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BACKGROUND
This document is designed to support the completion of the FACE Mental Capacity Assessment V3, provide basic guidance on the Mental Capacity Act 2005 (MCA) and demonstrate due regard to supporting Code of Practice as required by the legislation. For a more detailed explanation of the MCA you should refer to the MCA Code of Practice. For a more accessible document we would recommend Making Decisions: a guide for people who work in health and social care.

APPLICABILITY
The Mental Capacity Act 2005 (MCA) applies in England and Wales to everyone who works in health and social care and is involved in the care of a person who is over 16 years of age who may lack capacity to make a specific decision at a specific time.

THE FIVE CORE PRINCIPLES THAT UNDERPIN THE MCA
These are as follows:

1. A person is assumed to have capacity. A lack of capacity has to be clearly demonstrated.
2. No one should be treated as unable to make a decision unless all practicable and reasonable steps to help him or her have been exhausted and shown not to work.
3. A person is entitled to make an unwise decision. This does not necessarily mean they lack capacity.
4. If it is decided a person lacks capacity then any decisions taken on their behalf must be in their best interests.
5. Any decision taken on behalf of a person who lacks capacity must take into account their rights and freedom of action. Any decision/action must show consideration of the least restrictive options or intervention possible to meet need.

USING THE FACE MENTAL CAPACITY ASSESSMENT
This document provides guidance on the key terms occurring in the FACE Mental Capacity Assessment and on what should be recorded in relation to its various sections. The notes follow the order of the assessment.

The Act covers a wide range of decisions made, or actions taken, on behalf of people who may lack capacity to make specific decisions (MCA Code of Practice 2005) and it needs to be clear about why the Mental Capacity Assessment is being undertaken by answering the following:

‘What prompted this assessment?’
Any lack of capacity must be clearly demonstrated as a person is assumed to have capacity. No one should be treated as unable to make a decision unless all practicable and reasonable steps to help them have been exhausted and shown not to work.
Doubts about a person’s capacity can occur because of:

- The person’s behaviour
- Their circumstances
- Concerns raised by someone else

However, age, appearance and condition do not by themselves establish lack of capacity. It is also important to acknowledge the difference between unwise decisions (which a person has the right to make) and decisions based on a lack of understanding of risks, or an inability to weigh up information relevant to a decision.

Practitioners should use this space to provide sufficient context about the person such that the Mental Capacity Assessment can be read as an independent entity without reference to other documentation.

**‘What is the specific decision to be taken?’**

The decision to be taken needs to be described clearly, e.g. an assessment of whether X has the mental capacity to make a decision about where they should live. Clarity at this stage will be maintained throughout the assessment and will support the Decision Maker to go through the process. Any recommended course of action must be checked against the best interest checklist (see Chapter 5 Code of Practice) to ensure that it is the most appropriate decision in the circumstances for the person and to determine whether it needs to be reconsidered.

**KEY ROLES**

Any of the following people who hold key roles may be involved:

**Enduring Power of Attorney (EPA)**

Enduring Power of Attorney is legally binding until death, even if the person loses mental capacity. As of October 2007, the concept of Enduring Power of Attorney has been superseded by that of Lasting Power of Attorney (see below). However, Enduring Powers of Attorney set up before October 2007 remain legally binding.

**Lasting Power of Attorney (LPA)**

This role replaces the Enduring Power of Attorney role. A person with mental capacity can set up a Lasting Power of Attorney to allow someone to act on their behalf/make decisions with regard to their finances, welfare and health care for a time in future when they may lack capacity. In order to be valid, a Lasting Power of Attorney must be registered with the Public Guardian on the prescribed form of which there are two and they may have one or the other or both and which should be recorded on the assessment. Lasting Power of Attorney can be granted for Financial or Health and welfare.

These domains of responsibility can be split between two people, or a single individual may be given Lasting Power of Attorney for both domains.

**Deputy appointed by Court of Protection**

From October 2007, a deputy appointed by the Court of Protection can make ongoing decisions about a person who lacks capacity. The Court of Protection will have defined the remit of their powers.
The Public Guardian
The Public Guardian has a number of roles. These include: keeping a register of people with Lasting Power of Attorney, keeping a register of orders appointing deputies, supervising deputies appointed by a court, directing Court of Protection visitors, receiving reports from attorneys, providing reports to courts and dealing with enquiries and complaints about the way deputies or attorneys use their powers.

Independent Mental Capacity Advocate (IMCA)
Local Authorities and NHS bodies are being increasingly encouraged to involve an IMCA in a wide range of circumstances. They must be appointed to represent the interests of those who have been or are being assessed as lacking capacity to make a decision about treatment or care and have no one else to speak to them, i.e. they are unbefriended and either:

- The decision is about serious medical treatment provided by the National Health Service (NHS) (but excludes treatment regulated under Part 4 of the Mental Health Act 1983).
- An NHS body or a Local Authority (LA) is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home (where that accommodation or move is not a requirement of the Mental Health Act 1983) and either the person will stay in hospital longer than 28 days or they will stay in the care home for more than 8 weeks.
- If they are subject to Safeguarding Adults procedures. In these cases alone the rule that the person is unbefriended does not apply.

‘Are there any documents relating to key roles (e.g. LPA forms, etc.)?‘
Please make reference to any relevant forms or documents relating to any key roles.

ASSESSMENT OF CAPACITY
Mental capacity must be assessed with regard to a specific decision. The following two-stage test of capacity must have been followed:

- Is there an impairment of or disturbance in the functioning of the person’s mind or brain?
- Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

Anyone caring for or supporting a person who lacks capacity should be involved in the test to assess capacity when relevant and appropriate. This will include family members and carers as well as health and care staff. The more significant the decision, the greater the number of people likely to be involved. Expert evaluation by doctors or psychologists may be required in some complex cases but, even when used, may not be the only form of assessment. Who is involved will depend on individual circumstances. Sources of help may include:

- Clinical psychologist
- Psychiatrist/Psycho-geriatrician
- Nurse consultant
• Specialist nurse, e.g. in dementia care or liaison psychiatry
• Senior nurse
• Occupational therapists
• Social Care staff

The conclusions must show that this two-stage test has been applied. The evidence must show that on the balance of probabilities the person lacks capacity to make that particular decision at that particular time. Remember, this is a specific determination pertaining to a specific decision. Any documentation used in making the decision should be referenced. Remember:

• An unwise decision does not in itself indicate lack of capacity
• A person may be unable to make a complex decision about, e.g. where they should live, but be perfectly capable of making decisions about what they eat, drink and wear

Transient capacity must also be considered. For example, is the person’s understanding better at different times of the day or in particular contexts? Are they able to make decisions when they are in a comfortable environment, perhaps with loved ones in attendance? Consider also the effects of medication over the course of the day. A decision about capacity should not be pushed through when capacity is at its lowest. Whether capacity is fluctuating, temporary or affected by a medical condition, all steps taken to maximise the person’s ability to make a decision should be recorded.

First Stage Diagnostic Test
The first stage diagnostic test requires evidence that the person has impairment or other disturbance of the mind or brain that affects their ability to make a decision. An individual’s capacity to make a decision can be affected by a number of circumstances. For example:

• A stroke or brain injury
• A mental health problem
• Dementia
• A learning disability
• Confusion, drowsiness or unconsciousness because of illness or the treatment for it
• Substance misuse

Second Stage Functional Test
The second stage functional test is to assess whether, as a result of the impairment/disturbance, the person lacks capacity to make a specific decision. The first three are applied together as a sequential process to determine if a person is able to make a decision. The fourth only applies if a person cannot communicate their decision in any way (MCA Code of Practice 2005).
A person is unable to make a decision if they cannot:

- **Understand information related to the decision**
  Every effort should be made to present the information in a way that the person can understand, i.e. in plain language. It should relate the nature of the decision, the reason the decision is needed and the likely effects of making no decision at all (MCA Code of Practice 2005).

- **Retain information related to the decision**
  The person must be able to hold onto the information long enough to make an effective decision. This may be only for a short time but it depends on how long it is necessary for them to decide. They may need additional resources, e.g. notebooks, photographs, posters, videos and voice recorders to help them retain information (MCA Code of Practice 2005).

- **Use or weigh up the information whilst making the decision**
  For a person to have capacity they must be able to weigh up the information and arrive at a decision. Sometimes they may understand the information but the impairment or decision stops them using it or they may make a decision without understanding or using the information they have been given.

- **Communicate their decision (verbally, by sign, or any other means)**
  If a person cannot communicate their decision in any way at all, the Act says that they should be treated as unable to make the decision however; they may be able to communicate their decision by the blink of an eye or the squeeze of a hand. It is important that all practical steps are used to help them communicate their decision which may be the involvement of other health professionals, e.g. speech and language therapists.

‘If Yes to all questions above the assessment is complete. Please go to Assessment and Best Interests Summary on page 4. If the answer is No to any of these questions, then the person does lack capacity.’

This prompt has been included for the benefit of those who may read the assessment but may not have been involved in its completion.

A ‘No’ answer in any of the 4 domains above represents a lack of capacity. This is made explicit by answering Yes or No to the following:

‘Does the person lack capacity to make this specific decision?’

If ‘No’, the following questions should then be completed:

‘Who was consulted about the assessment of capacity to make this decision?’

Please identify who was consulted about the determination. If someone significant was not consulted please identify who and why. The decision-maker should identify anyone already known to the person who can appropriately represent them (e.g. relative/friend). If there is a Lasting Power of Attorney or a deputy appointed by the Court of Protection they must be consulted. If a case conference was held, detail who attended.

‘Were all reasonable steps taken to maximise the person’s capacity to make the decision?’

This item prompts practitioners to check and document that all reasonable steps were taken to assess a person’s capacity at its maximum. Consideration should be given to factors that maximise a person’s capacity. For instance, what stage a person is in their drug cycle, the time of day they are assessed or whether the presence of people close to the person helps the individual.
‘Can the decision be delayed because the person is likely to regain capacity in the near future?’
Please answer Yes or No and give details to support your answer. Careful consideration needs to be given to whether a person is likely to regain capacity within the time limits required by a decision. This question prompts practitioners to check and document that mental capacity decisions are not unnecessarily rushed. However, in some cases, it will be in the best interests of the person that a decision is made on their behalf even though it is expected that the person’s capacity will improve in the near future. Where capacity may improve, consideration should be given to when this decision should be reviewed.

ADVANCE DECISION TO REFUSE MEDICAL TREATMENT
A competent (has capacity) and informed adult (18yrs+) who is capable of understanding the implications of his or her decisions has a legal right to refuse specific medical treatment in advance time when they have capacity to come into effect at a time when they do not have capacity to make a specific decision. No individual, whether or not he or she has capacity, has the right to demand specific forms of medical treatment. An advance decision does not need to be in writing unless life-sustaining treatment is being refused.

‘Is there an advance decision relevant to this decision?’
If ‘Yes’ select the option and give details.

An advance decision is applicable if:

- The proposed treatment is specified in the advance decision
- The circumstances at the time the decision needs to be made are similar to those set out in the advance decision to make the advanced decision valid and applicable

‘What was the decision?’
Give details. If the advance decision was verbal, detail to whom and in what circumstances.

‘Is this decision still applicable?’
An advance decision is no longer applicable if:

- It is withdrawn – this does not need to be in writing; if verbally retracted, detail to whom, in what circumstances
- There are reasonable grounds for believing that circumstances have now arisen which the individual did not anticipate when he or she made the advance decision and would have affected their decision had they known
- A Lasting Power of Attorney was granted to allow someone to act on behalf of a person with regard to welfare and health care after the advance decision was made and gave the Attorney the right to consent or refuse a particular treatment; in order to be valid an LPA must be registered with the Public Guardian on the prescribed form
- The person has subsequently done something inconsistent with the advance decision
• The person is being detained under the Mental Health Act 1983 and the treatment is for their mental disorder, however, even if a person is being treated without their consent under Part 4 MHA, an advance decision to refuse other forms of treatment is still valid (see Code of Practice 13.35-13.37)

**What is the difference between an advance decision and an advance statement?**
An advance decision to refuse medical treatment is legally binding. An advance statement expresses preferences, wishes, beliefs and values regarding future care to guide anybody making a Best Interests decision in the future should they not have capacity and it is not legally binding.

**FACE DETERMINATION OF BEST INTERESTS**
This can be used as a standalone document or as part of the FACE Mental Capacity Assessment. If it is decided that a person lacks capacity then any decision made on their behalf must be in their best interests (see Ch. 5 Code of Practice). Points for consideration will depend on individual circumstances, but amongst these would be:

• Whether the person is likely to regain capacity and whether the decision or act to be undertaken can wait

• How to support the person to take part in or improve their ability to participate in the decision making process

• The past and present wishes, feelings, beliefs and values of the person and any other relevant factors

• The views of other relevant people

• What is the least restrictive option/intervention?

Specific questions with regard to best interest have been added throughout the document.

‘Is an IMCA required?’
Is an Independent Mental Capacity Advocate required? If so, what is their name and telephone number?

‘If a person lacks capacity and a decision has to be made on their behalf, please record the benefits and disbenefits of each option below’
This clearly identifies each option and the associated benefits and disbenefits. This section also provides evidence that the decision maker has fully considered a number of different options when determining the ‘Best Interests’ of the person involved before making their final decision. Detailed options should be available to help the person make choices where possible, whether or not they have capacity the likely consequences of that a decision should be highlighted.

‘What is most important to the person regarding this decision?’
Though the person lacks capacity they may still retain wants and wishes relevant to the decision at hand. Identify what is most relevant to the individual who lacks capacity in the context of the decision being made. Wherever possible, what is of most importance to the individual should be taken into account.

A person may have had strong views in the past that are relevant to the decision at hand. This could be made clear by their behaviour or they may have expressed these views in the past, e.g. verbal communication, writing, behaviour and habits, or recorded on video or audiotape. They may have outlined
how they would like to be treated and cared for, e.g. stating that they wish to be cared for at home rather than hospital if dying of a terminal illness. These types of advance statement are not legally binding but should assist the planning of care and treatment for individuals.

The Mental Capacity Act gives special weight to written statements and the decision-maker ‘...should consider a written statement carefully. If their decision does not follow something a person has put in writing, they must record the reasons why. They should be able to justify their reasons if someone challenges their decision.’ (5.43)

Every effort should be made to communicate with someone. Very few people lack capacity based on this ground alone. Those who do might include people who are unconscious or in a coma, or suffer from a rare neurological condition known as ‘locked in’ syndrome. However, in many other cases simple actions such as blinking or squeezing a hand may be enough to communicate a decision. Input from professionals in communication is likely to be needed in this area.

‘Views of interested others’
Include names and roles. Professionals are obligated to consult with people who are interested in the welfare of a person. If the person has no independent party representing their interests explain why and what is being done about this situation. For instance, a person may require emergency treatment and it is not possible to contact an LPA or person close to the person in time, or to arrange for them to have an IMCA or Court of Protection Deputy assigned to them.

‘Views of professionals involved’
Include names and roles. Detail the views of the various professionals involved.

‘Which option has been decided?’
This needs to be identified here so that it is clear what decision has been decided to anybody who reads the assessment.

‘Is this the least restrictive option?’
This question needs to be considered at this stage to support the final decision.

‘Details of why the decision for chosen option was taken and why other options have been disregarded’
Having reviewed the benefits and disbenefits of each option and considered the views of all interested parties, justification needs to be given as to why this option has been chosen over the others which have been considered. It is also good practice for health and Social Care Staff to record why this specific option has been chosen especially if it goes against the views of somebody who has been consulted whilst working out somebody’s best interests (MCA Code of Practice 2005).

‘Are there any conflicts or disagreements with regard to this decision?’
Please answer Yes or No and give details. It is important to identify any possible conflicts of interest with regard to the decision. This is particularly the case if a decision is in dispute. Consider whether there are any Safeguarding Adults concerns and document these if relevant.

ASSESSMENT AND BEST INTERESTS SUMMARY
‘Does the person lack capacity to make this decision?’
Please answer Yes or No.
‘Has a Best Interests Decision been made?’
Please answer Yes or No.

‘Does the decision require arbitration?’
Some decisions are extremely complex. Seeking independent arbitration is therefore sometimes necessary. This can involve use of an independent arbiter agreed by the conflicting parties, or a more formal application to the Court of Protection can be made.

Courts of Protection are being set up nationwide to provide a higher court for capacity and best interest decisions. As well as resolving serious disputes, the Court of Protection should be involved with decisions involving the following:

- The proposed withholding or withdrawal of artificial nutrition and hydration from patients in a permanent vegetative state
- Cases involving organ or bone marrow donation by a person lacking capacity to consent
- The proposed non-therapeutic sterilisation of a person lacking capacity to consent to this (e.g. for contraceptive purposes)
- Some termination of pregnancy cases
- Other cases where there is doubt or dispute about whether a particular treatment will be in the person’s best interests

‘Considering all the factors what final decision has been reached?’
Give details of the final decision. This decision and the assessment as a whole should show that the decision-maker has made a decision on the best available evidence and has taken into account conflicting views.

The Mental Capacity Act provides legal protection from liability for carrying out care if:

- The principles of the Act have been observed
- The decision-maker can demonstrate they assessed capacity
- The decision-maker reasonably believes the person lacks capacity with regard to the decision
- The decision-maker reasonably believes the action is in the best interests of the person

Ordinarily a person representing the interests of the person should be consulted before making a decision. However, in emergency situations it will often be in the best interests of the person to provide urgent care without delay. If there is a dispute then it should be clearly identified. If there is a dispute then the following things can assist the decision-maker:

- Involve an advocate who is independent of all parties involved
- Get a formal second opinion
- Hold a best interests case conference
• Go to mediation

• Make an application to the Court of Protection for a ruling

‘This decision is the less restrictive option or intervention possible’

Any decision taken on behalf of someone who lacks capacity must take into account their rights and freedom of action. Any decision should show that the least restrictive option or intervention is achieved. Restraint should only be used as a last resort or in exceptional circumstances. The way in which it might be used must be recorded in a person’s care plan and all instances of restraint must be recorded. Conditions that may justify restraint include:

• The person taking action must reasonably believe that it is necessary in order to prevent harm

• That the act is a proportionate response (in terms of both the degree and duration of the restraint)

‘Special considerations for life-sustaining treatment have been considered or are not applicable’

Where life-sustaining treatment may be in the person’s best interests the person making the decision must not be motivated to bring about a person’s death.

‘This decision has not been biased by age, appearance, condition, gender or race’

Please refer to local protocols with regard to discrimination.

‘Every effort has been made to communicate with the person concerned’

Irrespective of the person’s disabilities every effort must be made to communicate with the individual concerned.

CHILDREN AND YOUNG PEOPLE

The Act only applies where the person lacking capacity is 16 years or older. Any decisions regarding children younger than 16 are made with the consent of people with parental responsibility. The Court of Protection has the powers to make decisions about the property and affairs of people under the age of 16.

Only people who have reached the age of 18 can make LPAs, advance decisions and wills. Whilst 16 or 17 year olds who have capacity may give or refuse consent to treatment at the time it is offered they cannot make advance decisions. However, the views expressed when they have capacity should be taken into consideration.

RECORD KEEPING

Where long-term or significant decisions are to be made in relation to a person who may lack capacity, professional staff must keep a record of how capacity was assessed and any ensuing decisions made. This involves documenting:

• What the decision was

• Why the decision was made

• How the decision was made – Who was involved? What information was used?
Such records provide evidence for staff if they face civil or criminal charges or complaints. Completing the FACE Mental Capacity Assessment appropriately will help ensure that you meet the requirements of the Mental Capacity Act.

The Decision Maker

There are times when a number of people may be involved in making recommendations in relation to a decision. 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.

- In accommodation issues it can be the person who is facilitating a move or funding a placement
- 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
- 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 most day-to-day actions or decisions, the decision-maker will be the person most directly involved with the person at the time
- 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
SOURCES AND REFERENCES


Department of Health (DOH) – range of material, leaflets, training material.


Justice Department – range of material including the statutes, leaflets and training materials.
http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

Making Decisions: A guide for people who work in health and social care; Published by the Department for Justice.

Mental Capacity Act 2005: Code of Practice.

Presentation: Mental Capacity Act 2005 by Dora Jonathan-Withers.


ACKNOWLEDGEMENT

The FACE Mental Capacity Assessment and guidance were developed in consultation with Dora Jonathan-Withers BSc (Hons) MSc (Clinical Psych) LLM. Dora is a psychologist and until recently the CSIP WM Regional lead on mental health legislation and the Mental Capacity Act.