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Consent to Examination, Screening or Intervention Policy

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Purpose and Summary of Document:

This document sets out to inform all staff of the policy in relation to consent for examination, screening or intervention and the legal requirements in relation to obtaining consent.

Intended audience: All staff but particularly those in clinical areas

Interdependencies with other policies:

- Safeguarding Policies and procedures accessible: [here](#)
- NHS Wales Governance e-manual accessible [here](#)

Standards for Health Services in Wales:

- Governance, Leadership & Accountability
- Standard 1.1: Health Promotion, protection and Improvement
- Standard 2.7: Safeguarding Children and Safeguarding Adults at Risk
- Standard 3.1: Safe and Clinically Effective Care
- Standard 3.2: Communicating Effectively
- Standard 3.4: Information Governance and Communications Technology
- Standard 3.5: record Keeping
- Standard 4.1: Dignified Care
- Standard 4.2: Patient Information
- Standard 6.1: Planning Care to Promote Independence
- Standard 6.2: Peoples Rights
- Standard 6.3: Listening and Learning from feedback
- Standard 7.1: Workforce

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1 Introduction

Valid consent is absolutely central in all forms of healthcare; it is not only a legal obligation but also a matter of common courtesy between staff and users of our services. Both Public Health Wales and individual members of staff may become subject to legal action if valid consent is not obtained before an examination, screening test or intervention is carried out.

The Welsh Assembly Government (now the Welsh Government) published a Welsh Health Circular (WHC) (2008) 10 – Reference Guide for Consent to Examination of Treatment in 2008. The Welsh Government also issued the Good Practice in Consent Implementation Guidance: consent to examination or treatment (WHC (2008) 36) which sets out the details of the law on consent and good practice.

This policy applies to all Public Health Wales staff but in particular those who have contact with service users in the course of providing them with all aspects of examination, screening or intervention (including research). Staff have a responsibility to familiarise themselves with and follow the content of this Policy and to ensure that they remain up to date with regard to the law, case law and guidance regarding consent and capacity. This is also a professional requirement of those who are registered with professional bodies eg General Medical Council, Nursing Midwifery Council.

2 Policy aims and objectives

The aim of this policy is to provide information and direction to staff regarding all aspects of the consent process, enabling Public Health Wales staff to deal with consent issues lawfully. This Policy should be read in conjunction with the legislative documents referenced and with relevant professional codes of conduct and guidance.

3 Scope

Applies to all staff within the organisation that are required to obtain consent from service users and/or who develop resources /guidance/ training / standards that facilitate informed consent.

4 Roles and responsibilities

Responsibility for implementation of this policy ultimately sits with the Executive Team but all Directorates are responsible for ensuring that staff are aware of the policy and for ensuring that it is applied correctly.

5 Consent, capacity and best interests

“Consent” is the expression of the right of the individual to decide what is done, or not done, to them (autonomy). Undertaken appropriately it protects staff from being charged with assaulting the individual who has given consent. Before providing examination, screening or intervention staff should be satisfied that the individual has given his or her valid consent. If consent is not obtained this should be recorded.

The consent process starts with provision of information including the risks and benefits (both of having the intervention and not having it). This information can then be considered by the individual so that they can make their own decision on how to proceed without undue influence of others. After making a decision that individual can communicate their decision. Where there are significant risks involved with accepting or refusing an intervention this is usually done in writing. An individual who has given consent can withdraw it at any time. More detail on the nature and purpose of consent are included in Appendix A.

When a child is old enough to consent for him/herself they can do so. The law presumes that those under 16 cannot consent unless they demonstrate that they have the mental capacity to do so. More detail on consent for children is included in Appendix A. Information on mental capacity and how to test it is included in Appendix B.

The Mental Capacity Act 2005 assumes all those aged 16 or older have capacity to consent until shown otherwise. An individual lacks capacity if he or she is unable to make a specific decision for themselves in relation to a matter at the time it needs to be made because they have an impairment of, or disturbance of the mind or brain. This impairment or disturbance can either be temporary or permanent. Where there is doubt about a person’s capacity, an assessment should be carried out and the member of staff must take specific actions and be able to justify their conclusions.

The test of capacity for a person with an impairment or disturbance of mind or brain asks if they are able to understand, retain and weigh information relevant to the decision and then communicate a decision (Appendix C).

Further information on how to assess capacity and record appropriate actions in undertaking this can be found in Appendix B.

6 Decision Making for Those who Lack Capacity

For children lacking capacity parents are normally the persons able to provide or refuse consent (Appendix D). When an adult lacks capacity

someone else may have been given the power to decide on their behalf (Lasting power of Attorney/Court Appointed Deputy – Appendix E and F). If not then the examining clinician will have to make a best interests decision (Appendix G and H) on what the person would have chosen to do, with or without support of a person appointed to discover and share the values, beliefs and preferences of the patient (advocate).

7 Training for Staff

Communication issues including those related to consent are common causes of medical litigation. It is therefore important that staff understand the legal expectations regarding consent and follow due process.

Training on consent and mental capacity will be required for all staff who take consent for examination, screening or intervention. Staff who are required to undertake Level 2 Safeguarding training will be required to undertake consent and mental capacity training.

This will be delivered by e-learning and face to face training.

8 Monitoring and Review

This policy will be reviewed annually by the Quality Management Group to ensure that it is compliant both with existing and emerging legislation. The policy will also be reviewed if any pertinent case law emerges.

A spot audit will also be undertaken annually across the organisation to ensure that the policy is being adhered to. The results of this will be reported to the Quality Management Group and the Executive Team.

9 Information Governance Statement

This policy recognises that Public Health Wales staff taking and gaining consent for examination, screening or interventions may be dealing with confidential and sensitive information. This information and any sharing of it must only occur as part of the examination, screening or intervention. Any paperwork containing information (eg Form 4) or their electronic equivalent must be given security appropriate to the nature of the information collected.

Staff should also refer to the [Confidentiality and Disclosure. policy here or available on the intranet](#)

Appendix A The Nature and Purpose of Consent

What is Consent?

“Consent” is the expression of the right of the individual to decide what is done, or not done, to them (autonomy). Undertaken appropriately it protects staff from being charged with assaulting the individual who has given consent. Before providing examination, screening or intervention staff should be satisfied that the individual has given his or her valid consent.

Provision of Information

The provision of information is central to the consent process. Before individuals can come to a decision about an examination, screening or intervention, they need comprehensible information about these including the risks and benefits (both of having the intervention and not having it).

In *Montgomery v Lanarkshire Health Board* - (<http://www.bailii.org/uk/cases/UKSC/2015/11.html>), the Supreme Court held that

*"An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. **The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the individual's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular individual would be likely to attach significance to it**".(Para 87)*

The two exceptions to this are where the doctor considers that disclosure would be seriously detrimental to the individual's health; and where an individual needs emergency treatment (Part 1 sec 7 Serious Medical Treatment / SMT), but is unconscious or otherwise lacks mental capacity to decide about it. Note that these are exceptions and must not be abused.

Drawings, diagrams and models may be used to facilitate the provision of information where appropriate. Good communication skills are essential (Appendix C). The use of information leaflets can be an effective tool for staff to provide individuals with the information they need to help them to arrive at an informed decision. Individuals can review the information after

the consultation, which may prompt them to ask further questions of staff to more fully understand the examination, screening or intervention being proposed. However, the use of leaflets does not remove the staff member's responsibility to provide a verbal explanation of often much the same information. Where an individual requests more detailed information, the same should be provided. When considering the provision of written information it is necessary to ensure that it is bilingual (Welsh/English), of a high quality, age appropriate and takes account of the individual's ability to read and comprehend the information. It may be necessary to translate information into other community languages, provide in Braille, large print or audio format. The use of Easy-read leaflets which are specially written to assist people with learning disabilities is also encouraged.

Individuals also need to know the scope of the intended examination, screening test or intervention and whether additional procedures are likely to be necessary as part of the procedure, for example removal of particular tissue. Once a decision to have a particular examination, screening test or intervention has been made, individuals need information about what will happen and how they will feel afterwards and so on. Individuals and those close to them will vary in how much information they want: from those who want as much detail as possible, including details of rare risks, to those who ask staff to make decisions for them. The individual should always be encouraged to make the decision for him or herself although there will always be an element of clinical judgement in determining what information should be given. However, the presumption must be that the individual wishes to be well informed about the risks and benefits of the various options. Where the individual makes clear (verbally or non-verbally) that they do not wish to be given this level of information it should be explained that declining to have information may mean that their consent is not valid and the examination, screening or intervention cannot proceed. If the individual still declines any information offered, it is essential to record this fact in the notes. It must be made clear to the individual that they can change their mind and have more information at any time.

Why do we Obtain Consent?

Consent encompasses the sharing of information on what is to be done, why it is to be done, associated risks and alternative options. There should then be an opportunity to ask questions before the individual is asked if they wish to proceed and that decision is acknowledged.

For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. Note that the capacity to consent is related to the ability to understand information relevant to the decision to be made, so someone may have capacity for simple decisions, but not complex decisions. The

informed person may either be the service user, someone with parental responsibility (Appendix D) or a person who has authority under a Lasting Power of Attorney (Appendix E) for personal welfare (including healthcare) or a deputy appointed by the Court of Protection for personal welfare decisions (including healthcare) ("Court Appointed Deputy") (Appendix F). Consent will not be legally valid if the individual has been misled or where they are under the undue influence of another. Consent may also be negligently obtained if appropriate and adequate information is not provided.

While co-operation after an explanation and an opportunity to ask questions may be an expression of consent, compliance where the person does not know what the examination, screening or intervention entails is not "consent". Where a person aged 16 or over does not have capacity to give consent, treatment may be given providing it is given in accordance s12 of the Mental Capacity Act 2005¹. The mandatory provision outlined by the Mental Capacity Act must be followed in circumstances where there is any suspicion that a person might not have capacity to consent.

Some individuals, become very well informed about their health and may actively request particular examinations, screening or interventions. In many cases, 'seeking consent' is better described as 'joint decision-making': the individual and staff member need to come to an agreement on the best way forward, based on the individual's values and preferences and staff knowledge. It should be noted that the Mental Capacity Act 2005 gives an individual the right to refuse any treatment but it does not give the right to demand any particular treatment options.

It is particularly important to take equality issues into account during the consent process. For example, in relation to religious and cultural diversity, members of some faiths are extremely modest in relation to exposure of parts of the body and may only consent to examination, screening or intervention if it is undertaken by someone of the same sex. It is equally important to take Welsh language issues into account during the consent process.

To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the individual either to accept or refuse examination, screening or intervention. Such pressure can come from partners or family members as well as staff. Staff should be alert to this possibility, and where appropriate should arrange to see the individual on their own to establish that the decision is truly that of the individual.

¹ Mental Capacity Act and Code of Practice <http://www.legislation.gov.uk/ukpga/2005/9/contents> and https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Consent can be given in writing, verbally or implied (for example by presenting an arm for a pulse to be taken). In all cases, an adequate record of the consent process and the nature of consent should be maintained within the individual's health record for future reference. Each Directorate will agree how they should document the consent process for the examinations, screening and interventions they undertake and this list should be available for staff. Where the signing of a consent form is not required, staff members must follow the Standard Operating Procedures for their area or document the process followed.

It is often wrongly assumed that an individual's signature on a consent form is valid consent. A signature on a form is evidence that the individual has signed the form, but is not proof of valid consent. If an individual is rushed into signing a form, on the basis of too little information, the consent may be either inadequately informed or invalid, despite the signature. Similarly, if an individual has given valid verbal consent, the fact that they are physically unable to sign the form is no bar to treatment. Individuals may, if they wish, withdraw consent after they have signed a form: the signature is evidence of a stage in the process of consent-giving, not a binding contract.

It is rarely a legal requirement to seek written consent (The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990, as amended, require written consent in certain circumstances), but it is good practice to do so if any of the following circumstances apply:

- the treatment or procedure is complex, or involves material risks;
- the procedure involves general/regional (e.g. limb blocks) anaesthesia or sedation;
- there may be significant consequences for the individual's employment, social or personal life;
- the treatment is part of a project or programme of research approved by Public Health Wales.

Oral or Written Consent

In many cases, it will be appropriate for staff to initiate an examination, screening test or intervention immediately after discussing it with the individual. If the individual is willing, they will then give their consent and the examination, screening or intervention can go ahead immediately. In many such cases, consent will be given orally – this oral consent should be recorded in the individual's notes.

If a proposed procedure carries significant risks (guidance from professional bodies as to what constitutes "significant risk" must be followed), it will be appropriate to seek written consent, and staff must

take into consideration whether the individual has had sufficient chance to absorb the information necessary for them to make their decision. As long as it is clear that the individual understands and consents, the member of staff may then proceed.

In most cases where *written* consent is being sought, the examination, screening test or intervention options will generally be discussed well in advance of the actual event. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (oral) decision, and the second being confirmation that the individual still wants to go ahead. The bilingual (Welsh/English) consent form should be used as a means of documenting the information stage(s), as well as the confirmation stage.

Individuals need to be given both the opportunity to understand and to ask questions. When confirming the individual's consent and understanding, it is important to use a form of words which requires more than a yes/no answer from the individual: for example beginning with "tell me what you're expecting to happen", rather than "is everything all right."

While administrative arrangements will vary, it should always be remembered that for consent to be valid, the individual must feel that it is possible for them to refuse, or change their mind. It will rarely be appropriate to ask an individual to sign a consent form after they have begun to be prepared for an examination, screening test or intervention (for example, by starting to remove their clothes).

An individual's written consent may be obtained by post, although staff should be mindful of the population's literacy levels. Posting information gives the individual time to read and reflect on the consent form and information provided. However, any person carrying out a procedure on an individual must ensure that, immediately before the procedure, the individual has understood the information, including the risks and benefits, and that they still give their consent. If the individual has queries or concerns he or she must be given time to consider any additional information.

Consent for Young People and Children

Young people aged 16 or 17 are presumed to have capacity to consent for or refuse their own treatment.

A child under the age of 16, is in law presumed to lack capacity to consent or refuse. A child under the age of 16, who has sufficient maturity and intelligence to be capable of understanding the treatment and making a decision based on the information provided (*Gillick* competent) may have capacity to consent or refuse examination, screening or intervention. If a competent child consents or refuses an intervention a parent cannot over-ride that consent. As with adults, consent will only be valid if it is given

voluntarily by an appropriately informed individual who has capacity to consent to the particular examination, screening test or intervention.

The prior presumption is that a child under 16 lacks capacity to make a decision unless they demonstrate that they can understand, retain and weigh/use information and communicate that decision as per *Gillick* competency. The consent process with the child should be recorded in writing.

When treating children, staff should take particular care to ensure that they are familiar with the relevant law and should consider carefully whether the child is competent to give his or her consent. If the child is not competent to give consent, then staff may undertake examination, screening or intervention on the basis of parental consent. For children consent may be given by any person who has "parental responsibility" (Children Act 1989, section 3(1)) for the child which may not necessarily be the parents.

If staff have any doubt about young people and children's consent then legal advice should be sought.

Withdrawal of consent

An individual with capacity is entitled to withdraw consent at any time, including during the performance of any intervention. Where an individual does object during examination, screening or an intervention, the member of staff, should immediately stop (except in exceptional circumstances when the outcome could be detrimental to the individual), establish the individual's concerns, and explain the consequences of not completing the examination, screening or intervention. If the individual still wishes to withdraw consent, the member of staff must document the individual's decision in the notes and inform all relevant colleagues.

In exceptional circumstances, where stopping the intervention at that point would genuinely put the life of the individual at risk, and the member of staff reasonably believes that the individual is unable to understand the implications of their objection, maybe because they temporarily lack capacity, the member of staff may be entitled to continue the intervention until this risk no longer applies, acting in the individual's best interest. Even so they should choose the least restrictive option to avoid the risk to life (Human Rights Act, 1988).

Appendix B Decision Making for Those Who May Lack Mental Capacity

What is Capacity?

Capacity is the ability of an individual to have the required amount of understanding to enable them to make specific decision for themselves.

The Mental Capacity Act (MCA) applies in relation to determining whether an individual has capacity to give their consent. It is a key principle of the MCA that a person is assumed to have capacity to make decisions for themselves unless it is established on the balance of probabilities that they do not. An individual lacks capacity if he or she is unable to make a specific decision for themselves in relation to a matter at the time it needs to be made because they have an impairment of, or disturbance of the mind or brain. This impairment or disturbance can either be temporary or permanent. In ascertaining an individual's capacity, the member of staff must not make a judgement on the basis of the individual's age, appearance, assumptions about their condition or any other aspect of his or her behaviour. It is important to take all possible steps to try and help the individual make a decision for themselves (see chapter 3 of the MCA Code of Practice). Where there is doubt about a person's capacity, an assessment should be carried out and the member of staff must be able to justify their conclusions.

The member of staff undertaking the examination, screening or intervention needs to be satisfied that a valid consent has been obtained. Good communication is key to this process (see Appendix C). More complex decisions are likely to need more formal assessments, which may include a professional opinion (for example from a speech and language therapist/psychologist), but the final decision about the individual's capacity must be made by the person intending to carry out an examination, screening or intervention.

Staff who carry out actions related to an examination, screening or intervention of individuals who lack capacity to consent to them at that time may be protected from liability if they reasonably believe that the individual lacks capacity to make that particular decision at the time it needs to be made and the action is in the person's best interests. (For further guidance see Chapter 6 of the MCA Code of Practice and note that the MCA imposes limitations on acts which can be carried out with protection from liability – including where there is inappropriate use of restraint or where the individual who lacks capacity is deprived of their liberty).

The Test of Capacity and Best Interests

The MCA provides that a person is unable to make a decision, because of a two stage test that is made on:

Part 1: an impairment or disturbance of mind or brain

and

Part 2: If they are unable:

- a. to understand the information relevant to the decision, and
- b. to retain that information, and
- c. to use or weigh that information as part of the process of making the decision, or
- d. to communicate his or her decision, whether by talking, using sign language or any other means eg blinking

Points a to c should be applied together. If an individual cannot do any one of these three things they will be treated as unable to make the decision. Point d only applies in situations where the individual cannot communicate their decisions in any way. The British Medical Association has published advice on the assessment of capacity - <http://bma.org.uk/support-at-work/ethics/mental-capacity/mental-capacity-tool-kit>

Capacity should not be confused with a member of staff's assessment of the reasonableness of the individual's decision. An individual is entitled to make a decision which is based on their own religious belief or value system. Even if it is perceived by others that the decision is unwise or irrational, the individual may still make that decision if he or she has capacity to do so.

If an individual is making a decision which is extremely unwise (appears to be both irrational and present a significant risk to life) staff would be wise to consult with a senior colleague as involvement of legal advice and Court action may be needed.

Further information can be found in the Mental Capacity Act 2005 Code of Practice.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

When Adults may Lack Capacity to Consent

Where an adult lacks capacity to give his or her consent to treatment, no one can give consent for that person unless they have authority under a

Lasting Power of Attorney for personal welfare or have been authorised to make treatment decisions as a deputy appointed by the Court of Protection for personal welfare. If someone has Lasting Power of Attorney the certificate authorising the power should be viewed before any treatment commences (see end of Appendix G). However, decisions still need to be made about the person's care and treatment. The MCA provides a statutory basis on which treatment may be given to individuals who are 16 years or above and lack capacity, and sets out the principles which must be applied.

Where an adult **may** not have the capacity to give or withhold consent, **Form 4** (form for adults who are unable to consent to investigation or treatment – Appendix G)) must be used. Although Form 4 is referred to as a consent form it should be noted that no-one, other than a person who has authority under a Lasting Power of Attorney for personal welfare or a Court appointed Deputy for personal welfare, can give consent on behalf of an adult. If a person who has authority under a Lasting Power of Attorney or a Court appointed Deputy is giving consent then they should sign the appropriate section of consent Form 4. A copy of Form 4 should be offered to the person with authority under a Lasting Power of Attorney or deputy, if there is one.

Form 4 requires staff to document both how they have come to the conclusion that the individual lacks the capacity to make this particular healthcare decision, and why the proposed treatment would be in the individual's best interests, in accordance with the Mental Capacity Act 2005. Where the views of the individual's family and friends about their best interests have been taken these must also be recorded.

Temporary Incapacity

Individuals may suffer a temporary lack of capacity. As with any other situation, an assessment of that individual's capacity must only examine their capacity to make a particular decision when it needs to be made. Unless the individual has made a valid and applicable advance decision to refuse treatment of which the member of staff is aware, then they may be treated insofar as is reasonably required in the individual's best interests pending the recovery of capacity. If an examination, screening or intervention is thought to be in the individual's best interests but can be delayed until the individual recovers capacity and is able to consent (or refuse), it must be delayed until that time.

Fluctuating Capacity

It is possible for an individual's capacity to fluctuate. In such cases, it is good practice to establish whilst the person has capacity their views about any examination, screening or intervention that may be necessary during a period of incapacity and to record these views.

Individuals who Lack Capacity to Give or Withhold Consent

In determining whether an individual aged 16 years and over lacks the mental capacity (either temporarily or permanently) to give or withhold consent for themselves, members of staff must apply the principles set out in the MCA. It is important to remember that **no-one other than a person who has authority under a Lasting Powers of Attorney for personal welfare (including healthcare) or is a deputy appointed by the Court of Protection for personal welfare decisions (including healthcare) , can give consent on behalf of an adult.** An individual who lacks capacity can, however, be examined, screened or have an intervention if it is in their best interests in accordance with the MCA, as long as the individual has not made a valid and applicable advance decision refusing that specific examination, screening or intervention. When carrying out an examination, screening or an intervention, on individuals who may lack capacity, staff must have due regard for MCA Code of Practice.

Best interests

In determining what is in the individual's best interests, staff must –

- encourage the individual to take part or improve their ability to take part in making the decision
- look at the individual's circumstances as a whole and not just at what is in the individual's best medical interests
- try to find out the individual's past and present wishes and feelings, and any beliefs and values that would be likely to influence the individual 's decision
- take account of any other factors that the individual might think relevant if they were making the decision
- try to work out what the individual would have wanted if he or she had capacity, rather than what staff believes to be in his or her best interests

Staff must not make assumptions about someone's best interests simply on the basis of that individual's age, appearance, condition or behaviour. They should also consider if the individual is likely to regain capacity and if so if the decision can wait until then.

They must also, so far as is practicable and appropriate, consult other people for their views about the individual's best interests and to see if they have any information about the individual's wishes, feelings, beliefs and values. In particular they should try to consult:

- Any person who is named by the individual as a person who should be consulted on such matters
- Anyone engaged in caring for the person or interested in his welfare
- Any person who has been granted a Lasting Power of Attorney by the individual; and
- Any deputy appointed for the individual by the Court of Protection to make decisions for that individual

(See Appendix H: Flowchart Mental Capacity Decision making Process)

The purpose of consulting is to ascertain what the individual would have wanted if they had capacity and what would be in their best interests -not what the persons consulted believe should happen. Where an individual has made a Lasting Power of Attorney for personal welfare (including healthcare), or a deputy of the Court of Protection (for personal welfare) has been appointed, and if it is within their authority, it will be for the attorney or deputy to make the decision on the individual's behalf. However, they too must act in the individual's best interests and, where practicable and appropriate, consult the people indicated above

If an individual has no one who may be consulted then staff must consider whether the circumstances are such that an Independent Mental Capacity Advocate (IMCA) should be instructed (see section 12.10). If the decision is about Serious Medical Treatment (SMT) and the individual is un-befriended then an IMCA must always be appointed unless it is life sustaining treatment and the time delay would interfere significantly with the treatment however as soon as practical a referral to an IMCA must be made.

If the individual has a valid and applicable Advance Decision made under s24 MCA, then the individual's refusal of treatment is binding on staff bearing in mind that an Advance Decision can be withdrawn at any time and need not be in writing. It is therefore imperative that staff consult with relatives and/or GP to ensure that the Advance Decision is still valid before acting upon it. An Advance Statement is to be distinguished from an Advance Decision. It is a tool for an individual to record their wishes and likes and dislikes etc. Where an Advance Statement has been made, staff should still take that statement into account during the process of arriving at a best interest decision in accordance with s4 MCA.

Appendix C: Communication Issues

Staff have a role to play in ensuring that the individual is sufficiently informed about the proposed examination, screening or intervention and feel at ease. Effective communication is the key to achieving this.

Staff should take all reasonable steps in the circumstances to facilitate communication with the individual. In particular, careful consideration should be given to the way in which information is explained or presented to the individual. An individual's communication requirements must be identified in advance of an appointment, and the details must be recorded and maintained within the individual's health record for future reference. Arrangements must be made to ensure that the individual's communication requirements are met during the consent process, as failure to do so could potentially render the consent process invalid.

Interpreters or communication aids should be used as appropriate. Where appropriate, those who know the individual well, including their family, carers and staff from professional or voluntary support services, may be able to advise on the best ways to communicate with the person. However, unless there are exceptional circumstances, they should not be used to interpret.

An individual must not be assessed as lacking capacity to consent to the particular examination, screening or intervention merely because they have a limited or a particular communication requirement. Care should be taken not to underestimate the ability of an individual to communicate, whatever their condition. In some cases it may be because English is not the individual's first language or due to the individual's disability. Where Welsh language communication requirements are identified, an appropriate Welsh speaking member of staff must be present during the consent process.

Appendix D - Parental responsibility

Proof should be requested if there is any doubt as to whether the person accompanying the child has parental responsibility.

The Children Act 1989 sets out persons who may have parental responsibility. These include:

1. the child's mother;
2. the child's father if he was married to the mother at the time of the birth;
3. unmarried fathers who can acquire parental responsibility in several different ways:
 - (a) for children born before 1 December 2003, unmarried fathers will have parental responsibility if they
 - (i) marry the mother of their child or obtain a parental responsibility order from the court, or
 - (ii) register a parental responsibility agreement with the court or by an application to the court;
 - (b) for children born after 1 December 2003 unmarried fathers will have parental responsibility if they:
 - (i) register the birth jointly with the mother at the time of the birth, (ii) re-register the birth if they are the natural father,
 - (ii) marry the mother of their child or obtain a parental responsibility order from the court; or
 - (iii) register with the court for parental responsibility.

In addition, in accordance with the Children Act 1989, the following will also have parental responsibility:

- a child's legally appointed guardian (whether appointed by the court or appointed by a parent with parental responsibility to act as guardian in the event of their death);
- a person in whose favour the court has made a residence order concerning the child;
- a local authority designated in a care order in respect of the child and a local authority or other authorised person who holds an emergency protection order in respect of the child;
- an adopter of a child;
- an adoption agency.

It should be noted that a person who has parental responsibility does not cease to have that responsibility because some other person subsequently acquires it.

In the case of foster parents, (upon whom parental responsibility will not automatically be conferred) if the arrangement involves the Local Authority, make contact with that Authority. If it is a private arrangement, consent is required from a parent of the child with parental responsibility. In the case of uncertainty, contact the Local Authority.

Section 4ZA of the Children Act (1989) sets out the circumstances in which a second female parent may acquire parental responsibility (where a child has a parent by virtue of section 43 of the Human Fertilisation and Embryology Act 2008). The second female parent will have parental responsibility if she:

- is in a civil partnership with or is married to the mother of the child at the time of the child's birth;
- has entered a parental responsibility agreement with the mother of the child (and any other person who already has parental responsibility);
- obtains a parental responsibility order from the court in relation to the child;
- has obtained a residence order in relation to the child.

Section 4A sets out the circumstances in which a step parent may acquire parental responsibility for a child. The child's parent who has parental responsibility, or, if another parent has parental responsibility, both parents may by agreement with the step parent provide for the step parent to have parental responsibility or a court may, on the application of a step parent, order that the step parent has parental responsibility for the child. Any parental responsibility agreement must be in the form prescribed by section 4(2) of the Children Act 1989.

In some instances a person may not have parental responsibility for a child but may, for the time being, be responsible for their care - for example, a child minder or grandparent. That person may give consent to treatment on behalf of the child if staff are satisfied that the person with parental responsibility has consented in advance. Also it is reasonable to act without first obtaining the consent of the person with parental responsibility, for example where the treatment is urgently required. In order to provide valid consent on behalf of a child, the person with parental responsibility must have the mental capacity to do so.

When babies or children who are not competent to give consent are being cared for in hospital, it may not seem practicable to seek the consent of

the parents on every occasion for every routine intervention such as blood or urine tests or X-rays. However, staff should remember that, in law, such consent is required although it is possible for this consent to be given in advance.

Appendix E: Lasting Power of Attorney

The Mental Capacity Act introduced a Lasting Power of Attorney (LPA). An LPA may be executed by any person of 18 years or over whilst they have capacity to make such a decision for health and welfare and only takes effect when they no longer have capacity. A person with capacity over the age of 18 may complete the LPA paperwork which when signed off appoints between 1 and 5 people to act as an attorney to make decisions about a person's welfare and medical treatment when that person lacks the capacity to make that particular decision. The attorney acting under a personal welfare LPA must make the decision in the person's best interests. An LPA must be registered with the Office of the Public Guardian before it can be used. An LPA does not, however, authorise an attorney to refuse or give consent to life-sustaining treatment unless this is specifically expressed in the instrument that creates the LPA.

If two or more people have been appointed as attorneys, then they may either be appointed to act jointly or jointly and severally. If they are acting jointly then any decision must be by consensus. However if they are acting jointly or severally, then either of the attorneys can make a decision independently of the other. If it is not clear how the attorneys have been appointed, then it is assumed that they are appointed to act jointly. The LPA paperwork must be requested and checked by the practitioner, prior to any procedure, screening or intervention, if they are unsure if it is legitimate or appropriate then they should contact Public Health Wales safeguarding team and/ or seek legal advice.

If the individual has made a valid and applicable advance decision to refuse treatment, then this can be overridden by an attorney providing that his or her authority under the LPA extends to making decisions about treatment that is the subject of the advance decision. But only if the LPA post-dates the advance decision. If the LPA pre-dates the advance decision and person had capacity when the advanced decision was made then LPA cannot override the advanced decision (NB Advanced decisions can only be made by those 18 and over). An attorney, like any person who is making a decision on behalf of a person who lacks capacity, must act in accordance with the MCA and must have regard to the MCA Code of Practice.

When acting on the basis of a decision by an attorney, a staff member should, so far as is reasonable, try to ensure that the attorney is acting within their authority. This would include asking to view the certificate donating the extent of the power. Any disputes between staff and an attorney that cannot be resolved, or cases where there are grounds for believing that the attorney is not making decisions that are in the best interests of the individual, should be referred for legal advice.

An LPA can also be made for Property and Affairs, if an attorney has one of these that does not give them the ability to make decisions about Health and Welfare.

Appendix F: Court Appointed Deputies

Whilst a decision made by the Court is always preferred, the Mental Capacity Act (MCA) now provides that the Court can appoint deputies to make decisions on its behalf. This may be necessary if there are a number of difficult decisions to be made in relation to the individual. Deputies will normally be family, partners, friends or people who are well known to the individual. These are rarely appointed in practice. There is case law suggesting that deputies should only be appointed in exceptional circumstances. This is because the court believes that healthcare members of staff should be able to arrive at a best interest decision and where the decision is challenged by the family it is better to be referred to the court than to allow one person to veto a decision made by an MDT.

As with attorneys appointed under a Lasting Power of Attorney, deputies may only make decisions where they have reasonable grounds to believe that the person they are acting for does not have capacity, and any decisions they take will be strictly limited to the terms specified by the Court and in accordance with the MCA. Deputies are also subject to a number of restrictions in the exercising of their powers. For example, a deputy cannot refuse consent to the carrying out or continuation of life-sustaining treatment for the individual, nor can he or she direct a person responsible for the individual's healthcare to allow a different person to take over that responsibility. A deputy cannot restrict a named person from having access to the individual.

Staff should co-operate with deputies with the aim of doing what is best for the individual. Where a deputy acting within their authority makes a decision that the individual should not receive a treatment that is not life-sustaining or requires that a treatment that is not life-sustaining should be discontinued, that member of staff must act in accordance with those instructions. Deputies do not have the power to make decisions about life sustaining treatment. However a deputy cannot require staff to give a particular type of treatment, as this is a matter for his or her clinical judgement. In such cases where staff have declined to give treatment, then it is good practice to seek a second opinion, although the deputy cannot insist that the staff member steps aside to allow another member of staff to take over the case. Deputies are supervised by the Office of the Public Guardian, and where staff suspects that a deputy is not acting in the interests of the individual, he or she should refer the matter to the Public Guardian.

Appendix G: Form 4 Treatment in best interests



Treatment in best interests (Form 4)

Form for patients aged 16 years and over who may lack the capacity to consent to examination or treatment

This form should be completed by the health professional responsible for the proposed procedure or course of treatment. To be retained in patient's notes.

Patient details (or pre-printed label)

Patient's surname/family name .. Patient's first names

Date of birth Male Female

NHS number (or other identifier).....

Special requirements (e.g. other language/communication method):.....

Decision maker's name²:

Professional registration number (e.g. GMC, NMC, GDC, HCPC, etc).....

A. Details of decision that needs to be made (i.e. procedure or course of treatment proposed)

(NB: See Section 7 of attached Guidance Notes for details of situations where court approval must first be sought)

B. Assessment of patient's capacity (in accordance with the Mental Capacity Act 2005) (see Section 1 of the Guidance Notes)

Tick **YES** or **NO** as applicable and enter relevant information into each box.

² Where the decision involves the provision of medical treatment, the doctor or other member of health care staff responsible for carrying out the particular treatment or procedure is the decision-maker.

B1. Is there reason to doubt that the person has capacity to make the above decision?

YES - record doubts and go to box B2:

NO - presume capacity and end assessment (*go to box B9*).

B2. Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?

YES - record the nature of the impairment or disturbance and go to box B3:

NO - presume capacity and end assessment (*go to box B9*).

B3. Would the person be able to make the decision with practical help and support?

YES - record support given and presume capacity (*go to box B9*):

NO - go to box B4.

B4. Would the person be able to make the decision at a different time, place or under different circumstances?

YES - record what would help the patient and reassess capacity at appropriate time and sign Section F:

NO - go to box B5.

If the answer is 'No' to ANY of questions B5-B8, then this person lacks capacity to make this decision.

B5. Does the person understand the nature and consequences of accepting or refusing the proposed treatment, or of not making the decision?

YES - go to box B6.

NO - explain and go to box B9:

B6. Is the person able to retain the information long enough to make the decision?

YES - go to box B7.

NO - explain and go to box B9:

B7. Is the person able to use or weigh the information as part of making the decision?

YES - go to box B8.

NO - explain and go to box B9:

B8. Is the person able to communicate their decision in some way?

- YES** – If you have answered 'Yes' to questions B5 - B8 then this person has capacity to make this decision – go to box B9. Please obtain the patient's consent using the appropriate consent form.
- NO** – explain and go to box B9:

B9. Outcome of assessment

I have assessed this patient's capacity to make the decision in question and it is my belief, on the balance of probabilities and given the evidence above, that this patient:

- has the mental capacity to make the decision about the proposed procedure or course of treatment (*sign Section F*) (obtain the patient's consent using the appropriate consent form).
- lacks the mental capacity to make the decision about the proposed procedure or course of treatment (*move on to Section C*).

C. Advance Decision, Personal Welfare Lasting Power of Attorney, Court Appointed Deputy - Complete BOTH sections (C1 – C2)

C1. Advance Decision to refuse treatment (see Section 2 of the Guidance Notes)

- There is a valid and applicable advance decision which refuses the procedure or course of treatment identified in Section A and/or which refuses a procedure which could arise in the course of the proposed procedure or course of treatment (The patient's decision to refuse the treatment must be respected) (*file a copy of the advance decision in the medical record, if it is in writing, or make detailed notes if it was a verbal advance decision*).
- I am not aware of a valid and applicable advance decision which refuses the procedure or course of treatment identified in Section A, and/or which refuses a procedure which could arise in the course of the proposed procedure or course of treatment.

C2. Personal Welfare Lasting Power of Attorney / Court Appointed Deputy (see Sections 3 & 4 of the Guidance Notes)

Where the patient has authorised an Attorney to make decisions about the procedure in question under a Personal Welfare Lasting Power of Attorney (LPA) **or** a Court Appointed Deputy has been authorised to make decisions about the procedure in question, the Attorney or Deputy will have the final responsibility for determining whether a procedure is in the patient's best interests.

Tick one box

- I have not been made aware of the existence of a Personal Welfare LPA / Court Appointed Deputy with the necessary authority to make this decision.

- I have seen and read the Registered Personal Welfare LPA document and I am satisfied that the Attorney has the authority to take this decision about the proposed treatment (file a copy in notes).
- I have seen and read the Court order appointing the Deputy and I am satisfied that the Deputy has the authority to take this decision about the proposed treatment (file a copy in notes).

Llofnod yr Atwrnai / Dirprwy	Signature of Attorney / Deputy
<p>Rwyf wedi cael fy awdurdodi i wneud penderfyniadau am y driniaeth dan sylw o dan Atwrneiaeth Arhosol - Lles Personol* / fel Dirprwy a Benodwyd gan y Llys* (<i>*dilëwch fel y bo'n briodol</i>). Rwyf wedi ystyried yr amgylchiadau perthnasol yng nghyswllt y penderfyniad dan sylw ac, yn fy marn i, mae'r driniaeth a ddisgrifiwyd yn Adran A (<i>ticiwch un blwch</i>):</p>	<p>I have been authorised to make decisions about the procedure in question under a Personal Welfare Lasting Power of Attorney* / as a Court Appointed Deputy* (<i>*delete as appropriate</i>). I have considered the relevant circumstances relating to the decision in question and believe the procedure described in Section A (<i>tick one box</i>):</p>
<p>er budd pennaf y claf ac rwy'n <input type="checkbox"/> cydsynio i'r driniaeth.</p>	<p>is in the patient's best interests and I <input type="checkbox"/> consent to it being undertaken.</p>
<p>ddim er budd pennaf y claf ac nid <input type="checkbox"/> wyf yn cydsynio i'r driniaeth.</p>	<p>is not in the patient's best interests and I do not consent to it.</p>
<p>Unrhyw sylwadau eraill (gan gynnwys yr amgylchiadau a ystyriwyd wrth asesu beth sydd er budd pennaf y claf)</p>	<p>Any other comments (including the circumstances considered in working out what is in the patient's best interests)</p>
<p>.....</p>	
<p>Perthynas â'r claf / Relationship to patient:</p>	
<p>Cyfeiriad (os yw'n wahanol i'r claf) / Address (if not the same as patient):</p>	
<p>Llofnod yr Atwrnai/Dirprwy / Signature of Attorney/Deputy:</p>	
<p>Enw (LLYTHRENNAU BRAS) / Name (PRINT):.....</p>	
<p>Dyddiad / Date:</p>	

If there is a valid and applicable advance decision refusing the procedure or course of treatment OR a decision of an attorney or deputy, you do not need to complete the rest of this form. Please sign Section F.

D. Independent Mental Capacity Advocate (IMCA) (see Section 5 of the Guidance Notes)

For decisions about **serious medical treatment**³, where there is no one appropriate to consult (see section E5) other than paid staff, an Independent Mental Capacity Advocate (IMCA) **MUST** be instructed.

Has an IMCA been instructed?

- Yes Not applicable (*go to Section E below*)

If Yes, the report of the IMCA **must** be considered in coming to a decision about what is in the patient's best interests (see Section E). A copy of the report should be filed in the medical record.

How have you taken into account the IMCA's report in deciding what is in the person's best interests?:

.....

E. Working out what is in the patient's best interests (see Section 6 of the Guidance Notes)

The law requires you to do everything you reasonably can to work out what the patient's best interests are.

All the boxes below must be completed.

E1. Is the person likely to have capacity for this decision at some time in the future?

- YES** – record this consideration:
 NO

If 'Yes', is it possible to delay the decision?

- YES** – **do not proceed. Wait until the person regains capacity to consent or refuse.**
 NO – Capacity unlikely to change or decision cannot be delayed. Record your reasons:

E2. Are there any alternatives to this decision that are less restrictive?

- YES** – record considered alternatives and why they are not the best option:
 NO – There are no satisfactory less restrictive alternatives.

E3. Have you supported the person as much as possible to be involved with this decision (although they don't have the capacity to make the decision)?

- YES** – record support given:

³ This form only requires one signature – that of the decision maker (see footnote 2)

NOT POSSIBLE – explain reasons:

E4. Have you considered:

- (a) any verbal or written wishes and feelings that the person has previously expressed or is currently expressing,
- (b) the beliefs and values that would be likely to influence the person's decision if he had capacity, and
- (c) any other factors that the person would have considered if they were able to do so?

YES – record considerations:

NO – There are none available.

E5. The following people, if practical and appropriate, must be consulted for their views about the person's best interests and any information about the person's wishes, feelings, beliefs and values and other relevant factors, although they do not have the authority to make the decision on behalf of the patient.

Please tick relevant boxes to identify who of the following has been consulted:

- Anyone the person has previously named as someone they want to be consulted.
- Anyone involved in caring for the person (e.g. referrer, paid or unpaid carers, spouse, partner, civil partner, parents, other family members).
- Anyone interested in the person's welfare (e.g. family members, friends, an advocate already working with the person).
- An attorney appointed by the person under an LPA (but without authority to make this decision).
- A deputy appointed by the Court of Protection (but who does not have authority to make this decision).

Give names and relationship of people consulted and details of discussions held:

If no-one has been consulted, explain why not (*if the decision is about serious medical treatment⁴, you must instruct an IMCA if there is no-one [other than paid professionals/carers] available to consult – go back to Section D*):

E6. Were there any disagreements encountered during the assessment of best interests?

YES – record what these are, how they are being taken into account and what steps you are taking to resolve them (NB: If the decision is disputed you must seek legal advice). Go to box E7.

NO – go to box E7.

E7. Was it necessary to involve the Court of Protection?

YES – record decision made by the Court (*sign Section F*):

NO – go to box E8.

E8. Best interests decision

You, as the decision-maker, are responsible for the final decision. Record the decision that has been made in the person's best interests in the space below.

I confirm that, in my judgement as the decision maker,
(*insert procedure / course of treatment*)
 is in the best interests of this patient because

.....

 (*insert summary of reasons for coming to this decision*). Sign Section F.

F. Signature of health professional⁴ completing this form

I confirm that I have (*tick all relevant boxes*):

- undertaken an assessment of capacity
- considered whether or not there is an advance decision / someone with legal authority to make this decision
- consulted with relevant people regarding what is in the patient's best interests
- worked out what course of action is in the patient's best interests and made a decision.

Signature: Date:

Name (PRINT): Job title:

⁴ This form only requires one signature – that of the decision maker (see footnote 1)

Professional registration number (e.g. GMC, NMC, GDC, HCPC, etc)

G. Related documents copied and filed in medical record

Where applicable, the following documents have been copied and filed in the patient's medical record:

- Valid and applicable advance decision
- Personal Welfare Lasting Power of Attorney documentation
- Court order appointing the Deputy
- IMCA report
- Court order/decision

Guidance Notes for health professionals (to be read in conjunction with Consent Policy)

This form should only be used where it would be usual to seek written consent, but an adult patient (16 or over) lacks capacity to give or withhold consent to treatment. If a patient of 16 years and over **has** capacity to accept or refuse treatment, you should use Consent Form 1 and respect any refusal. In respect of young persons aged 16 or 17 who have capacity but are refusing treatment see the Welsh Government's Reference Guide for Consent to examination or treatment for further guidance. Where treatment is very urgent (for example if the patient is critically ill), it may not be feasible to fill in a form at the time, but you should document your clinical decisions appropriately afterwards. If the adult now lacks capacity, but has made a valid advance decision to refuse treatment that is applicable to the proposed treatment, then you must abide by that refusal. For further information on the law on consent, see the Welsh Government's *Reference guide to consent for examination or treatment* (www.wales.nhs.uk/consent).

Health professionals should only take consent in specific clinical situations where they have undertaken formal training including on consent and mental capacity and have been competency assessed. They should familiarise themselves with any appropriate professional guidance, their organisation's consent policy and Welsh Government's guidance on consent.

1) MENTAL CAPACITY

When treatment can be given to a patient who lacks the capacity to consent

All decisions made on behalf of a patient who lacks capacity must be made in accordance with the Mental Capacity Act 2005 and its accompanying Code of Practice⁵. Treatment can be given to a patient who is unable to consent, only if:

⁵ Mental Capacity Act 2005 Code of Practice - www.publicguardian.gov.uk/mca/code-of-practice.htm

- the patient lacks the capacity to give or withhold consent to this procedure
AND
- the procedure is in the patient's best interests.

Capacity (MCA Code of Practice, Chapter 4)

A person lacks capacity if they have an impairment or disturbance (for example, a disability, condition or trauma, or the effect of drugs or alcohol) that affects the way their mind or brain works which means that they are unable to make a specific decision at the time it needs to be made. It does not matter if the impairment or disturbance is permanent or temporary. A person is unable to make a decision if they cannot do one or more of the following things:

- Understand the information given to them that is relevant to the decision.
- Retain that information long enough to be able to make the decision.
- Use or weigh up the information as part of the decision-making process.
- Communicate their decision - this could be by talking or using sign language and includes simple muscle movements such as blinking an eye or squeezing a hand.

You must take all steps reasonable in the circumstances to assist the patient in taking their own decisions. This may involve explaining what is involved in very simple language, using pictures and communication and decision-aids as appropriate. People close to the patient (spouse/partner, family, friends and carers) may often be able to help, as may specialist colleagues such as speech and language therapists or learning disability teams, and independent advocates (as distinct from an IMCA as set out below) or supporters. Sometimes it may be useful to seek advice from a colleague: however, it is your responsibility, as the decision maker¹, to reach a final decision about the patient's mental capacity.

Capacity is 'decision-specific': a patient may lack capacity to take a particular complex decision, but be able to take other more straight-forward decisions or parts of decisions. Capacity can also fluctuate over time and you should consider whether the person is likely to regain capacity and if so whether the decision can wait until they regain capacity.

2) ADVANCE DECISIONS (MCA Code of Practice, Chapter 9)

An advance decision enables a person aged 18 years and over, while still capable, to refuse specified medical treatment at a time in the future when they lack the capacity to consent to or to refuse that treatment. The advance decision must be valid and applicable – if it is, it has the same effect as a decision that is made by a person with capacity. If the advance decision concerns the refusal of life-sustaining treatment, it must be in writing, signed and witnessed and state clearly that the decision applies even if the patient's life is at risk.

3) PERSONAL WELFARE LASTING POWER OF ATTORNEY (sometimes called a 'Health and Welfare' LPA) (MCA Code of Practice, Chapter 7)

A person of 18 years and over, who has capacity, can appoint an attorney to look after their health and welfare decisions, if they lack the capacity to make such decisions in the future. Under a Personal Welfare Lasting Power of Attorney (LPA) the attorney can make decisions that are as valid as those made by the

person themselves. You **must** see a copy of the registered LPA document before allowing an attorney to make decisions. It will be stamped on every page with the perforated words 'Validated – OPG' (See image below). If in doubt about its validity, seek advice. The LPA may specify limits to the attorney's authority and the LPA must specify whether or not the attorney has the authority to make decisions about life-sustaining treatment. The attorney can only, therefore, make decisions as authorised in the LPA and must make decisions in the person's best interests. An attorney cannot consent to treatment if the patient has made a valid and applicable advance decision to refuse a specific treatment (see chapter 9 of the MCA Code of Practice). But if the patient made a Lasting Power of Attorney after the advance decision, and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the advance decision. An attorney cannot consent to or refuse most treatment for a mental disorder for a patient detained under the Mental Health Act 1983. An attorney cannot authorise the giving or refusing of consent to the carrying out or continuation of life-sustaining treatment, unless the LPA document contains express provision to that effect.

4) COURT APPOINTED DEPUTY (MCA Code of Practice, Chapter 8)

The Court of Protection may appoint a person (known as a Deputy) to make decisions for people who lack capacity to take particular decisions for themselves, including healthcare. Deputies for personal welfare decisions will only be required in the most difficult cases where important and necessary actions cannot be carried out without the court's authority or where there is no other way of settling the matter in the best interests of the person who lacks capacity. If a deputy has been appointed to make treatment decisions on behalf of a person who lacks capacity, then it is the deputy rather than the health professional who makes the treatment decision and the deputy must make decisions in the patient's best interests. Deputies cannot make decisions to refuse the provision or continuation of life sustaining treatment. These must be referred to the Court of Protection.

5) INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) (MCA Code of Practice, Chapter 10)

The Mental Capacity Act introduced a duty on the NHS to instruct an independent mental capacity advocate (IMCA) in serious medical treatment decisions⁶ when a person who lacks capacity to make a decision has no one who can speak for them, other than paid staff. IMCAs are **NOT** decision makers for the person who lacks capacity. They are there to support and represent that person and to ensure that decision making for people who lack capacity is done appropriately and in accordance with the Act. Paragraph 4.17 of the Welsh Government's Reference Guide for Consent to Examination or Treatment provides guidance on the meaning of "serious medical treatment".

⁶ Serious medical treatment is defined as treatment which involves providing, withdrawing or withholding treatments where:

- if a single treatment is proposed there is a fine balance between the likely benefits and burdens to the patient and the risks involved;
- a decision between a choice of treatments is finely balanced; or
- what is proposed is likely to have serious consequences for the patient (either from the effects of treatment or its wider implications)

Whether procedures are considered 'serious medical treatment' in any given case will depend on the circumstances and consequences for the patient.

6) BEST INTERESTS (*MCA Code of Practice, Chapter 5*)

The Mental Capacity Act requires that a health professional **must** consider all the relevant circumstances relating to the decision in question, including, as far as possible:

- the person's past and present wishes and feelings (in particular if they have been written down)
- any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question and
- any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves

When determining what is in a person's best interests a health professional must not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour. If the decision concerns the provision or withdrawal of life-sustaining treatment the health professional must not be motivated by a desire to bring about the person's death.

If it is practical and appropriate to do so, the Mental Capacity Act requires a health professional to consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values. In particular, a health professional should try to consult: anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues; anyone engaged in caring for the person; close relatives, friends or others who take an interest in the person's welfare; any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person or any deputy appointed by the Court of Protection to make decisions for the person.

7) THE COURT OF PROTECTION (*MCA Code of Practice, Chapter 8*)

Where treatment is complex and/or people close to the patient express doubts about the proposed treatment, a second opinion should be sought, unless the urgency of the patient's condition prevents this. The Court of Protection deals with serious decisions affecting personal welfare matters, including addressing disagreements about healthcare.

Cases involving the following should be referred to the Court for approval:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS) or minimally conscious state;
- cases involving organ, bone marrow or peripheral blood stem cell (PBSC) donation by an adult who lacks capacity to consent;
- cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes); and
- all other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests (including cases involving ethical dilemmas in untested areas, where the medical treatment has a fine balance of benefits and risks, where the choice between treatments is finely balanced or there is likely to be a serious consequence to the patient).

The Court can also be asked to make a decision in cases where there are doubts about the patient’s capacity and also about the validity or applicability of an advance decision to refuse treatment.

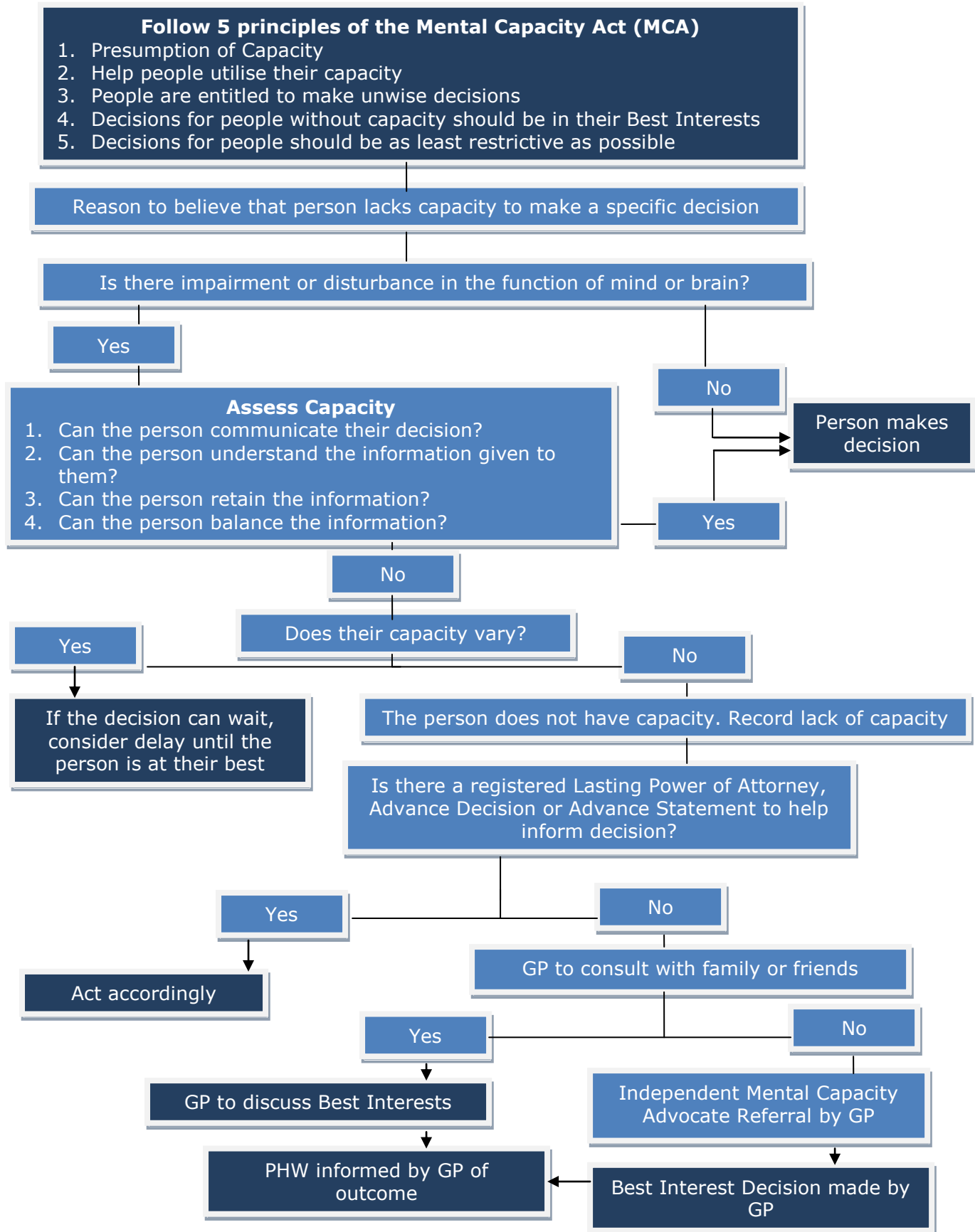
Example of Validated Lasting Power of Attorney

The image shows a form for a Lasting Power of Attorney (LPA) with the following fields:

- Date of birth:** 03 / 05 / 1947 (Day, Month, Year)
- Address:** 156 First Line Road, Town, County, Postcode PO12 3ST
- Email address (optional):** N/A@N/A.com
- For OPG office use only:** LPA registration date 15 / 01 / 2016 (Day, Month, Year) and OPG reference number 7000-0000-0001.

A red circle highlights the "For OPG office use only" section. Below this section, there is a stamp that reads "VALIDATED-OPG" and the text "Only valid with the official stamp here." The footer of the form includes "LPIH Health and welfare (07.15)" and a small icon.

Appendix H: Flowchart – Mental Capacity Decision Making Process



(Adapted from the RCGP: <http://www.rcgp.org.uk/~media/Files/CIRC/CIRC-76-80/CIRC-Mental-Capacity-Act-Toolkit-2011.ashx>)

Glossary

Best Interests: If a person lacks mental capacity, in relation to a matter, then other people can make decisions about that matter for them in their 'best interests'. When and how this can happen is set out in Section 4 of the Mental Capacity Act (MCA) 2005.

Consent: is the agreement from an individual to decide what is done, or not done, to them. This can be in writing, by mouth or by hand or body gesture.

Court Appointed Deputy: is an individual who is authorised by the Court of Protection to make decisions on an individual's their behalf if they lack mental capacity (For further information see: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf).

Disclosure: is the action of sharing information.

Directorate: is a department in an organisation responsible for certain functions.

Easy Read Leaflets: are leaflets that are written in simple words and use pictures to help explain what happens in certain situations or procedures.

Fluctuating Capacity: is when capacity can fluctuate with time. An individual may lack capacity to make a decision at one point in time, but may be able to make the decision at a later point in time.

Gillick Competent: is used in medical law to decide whether a child (16 years or younger) is able to agree (consent) to his or her own medical treatment, without the need for parental permission or knowledge.

Independent Mental Capacity Advocate: These are individuals who act as a legal safeguard for people who lack the mental capacity to help them make specific important decisions (for further information see Code of Practice: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf).

Intervention: is an action or process of intervening to improve something or prevent it getting worse.

Lasting Power of Attorney: The process undertaken by one individual of donating the power to another individual to make decisions on their behalf (For further information see: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf).

Materiality: is whether or not a particular risk is significant to a person or whether the health care professional ought reasonably to have known that the person would attach significance to it.

Mental Capacity: (as defined in the Mental Capacity Act) means being able to understand, retain and weigh up information and communicate your own decisions.

Mental Capacity Act (MCA) 2005: is a law that applies to everyone involved in the care, treatment and support of people aged 16 and over living in Wales and England who are unable to make all or some decisions for themselves. (For further information see: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf).

Parental Responsibility: is a legal term (as defined by the Childrens Act: <http://www.legislation.gov.uk/ukpga/2004/31/contents>) that means having all the legal rights, duties, powers and responsibilities for a child (a child is a person under the age of 18). This does not have to be the child's parent.

Screening: is a way of identifying people who appear healthy but who may be at increased risk of a disease or condition. These people can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.

Sound Mind: is having the capacity to think, reason, and understand for oneself.

Standard Operating Procedures: is a document(s) that explains in detail how certain procedures or activities are to be undertaken and completed.