Care Plans Consent and Capacity

Introduction

It can be difficult sometimes for providers to know how to record consent, capacity, best interests and restraint in an individual’s care plan.

The guide has been developed to give you a brief overview of how this can be done effectively but does not replace the MCA Code of Practice.

Any staff member who has a responsibility for writing a care plan should have a detailed knowledge of Chapters 1-6 of the Code of Practice, and the other supporting Chapters, where relevant to the clients they support.

Background to the Mental Capacity Act

The Mental Capacity Act provides a framework for:

- People who lack capacity to make decisions for themselves,
- Who have and want to make preparations for a time when they may lack capacity in the future.
- It also sets out who can make decisions on a person’s behalf, when that person lacks capacity and how the decisions should be made in that person’s ‘best interests’.

Section 1 of the Mental Capacity Act sets out the five ‘statutory principles’ – the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives.

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

Use this video link to see how to put the principles into practice.
Consent and the Assumption of Capacity

Consent is a fundamental principle of medical and social care law. The basic rule is simple: No-one has the right to touch anyone else without lawful excuse and if doctors, nurses or health/social care staff do so it may well undermine a person’s trust.

Such behaviour may lead to a complaint to the Care Quality Commission (CQC), a negligence claim or even civil or criminal proceedings for assault.

Valid Consent:

To give valid consent or permission the person needs to have:

- Information about the decision
- Free choice
- The Mental Capacity to be able to consent or refuse

Obtaining Consent

To help someone to decide whether or not to consent we need to:

**Explain** why the care or treatment is needed

**Explain** the options available and what they entail.

**Explain** what is likely to happen if the person does consent

**Explain** what is likely to happen if the person refuses the care or treatment

It is crucial that consent is sought for the following aspects of care and recorded (this list is not exhaustive and may not apply to all settings):

- To being a resident/tenant in your service for the purpose of receiving care and support to meet their assessed needs.
- To having people access their home (domiciliary care) for the purpose of receiving care and support to meet their assessed needs
- For meeting each aspect of their care needs
- To manage any aspect of their finances on their behalf
- To manage/control their medication
- For any controls/restraints and/or restrictions that may be in place (for example; bed rails, a key safe, pressure pads that set off alarms or anything that restricts their liberty/freedom of movement)

Where someone can consent to the arrangements to meet their needs the care plan should reflect exactly how that person wishes to be supported, for example:

“After discussing with James his support with his personal care, showering and toileting in the morning, James has requested that he is not to be disturbed until 10 am, at which point staff should support him to go to the toilet. After this staff should help him into his dressing gown, sit him by his computer, bring him a cup of tea and put on Radio 6 music. He will then inform the staff how he would like his personal care to be delivered that day. He has suggested that he prefers having his shower in the morning, after his tea, and would prefer a male care assistant to support him with his moving and handling, getting dressed or when supported in the shower”

- a mentally competent adult has the absolute right to refuse medical treatment, for any reason, rational or irrational, or for no reason at all.”
  *(Re MB [1997])*
Supportive Decision Making

Before deciding that someone lacks capacity to make a particular decision, it is important to take all steps to enable them to make that decision themselves (statutory principle 2, see chapter 2 of the MCA Code of Practice).

As section 3(2) of the Act underlines, these steps (such as helping individuals to communicate) must be taken in a way which reflects the person’s individual circumstances and meets their particular needs. Chapter 3 of the MCA Code of Practice provides practical guidance on how to support people to make decisions for themselves, or play as big a role as possible in decision-making.

Note: Even when people have been deemed to lack capacity to make a specific decision, they should still be involved and supported in any best interest decision made on their behalf.

Assessing Capacity

Section 4.2 of the MCA Code of Practice States:

The starting point must always be to assume that a person has the capacity to make a specific decision (see chapter 2 of the MCA Code of Practice, principle 1). Some people may need help to be able to make or communicate a decision (see chapter 3). But this does not necessarily mean that they lack capacity to do so. What matters is their ability to carry out the processes involved in making the decision – and not the outcome.

Whenever someone doubts someone’s capacity to make a decision the assessment must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general.

The person who assesses an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone’s capacity to make different decisions at different times.

With this in mind, should you think that someone lacks capacity to make a specific decision in relation to an aspect of their care plan, you should be able to provide proof (see 4.10 of your MCA Code of Practice for more information).

When completing an assessment of capacity there are 2 key questions that must be answered and evidenced:

- The person’s inability to understand / retain / use or weigh / communicate information relevant to this decision (see chapter 4 of the MCA Code of Practice for more information).
- The person’s inability to make this decision is because of the impairment of or a disturbance in the functioning of the mind or brain at this particular time.

Recording Assessments of Capacity

Section 4.10 of the MCA Code of Practice States:

Anybody who claims that an individual lacks capacity should be able to provide proof. They need to be able to show, on the balance of probabilities (emphasis added), that the individual lacks capacity to make a particular decision, at the time it needs to be made (section 2(4)). This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question.
Some providers have worried that this means you have to complete a formal capacity assessment for every decision. This is **NOT** the case. The MCA Code of Practice states the following:

4.60 **Assessments of capacity to take day-to-day decisions or consent to care require no formal assessment procedures ...**

4.61 **It is good practice for professionals to carry out a proper assessment of a person's capacity to make particular decisions and to record the findings in the relevant professional records.**

To be able to provide proof the person assessing capacity should use the 2 stage assessment of Capacity.

To see the 2 stage assessment go to 4.10-4.14 of your [MCA Code of Practice](#).

An example of this can be seen below, but should be read in conjunction with your MCA Code of Practice.

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The presumption that P has capacity is fundamental to the Act. It is important to remember that P has to ‘prove’ nothing. The burden of proving a lack of capacity to take a specific decision (or decisions) always lies upon the person who considers that it may be necessary to take a decision on their behalf (or will invite a court to take such a decision).

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Therefore assessments of capacity for day to day decisions can be completed relatively easily.

An example of a day to day decision requiring a capacity assessment is given below:

“After discussing with Mary the need for support with the changing of her continence pad when the domiciliary care staff arrive at her home, it became clear that Mary didn’t seem to understand that she has been doubly incontinent for the past 2 years and has been receiving support from her daughter with this. Mary was also supported by her daughter who prompted Mary by explaining how she supports her (on a daily basis) with the changing of her continence pads. Mary kept on saying ‘I do these things on my own.’ and ‘I don’t need the toilet’. I think that Mary’s inability to understand the fact that she is incontinent and wears continence pads, is because of her dementia.”

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Who should assess capacity?

As the MCA Code of Practice states:

4.38 The person who assesses an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone’s capacity to make different decisions at different times.

For most day-to-day decisions, this will be the person caring for them at the time a decision must be made. For example, a care worker might need to assess if the person can agree to being bathed. Then a district nurse might assess if the person can consent to having a dressing changed.

What is a ‘reasonable belief’ of lack of capacity?

4.44 Carers (whether family carers or other carers) and care workers do not have to be experts in assessing capacity. But to have protection from liability when providing care or treatment (see chapter 6), they must have a ‘reasonable belief’ that the person they care for lacks capacity to make relevant decisions about their care or treatment (section 5 (1)). To have this reasonable belief, they must have taken ‘reasonable’ steps to establish that the person lacks capacity to make a decision or consent to an act at the time the decision or consent is needed. They must also establish that the act or decision is in the person’s best interests (see chapter 5).

They do not usually need to follow formal processes, such as involving a professional to make an assessment. However, if somebody challenges their assessment (see paragraph 4.63 below), they must be able to describe the steps they have taken. They must also have objective reasons for believing the person lacks capacity to make the decision in question.

Formal assessments of capacity

Not all decisions are day to day decisions. Some decisions can directly interfere with a person’s rights such as their right to liberty or the right to a private/family life, and as such many care providers are likely to have situations where more formal recording will be needed to evidence how capacity or incapacity was established.

Some examples of when more formal recording would be needed include:

- Someone accessing a service for the purpose of receiving care/treatment.

Note: Where the person has been placed in a service in their ‘best interests’ by a Local Authority or through Continuing Health Care a capacity assessment and best interest decision should have already been completed and evidenced and given to you as the provider (you may have already been part of that best interest meeting). It is best practice for the provider to also evidence whether the person lacks capacity to give valid consent to accessing your service for the purpose of being given the proposed care and or treatment.

‘... Capacity is decision-specific. The statement ‘P lacks capacity’ is, in law, meaningless. You must ask yourself “what is the actual decision in hand”? If you do not define this question with specific precision before you start undertaking the assessment, the exercise will be pointless.’

(39 Essex Street, Brief Guide to Capacity assessment, 2014)
Whenever there are restraints or restrictions in place (always consider the frequency, intensity and duration of any restraint)

Where you are controlling an individual’s finances

In these cases more detail would be needed to justify your decision making and as such a more formal capacity assessment tool should be used to support your evidence. We have provided a suggested framework for a formal capacity assessment and best interest tool at the end of this guide.

Best Interest Decisions

If you conclude that someone lacks capacity, then and only then should you make a best interest decision. As already mentioned in the earlier sections of this guide, the level of recording will depend on the situation in hand. However, there are some key factors that should always be considered when making any best interest decision (for more detail go to Chapter 5 of the MCA code of Practice):

**Encourage participation**

• do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision

**Identify all relevant circumstances**

• try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves

**Find out the person’s views**

• the person’s past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.

• any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.

• any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

**Avoid discrimination**

• not make assumptions about someone’s best interests simply on the basis of the person’s age, appearance, condition or behaviour.

**Assess whether the person might regain capacity**

• consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?

**Consult others**

If it is practical and appropriate to do so, 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, 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
The purpose of the best interests test is to consider matters from the patient’s point of view... But insofar as it is possible to ascertain the patient’s wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.

Avoid restricting the person’s rights

- see if there are other options that may be less restrictive of the person’s rights.
- **Take all of this into account**
- weigh up all of these factors in order to work out what is in the person’s best interests.

Restrain

When people hear the word restraint, some people can worry, and assume that restraint or restrictions are always bad or illegal. This is not necessarily the case as long as the restraint or restriction can be justified in law.

What is restraint?

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

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

There are 2 ways in which restraint can be recorded:

For someone who is consenting to the restraint or restriction your evidence should be able to show that:

- The person who will be restrained or restricted is consenting to such a restraint when that restraint is necessary. In these cases the restraint is only justified if the person continues to consent to those restraints/restrictions.
As an example (supported living service):

“Peter has a history of drinking heavily and due to his alcoholism has been diagnosed with Korsakoffs Syndrome. Since being with us Peter has reduced his drinking and to help Peter with this Peter has asked us to hold his money for him in the office safe and when he buys his 4 pack of beers we are to always hold 2 of those in the safe with his money until he asks for them back (we have no reason to doubt Peter’s capacity to make decisions regarding his alcohol consumption). This has been agreed by Peter, but can only continue with Peter’s consent. If Peter asks for either his money or his beer from the safe staff are to explain to Peter the arrangement that we have in place, but if he continues to request these items staff are to hand them over to Peter.”

There can also be cases where people cannot consent to the restraint and restrictions that are being put in place. The MCA Code of Practice, outlines the following to help evidence your conclusions on this:

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

- the person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.

Paragraphs 6.44–6.48 of the MCA Code of Practice offers more explanation of the terms necessary, harm and a proportionate response.

Capacity Assessments: A Suggested Framework

The following suggestions for how to document a formal capacity assessment is for guidance purposes only. No responsibility or liability will be accepted for any action taken or not taken in relation to this.

Steps to take:

1. **REMEMBER:** A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success - MCA, section 1(3).
2. What is the decision the person is being asked to make / give consent to?
3. Why do you doubt the person’s capacity to make this decision at this time?
4. Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?
5. Describe the support you gave to help the person make the decision. This should include; **When, where and at what time was the meeting held**, how you supported the person with any specific challenges around comprehension and communication, **how long the meeting lasted (also record how many earlier meetings you had with the person to discuss the decision at hand)**, who else was present or involved in supporting the person with the decision, **how you explained the options which could be offered around the specific decision, and the likely consequences of those options, including the consequences of not making a decision** and where possible document the person’s own words or responses.
6. Finally, on the balance of probabilities, do you have sufficient reasons to justify the person lacks capacity? If so, you must provide evidence on the person’s inability to understand / retain / use or weigh / communicate information relevant to this decision & evidence on how the person’s inability to make this decision is because of the impairment of / disturbance in the functioning of the mind or brain at this particular time.
Best Interest Decisions: A Suggested Framework

REMEMBER:

- An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests – MCA, section 1(5). In addition:
- The decision must not be made on the basis of the person’s age, appearance, condition or behaviour, MCA section 4(1).
- Any decision relating to life sustaining treatment must not be motivated by a desire to bring about the death of the person, MCA section 4(5).

Steps to consider:

1. Is there a legal arrangement that has authority for this decision?
   - Lasting Power of Attorney for Property and Financial Affairs (see chapter 7 of MCA Code of Practice for more information)
   - Lasting Power of Attorney for Health and Welfare (see chapter 7 of MCA Code of Practice for more information)
   - Enduring Power of Attorney (only covers Property and Financial Affairs)
   - Court Appointed Deputy
   - Advance Decision to Refuse Treatment (see chapter 9 of MCA Code of Practice for more information)

2. Is it likely that the person will regain capacity in the future regarding the decision (can the decision be delayed)?

3. What attempts have been made to involve the person in the decision and have you recorded this?

4. What is known of the person’s past and present wishes in relation to the decision (in particular any written statement made when the person had capacity)?

5. What is known of the person’s beliefs and values that would be likely to influence the decision if the person had capacity? What other factors would the person have considered if she/he had capacity?

6. What are the views of (if practicable and appropriate to consult):
   - Anyone named by the person?
   - Anyone engaged in caring for the person or interested in her/his welfare?
   - Lasting Power of Attorney or Deputy appointed by the Court?

7. Document decision taken and document any other comments justifying Best Interests decision. **Note:** Is this option least restrictive of the person’s rights and freedoms?

8. What is the response of the person who lacks capacity to make this decision? Is there a disagreement over the final decision with anyone who was consulted? **Note:** In these situations it may be appropriate to seek additional advice or guidance, and in certain circumstances legal advice could be required.

9. What action can be taken to enhance the person’s capacity in the future?
Further Information can be found at these links:

**Essential Read**

The 39 Essex Street capacity assessment guide has now been updated and can be found [here](https://www.gov.uk/become-appointee-for-someone-claiming-benefits). Their new guide to considering best interest decisions can be found [here](https://www.gov.uk/become-deputy/overview).

**Information on appointeeship:**

[https://www.gov.uk/become-appointee-for-someone-claiming-benefits](https://www.gov.uk/become-appointee-for-someone-claiming-benefits)

**Information on Deputyships:**

[https://www.gov.uk/become-deputy/overview](https://www.gov.uk/become-deputy/overview)

**Information on Lasting Powers of Attorney:**

[https://www.gov.uk/power-of-attorney/overview](https://www.gov.uk/power-of-attorney/overview)

**A useful guide on the MCA (includes videos):**


**A range of resources on the MCA**


**Making Financial Decisions: Guidance for assessing, supporting and empowering specific decision-making**

[http://www.empowermentmatters.co.uk/?page_id=654](http://www.empowermentmatters.co.uk/?page_id=654)

**A simplified guide to capacity assessments**

[http://www.assessright.co.uk/](http://www.assessright.co.uk/)

**Further Safeguarding, MCA and DoLS Training**

If you are interested in finding out further information on the training we have available:

For MCA and DoLS Training click [here](https://www.gov.uk/become-deputy/overview).

For Safeguarding Training click [here](https://www.gov.uk/become-deputy/overview).

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