

Care providers and the Mental Capacity Act 2005

Advice for members of care providers' boards



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The Winterbourne View Joint Improvement Programme (JIP) was established to help local areas develop health and care services that enable people with learning disabilities and/or autism who have mental health conditions and / or behaviour that challenges to live locally in community-based settings.

This paper was commissioned by the JIP in partnership with the Care Provider Alliance (CPA), to support providers in applying the Mental Capacity Act so that the legal rights of those who may lack capacity are upheld and that the individual is at the heart of decision-making. While the work of the JIP is focused on people with learning disabilities and/or autism, the Act applies to a wider range of individuals. This paper is therefore relevant to any provider of community services for individuals who may lack capacity.

Introduction

The Mental Capacity Act 2005 (MCA) has been in force since 2007. In England and Wales, it is the main law about the care and treatment of adults (16+) who lack the mental capacity to make their own decisions as well as the management of their property and affairs.

The MCA is relevant to much of what care providers and their staff do every day. But report after report, including those about the Winterbourne View scandal, suggests that it is not understood or applied as well as it ought to be.

That means vulnerable service users are missing out on protections which are their legal right, and providers are missing opportunities to improve the quality of their care.

It also means providers are exposing themselves to avoidable legal, regulatory and reputational risks. As regulators – especially the Care Quality Commission (CQC) – develop their own understanding of the MCA, they are increasingly focussing on providers' compliance with it.

This paper is aimed at board members of care providers. It has been published alongside a guide for providers: 'Mental Capacity Act: A brief guide for providers of Shared Lives and other community services'. Board members may wish to refer to the full guide for further information on the detail of the Act.

The Mental Capacity Act: what it's about and why it matters

Capacity and consent

The need to involve people in decisions about what they want and how they want it, and to seek agreement and consent is central to all care provision. People should be in control of their lives and staff shouldn't be touching adults or their possessions, going into their homes, using their money or sharing their personal information unless the individual gives them permission to do so. Doing so may well be a criminal offence and could open the staff (and the provider) to civil liability.

But a problem arises where the person lacks mental capacity to consent – in other words, to decide for themselves whether to allow something to be done to, or for, them. That is where the MCA comes in. It sets out how things can be done to, or for, people in those circumstances without breaking the law or incurring liability.

To understand what consent is (and why it matters), staff also need to understand how the MCA defines mental capacity. They need to make it a habit to ask themselves whether the person they are dealing with has the capacity to make a decision about each thing they propose to do – and to understand that people must be given help and support to make their own decisions before anything is done without their agreement.

Effective systems for seeking consent from people who have capacity and for decision-making about people who lack capacity is a core regulatory requirement for care providers under the Health and Social Care Act 2008 in England – one which the CQC scrutinises carefully.

Consent on someone else's behalf

Many people think that if someone lacks the capacity to make a decision about their care or treatment, a family member can consent on their behalf instead. That is simply not true. Regulators are quick to flag up (and criticise) examples of providers and their staff claiming to have done things on the basis of permission from the family.

In fact, only a small group of people can legally take these decisions on behalf of someone else. The MCA sets out the role of lasting powers of attorney, the Court of Protection and court-appointed deputies – and the limits to the decisions they can make.

Lasting powers of attorney: people chosen by the individual to make decisions on their behalf.

Court of Protection: can take decisions and decide disputes on behalf of people who lack capacity. A **court-appointed deputy** is someone appointed by the Court to take decisions on behalf of people who lack capacity to make those decisions themselves.

Acting where people lack capacity to make their own decisions

Day in, day out, care providers and their staff have to support people with things when they lack the capacity to decide whether or not to agree. From everyday things like washing, help with eating, to blood tests and medication,

through to life-changing decisions about health care, where the person is going to live, or who will be allowed to see them.

As they cannot decide for themselves, by definition they cannot consent. So there has to be some other basis for providers to do what is needed, without breaking the law or incurring liability. In most cases, that is now the MCA.

Importantly, the MCA says a person's capacity must always be assessed in relation to a particular decision at a particular time. There should not be an assumption that someone cannot take one decision just because they cannot make another one.

Best interests

The concept of best interests is central to the MCA. Broadly speaking, best interests means what is best for the individual, all things considered. In general, provided the requirements of the MCA are complied with, acts in connection with the care or treatment of someone who lacks capacity to consent to them can be done without breaking the law or incurring liability, as long as what is done is in their best interests.

The MCA sets out a best interests checklist of steps that need to be followed when deciding what is in someone's best interests. That includes involving them as much as possible, consulting certain other people, working out as far as possible what their wishes and feelings about the decision are, and taking account of their beliefs and values.

Restraint and restriction of liberty

There are limits to what can be done in someone's best interests. In particular, the MCA sets strict limits on the use of restraint, which it defines as the use (or threat) of force to do something the person resists, as well as any actions which restrict a person's freedom of movement (whether or not the person resists). That covers physically restraining

people. It can also mean things like locks on doors, bed-rails and similar equipment, restrictions on people moving around without an escort, and medication used to control behaviour.

Restraint must be necessary and proportionate to the harm the person might otherwise suffer. That Act also says that staff must always be trying to find a less restrictive way of achieving what is best for the individual.

The CQC expects providers to have an empowering ethos, minimising restrictions where possible. Having suitable arrangements to ensure all restraint is lawful and not excessive is another core regulatory requirement, and the CQC regularly faults providers for not understanding their responsibilities in this area.

Deprivation of liberty

All providers aim to promote independence and autonomy. But there are some people whose needs are such that it is in their best interests to be subject to a level of restriction which results in them actually being deprived of their liberty.

Deprivation of liberty should be avoided wherever possible, by making sure no unnecessary restrictions are placed on service users. But if it is unavoidable, and the person lacks capacity to agree, it can be done under the MCA, as long as the right steps are taken.

In hospitals and care homes this generally means an appropriate authorisation under the MCA's deprivation of liberty safeguards (DoLS). Providers themselves are responsible for applying for these authorisations from the relevant supervisory bodies (local authorities) and, where necessary, issuing urgent authorisations in the interim. In other settings (eg shared lives, supported living) authorisation should be sought from the Court of Protection.

A recent Supreme Court judgment in March 2014 (in a case known as "Cheshire West")

has clarified what deprivation of liberty means in a care context. This judgement is likely to significantly increase the number of people likely to be deprived of liberty. The Court said that the “acid test” of whether people who cannot consent are deprived of their liberty is whether they are “under continuous supervision and control” and “not free to leave”. This applies whether or not they are resisting what is being done and regardless of whether it is the “normal” way to care for someone with their needs.

At the time of publication, the full implications of the Supreme Court judgement are still emerging. However, the Government has agreed that more attention is needed for those individuals who lack capacity and are deprived of their liberty in supported living arrangements. As a result, the Law Commission has been asked to consider a new legal framework to allow for the authorisation of a best interests deprivation of liberty in supported living arrangements – although this work will take several years.

Staff and managers need to be alert to when deprivation of liberty might be an issue (especially in the light of the Supreme Court ruling, which may cover types of care they would not previously have considered likely to be relevant). They also need to understand the procedures for obtaining authorisations, what they do (and do not) allow, and what they require of providers in terms, for example, of information for service users, notifications to the CQC and reviews.

Extensive guidance (including a Code of Practice) is already available about the operation of the MCA DoLS in hospitals and care homes. The Court of Protection has also recently begun to issue advice about what it expects in other settings (where the Court itself needs to authorise any Deprivation of Liberty) and has issued new practice directions and standard application forms (albeit on a pilot basis). Hence the situation is fluid and it may be best to talk to a lawyer or the local authority’s MCA DoLS team to get the latest position.

Depriving someone of their liberty without the proper authority – however well-meaning – is a failure of care, and potentially a very serious regulatory breach. In addition, the Human Rights Act 1998 gives people unlawfully deprived of their liberty an enforceable right to compensation.

The CQC has a special statutory role in monitoring deprivation of liberty, on top of its normal regulatory role. It has recently said its inspectors will be paying particular attention to this area.

Ill-treatment and neglect

Providers and their staff need to be aware that the MCA makes it a specific criminal offence to ill-treat or wilfully neglect people in their care who lack capacity and that the Government is pursuing a new law of wilful neglect of people who have capacity too.

Other topics

Providers and their staff may well also need to understand other aspects of the MCA, like:

- how people can make a binding **advance decision** to refuse specific medical treatment in future if they happen to lack capacity when it becomes an issue
- special rules and restrictions on involving people who lack capacity in **research** (which are not the same as the rules applying to other decisions about care and treatment)
- the role – and rights - of statutory **Independent Mental Capacity Advocates** (IMCAs) in helping people who lack capacity to make certain important decisions. Although it is for local authorities or the NHS (as appropriate) to instruct IMCAs to help people, in certain cases care home providers are legally required to notify them when an IMCA is needed
- the extent to which providers may use the **money** of a person who lacks capacity as part of caring for them, and the basis on

which people can be expected to pay for goods and services even though they do not have the capacity to contract for them

- the role of lasting powers of attorney, deputies and the Court of Protection in managing the **property and affairs** of people who lack capacity
- when and how to apply to the **Court of Protection** for a decision in connection with someone who lacks capacity which only the Court can make.

Code of Practice

The Ministry of Justice issues a Code of Practice which explains what the MCA says and gives guidance on how it should be applied. Care providers and their staff have a legal duty to have regard to the Code when doing things and making decisions to which the MCA applies.

Key principles

Finally, no-one can apply the MCA correctly without knowing its five key principles:

- everyone must be assumed to have capacity to take a decision unless it is shown they do not
- people cannot be treated as lacking capacity unless all practicable steps have been taken to help them make the decision
- people do not lack capacity just because they make an unwise decision
- decisions and acts taken for people who lack capacity must be in their best interests
- consideration must always be given to whether their best interests can be served by a different approach which is less restrictive of their rights and freedom.

Questions to ask your managers

Board members of care providers will want assurance that the MCA is being properly applied throughout their organisations, so service users are not being deprived of their rights, and providers are not being exposed to avoidable risks.

The table overleaf sets out some questions they might want to ask their officers and managers.

Key questions to ask

<p>Training and awareness</p>	<p>Have all relevant staff been trained in the MCA?</p> <p>Are there robust arrangements for training new staff?</p> <p>How is staff's understanding of the MCA monitored?</p> <p>Do they have access to the Code of Practice and know what it is?</p>	<p>Is all this documented?</p> <p>How is the effectiveness of training audited?</p>
<p>Policies and procedures</p>	<p>Can we demonstrate to regulators (and, if necessary, the courts) that we have the policies and procedures in place to comply with the MCA?</p> <p>In particular can we show that we have the right policies and procedures in place to:</p> <ul style="list-style-type: none"> • promote service users' independence and autonomy, and avoid unnecessary restrictions? • ensure service users' capacity to make decisions and to consent to what is being done is properly assessed and recorded? • ensure that "best interests" is central to decisions made about the care of service users who lack capacity? <p>Do we have robust policies and procedures for identifying when service users are at risk of being deprived of their liberty and for taking steps to avoid it?</p> <p>Where deprivation of liberty is unavoidable, do we have robust systems in place for obtaining, and complying with, and renewing necessary authorisations?</p>	<p>When were these policies and procedures last reviewed?</p> <p>How are they quality assured?</p> <p>How do we audit compliance with them?</p> <p>Have regulators, commissioners or other external bodies commented on these issues in any of our services?</p>

<p>Record keeping</p>	<p>Do our service users' records routinely include evidence of:</p> <ul style="list-style-type: none"> • proper assessment of their capacity to take particular decisions? • the steps taken to help them make their own decisions? • their consent, where they can give it (or the consent of someone legally able to give it on their behalf)? • the steps taken to determine what is in their best interest, where they cannot consent? <p>Do records show that all uses of any kind of restraint are properly identified as such and justification for it?</p>	<p>How is this audited?</p> <p>Have regulators, commissioners or other external bodies commented on these issues in any of our services?</p>
<p>Deprivation of liberty authorisations</p>	<p>How many service users are we currently depriving of liberty, and where?</p> <p>What have we done to review the position of existing service users in the light of the Supreme Court judgement?</p> <p>Who is responsible in our services for ensuring compliance with deprivation of liberty rules?</p> <p>How do we know our deprivation of liberty related paper-work is up-to-date, easily accessible and complete?</p>	<p>Have regulators, commissioners or other external bodies commented on these issues in any of our services?</p>

Winterbourne View Joint Improvement Programme

This programme is led by the Local Government Association (LGA) and NHS England, and is funded by the Department of Health.

Our vision:

Everyone, with no exception, deserves a place to call home. Person by person, area by area, the number of people with learning disabilities and autism in secure hospitals or assessment and treatment settings will permanently reduce. At the same time local community-based support and early intervention will improve to the point that it will become extremely rare for a person to be excluded from the right to live their life outside of a hospital setting.

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