

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

Advance Decisions to refuse treatment

9.6. Sometimes people have clear views about what types of treatment they don't want to have and would not consent to. An Advance Decision allows them to express these views clearly, before they lose capacity. Advance Decisions can currently be made under common law and the Mental Capacity Act puts them on a statutory footing. It also explains what is required in law for an Advance Decision to be valid and applicable and introduces new safeguards.

9.7. An Advance Decision is where a person aged 18 or over may set out what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent to this treatment for themselves in the future. It can be about any treatment even if it may result in the person's death, and if it is valid and applicable it must be followed as it is legally binding and has the same force as when a person with capacity refuses treatment.

What are the requirements for Advance Decisions?

9.8. The MCA introduces a number of rules people must follow when making an Advance Decision. If you are making a decision about treatment for someone who is unable to consent to it, you must be satisfied that the Advance Decision exists and is valid and applicable to the particular treatment in question.

9.9. For more information please see our Advance decisions to refuse treatment policies:

RDE: Advance Decision to Refuse Treatment Policy

NDDH: Advance Care Planning Policy

Court of Protection and Court Appointed Deputies

9.10. The Court of Protection was established under the Mental Capacity Act 2005, to make a decision or to appoint a decision-maker on someone's behalf in cases where there is no other way of resolving a matter affecting a person who lacks capacity to make the decision in question.

9.11. The Court of Protection has powers to:

- Decide whether a person has capacity to make a particular decision for themselves
- Make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions.
- Appoint deputies to make decisions for people lacking capacity to make those decisions.
- Decide whether an LPA or EPA is valid, and remove deputies or attorneys who fail to carry out their duties.
- Serious healthcare and treatment decisions, such as withdrawing artificial nutrition, bone marrow or organ donation, non-therapeutic sterilisation or other instances where there is doubt about whether a particular treatment is in the person's best interest should be put to the Court of Protection for approval.

10. FURTHER SUPPORT AND ADVICE

10.1. If you are unable to find the answer to a question in this Policy or the MCA Code of Practice, and having discussed the matter with your line manager there are several routes for further support.

- The Devon County Council DoLS service – [redacted]
- Royal Devon Eastern Services MCA team – [redacted]
- Royal Devon Northern Services MCA team – [redacted]
- Royal Devon Legal Team – [redacted]

11. STANDARDS FOR RECORD KEEPING

All issues relating to Mental Capacity Assessments must be recorded in the patient's notes and all relevant professionals must be made aware of any authorisations in place. All record keeping must be in line with organisational policies and professional guidelines. Care planning documentation must be reviewed to ensure it incorporates a process to consider whether a person has capacity to consent to the care/treatment.

12. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's 'archived policies' shared drive, and will be held indefinitely.

13. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

To evidence compliance with this policy, the following elements will be monitored:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
	MCA Audits Internal Reviews	MCA/LPS Operational Group Safeguarding Adults Operational Group Joint Integrated Safeguarding Committee

14. REFERENCES

Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice - Issued by Ministry of Justice (2008)

Mental Capacity Act 2005 Code of Practice (2007)

Mental Capacity (amendment) Act 2019,

Royal College of Medicine: The Mental Capacity Act in Emergency Medicine

RDE: Advance Decision to Refuse Treatment Policy

NDHT: Advance Care Planning Policy

RDE: Violence Reduction and Prevention Policy

NDHT: Restraint and Restrictive Practice Policies

RDE: Deprivation of Liberty Safeguards policy

APPENDIX A: Mental Capacity Assessment

Name: **Location:** **D.O.B:** Patient Identification Label

NHS
Royal Devon
University Healthcare
NHS Foundation Trust

MENTAL CAPACITY AND BEST INTERESTS ASSESSMENT

I am completing this assessment form on (date)..... because the patient named above appears to lack capacity at this time (Assessment context -*Remember assessment of Mental Capacity must be decision and time specific)*			
Please state below the details of the treatment decision(s) or other specific issue(s) for which this mental capacity and best interest's assessment is being completed?			
Determination of Capacity *(This is specific, not general determination)* See Decision Making flow chart in the Mental Capacity policy			
Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?	Permanent impairment ☐	Temporary impairment ☐	None ☐
Details:			
Can the decision be delayed because the person is likely to regain capacity in the near future?	Yes ☐	Not likely to regain capacity ☐	Not appropriate to delay ☐
Details:			
1. Is the patient able to understand information related to the decision?		Yes ☐	No ☐
Comments/Evidence:			
2. Is the patient able to retain information related to the decision?		Yes ☐	No ☐
Comments/Evidence:			
3. Has the patient been able to use and weigh up the information? Do they understand the risks and benefits of making or not making the decision?		Yes ☐	No ☐
Comments/Evidence:			
4. Person has ability to communicate their decision by any means?		Yes ☐	No ☐
Comments/Evidence: state what steps have been taken to achieve communication?			

Approved date: Feb 2018
Review date: Feb 2021

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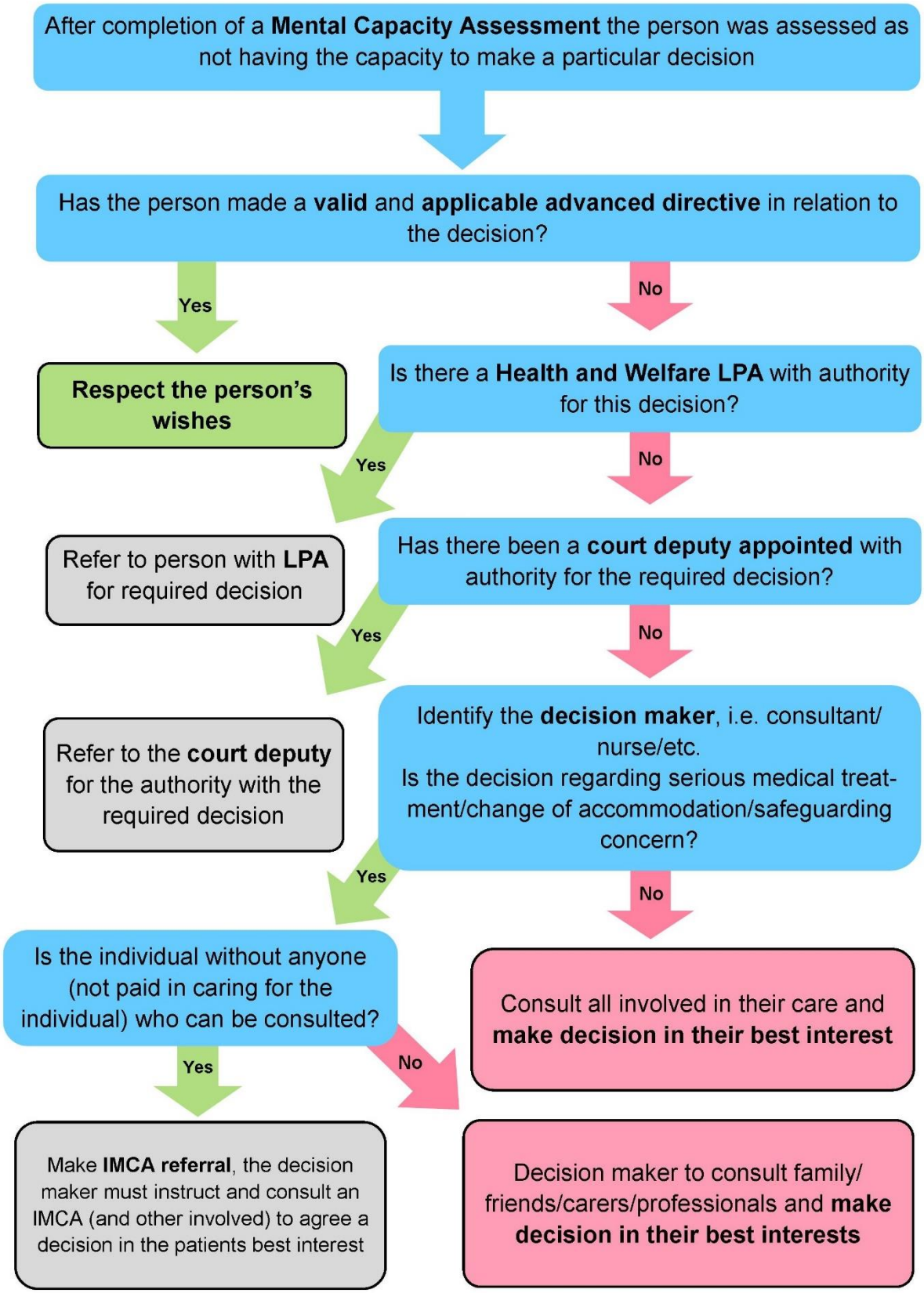
Lead: Safeguarding Adults Lead
Version 2

APPENDIX B: Best Interest Assessment



Best interest checklist

When making a decision in patient's best interest consider the following:

- Find out the **patient's views** (past and present wishes, religion, culture, beliefs)
- Find out if patient has a **Lasting Power of Attorney** for health and welfare or a **Court Appointed Deputy** (an Attorney or Deputy are the decision makers, if the decision is within their remit)
- Find out if patient has made any **advance decisions to refuse treatment** (must be valid and specific) or **advance statement** of wishes
- Encourage patient's **participation**
- **Consult** with others (Anyone the person has asked, or previously asked, to be consulted, anyone engaged in their welfare including relatives, friends and carers, any LPA, any Deputy, any IMCA)
- Try and **identify** all the things the patient would take into account if they had capacity and all relevant circumstances
- **Avoid discrimination** (do not make a decision based on age, appearance, behaviour, physical or mental health condition)
- Assess if a person **may regain capacity** and if the decision can be delayed
- **Do not make assumptions** about person's quality of life
- **Avoid restricting** a person's rights (ensure that a range of options are explored, to identify which is least restrictive of the person's rights)
- If the decision relates to **life sustaining treatment** you must ensure that: the decision is in no way motivated to bring about the person's death; and that no assumptions are made about the person's quality of life
- **Record** the Mental Capacity Assessment and best interest decision in the patient's notes. For serious medical treatment this must be recorded on a formal Mental Capacity Assessment and Best Interest form

  For more detailed information see:
  www.gov.uk/government/publications/mental-capacity-act-code-of-practice

APPENDIX C: IMCA referral form

Follow this link to access the full form: [redacted]

CONFIDENTIAL

IMCA use only	
Case ref no:	Main diagnosis:
Area:	Date IMCA started work:
Date of referral:	IMCA:
Decision:	

Devon and Torbay Independent Mental Capacity Advocacy (IMCA) Service REFERRAL FORM

For Information and advice on how to complete this form please phone the IMCA service on [redacted] or read the Referral Guidance notes on DCC website: https://new.devon.gov.uk/adultsocialcareandhealth/guide/mca-practice-guidance/part-15-independent-mental-capacity-advocates/
Failure to complete all relevant parts of this form will result in delayed allocation of this referral.
The referral form should be emailed to [redacted]

DETAILS OF THE PERSON BEING REFERRED

Name		D.O.B	
Permanent Address		Age	
		Gender	
Postcode		Tel	
Current address		Tel	
Postcode			

Client currently living in	Own home		Care home		Hospital		Supported living		Prison		Uncertain		Other (specify)	

THE DECISION

Is Serious Medical Treatment being proposed by an NHS body? If yes an IMCA instruction is a statutory requirement.	Yes		No	
Is a Change of Accommodation being proposed by an NHS body or Local Authority for longer than 28 days in a hospital or 8 weeks in a care home? If yes an IMCA instruction is a statutory requirement.	Yes		No	
Is a care review being carried out? If yes an IMCA instruction is discretionary.	Yes		No	
Is the person subject to Safeguarding of Adults proceedings? If yes an IMCA instruction is discretionary.	Yes		No	

Please note: If you have ticked no for all areas, the person is not eligible for an IMCA. Please consider Care Act Advocacy.

Details of the Decision to be made	
What are the options being considered	
Details of the proposed course of action	
Is there a date by which the decision must be made?	

1
IMCA Referral Form Revised April 2017

APPENDIX D: COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the policy	All Trust staff, students and volunteers.
The key changes due to it being a revised policy	The policy is now more accessible for staff to implement MCA as part of their work. The policy is focusing on the practical implementation for staff.
The key objectives	The purpose of this policy is to provide guidance to staff about when a MCA is required and how to complete. It also provides information for who to contact for support and advice. This policy is vital to protect the vulnerable patients in our trust.
Specific Issues to be raised with staff	Clinical staff should be made aware of the policy.
How new staff will be made aware of the policy	Cascade by email from manager and during the induction Process.
Training available to staff	
Any other requirements	N/A
Issues following Equality Impact Assessment (if any)	None Identified
Location of hard / electronic copy of the document	The original of this policy will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

APPENDIX E: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Mental Capacity Act Policy
Division/Directorate and service area	Safeguarding
Name, job title and contact details of person completing the assessment	[redacted] MCA/LPS Lead [redacted]) & [redacted] MCA/LPS Lead [redacted])
Date completed:	20/05/2022

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

This document gives guidance to staff around the Mental Capacity Act and mental capacity assessments, who work for Royal Devon University Healthcare NHS Trust.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	☒	☐

Sex - including: *Transgender, and Pregnancy / Maternity*	☐	☒
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

This policy may be particularly applicable to patients who have carers, who are more likely to lack capacity, and to benefit from consideration for consultation of their carers in relation to Mental Capacity Assessments. This policy is also particularly relevant to any group of individuals who have an impairment of the mind and/or brain.

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- ***Fairness** – how have you made sure it treat everyone justly?*
- ***Respect** – how have you made sure it respects everyone as a person?*
- ***Equality** – how does it give everyone an equal chance to get whatever it is offering?*
- ***Dignity** – have you made sure it treats everyone with dignity?*
- ***Autonomy** – Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

The MCA is by its very nature, legislation which is particularly applicable to certain categories of disability. Individuals with Dementia and Learning Disabilities are disproportionately more likely, by the nature of their condition(s), to lack capacity.

As such consultation has involved the relevant Dementia Clinical Nurse and Learning Disability Liaison Nurse. Consultation has encapsulated relevant individuals, including Matrons, from Wards, some of which are disproportionately more greatly impacted by MCA. This includes any ward with a greater proportion of patients with impairments of the mind and/or brain. Consultation has also included relevant individuals from the community, safeguarding and the Equality & Diversity Lead.

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	
Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	