Mental Capacity Policy and Procedures
Date Approved: 20th February 2014

**DOCUMENT PROFILE**

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<thead>
<tr>
<th>Document Registration</th>
<th>To be added by IGO</th>
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<tbody>
<tr>
<td>Document Purpose</td>
<td>Policy and Procedure</td>
</tr>
<tr>
<td>Short Title</td>
<td>Mental Capacity Policy</td>
</tr>
<tr>
<td>Author</td>
<td>Danny Wherry</td>
</tr>
<tr>
<td>Publication Date</td>
<td>21st February 2014</td>
</tr>
<tr>
<td>Target Audience</td>
<td>All staff working in H&amp;SS including locum, agency, contract, and bank staff.</td>
</tr>
<tr>
<td>Circulation List</td>
<td>All H&amp;SS via the intranet</td>
</tr>
<tr>
<td>Description</td>
<td>This document provides a guide to assessment of capacity in Health and Social Services practice. The principles are applicable to anyone* who may lack capacity. These guidelines are intended for everyone involved in all such assessments. *Those aged under 18 years have special guidelines see Page 4</td>
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<tr>
<td>Approval Route</td>
<td>Care Quality Group (C&amp;SS and G &amp; A) Integrated Governance Committee</td>
</tr>
<tr>
<td>Review Date</td>
<td>3 years from MCPP Approval</td>
</tr>
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</tr>
</tbody>
</table>

**CONTENTS LIST:**

1. Introduction 4
### Mental Capacity Policy and Procedures

2. **Scope of the MCPP**

3. **Guidance for staff regarding Children and Young People**

4. **Aim**

5. **Legislation and Guidance related to the MCPP**

6. **Roles and responsibilities**

7. **Principles**

8. **Assessment of capacity**

9. **Documenting capacity decisions**

10. **Monitoring**

11. **Training**

12. **Consultation Schedule**

13. **Implementation plan**

14. **Glossary of Terms**

### Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix I</td>
<td>Best Interests information and Check list</td>
</tr>
<tr>
<td>Appendix II</td>
<td>Advance Statements, Advance Decisions to Refuse Treatment, Power of Attorney, Curatorship, Guardianship, Enduring Power of Attorney, Lasting Power of Attorney, Deputy appointed by Court of Protection UK.</td>
</tr>
<tr>
<td>Appendix III</td>
<td>Social Intervention specific Procedure for assessing and recording mental capacity</td>
</tr>
<tr>
<td>Appendix IV</td>
<td>Mental Capacity Assessment form</td>
</tr>
</tbody>
</table>

### 1. Introduction
For the purpose of the Mental Capacity Policy and Procedures (MCPP) ‘Service User’ is used as a generic term that covers patients and clients.

The aim of the MCPP is to enhance Service Users autonomy, whilst making sure that those who lack capacity have decisions made for them in a way that protects their rights and freedoms and takes their previous choices and wishes into account.

2. Scope of the MCPP

This MCPP applies to all Health and Social Services Department (HSSD) staff who are involved in the care and/or treatment of a Service User and who lack capacity in relation to a specific decision at the material time.

The MCPP and the Mental Health (Jersey) Law 1969 (MHJL) are completely independent of each other. The MHJL applies to people who are diagnosed as having a mental health disorder which requires that they be treated or detained in the interests of their own safety or to protect other people. Prior to an application under the MHJL any decision maker should consider whether the aims of any intervention could be safely achieved by using the MCPP instead.

When a Service User is detained under Art. 6 or 7¹ of the MHJL they can be given treatment for their mental health disorder without their consent. However when a Service User is detained under the MHJL their consent is required for care or treatment other than their mental disorder and thus the MCPP may apply.

3. Guidance for staff regarding Children and Young People (Service Users under 18 years of age)

Everyone aged 16 or more is presumed to have capacity unless the opposite is demonstrated.

For a child under the age of 16 it is not enough that the child understands the nature of the advice which is being given, the child must also have sufficient maturity to understand what is involved. Parental rights yield to the child’s rights to make his or her own decisions when the child reaches a sufficient understanding and intelligence to be capable of making up his or her own mind on the matter requiring a decision. (Gillick competency).

¹ http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_common_law.asp
¹¹ Art 6, Admission for observation. Art 7, Admission for treatment
If children do not have capacity themselves, someone with parental responsibility retain the right to make decisions on their behalf.
Although children acquire capacity to make decisions for themselves as they grow older, people with 'parental responsibility' for a child retain the right to make decisions on the child’s behalf until the child reaches the age of 18.

Therefore, for a number of years, both the child and a person with parental responsibility have the right to make decisions about the child’s care although such decisions could be overridden by a court.

The law in this area is difficult and not fully tested. In theory; the permission of only one appropriate person is needed before providing treatment. (This could be the child’s or parent. If you are acting on a child’s permission it is not your responsibility to inform the parent although it would always be advisable to ask the child to do so.) This means that in theory it is lawful to provide care to a child which a person with parental responsibility has authorised, even if the child refuses; however treatment under these circumstances is likely to result in a contentious situation.

If there is conflict, and time permits advice should be sought and measures undertaken to seek agreement between child and parents. If disagreement persists, legal advice should be sought, with a view to a court order being obtained. Any differences of opinion between the child and their parents, or between parents, should be clearly documented in the Service User’s notes. Seeking legal advice is most usually in the case of life threatening events and the most usual response at these times should be proportionate to the issue.

Within HSSD, as a matter of good practice and to ensure compliance with the law, you should always gain a competent child’s consent before providing care and document this; unless any delay involved in doing so would put the child’s life or health at risk.

Younger children should also be as involved as possible in decisions about their healthcare.

**Parental responsibility**

The person(s) with parental responsibility will usually, but not invariably, be the child’s birth parents. People with parental responsibility for a child include: the child’s mother; the child’s father if married to the mother at the child’s birth; a legally appointed guardian; the Children’s Service (acting on behalf of the Minister) if the child is on a care order; or a person named in a Residence Order in respect of the child. Fathers who were not married to the child’s mother at birth will only have parental responsibility if they have acquired it through a court order or parental responsibility agreement.

If in doubt regarding these issues consult with your manager.

4. **Aim**
One of the States of Jersey’s core values is to improve the experience of people using our services; respecting people’s rights to make as many decisions for themselves as they can is fundamental to this. It is also fundamental to our core values that any decisions made on behalf of Service Users who lack capacity are the ones that are best for that person, at that point in time.

The aims of this MCPP are:

- to ensure that HSSD staff are aware of the principles and values of mental capacity
- to ensure that staff are aware of their duties and the actions they need to take in order to assess capacity and make decisions on behalf of people
- to ensure that staff are aware of the procedures to document assessment in relation to capacity.
- to describe the training requirements for implementation
- to outline management and monitoring arrangements

The MCPP sets out how HSSD intends to use current research and knowledge around Capacity to protect, not only Service Users but staff making the decisions. This is achieved by using best practice techniques and procedures developed by fellow professionals in other jurisdictions. The HSSD have been guided by the legislation and codes of practice developed in the UK.

The MCPP provides a framework for determining whether a person has capacity and then for making decisions on behalf of people over the age 16 or more who are considered to lack the mental capacity to make a decision, or decisions, for themselves.

5. **Legislation and Guidance related to the MCPP**

When implementing the MCPP, staff may also need to consider other relevant legislation and guidance. This will include:

Consent forms for medical procedures HSSD
Advance Directives Policy HSSD
Safeguarding Adults Policy
Consent to Medical Treatment Jersey Law 1973
Policy for Handling Complaints
Mental Health (Jersey) Law 1969
Mental Health (General Provisions) (Jersey) Order 1971
Mental Health Rules 1971
Nursing and Residential Homes (Jersey) Law 1994
Data Protection (Jersey) Law 2005
Human Rights (Jersey) Law 2000

Additional Information on good practice can also be found in the UK:
Mental Capacity Code of Practice UK

6. **Roles and Responsibilities**

Staff employed by HSSD have different responsibilities in relation to implementing the MCPP. These are outlined as follows:

6.1 All appropriate staff

- Awareness that Service Users are presumed to have capacity to make their own decisions unless there is reason to believe that they are unable to do so.
- Ensure that Service Users are enabled to make as many decisions as is possible for themselves
- Act in the best interests of Service Users at all times
- Awareness that there is a procedure for assessing capacity and for making decisions on behalf of those who lack capacity.
- Ensure that they attend relevant training in Mental Capacity, to ensure that their knowledge of POLICY and procedures is up-to-date
- Recognition that it is good practice to discuss case examples in supervision, to reflect upon professional and clinical care.
- Awareness of the relationship between the MCPP the Safeguarding Adults policy and the Consent policy.
- Responsibility to report any concerns relating to treatment or decision making on behalf of Service Users who lack capacity, to their line manager
- Should staff have concerns that they are unable to report to their line manager or their line manager fails to act, they have a duty to follow the “Whistle Blowing Policy” (HSSnet.)

6.2 Support Staff:

- Staff to have awareness of, and competence in, how to assess capacity in relation to specific routine decisions that Service Users might be making. They need to be aware of circumstances in which they might be required to assess capacity.
- Staff need to be aware of how to gather relevant information in order to contribute to best interest decision making.
- Staff need to be aware of, and contribute to, review of capacity and review of best interests as part of care planning.
- Staff need to be competent in appropriate record keeping

6.3 Registered Health and Social Care Practitioners

- Staff need to be competent in assessing capacity to consent to treatment or interventions that they may be delivering.
- Staff need to have competencies in participating in and, making best interests decisions.
• Staff need to have competencies in advising and guiding more junior or support staff on issues to do with mental capacity.
• Staff need to know how to document and record capacity assessments and best interests decisions

6.4 Managers – in addition

• Ensure that staff receive appropriate training
• Ensure all staff are aware of the MCPP, awareness is raised and that any concerns are escalated to a line manager and reported
• Ensure that policies and procedures in relation to Mental Capacity are carried out appropriately and there is evidence available to support knowledge of the MCPP e.g. local inductions, training records etc
• Ensure that records are kept up to date and all relevant documentation placed on the Service User’s record
• Ensure staff are supported through supervision and advised appropriately on mental capacity issues.

6.5 Service Directors/Divisional Leads

• Ensure that issues relating to the MCPP are considered in strategic, business and operational issues, and that resources are allocated as appropriate to fulfil obligations for delivery
• Ensure that staff are trained in the application of the MCPP and procedures, and that this training is monitored
7. **Principles**

The values and principles of mental capacity

Many jurisdictions now have legislation that state their particular values and principles of when someone should make a decision for another person who lacks capacity. HSSD have decided to follow the following principles as our best practice.

**Five Principles**

1. **Key Principle 1**
   
   *All Persons (16 +) are assumed to have capacity unless it is established that they lack capacity*

2. **Key Principle 2**
   
   *A person is not to be treated as unable to make a decision unless all practical steps have been taken to help them make a decision*

3. **Key Principle 3**
   
   *A person is not to be treated as unable to make a decision merely because they make an unwise decision*

4. **Key Principle 4**
   
   *Anything done for or on behalf of a person who lacks capacity must be done in their best interests*

5. **Key Principle 5**
   
   *Can the purpose for which an act is done or a decision made be achieved in any way that is less restrictive or would interfere less with the person’s right of freedom of action*
person is in an environment he is comfortable in or involves an expert in helping the person express his views

If a Service User has communication difficulties, practical steps could involve using a speech and language therapist or using a speech board etc to aid the discussion.

**Key Principle 3**

A person is not to be treated as unable to make a decision merely because they make an unwise decision

This principle underpins the right to personal autonomy by preserving the right of a person to make an irrational, unusual or eccentric decision which, if viewed objectively, is not in that person’s best interests without the person being treated as being mentally incapable.

It does not prevent a capacity assessment being undertaken in respect of a person who makes an unwise decision, a series of unwise decisions, a decision that puts that person at risk, or who makes a decision which does not reflect that person’s values, beliefs or approach to risk taking.

**Key Principle 4**

Anything done for or on behalf of a person who lacks capacity must be done in their best interests

The best interest’s principle, which must guide all actions done or decisions made on behalf of a person who lacks capacity can be achieved by using the guidance in ‘What is in a person’s best interests – guidance for decision making’ Appendix 1.

**Key Principle 5**

Anything done for or on behalf of a person who lacks capacity must be done in their best interests

Any person making a decision on behalf of a mentally incapacitated person must consider whether it is possible to decide or act in a way that would interfere less with the person’s rights and freedom of action, or whether there is a need to act at all. The intervention should be proportionate to the particular circumstances of the case. Regard should be given to the least restrictive option when considering an action taken in the person’s best interest.

8. **Assessment of capacity**

The inability to make a decision must be caused by an impairment of, or disturbance in the functioning of, the mind or brain. This could cover a range of problems, such as psychiatric illness, learning disability, dementia, brain damage or even a toxic confusional state.

A person will only lack capacity in relation to a matter if “at the material time he is unable to make a decision for himself in relation to the matter
because of an impairment of, or a disturbance in the functioning of, the mind or brain".

This reflects the fact that people may lack capacity to make some decisions for themselves, but will have capacity to make other decisions. For example, they may have capacity to make small decisions about everyday issues such as what to wear or what to eat, but lack capacity to make more complex decisions about financial matters.

It also reflects the fact that a person who lacks capacity to make a decision for themselves at a certain time may be able to make that decision at a later date. This may be because they have an illness or condition that means their capacity changes. Alternatively, it may be because at the time the decision needs to be made, they are unconscious or barely conscious whether due to an accident or being under anaesthetic or their ability to make a decision may be affected by the influence of alcohol or drugs.

Finally, it reflects the fact that while some people may always lack capacity to make some types of decisions – for example, due to a condition or severe learning disability that has affected them from birth – others may learn new skills that enable them to gain capacity and make decisions for themselves.

Someone’s capacity to make a decision for themselves should be assessed using the two-stage test of capacity. Both tests need to be met in the affirmative before a person can be determined as lacking capacity in relation to the decision under question.

**Test 1:**

Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn’t matter whether the impairment or disturbance is temporary or permanent.)

**Test 2:**

If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

Test 2 is an in-depth question that requires an assessment of ability to make the particular decision in question: If the person is unable to do any of the 4 requirements below, they are deemed to lack capacity to make the specific decision.

- Does the person have a general understanding of what decision they need to make and why they need to make it?

- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
• Is the person able to understand, retain, use and weigh up the information relevant to this decision?

• Can the person communicate their decision (by talking, using sign language or any other means)?

Information regarding the decision to be taken should be presented to the individual in a manner that will best meet their needs, so it may be necessary to seek advice from professionals such as Speech and Language therapy regarding communication.

The timing and venue of an assessment, along with the provision of appropriate communication aids and information to make an informed decision should all be considered in any assessment of capacity.

Where possible, one assessor should have an established relationship with the Service User.

9. Documenting capacity decisions

There are two mechanisms for documenting capacity decisions, dependent on whether it is a medical intervention or a social intervention.

Medical intervention.

Staff considering making a decision regarding a medical treatment or intervention for someone who is incapacitated must follow the HSSD consent POLICY and use the appropriate forms. These can be found on HSSnet.

Social intervention

Any person who is making a decision regarding a social decision (what to wear, move to care home etc.) must follow the procedure set out in Appendix III.

10. Monitoring

The MCPP will be reviewed every 3 years or sooner as a result of changes in Jersey Law.

11. Training

In order to ensure compliance with the MCPP, HSSD will offer multi-agency training to those working with Adults who may lack capacity. The training aims to provide practical guidance and application of the MCPP through a range of training suites, which vary in content and are graded from levels 1 to 4.
Level of Training

**Level 1  Awareness Raising**

Basic principles of Mental Capacity.

This training should be delivered to all staff working with the elderly or others that may lack capacity.

**Time frame for training:**
All staff should have received this training within 1 year of the approval of the MCPP.

**Frequency:** Staff should have a refresher course every 5 years.

Service Managers will determine if their particular staff group require training at a higher level.

**Level 2  How to apply the MCPP**

Basic principles overview with scenarios ½ day

**Level 3  Teaching others about the MCPP**

Or ‘Train the Trainer’ 1 day course.

Staff attending this training will be provided with a ‘train the trainers’ pack that they will be responsible for cascading training to their respective teams. This training pack (MCA12) is available on the internet.

**Level 4  Complicated decision making within the Mental Capacity framework**

2 day intensive course for those participating in the most complex assessments of capacity.
12. Consultation Schedule

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<th>Name and Title of Individual</th>
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<tr>
<td>Tina Lightfoot, Manager Older People Social Services</td>
<td>October 2012</td>
</tr>
<tr>
<td>Ann Kelly, Information Governance Officer</td>
<td>April 2013</td>
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<td>Michelle Cabot, Information Governance Manager</td>
<td>April 2013</td>
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<tr>
<td>Angela Bradshaw, Macmillan Palliative Care Nurse Specialist</td>
<td>April 2013</td>
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<td>Helen O’Shea, Hospital Director</td>
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<td>Angela Body, Director of Operations</td>
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<tr>
<td>Nicola Bailache, Associate Specialist Palliative Care</td>
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<tr>
<td>Judith Gindall, Head of Nursing Theatre and Anaesthetics</td>
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<td>Bernard Place, Head of Nursing Emergency Care</td>
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<td>Gary Kynman, Head of Nursing Inpatients</td>
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<tr>
<td>Elaine Torrance, Head of Midwifery</td>
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<td>Richard Jouault, Managing Director of Community and Social Services</td>
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<td>Phil Dennett, Director of Children’s Services</td>
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<td>Ian Dyer, Director of Older People Services</td>
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<td>Chris Dunne, Director of Adult Services</td>
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<td>Lisa Perkins, Head of Service, Specialist Services</td>
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<td>Advocate V Dempsey, Legal Advisor Law Officer’s Department</td>
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<td>18th June 2013</td>
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<td>General and Acute Care Quality Group</td>
<td>18th June 2013</td>
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<td>Integrated Governance Committee</td>
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13. Implementation plan

As there are distinct differences between procedures and the frequency these decisions will be made for ‘Medical’ and ‘Social’ reasons, it is envisaged that each Division will take responsibility for training their staff.

Each Division will decide who will deliver and receive this training.
There are no identified funds for this training therefore each Division will have to make provision for this training within their existing training budgets.

This MCPP will be posted on the HSSnet and will be included in the induction of new staff as appropriate.

Following ratification of the MCPP at the Integrated Governance Committee an ‘all users’ e-mail referring staff to this MCPP will be sent

14 Glossary of Terms

**Independent Mental Capacity Advocate (IMCA):**
This is not a legally qualified Advocate but a person who has skills to assess the Mental Capacity of someone and to advocate on behalf of a Service User.
Appendix I

Best Interests Information and Check list

Best interests should be considered in a broad sense – it is not just about what the person needs medically, for example, but also how will it affect their welfare, how will it impact on them emotionally, what impact it will have on their social circumstances.

If there is a significant decision to be made relating to health or a change of residential placement, and the person has no family to be consulted, staff where possible should seek a IMCA to participate in the Best Interests decision making.

Staff will need to be able to justify why they think a decision is in someone’s best interests, as it can be open to a legal challenge.

Best interest decisions will need to be formally documented as per the procedures in your Division.

Less significant care and treatment decisions or routine matters

Normally, it is not lawful for anyone to interfere physically with a person or their property without that person’s permission. If a person lacks the capacity to make these decisions and it is in the person’s best interests for an action to be taken, staff are allowed to provide personal care, deliver some healthcare treatments, use money to go shopping or pay for necessary items.

Staff are not expected to undertake capacity assessments and hold best interests meetings about these matters on a daily basis, as this would clearly be unworkable. For routine decisions, it will be sufficient for the judgements about capacity and best interests to be made and documented as part of the care planning process and reviewed with the care plan. Significant decisions will need separate Best Interests meetings and records.

Best interest Checklist

The following provide a checklist of factors which need to be considered when making decisions on behalf of someone who lacks capacity.
What is in a person’s best interests – guidance for decision making.

Preliminaries

Satisfy yourself that the person:

1. Lacks capacity to make a decision on the issue in question
2. Has not made a relevant and valid Advance Statements (see Appendix II)

In the above circumstances the registered professional providing treatment or care (the decision maker) must decide what is in a Service User’s best interests by taking actions as follows:

1. 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 e.g. use simple language or illustrations; choose a time/location where the person is most at ease.

2. Identify all relevant circumstances

   - Try to identify all the points that the person who lacks capacity would take into account if they were making the decision or acting for themselves i.e. risks and benefits of treatment and alternatives.

3. Find out the person’s views

   - Try to find out the views of the person who lacks capacity, including:
     - The person’s past and present wishes and feelings – these may have been expressed verbally, in writing, or through behaviour or habits. A IMCA may help.
     - Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question. The person may have made an advance statement.
     - Any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

4. Avoid discrimination

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

5. Assess whether the person might regain capacity

   - Consider whether the person is likely to regain capacity e.g. after receiving medical treatment or learning new skills. If so, can the decision wait until then?
6. If the decision concerns life-sustaining treatment

- The decision maker should not make assumptions about the person’s quality of life, nor be motivated in anyway by a desire to bring about the person’s death.

7. Consult others

- If it is practical and appropriate staff must 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.
  - Close relatives, friends or others who take an interest in the person’s welfare.
  - For decisions about major medical treatment or where the person should live, and when there is no-one who fits into any of the above categories, an IMCA may be consulted.
  - When consulting, remember that the person who lacks capacity to make the decision or act for themselves still has a right to keep their affairs private – so it would not be right to share every piece of information with everyone. Select information on a need-to-know basis.
  - The weight given to the views of others should reflect the length of time the individual has known the person who lacks capacity and how close the relationship is.

8. Avoid restricting the person’s rights

- See if there are other options that may be less restrictive of the person’s rights.

Then weigh up all of these factors in order to work out what is in the person’s best interests?

Recording best interests decisions.

All best interests decisions must be recorded on the Service User’s case notes/file as defined in the procedures for the separate Divisions and include the following:

1. How the decision about the person’s best interests was reached.
2. What the reasons for reaching the decision were.
3. Who was consulted to help work out best interests
4. What particular factors were taking into account

Disputes

If someone wants to challenge a decision-maker’s conclusions, consider:
- Involving a IMCA to act on behalf of the person who lacks capacity to make the decision
- Getting a second opinion
- Holding a formal or informal Best Interests case conference
- Attempting some form of mediation
- The Decision Maker could suggest the person challenging the decision pursue a complaint through the organisation’s formal complaint procedures

If all attempts to resolve the dispute fail refer the matter for legal advice through your line Manager.
Appendix II

Advance Statement, Advance Directive/Decision to Refuse Treatment, Curatorship, Enduring Power of Attorney or Lasting Power of Attorney

It is important that at any time when making decisions particularly when making Best Interest Decisions that you consider whether the Service User has made or is subject to, the following:

Advance Statement

An Advance Statement is "a mechanism whereby a competent Service User can provide instructions about what is to be done if they subsequently lose the capacity to make a decision or to communicate". (BMA, 1995). Advance Statements record general requests about future healthcare, religious beliefs, advance refusals of treatment or the nomination of a friend or relative to make healthcare decisions on their behalf. Advance Statements can be written or oral and include such documents known as Living Wills, Advance Directives or.

Advance Direction to Refuse Treatment (ADRT)¹

Advance Direction to Refuse Treatment

An (ADRT) is "a clear instruction refusing some or all medical procedures", and the authority for that instruction is derived from the established legal right of competent, informed adults to refuse treatment, irrespective of the wisdom of their judgement" (BMA, 1995). In the case of Attorney General v X 2004 JLR 1, which is a decision of the Royal Court and legally binding in Jersey, the Royal Court upheld an Advance Directive which refused nutrition, hydration or medical treatment. It is only these advance refusals which are regarded as legally binding on healthcare staff. For further information on the legal background please see the Advance Directive Policy

An ADRT must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity.

A HSSD employee who follows a valid and applicable ADRT is not acting "for or on behalf of a person who lacks capacity", he or she is acting on the instructions of a capacitated individual. The best interests’ principle does not therefore apply to such decisions and healthcare professionals must comply with a valid and applicable advance decision, even if they do not consider that it would be in the Service User’s best interests to do so.

The Advance Directive Policy contains further information on this subject.

¹ An Advance Direction to Refuse Treatment (ADRT) is sometimes known as an Advanced Directive. The wording has been changed to ensure there is no confusion regarding the different directives or decisions and is endorsed by the BMA.
Powers of Attorney

Ordinarily, a Power of Attorney that has been made by a person who is resident in Jersey will be deemed to have been revoked on the incapacity of the donor in accordance with Article 9(5) of the Powers of Attorney (Jersey) Law 1995.

Curatorship

Staff will need to be aware if a Curator has been appointed by the Royal Court to look after a Service User’s financial affairs and assets. Staff should be able to ascertain whether a Curator has been appointed, and if so, who the Curator is, from relatives or carers of the Service User. It is important to note that a Curator does not have authority in relation to welfare matters.

Guardianship

An application can be made to the Royal Court under the MHJL for a person to be received into guardianship if the person is suffering from a mental disorder or addiction, and it is necessary to do so in the patient’s interests or for the protection of others. The application may be for the Minister for Health and Social Services, or another person, to be the Guardian.

Enduring Powers of Attorney or Lasting Power of Attorney

Enduring Powers of Attorney and Lasting Powers of Attorney are concepts of English law and therefore are unlikely to be relevant to Jersey resident Service Users. Where it becomes known that a non-resident Service User has made such a power of attorney, its ambit should be ascertained to see whether it is relevant to welfare and/or financial decisions. Thereafter, a pragmatic approach should be adopted so as to take account of the views of a non-resident Service User’s attorney, to the extent that it is appropriate to do so, as part of any ‘best interests’ decision making process.

Appointment of ‘Deputy’ by English Court of Protection

If a ‘Deputy’ has been appointed by the Court of Protection in England and they have registered a Power of Attorney in Jersey that person has the right to make decisions on financial affairs for the incapacitated person. (Depending on the authority given to the Deputy by the Court of Protection)

It does not matter whether the Power of Attorney has been registered or not by the Deputy in Jersey regarding Care and Social issues, it has no standing in Jersey Law. However the Deputy’s position would be a factor to take into consideration, but not on any legal recognition.
Appendix III

Social Intervention.
Specific Procedure for assessing and recording mental capacity

For day-to-day routine decisions staff are not expected to undertake capacity assessments and hold best interests meetings about these matters on a daily basis, as this would clearly be unworkable.

These decisions of capacity may be assessed by a single professional and must be documented in the Service Users’ clinical/social care case notes using Mental Capacity Assessment (MCA) form (Appendix III).

Significant Decisions

Significant decisions will need separate Best Interests meetings and records.

A formal assessment of capacity MUST be completed by two appropriately qualified registered professionals where a significant decision is being made and there are concerns that a Service User may not have the capacity to:

- Consent to an informal admission (to hospital, nursing or care home)
- Consent to arrange accommodation (or change of accommodation) – (e.g. move from inpatient bed to different hospital, nursing or care home & they will stay in hospital for more than 28 days or in a care home for more than 8 weeks)
- Request a Tribunal Hearing when detained under the MHJL (1983)
- Manage their property or financial affairs, health or welfare
- Consent to their confidentiality being breached – e.g. during Safeguarding Adults investigation

The above list is not exhaustive and professional judgement must be used. All assessments must follow the five principles and the test of capacity. All significant decision capacity assessments MUST be conducted jointly by two registered professionals; in exceptional circumstances, the assessment may be conducted – where only one person is a registered professional and the second is for instance a support worker. When the second assessor is a support worker, they should only be involved in the assessment where they have an established relationship with the Service User and where their knowledge of the Service User will contribute positively to the assessment.

It must be noted that all assessments of capacity are issue specific; so it is probable that a Service User may have several different assessments of capacity in respect of different issues and decisions documented both on the electronic record and in their case notes. Professional judgement will
need to be used to determine whether an assessment of capacity should be repeated, if an adult’s capacity appears to change in respect of a specific decision.

In assessing capacity:

- One registered professional should - wherever possible - have an established relationship with the Service User.

- The timing of an assessment, venue, use of appropriate communication aids & ensuring a Service User has received sufficient information to be able to make an informed decision should all be considered in any assessment of capacity.

- Outcomes of all capacity assessment in respect of significant decisions MUST be documented on the MCA form (Appendix IV) and a copy MUST be logged onto the Service User’s electronic record with a scanned signed dated copy.

Whilst the assessment is actually carried out by two people there is only ever one ‘decision maker’ and their name needs to be recorded on the appropriate form.

Where professionals are unable to agree if a Service User has the capacity to make a decision, then a formal second opinion should be sought from a suitably qualified professional within the field. Each service area should identify staff that would be able to provide this formal second opinion.

**Who is the Decision Maker?**

Following any assessment of capacity by the two professionals it is only ever one person who is the ‘decision maker’. The decision maker is determined by the nature and complexity of the decision to be made. Day to day care decisions may be made by a paid or unpaid carer. Significant social care, finance and accommodation decisions may be made by health and social care professionals in accordance with any protocols or policies that may apply.

The decision maker’s name must be recorded on the MCA form. Whilst it is expected that the decision maker would have been involved in the assessment of capacity, exceptionally the decision-maker may have delegated responsibility for assessing capacity to another professional. Where this has occurred, the rationale for such a decision MUST be recorded in the case notes and on the Service User’s electronic record. The name of the decision-maker must be recorded clearly on the MCA form.
### Mental Capacity Assessment form (Social Care)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Main ID:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed by</td>
<td>Name:</td>
</tr>
<tr>
<td>FACE Mental Capacity Assessment</td>
<td></td>
</tr>
<tr>
<td>What prompted this assessment? <em>(I.e. summary of relevant history)</em></td>
<td></td>
</tr>
<tr>
<td>Details:</td>
<td></td>
</tr>
<tr>
<td>What is the specific decision to be taken? <em>(If this is a review, detail previous decision about capacity)</em></td>
<td></td>
</tr>
<tr>
<td>Details:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key roles</th>
<th>Closest person</th>
<th>Advanced Statement</th>
<th>Curator</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Determination of capacity *(This is a specific, not general determination. Note any documentation referenced)*

| Is there an impairment of or disturbance in the functioning of the person’s mind or brain? |
|-----------------------------------------------|---------------------------------|-----------------|-----------------|------|------|
| Permanent impairment | Fluctuating impairment | Temporary impairment | No |
| Details: |

| Is the person able to understand information related to the decision? | Yes | No |
| Details: |

| Are they able to retain information related to the decision? | Yes | No |
| Details: |

| Are they able to use or weigh the information whilst considering the decision? | Yes | No |
| Details: |

| Are they able to communicate their decision by any means? | Yes | No |
| Details: |

*A ‘No’ answer in any of the 4 domains above constitutes incapacity. If all ‘Yes’ go to Assessment Summary.*

| Were all reasonable steps taken to maximise the person’s capacity to make the Decision? | Yes | No |
Details:

<table>
<thead>
<tr>
<th>Can the decision be delayed because the person is likely to regain capacity in the near future?</th>
<th>Yes</th>
<th>Not likely to regain capacity</th>
<th>Not appropriate to delay</th>
</tr>
</thead>
</table>

Details:

Who was consulted about the determination? *(Give names and roles. If case conference held detail attendees)*

Details:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Main ID:</th>
</tr>
</thead>
</table>

**Advance decision to refuse treatment** *(Note any documentation referenced)*

<table>
<thead>
<tr>
<th>Is there an advance decision relevant to the decision?</th>
<th>No</th>
<th>Yes</th>
<th>If yes select option and give details</th>
<th>Similar treatment</th>
<th>Similar circumstances</th>
</tr>
</thead>
</table>

Details of similar treatment or circumstances:

<table>
<thead>
<tr>
<th>Advance decision type</th>
<th>Written</th>
<th>Verbal</th>
<th>Date of Advance decision</th>
</tr>
</thead>
</table>

What was the decision? *(Give details. If advance decision was verbal, detail to whom, in what circumstances)*

Details:

<table>
<thead>
<tr>
<th>Is this decision still applicable?</th>
<th>Yes</th>
<th>No</th>
<th>If ‘No’ select option below and give reasons (check guidance)</th>
</tr>
</thead>
</table>

Withdrawn | Unanticipated circumstances | Detained under Jersey Mental Health Law 1969 | Other |

Details:

**Determination of best interest** *(Note any documentation referenced)*

<table>
<thead>
<tr>
<th>IMCA</th>
<th>Yes/NO</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Tel:</th>
</tr>
</thead>
</table>

What is most important to the person as regards this decision? *(Current and past views, e.g. written statement)*

Details:

Views of interested others *(E.g. family, friends, carers, Curator, etc. Give names and roles. If no-one justify)*

Details:

Views of professionals involved

Details:

Describe any possible conflicts of interest with regard to this decision

Details:
**Assessment summary** *(Remember any judgment about mental capacity is specific to this decision)*

| Decision requires arbitration? | No | Independent mediation | Royal Court |

Considering all the factors what final decision has been reached? *(If arbitration required detail)*

Details:

I confirm that this decision is the least restrictive option or intervention possible. Special considerations for life-sustaining treatment have been considered or are not applicable. This decision has not been biased by age, appearance, condition, gender or race. Every effort has been made to communicate with the person concerned.

<table>
<thead>
<tr>
<th>Decision-maker</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation</td>
<td>Telephone no.</td>
</tr>
</tbody>
</table>

| Signature | Electronic | Decision date |
