Multi-Agency Capacity Policy and Procedures [Jersey] February 2018

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Contents

1. Introduction

For the purpose of the Capacity Policy and Procedures [CPP] 'Service User' is used as a generic term for those that access services.

Capacity is the concept which refers to an individual having the ability to make a specific decision at the time it needs to be made. A person aged 16 + is assumed to be capable of making their own decisions. This assumption can only be overridden if the person concerned is assessed as lacking the capacity to make a particular decision for him or herself at the relevant time.

The aim of the CPP is to provide a policy framework for Jersey to support people to make decisions for themselves or, failing that to ensure that decisions are made for the person in the person's best interests. The CPP applies primarily to people aged over 16, who should be presumed to have capacity. However, parts of the policy make reference to decision making in respect of children aged under 16.

This Policy will be replaced by the Capacity and Self Determination (Jersey) Law 2016 and the Mental Health (Jersey) Law 2016 when they come into force. These Policy and Procedures will remain in place until this time.

Relationship to the Mental Health Law

This CPP has been issued to support all staff who are involved in the care and/or treatment of a Service User who may lack capacity in relation to a specific decision, when that decision needs to be made.

The CPP and the Mental Health (Jersey) Law 1969 (MHJL) contain separate processes that in some cases may both need to be used in respect of a Service User. Prior to an application under the MHJL it will often be appropriate for the decision maker to apply the CPP and consider whether the aims of any intervention could be safely achieved without using the compulsory powers available under the MHJL.

The MHJL applies to people who may have, or are diagnosed as having a mental disorder (which includes both learning disability and mental health conditions). The MHJL provides powers to compulsorily detain a person for the purposes of assessment and treatment where that is necessary in the interests of their own health or safety, or to protect other people. It also provides powers to place a person with a mental disorder into guardianship, so that they can be supported to live in a particular place determined by the guardian.

When a Service User is detained under the MHJL their consent is required for care or treatment other than for their mental disorder and thus the CPP may apply.

2. Aims of the CPP

The aims of the CPP are:

- to ensure awareness of the principles and values of capacity and best interests decision making;
- to ensure awareness of duties and actions to be taken in order to assess capacity and make decisions of behalf of people [only if a lack of capacity is established];
- To ensure awareness of the requirements to document assessments in relation to capacity;

- To use current research and knowledge around capacity to empower and protect service users and staff;

- Using legal principles, best practice guidance and evidence from other jurisdictions

This policy and procedure have been guided by the legislation and codes of practice developed in the UK. The policy is intended to reflect the requirements of the European Convention on Human Rights which is enforceable in Jersey by virtue of the Human Rights (Jersey) Law 2000. Public authorities in Jersey are required to act compatibly with the rights in the Convention.

3. Legislation and Guidance

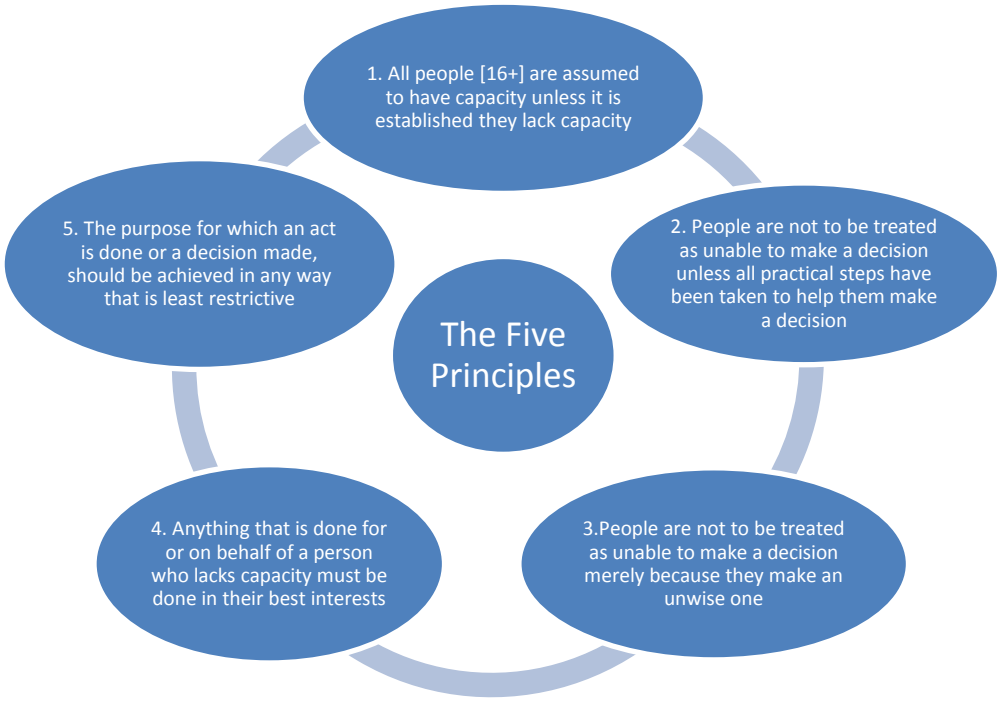
- Mental Health [Jersey] Law 1969 currently in force
- Mental Health (Jersey) Law 2016 due to come into force in 2018
- Capacity and Self Determination Law (Jersey) 2016 due to come into force in 2018
- Data Protection [Jersey] Law 2005
- Safeguarding Adults Procedures
- Safeguarding Children – Interagency Child Protection Procedures

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

4. Principles

The values and principles of 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. The following principles are adopted by member agencies of the Safeguarding Partnership Board in Jersey.



Key Principle 1

All Adults (16 +) are assumed to have capacity unless it is established that they lack capacity

A person aged 16 + is assumed to be capable of making their own decisions. This assumption can only be overridden if the person concerned is assessed as lacking the capacity to make a particular decision for him or herself at the relevant time.
Practitioners are reminded the presumption of capacity can be challenged when there are grounds for doing so. This principle should not be used as a means of justifying a failure to assess an individual's capacity where there are reasons to believe the person may lack capacity.

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

This provision is aimed at maximising the decision-making capacity of individuals. All practicable steps could include providing information relevant to the decision in an accessible format, making sure the person is in an environment they are at their best in or involves an expert in helping the person express their views

For example, using specific communication strategies, providing information over time to allow a person to assimilate information more completely thereby maximising their actual understanding.

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 or unusual decision which, if viewed objectively, is not in that person's best interests.

It may be appropriate for a capacity assessment to be 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. This reflects learning from Serious Case Reviews and research which shows the importance of practitioners understanding the difference between unwise decision making and decisions made on a lack of understanding of risks or an inability to weigh up the information about making the decision. All of these are critical in assessments of capacity.

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 is set out in more detail in Appendix 3 must guide all actions taken or decisions made on behalf of a person who lacks capacity. This ensures compliance with legislation and professional registration requirements where relevant. The Best Interests Checklist sets out a range of factors that must be taken into account before a decision made or an act carried out.

Key Principle 5

The purpose for which an act is done or a decision made on behalf of a person who lacks capacity should be achieved in ways that are least restrictive to the person concerned

Any person making a decision on behalf of a person who lacks capacity 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
- whether there is a need to act at all.

And ensure:

- The intervention should be necessary and 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.

5. Assessment of capacity

Capacity assessments can be undertaken by anyone in relation to a person's decision-making capacity. To assess whether a Service User lacks capacity, the 'test' has three elements. It requires that you consider whether a person is unable to make a decision for themselves because they suffer from an impairment, or a disturbance, of the functioning of the mind or the brain.

When carrying out the test of capacity there is a duty on staff to ensure the person has the best possible opportunity to understand the information and communicate their decision. You must therefore take all practicable steps to help the person to make their own decision even when undertaking a capacity assessment. Practical steps could include:

- The use of pictures, simple language, non-verbal means or communication aids.
- Using others such as family or speech therapists, who could help the person understand the information and can translate their decision where the assessor cannot recognise their means of communication.
- A person can communicate their decisions using any method including for example by hand signals, other gestures or behaviour. It could be by simple muscle movements.

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. The advantage of being issue specific is that it allows service users to make decisions in respect of one issue but not another, which maximises their decision-making capabilities.

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 fluctuates. 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. If there is any uncertainty, capacity should be presumed.

Please note the fact that a service user may have, for example, a mental illness or dementia, does not of itself render that person incapable of making a particular decision. A finding on incapacity can only be made if it is established that the inability to make the decision is because of the mental illness or dementia.

Prejudicial assumptions should not be made about capacity based upon a service user's impairment, disability, age or appearance. In the absence of a capacity assessment any uncertainty has to mean capacity should be presumed.

The Capacity Test

Part 1

Is the person unable to make the decision in question at the time it needs to be made?

To have capacity to make a decision a person must be able to:

1. Understand the information relevant to the decision (including the reasonably foreseeable consequences of making or not making a decision)

and

2. Retain that information (long enough to make the decision)

and

3. Use or weigh the information (as part of the decision-making process)

and

4. Communicate the decision (in any recognisable way)

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, the assessor should have an established relationship with the Service User and if there is a need for two assessors [see own agencies guidelines/policy] then at least one assessor should have an established relationship with the Service User.

Some service users may have fluctuating capacity and if this is the case then it should be demonstrated and recorded that every effort has been made to accommodate this when looking at capacity issues.

Part 2

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 does not matter whether the impairment or disturbance is temporary or permanent.

A wide range of conditions can amount to such an impairment or disturbance, including psychiatric illness, learning disability, dementia, brain injury, stroke or even intoxication with alcohol or drugs.

Part 3

In order to lack capacity to make a specific decision the person must be unable to make the decision because of the identified impairment or disturbance in the functioning of the mind and brain.

6. Limitations of the CPP (Excluded decisions)

There are certain decisions that it will not be possible to make or that should not be made on behalf of individuals who lack capacity and include the following matters:

- Consenting to marriage or civil partnership
- Consenting to sexual relationships
- Consenting to divorce or dissolution of partnership
- Placing a child for adoption, making an adoption order or discharge of parental responsibilities (other than in relation to a child's property)
- Organ donation
- Fertility treatment
- Consenting to making a decision in respect of voting

Organisations should make the limitations of these processes clear to their staff and ensure that staff can raise questions about whether it is appropriate to make a particular decision on behalf of a person in their best interests.

7. Documenting capacity decisions

Where there is doubt about the service user's capacity and the decision is significant, complex, or places the service user at risk, it is suggested that a formal capacity assessment should be undertaken.

Capacity assessments must be recorded in line with agency guidance; both medical and social care decisions should be undertaken with equal thoroughness and considered of equal importance.

Pro formas for medical intervention or social care intervention can be found at Appendix 1

If there is a challenge as to whether the service user had capacity, the decision maker would need to show that there were reasonable grounds for believing/ assessing that the service user lacked the capacity to make the decision at that particular time.

8. Medical Intervention/Procedures

Patients requiring invasive medical / surgical procedures should give valid consent using the relevant forms on hospital or primary care settings.

Medical staff considering making a decision regarding a medical treatment or intervention for someone who lacks capacity must follow their agency consent policy/guidance and use the appropriate forms. Where consent to medical treatment is required, the doctor/health professional proposing the treatment should be responsible for the capacity assessment.

The General Medical Council and other professional bodies set out standards for professional practice which must be followed. This policy, the key principles and the pro forma for assessing and

documenting the assessment of capacity are useful tools in meeting these professional standards in the majority of clinical scenarios, as well as consenting for invasive procedures.

9. Social Intervention

Formal capacity assessments should be used for significant decisions. In respect of daily living decisions that a person needs to make each day, for example in relation to what to wear, what to eat, or whether the service user should go for a walk it is more appropriate to follow the model of assessment in case recording. Decisions formalised through the best interests process are often incorporated into the service users care plan.

10. Information sharing

Adults have a general right to control information about themselves. However, in the context of adult safeguarding the rights of adults with or without capacity can be overridden where the public interest served outweighs the interest in protecting confidentiality, for example where a serious crime may be prevented or there is safeguarding risk to the person or others.

11. Monitoring

The CPP will be reviewed annually.

12. Agency responsibility

All agencies that provide care and support to adults and young people over 16 need to have guidance relevant to their function in place.

12.1 All staff who provide care and support have knowledge of the CPP which would include the following:

- 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
- Awareness and understanding of the five principles of capacity
- Ensuring Service Users are enabled to make as many decisions as is possible for themselves
- An awareness that there is a procedure for assessing capacity and for making decisions on behalf of those who are assessed to lack capacity
- Ensuring that they attend relevant training in capacity, to ensure that their knowledge is current
- Awareness of the relationship between the CPP and the SAPB Safeguarding Adults Procedures
- The responsibility to report any concerns relating to care, support or decision making on behalf of Service Users who lack capacity, to their line manager and/or follow the Safeguarding Adult Procedures if required
- Where 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 their agency “Whistle Blowing Policy”.

12.2 In addition, for staff that may be involved in specific routine decisions that a service user might be making – for e.g. personal care:

- Staff to have awareness of, and competence in, how to assess capacity in relation to specific routine decisions that a Service User might be making.
- Staff need to be aware of circumstances in which they might be required to assess capacity.
- Where a lack of capacity is established in relation to a particular decision staff need to be aware how they may contribute to best interest decision making.
- Staff need to be aware of circumstances in which they might be required to make a best interests decision on behalf of a Service User.
- Staff need to be aware of how to document and evidence any decision making in relation to CPP.
- Staff need to be competent in appropriate record keeping in order to justify actions undertaken.

12.3 In addition, for any registered practitioner:

- Practitioners need to be competent in assessing capacity
- Practitioners need to have competencies in contributing to and, making best interests decisions when a lack of capacity to make the decision is established.
- Practitioners need to be aware and comply with their own professional registration requirements, including record keeping
- Practitioners need to know how to document and record capacity assessments and, if needed, best interests decisions which include clear recording of how and why the decision reached is in the Service User's best interests.

12.4 In addition, for Managers:

- Ensure that staff receive appropriate training and that this is monitored
- Ensure staff are competent to a level suitable for their role through supervision and appraisal arrangements and that appropriate support and development is offered
- Ensure all staff are aware of the CPP and that any concerns are escalated to a line manager and reported
- Ensure that policies and procedures in relation to capacity are carried out appropriately
- Ensure staff comply with record keeping policies, procedures and guidance

13. Considerations for children

This Capacity Policy and Procedure applies to anyone over the age of 16.

13.1 Consent to care and treatment

The Consent to Medical Treatment (Jersey) Law 1973 provides that young people 16 years of age and over may give effective consent to surgical, medical or dental treatment and to associated procedures, such as nursing care.

However, some children who are under 16 may have capacity to consent to some or all medical treatment or care they might receive.

Where a person proposing treatment or care thinks there is a question as to whether a child has capacity to consent to treatment/care then the child's capacity should be assessed using the test of 'Gillick competence'. This is a reference to a particular legal case in England in which the question of how to assess a child's capacity to consent to medical treatment was considered. The principles established in *Gillick* can be applied in Jersey. Assessing competence by reference to these principles is very similar to assessing capacity where a question arises as to an adult's capacity. Essentially an assessment should be made as to whether the young person has sufficient intelligence, maturity and understanding to comprehend what is proposed.

If a child is assessed as Gillick competent, they have capacity to consent to medical treatment or care and their decision must be respected. If the child makes a Gillick competent decision to refuse treatment/care this must also be respected – even if someone who has parental responsibility wishes to consent on their behalf.

If a child is not Gillick competent, the decision should be made in the child's best interests either by the person with parental responsibility for the child or by another appropriate decision maker following the processes in the CPP.

13.2 Who has parental responsibility and what is it?

Someone who has parental responsibility for a young person may be asked to make decisions about their care or treatment. It is important to be clear who has parental responsibility as it is not necessarily the young person's parent.

- A mother automatically has parental responsibility for her child, unless the child is legally adopted by someone else.

- A father who is married to the mother at the time of the birth, or if the child is jointly adopted, automatically has parental responsibility. If the father and mother subsequently marry, the father can acquire parental responsibility if the birth is re-registered.

- An unmarried father of a child born on or after 2nd December 2016 automatically acquires parental responsibility provided he is registered as the father on the child's birth certificate. Other unmarried fathers can gain parental responsibility by way of a formal parental responsibility agreement between him and the mother or by Court Order.

- If the child is involved in care proceedings, parental responsibility can be assigned to the person they are living with. If the child is subject to a Residence Order the person the child lives with acquires parental responsibility.

- If the child is subject to a Care Order or an Interim Care Order the States of Jersey has parental responsibility.

Parental responsibility lasts until the child is 18. If parents divorce the father retains parental responsibility, if the father had parental responsibility previously. The parent the child lives with does not have more powers than the other parent. Parental responsibility means the: 'rights, duties, powers responsibilities and authority which by law a parent has in relation to a child' (Children's (Jersey) Law 2002).

There is no statement of the decisions that a person with parental responsibility has a right to make on a

child's behalf. Organisations should seek their own advice where they are unsure whether a person or people who have parental responsibility for the child should make a decision. Such questions may arise in particular where the decision relates to proposed treatment or care is particularly invasive or controversial, or if the interests of the parents conflict with the perceived best interests of the child.

For advice, support and guidance in this area practitioners are reminded in the first instance to discuss with their line manager/ designated safeguarding lead.

It may be that legal advice and support is needed. The Courts can make determinations about a child's best interest's decision. This should only be used as a last resort.

14. Training and Implementation

Agencies and services are responsible for ensuring:

- The development, implementation and revision of any single agency Capacity Guidance/procedures for staff [paid and unpaid]
- The provision of training and development opportunities to ensure staff they are responsible for have awareness, understanding enabling the effective operation of this multi-agency policy and procedure and any single agency guidance/procedures
- Training and development opportunities should reflect the roles and responsibilities of staff in terms of depth and content.
- Agencies and services may wish to work in partnership to ensure effective provision of training

The Safeguarding Partnership Board will:

- Ensure this multi-agency policy and procedure is reviewed annually
- Continue awareness raising of this policy and procedures in relation to the SPB's Safeguarding remit
- Ensure access and availability of this multi-agency policy and procedure

Appendix 1: Capacity Assessment & Best Interests Pro forma

Name:	**Main ID:**	
Assessed by	**Name:** **Role:**	**Name:** **Role:**

Capacity Assessment

What prompted this assessment? *(I.e. summary of relevant history)*

Details:

What is the specific decision to be taken? *(If this is a review, detail previous decision about capacity)*

Details:

Key roles	**Closest person**	**Advanced Statement**	**Curator**	**Other**	
Role					

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

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.

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

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:								

Can the decision be delayed because the person is likely to regain capacity in the near future?	*Yes*		*Not likely to regain capacity*		*Not appropriate to delay*		
Details:							
Detail why the inability to make the decision is **because of** the impairment or diagnosis							
Details:							
Who was consulted about the determination? *(Give names and roles. If case conference held detail attendees)*							
Details:							
Name:	Main ID:						
Advance decision to refuse treatment *(Note any documentation referenced)*							
Is there an advance decision relevant to the decision?	*No*	*Yes*		*If yes select option and give details*	*Similar treatment*		*Similar circumstances*
Details of similar treatment or circumstances:							
ADRT type *Written*		*Verbal*	Date of ADRT				
What was the decision? *(Give details. If advance decision was verbal, detail to whom, in what circumstances)*							
Details:							
Is this decision still applicable? *Yes No If 'No' select option below and give reasons (check*							
Withdrawn			*Unanticipated circumstances*		*Other*		
Details:							
Independent Capacity Advocate							
Yes/No							
Name:	Tel:						
Organisation:							
Determination of best interests *(Note any documentation referenced)*							
Background information							
Details:							
What is known about the persons values, wishes and feelings (*including any written statements*)							
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:

Options considered	
Option 1**:** (duplicate as needed)	
Advantages/Benefits:	Disadvantages/Risks:
Option 2**:** (duplicate as needed)	
Advantages/Benefits:	Disadvantages/Risks:

Assessment summary *(Remember any judgment about mental capacity is specific to this decision)*			
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			
Decision-maker		Role	
Organisation		Telephone	
Signature			Decision date

Appendix 2: Best Interests Checklist

When it is assessed that an individual does not have capacity in relation to a specific decision the Registered Professional providing treatment or care (decision maker) must decide what is in a person'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; chose a time/location where the person is at their best

2. Identify all relevant circumstances

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. An Independent Capacity Advocate [ICA] 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 decsion 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 , diagnosis 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 till 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 by a desire to bring about the person's death

7. Consult others

- When consulting, remember that the person who lacks capacity to make the decision or act for themselves still has the right to keep their affairs private - it would not be right to share every piece of information with everyone. Select information on a need to know basis
- If it is practical and appropriate the decision maker must consult and consider the views of other people about the person's wishes and feelings, beliefs and values. In particular try to consult:
  - anyone previously named by 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 where no-one who fits into any of the above unpaid categories an ICA must be consulted
  - other professionals actively involved in the person's care
  - 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 but there can only be one decision maker.
  - if no or little consultation is carried out the reasons for this should be recorded

8. Avoid restricing the person's rights

- The least restrictive option should be chosen.

Appendix 3: Guidance for Best Interests Decision Making

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 ICA 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 required by your agency/service's record keeping guidance

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, and 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.

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 Statement

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; chose 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. An ICA 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 ICA 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?

9. Recording best interests decisions.

All best interests decisions must be recorded on the Service User's case notes/file as defined in the agency's/service's recording policies/procedures 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?

10. Disputes

If someone wants to challenge a decision-maker's conclusions, consider:

- Involving a ICA 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 to your line Manager, as legal advice may be necessary.

ENDS

Appendix 4: Record of Decision to Administer Medication Covertly

Permission to reproduce from Boots [August 2015]

RECORD OF DECISION TO ADMINISTER MEDICINES COVERTLY

FOR MULTI-DISCIPLINARY HEALTHCARE TEAM USE

FULL NAME OF PATIENT	
DATE OF BIRTH	
ADDRESS	
DATE OF FORM COMPLETION	

	ASPECT TO CONSIDER (Complete all fields)	RECORD OF RESPONSES
1	**Has the prescriber performed an assessment to confirm whether the patient lacks the capacity to give consent?** • The law presumes every adult to be capable of giving consent unless demonstrated otherwise • Every patient should be assessed to ascertain whether he or she is capable of consenting • Assessment of a patient's capacity to consent should be subjected to continuous review	**YES / NO** (delete as appropriate) SURGERY NAME …….. PRESCRIBER'S NAME …… (State in capital letters) DATE OF ASSESSMENT …… DECISION RECORDED IN MEDICAL NOTES: **YES / NO**
2	**Is there a person available with power to consent on behalf of the patient?** (For example, welfare guardian) Treatment may only be administered covertly with that person's consent unless this is impractical	**YES / NO** (delete as appropriate)

3	**List the medication being considered for covert administration**		
4	**Why is this medication necessary?**		
5	**What alternatives have the multi-disciplinary team considered?** (For example, other ways to manage the patient, or other ways to administer treatment)		
6	**Why were these alternatives rejected?**		
7	**Is covert administration the least restrictive way to treat the patient?** (Give reasons)		
8	**What is the patient's view of the proposed treatment, if known?**		
9	**Has the patient expressed views in the past that are relevant to the present treatment?** If **YES**, what were those views? (State)	**YES / NO** (delete as appropriate)	
10	**Name all people involved in the best interest meeting to administer medication covertly** (For example, healthcare	**Name**	**Designation**

<table>
<tr><td></td><td>professionals, carers etc)

Name of PHARMACIST consulted to give advice on the administration of this medication (State)</td><td></td></tr>
<tr><td>11</td><td>Do any of those persons involved in the decision DISAGREE with the proposed use of covert medication?

If YES, they must be informed of their right to challenge treatment</td><td>YES / NO (delete as appropriate)

If YES, person / reason ……..

……

……

……

Date informed ……</td></tr>
<tr><td>12</td><td>Which members of care home staff will be administering the medication?</td><td colspan="2"><table><tr><th>Name</th><th>Designation</th></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table></td></tr>
<tr><td>13</td><td>Have these care home staff members received appropriate guidance on the administration of this medication?</td><td>YES / NO (delete as appropriate)</td></tr>
<tr><td>14</td><td>How will they be administering the medication?
(For example, mixed in yoghurt)</td><td></td></tr>
<tr><td>15</td><td>How will this covert administration be recorded on the MAR chart?</td><td></td></tr>
<tr><td>16</td><td>When will this need for covert</td><td>Date of first planned review ……</td></tr>
</table>

	administration be reviewed?	

SIGNATURE		NAME	
JOB ROLE		DATE	

- **CARE HOME** TO KEEP THE COMPLETED FORM AS PART OF THE PATIENT RECORD
- **PHARMACY** TO KEEP A COPY OF THE COMPLETED FORM IN THE RELEVANT CARE HOME'S FILE FOR **THREE YEARS**
- FORMS MAY BE USED AS EVIDENCE OF HOW A DECISION TO ADMINISTER MEDICATION COVERTLY WAS REACHED