

# Mental Capacity Act and Best Interests decisions

A practical guide primarily for health care practitioners

---

Dr Derick Wade,  
Consultant and Professor in Neurological Rehabilitation,

Produced in collaboration with  
the Coma and Disorders of Consciousness Research Centre



[www.cdcc.org.uk](http://www.cdcc.org.uk)

If you have any comments on this leaflet please email  
Jenny Kitziinger at [Kitziingerj@cardiff.ac.uk](mailto:Kitziingerj@cardiff.ac.uk)

Copyright@Coma and Disorders of Consciousness Research Centre, 2017

Copyright: This booklet may be printed, photocopied and reproduced in any quantities necessary. However, applications to reproduce part of, or adapt, the publication should be made to the copyright owners in writing.

v. 07/2017

Any comments, suggestions, corrections and improvements welcome.

For a related guide see: '*Serious Medical Treatment Decisions regarding people in a vegetative or minimally conscious state: the role of the family*'  
[[www.cdoc.org.uk](http://www.cdoc.org.uk)]

# Mental Capacity Act and Best Interests decisions

A practical guide primarily for health care practitioners

This document concerns how doctors, other healthcare professionals, healthcare teams and other people outside healthcare should approach decisions made in relation to patients who do not have the mental capacity to make decisions about their healthcare. It will also consider, in passing, the issue of capacity to make decisions on finances and property. It primarily covers situations concerning healthcare arising after the first 24 hours, for practical reasons, although the principles are valid at all times.

## Summary of booklet

- Good practice always requires good documentation of the evidence and reasoning underlying decisions made concerning a patient's clinical care, and this applies especially when the person cannot give consent.
- Additional good practice required by the Mental Capacity Act includes formal consideration and documentation of a person's capacity.
- If they do not have capacity then one must identify whether or not there is a pre-existing Advance Decision, or a Court appointed welfare deputy or an attorney nominated by a registered Lasting Power of Attorney (LPA) to take decisions on their behalf.
- If the person lacks capacity, and there is no relevant Advance Decision, and no deputy decision maker (Lasting Power of Attorney or Welfare Deputy) then doctors, other healthcare professionals, and healthcare teams have to take the decisions – acting in the patient's best interests.

## Summary of booklet continued:

- In order to do this they need to consult widely to establish the patient's likely views on any healthcare decisions that need to be made.
- Ideally this process should start as soon as possible, and it is suggested that there should always be a formal meeting with the first seven days in people who have acquired an injury leading to persisting incapacity.
- It is also recommended that the formal meeting should consider not only the specific decisions that may be required at that point but should also consider three additional issues:
  - what treatments should or should not be given if some acute life-threatening event requiring immediate or rapid decisions occurs (e.g. cardiac arrest, prolonged and uncontrolled epileptic seizures);
  - what treatments and other decisions can be taken without further review;
  - and situations that would specifically require a further best interests meeting.
- It is also suggested that it is reasonable to consider and give ongoing support to defined longer courses of treatment, such as radiotherapy and chemotherapy over many weeks. This obviates the need for repeated meetings. At all times the situation should be open to review (a) if the patient regains capacity or (b) the situation changes, for example with new information becoming available.

The Appendix contains a **'best interests' form** that might help.

# Index

- 1. Introduction .....4
- 2. The context .....6
- 3. Assessing capacity..... 10
- 4. What are ‘best interests’? ..... 13
- 5. Deciding best interests ..... 17
- 6. Welfare deputies and attorneys ..... 24
- 7. Summary..... 26
- 8. Appendix..... 28

## 1.0 Introduction

All healthcare (and indeed social care) actions are supposed to occur with the consent of the patient (the person who is the object of the action). This applies not only to actions that impinge directly on the person, such as operating on the person, or taking blood, or taking the pulse rate or giving tablets but also to actions such as providing information to another party, and moving them from one setting to another.

- 1.1 In reality the great majority of actions and decisions within healthcare are undertaken without any formal record of capacity and consent, and agreement is assumed on the basis of behaviour – if the person does not object or in some other way indicate disagreement, then agreement is implied.
- 1.2 However there are many situations where the patient is unable to give fully informed, legally valid consent. This circumstance is covered by the Mental Capacity Act 2005. This Act starts by outlining how Mental Capacity should be assessed.
- 1.3 If a person is unable to make a specific decision because of impaired mental functioning then the Act outlines several ways that decisions can be made:
  - a) using an Advance Decision (to refuse treatment) made by the patient that is valid and applicable to the particular situation
  - b) asking a court appointed welfare deputy or nominated attorney for health and welfare, provided that:
    - i. the Lasting Power of Attorney (LPA) has been registered with the Office of the public Guardian, **and**

- ii. it is for health and welfare decisions (as opposed to finances and property), **and**
- iii. the person lacks capacity for the particular decision, **and**
- iv. the attorney's powers include deciding upon the particular question, **and**
- v. the attorney considers the best interests of the patient,

- 1.4 The healthcare or other professional has no right to make any decision that is covered by a valid and applicable Advance Decision: the person's own decision is legally binding. Healthcare and other professionals also have no right to make any decision that has been assigned to an Attorney or Deputy, and cannot over-rule an Attorney/Deputy decision. If they have reason to believe that the Attorney/Deputy is not actually acting in the patient's best interests, then they will need to apply to the court of protection for an order revoking the Lasting Power of Attorney of Deputy ship order and/or a declaration that their course of action is not in patient's best interests.
- 1.5 In all other circumstances the healthcare professional is supposed to make decisions and undertake actions in the best interests of the patient. This document focuses upon when and how to make decisions in the best interests of a patient (and it also covers the involvement of Deputies and Attorneys).

## 2.0 The context

This section will set out and discuss some of the problems that arise in clinical practice, just to set the remainder of the discussion in context.

### 2.1 When to apply the Act?

In law no action should occur without the patient's consent, and consent cannot be assumed if the person does not have the capacity to make a decision. Thus the first question is "*Does this person have the mental capacity to make this decision?*" The Act emphasises that any assessment of capacity is specific to a particular question or situation; capacity is not a general phenomenon over time or across different decisions. The Act outlines a sensible and practical way of deciding whether someone does have the capacity to make a specific decision. The method is much less easily applied to making general classes of decision, such as agreeing the care that will be accepted each day.

- 2.2 There are many actions and interventions that occur every day for an ill patient, and many decisions need to be made ranging from the trivial or small to the large and complex. It is difficult to assess capacity for each and every action or decision.
- 2.3 In addition a patient's capacity will often fluctuate markedly over minutes or hours and it is not practical to wait until someone is at their best but equally one cannot assume that a positive assessment of capacity yesterday is still valid.
- 2.4 Thus for almost all patients admitted with acute illness, the team will inevitably assume capacity and (unless a capacitous patient decides otherwise) will always act in what they consider to be the patient's best interests.
- 2.5 It may be reasonable for hospital staff to act in what they consider to be a patient's best interests without input from

families, friends or others who knew the patient when they had the capacity for the first few hours or even days depending on the circumstances. However, this becomes increasingly unjustifiable as time passes because there must be a formal, documented, best interests decision involving those who knew the patient and can report on their prior wishes, values and beliefs. If no such people can be found, then an IMCA should be contacted as soon as reasonably possible (see 2.12)

2.6 A formal and properly documented best interests decision about all treatment and care decisions (including life-prolonging treatment) should be made within the first seven days of admission.

## 2.7 **What actions and decisions should be included?**

The law would suggest that in principle a patient who is in hospital should agree to each and every act and decision. While this can and should occur if the patient has capacity, it is not practical to go through a formal process on each occasion because there are many interventions and interactions every hour by many different people.

2.8 Every person who has capacity is faced with the same problem; some will not give much thought to their answer, others will give it a great deal of thought indeed. Thus it is important to acknowledge that some people agree to a general 'course of action', such as having chemotherapy and radiotherapy for a tumour, and therefore do not feel they need to think about each and every new change or choice. The person simply falls back on some value or attitude that they hold such as "I'll do whatever you think best" or "I just do not like taking drugs" or "I am too anxious about surgery". For others, however, it is very important to feel that they are making free and informed choices every step of the way. The person who has now lost capacity might have been someone who generally followed agreed courses of action without much thought, or they

might have been someone for whom individual autonomy was crucial.

- 2.9 Until there has been a formal process of establishing a person's values, wishes and expectations it is difficult for a healthcare team to act in a person's best interests because they lack knowledge of this key component of the best interests decision-making process.
- 2.10 Thus in the early phases, before a person's previous or existing wishes, values and attitudes to risk are known, one should probably only take actions and make decisions that cannot be delayed without immediate risk to the patient's health and wellbeing, on the initial assumption that a person would want treatment deemed appropriate by clinicians. This assumption is probably true more often than not.
- 2.11 Then as soon as is practical, and again this is probably at about one week, one should review what **courses of action** are within a person's best interests so that subsequent actions are covered, and one should establish what specific possible **decisions or actions should trigger a further formal review**, and what actions are sufficiently minor **not to require constant review**.

## 2.12 Representing the patient's point of view

It is vital to recognise that family members, friends and relatives are legally not allowed to make and execute any decisions on behalf of the patient (unless they are an appointed deputy or attorney). However they can provide information about the person's wishes, feelings values and beliefs, and these should be established as soon as possible.

- 2.13 If there are no family members or friends able to represent the patient's views, then one must consider appointing an Independent Mental Capacity Advocate (an IMCA) who will take on responsibility for supporting and representing the person when decisions are made in the patient's best interests.

Advocates are not needed when there are family members or others available, unless there are reasons to believe that the person or people are not representing the patient's values and wishes appropriately. An advocate may be appointed by either the family or the CCG/Trust in a situation where any party thinks this may be of benefit to the patient

- 2.14 The Act requires that an **IMCA must be instructed**, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), whenever:
- a. an NHS body is proposing to provide or withhold or withdraw serious medical treatment, **or**
  - b. an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, **and**
    - I. the person will stay in hospital longer than 28 days, **or**
    - II. they will stay in the care home for more than eight weeks.

## 2.15 **Is lack of capacity a common problem?**

Although there are no studies to confirm this, it seems likely that a high proportion (50% or more) of people in acute hospitals have reduced or absent capacity and it is likely that formal processes to determine mental capacity and best interests are rarely undertaken in acute hospital settings.

- 2.16 Most healthcare staff will be aware, in general, of the Mental Capacity Act and most hospitals will have policies and procedures arising from the Act. But, if my experience is valid, almost all of the policies focus on gaining consent for operations and assessing capacity, not on determining best interests.
- 2.17 Furthermore it is unlikely that most staff are aware of the role of a **welfare deputy, LPA** or an **Advance Decision**.

## 3.0 Assessing capacity

The formal process of assessing capacity will not be discussed here.

3.1 The **five principles** underlying the Act are:

- Assume capacity unless or until it is shown that the person lacks it
- Provide maximum support possible to enable the decision
- Do not judge capacity simply on the decision made
- The patient's best interests should guide decisions made on their behalf
- Be proportionate and use the least restriction possible.

3.2 The **initial steps** to be followed when assessing capacity, all of which should be recorded, are to:

- Determine whether or not the patient has a an impairment of, or a disturbance in the functioning, of the mind or brain. Its nature should be documented
- Define the decision or action
- Optimise the patient's ability to make a decision
- Determine the important information relevant to the decision that the patient needs.

3.3 Then the capacity assessment should be undertaken by **asking four questions**, each of which has to be answered positively for the person to have capacity. The evidence should be documented. The four questions are:

- Can the person **understand** the relevant information?
- Can the person **retain** the relevant information long enough to make a decision?

- Can the person **weigh up** the information? In other words, can they justify or explain their decision to show that they have used correct relevant information and not used erroneous or irrelevant information?
- Can the person **communicate** their decision?
- If the person is unable to do one or more of these things it must be further established that it is the mental impairment or disorder that causes this inability. If it is, then they can be said to lack the mental capacity to make the decision.

3.4 If the person is judged to lack capacity then:

- If possible and if improvement is possible within a reasonable time frame, the decision should be postponed
- Otherwise make a decision in the best interests of the patient.

### 3.5 **Difficulties in ascertaining Capacity.**

The Act makes the determination of capacity seem straightforward and simple. It rarely is.

3.6 For example, someone may not be judged to have full capacity to decide on having a PEG tube yet may consistently behave in a way that make safe sustained insertion of a feeding tube impossible (e.g by struggling against it). In such a case the behaviour may suggest a fixed and strong wish that should be given considerable weight when assessing best interests even if they do not have full capacity.

3.7 Conversely individuals assessed as having financial capacity may nonetheless repeatedly make decisions and spend money in ways that, during the formal assessment, they say they will not and that they agree afterwards was

not what they would have wanted.

- 3.8 In other words, and unsurprisingly, there is often a discrepancy between statements made and decisions made in one setting and actions performed in a different setting.
- 3.9 But the Act is written as if capacity can be assessed as an intellectual phenomenon – does the person have the intellectual capacity to make this decision under ideal circumstances? – without considering the inevitable influence of emotion, social context, and other factors that will influence the actual decision made
- 3.10 Thus when considering capacity it is important to take into account, when it is available, **the observed behaviour of the person relevant to the decision concerned as well as considering their apparent capacity and/or expressed decision.** It is also vital to consider **any views wishes or feelings that they may express even if judged to lack capacity.** The MCA makes this explicit in stating that even if a person lacks capacity to make the decision and have it respected, their wishes and feelings should nevertheless be taken fully into account.

## 4.0 What are ‘best interests’?

The important and often overlooked part of the Act relates to determining best interests. The Act does not define ‘best interests’ except through examples. It does however specify that a core aspect of any ‘best interests’ decision involves considering **what decision the person would have made if they were able to, and what decision they would make now if they were able to.**

- 4.1 The Act also makes it clear that best interests must be considered in a broad context. A decision in a person’s best interests must consider factors well beyond a restricted medical (healthcare) perspective. Factors identified cover domains such as the patient’s values, beliefs, wishes and feelings when competent, their current wishes, their general wellbeing and their spiritual/religious welfare etc.
- 4.2 Thus the decision should deliver the best outcome not only in terms of health and well-being but also in terms of being as concordant as possible with the person’s known or assumed life goals and values. Recent court decisions emphasize the importance of taking into account the patient’s prior values, wishes, feelings and beliefs. In case of Paul Briggs (2016) the judge pointed out that a ‘wait and see’ approach with a minimally conscious patient after a road traffic collision was NOT appropriate if it could be determined with sufficient certainty that the patient himself would not have wanted to ‘wait and see’ the extent of his recovery. In this case even the ‘best case scenario’ would not have been a level of recovery that Mr Briggs would have considered worthwhile and so the judge authorised withdrawal of the feeding tubes.
- 4.3 The following general areas should be considered. Only a few will be relevant to any particular situation, but they are listed to act as an aide memoire.

- 4.4 **Disease and survival.** The consequences of a decision in terms of its effect upon the underlying disease, and upon the individual's risk of death should be considered.
- 4.5 The Act states that *“Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.”*
- 4.6 This does not mean that prolongation of life is paramount, but it seems to mean that the decision must not be motivated by the desire to shorten life.
- 4.7 **Experience – symptoms.** The effect of a decision or action upon a person's experience, especially of pain but also upon their mood (depression, anxiety, distress) and any other symptoms should be considered.
- 4.8 **Activities and safety.** How much a decision might alter function, the activities that someone undertakes as part of their daily life is the third domain to consider. Will the person be more or less able to do the things he or she wants to?
- 4.9 **Risk.** At the same time one must consider safety, primarily of the person but also of others. Will the decision increase risk? (This is not determinative.)
- 4.10 **Social participation.** The final specific outcome, and for most people probably the most important, is that of making and maintaining social relationships and enacting desired roles. The consequences of a decision upon a person's abilities and outcome in this domain must be considered.
- 4.11 **Personal context.** The individual's life philosophy, their attitude to how he or she lived their life and what they were aiming for is important.
- 4.12 First, it will be necessary to determine the relative importance given to different aspects of the outcome

already mentioned. For example is prolongation of life more important than being able to meet friends or do what one wants? Some people participate in dangerous sports choosing excitement and fulfilment over safety. Second, the degree to which a decision is concordant with an individual's life philosophy will determine how content or distressed they are, which is part of outcome.

- 4.13 **Values.** Each person develops over their life a system of values, underlying beliefs about what is morally right or wrong. While the extremes, such as killing others generally have a common value across all people, many areas of concern do not. The willingness to eat meat is a clear area where there are wide variations between people.
- 4.14 **Attitudes to health and healthcare.** Most people develop their own approach to their health and what they are or are not willing to do to preserve health or avoid illness.
- 4.15 **Life goals – ambition.** Closely related to values is the concept of life goals. This refers to the things that someone considers important. For example some people might be most concerned about possessions, others about social status, and others about maintaining family relationships.
- 4.16 In general a person's values will constrain what they are prepared to do in trying to attain their life goals, whereas their life goals will motivate them towards something.
- 4.17 **Religion and spirituality.** This is probably most closely related to values, in that everyone has values but only a proportion of people will base their values and life goals upon a particular system of beliefs associated with a religion.
- 4.18 **A cautionary note.** The Act is phrased in a way that assumes the many of these factors remain reasonably stable over time. In particular it assumes that values held before some life-changing event remain the same afterwards. This is not necessarily true.

- 4.19 It is well recognised that after a non-disabling but major life-threatening event, such as being involved in a natural disaster, people can change their life priorities in a major way.
- 4.20 More importantly in the context of long-term physically disabling conditions, there is often a change from previously stated views. For example many people when asked in a hypothetical way whether they would want to continue living with alternate-day peritoneal dialysis or being dependent upon a ventilator or gastrostomy are adamant that they would not, sometimes documenting this. But, most people in that situation will adapt and want to continue living.
- 4.21 Thus it is vital not to continue assuming previously held beliefs and values and opinions will necessarily apply in a radically different situation; if at all possible they should be reassessed. But if they cannot be reassessed then prior expressed views must be respected (*Briggs v. Briggs* case 2016).

## 5.0 Deciding best interests

The Act does make some reference to the process of deciding best interests, but it does not give detailed guidance on a practical process. Some structured forms are available from Councils, Social Services and Healthcare Organisations.

5.1 The two main parts of the Act that do consider the deciding of best interests are:

- the role of the welfare deputy or attorney, if one exists
- the role of the decision maker, when a formal decision making process is set up

5.2 The role of a welfare deputy or attorney is considered in the next section.

5.3 The Act itself does not mention the decision making process or the decision maker, but the associated **Code of Practice** does.

### 5.4 **Code of Practice – principles**

The code of practice lays out some principles to be followed when making a decision in a patient's best interests. They are:

- a. Encourage participation by the patient as far as possible
- b. Identify all the factors that the person would consider when making the decision
- c. Discover the views of the person – wishes, beliefs and values etc – from others
- d. Avoid discrimination based on irrelevant factors
- e. Consider whether the decision can wait until recovery

occurs (if it is likely to) such that the person will regain capacity to make the specific decision for themselves

- f. Consult others about the person's likely views, values, wishes etc:
  - (1) anyone named before loss of capacity
  - (2) anyone caring for the person
  - (3) close relatives and friends
  - (4) any legally appointed attorney or deputy
- g. Avoid restricting the person's rights
- h. If the decision concerns life sustaining treatment
  - i) make no assumptions about quality of life
  - ii) do not be motivated to bring about death
- i. Use all the information to reach a decision

5.5 One matter not specified in the summary guidance, but stated elsewhere, is **to document the process, the reasoning and the facts used.**

5.6 This section will focus on discovering the person's views and consulting others.

### 5.7 **Establishing views, consulting others**

The most important fact to remember in this process is that **the goal is to establish the patient's views, not the views of the informant.** Obviously it may be difficult to disentangle the two, but the distinction is vital.

5.8 One approach which can help relatives to understand the distinction is to ask the following three questions, in this order:

- a. *“what do you want for the patient?”*
- b. *“what would you want for yourself if you were in the patient’s situation?”*
- c. *“what do you think the patient would want?”*

*It is the answer to question c. that should be taken into account in best interests decision making, not the answer to questions a or b.*

However this process allows the person to state their view – which they will usually want to do – before moving on and this may help the informant to understand the difference and will allow the questioner to evaluate the final answer.

- 5.9 Another question which can help is to ask *“If the patient could wake up for 15 minutes and understand his or her condition fully, and then had to return to it, what would he or she tell you to do?”*
- 5.10 It is also worth recognising that research suggests that both doctors and family members over-treat patients (as compared with the decisions patients say they would make for themselves).
- 5.11 When collecting this information one must identify a reasonable range of informants. Some people may have no-one – in which case an IMCA should be appointed – others very many. It is especially important to include any close person who may have alternative or different views. Generally it would be reasonable to limit the number to three or four provided no person with different views is known to be excluded.
- 5.12 The informants should be asked to give their opinion of the patient’s likely choice or decision, and should then be asked to support this in terms of giving the patient’s position on:

- values
- attitudes to health and health care
- life goals
- religion and spirituality

5.13 They should also be asked to identify any other factors that they think the patient would have used to make a decision, such as any habits and political views that might have influenced a decision.

5.14 As far as is practical, the informant should provide evidence (not in concrete terms, but verbally) in terms of written or other permanent records (e.g. entries on Facebook), or widely known verbally stated views, or behaviours that support the asserted view.

#### 5.15 **Making the decision**

The Act makes no specific requirement of the decision making process, but the Code of Practice suggests that there will usually be a multi-disciplinary meeting and there should be a decision maker.

5.16 It is not clear whether an actual meeting is an absolute requirement, and there will be circumstances when a meeting of all interested parties will be extremely difficult to achieve. Provided that all views and facts are collated, a meeting may not be important.

5.17 The decision-maker is determined primarily by the decision being made, and it is possible for a team to be the decision maker. Generally the decision-maker will be the most senior person available who is also involved in the execution of the decision. It is important for everyone involved with the patient to be clear about who the decision-maker is and to be able to make 'best interests' representations to that person (or team).

5.18 The main exception to this is when there is a legally appointed deputy or attorney when this person becomes the decision-maker.

5.19 Best Interests meetings should be held in comfortable surroundings, in a quiet and private room, comparable to those used for mental health tribunals. See guidelines to [www.mentalhealthlaw.co.uk/images/Room\\_specification\\_recommendations\\_for\\_tribunal\\_hearings.pdf](http://www.mentalhealthlaw.co.uk/images/Room_specification_recommendations_for_tribunal_hearings.pdf)

5.20 During the process it is important to establish the outcomes that arise from each of the possible decisions. This needs to be done in terms of risks and benefits for each choice in terms of disease, experience, activities, social contacts. The judgement of which choice is best then must also consider the many other factors listed.

5.21 It is also important to take into account another of the fundamental principles of the Act:

- *“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.”*

5.22 Thus when judging between choices it is important to consider the degree to which each decision is:

- reducing autonomy (freedom), **and**
- concordant with known values, beliefs, life goals etc, **and**
- consistent with previous similar decisions made when the person had capacity

### 5.23 Documenting the process

When a major decision is being made it is important to document the process adequately. As well as making the process transparent and accountable, it can help to

ensure every step has been followed. Documentation would include:

- identifying the decision and the choices considered
- recording who had been consulted (including the healthcare team members involved)
- recording in outline the views of the patient as determined from the evidence, and outlining that evidence
- delineating the reasoning behind the decision in terms of balancing: outcome, including risks and benefits; autonomy; likely views of the patient
- A form is given at the end of this document.

#### 5.24 **How to chair a best interests meeting**

As mentioned there is little guidance on this role. The following is written on the basis of my experience in meetings, and common sense.

- 5.25 The choice of chair should be mutually agreed, not assumed, and should usually be someone who has experience in the range of issues being discussed. It is not anyone's role by right, and anyone with a strong conflict of interest (e.g. holding the budget that may pay for the actions agreed) should probably avoid being the chair if an alternative exists.
- 5.26 The chair must declare and put to one side any strong beliefs, competing interests and other matters that might influence their decision.
- 5.27 The chair must be equitable, fair, facilitative and positively seek different views and opinions, ensuring that everyone can and does contribute, not excluding any relevant matter from discussion while curtailing repetition and irrelevant discussion. She or he should summarise regularly to ensure that everyone understands.

- 5.28 The final decision should if at all possible be mutually agreed by consensus. If it cannot be agreed by all, either further information should be sought with a further meeting or a decision made, documenting the different view(s) if everyone involved cannot agree then the decision will need to be referred to the court of protection.
- 5.29 Finally, the Chair should be fully responsible for documenting the meeting and ensuring that all parties receive a copy in a timely manner, usually within a few days.

## 6.0 Welfare deputies and attorneys

In law relatives and friends cannot make any decisions on behalf of a patient unless the patient has formally appointed that person as a Lasting Power of Attorney (LPA, health). When there is a Deputy or LPA then they can make any decisions outlined in their powers. For an LPA (Health) this may include decisions about life-sustaining treatment (check the LPA documentation). (A Welfare Deputy appointed by the court can never have such decision-making powers.) It must be emphasised that **deputies and attorneys who only have power over financial and property decisions are not thereby entitled to make healthcare decisions.**

- 6.1 When there is a welfare deputy or attorney the clinical team cannot, in principle make any decisions within their remit where the patient lacks capacity. In reality the welfare deputy or attorney cannot be present at all times, and a system should be developed that takes into account:
  - the availability of the deputy or attorney
  - the nature of the decision including its immediacy
- 6.2 If authorised, a welfare deputy or attorney can make almost any decision likely to arise in normal healthcare including where the patient may live. The deputy/attorney 'stands in the shoes' of the incapacitous patient for the purposes of most decisions
- 6.3 When capacity is impaired and a welfare deputy or attorney exists then an early meeting should be arranged to discuss how the deputy/attorney wants the medical team to support his/her decision-making and how to make the process practical. Sometimes the deputy/attorney may be facing very difficult choices – it is important to give the deputy/attorney all the information they need, and give

them time to make decisions – as you would if you were talking to the patient themselves.

#### 6.4 The most practical approach is to:

- identify what decisions are likely to need to be made during the admission/treatment spell
- list and agree decisions and actions that the deputy agrees can be undertaken without returning to the deputy for consent on each occasion, with limits on the extent if appropriate, also agreeing to what extent and how the deputy will be kept informed
- list and agree decisions and actions that require formal discussion with the welfare deputy at the time, also agreeing how this is to be undertaken and how any difficulties in making contact are handled
- list and agree decisions and actions that might arise when an immediate ‘best interests’ decision needs to be made and agree what that decision should be if possible
- consider more general matters that may arise that would need further discussion

#### 6.5 It is also wise to focus on agreeing ‘courses of action’ so that a multitude of secondary actions can occur without further contact unless specified deviations from the plan occur.

## 7.0 Summary

This document suggests significant changes in daily clinical practice. These changes are required in order to comply with the Mental Capacity Act

- 7.1 The first step is to consider and record formally for every patient whether he or she has the mental capacity to agree with all the healthcare interventions being undertaken. In an acute emergency and over the first 24 hours this might simply be a statement based on relatively incomplete assessment, but care should be taken to start the processes below sooner rather than later.
- 7.2 For every patient who is judged to have impaired capacity, the team should establish sooner rather than later whether there is a valid and relevant Advance Decision or a legally appointed deputy or attorney. giving any treatment that has been specifically refused in a valid and applicable advance decision is unlawful. If there is a deputy/attorney then contact should be made as soon as possible and a meeting arranged. At this meeting there should be agreement on the decisions that can occur with advance agreement from the deputy and what decisions require the deputy's agreement at the time, and how the deputy is to be contacted.
- 7.3 For all other patients where there is a significant impairment of capacity that is likely to persist for most or all of the episode of care, or where major decisions will be made, then an early review of the factors relevant to best interests decisions should occur.
- 7.4 In any patient where major decisions are being made concerning healthcare or welfare (such as placement into a nursing home) and where there are no relatives or friends to represent the patient then an Independent Mental Capacity Advocate must be appointed.

7.5 There should be full documentation of all formal decisions and meetings made under the best interests process to include:

- identifying the decision and the choices considered
- recording who had been consulted (including the healthcare team members involved)
- recording in outline the views of the patient as determined from the evidence, and outlining that evidence
- delineating the reasoning behind the decision in terms of balancing: outcome, including risks and benefits; autonomy; and likely views of the patient

## Appendix

### Best Interests Decision form

- This form gives all of the important points to be considered on the left, with guidance in italics on the right.
- The guidance should be deleted and replaced with the information ascertained.
- At all points you should take full account of the decision the person would have made in the past, as well as considering their current wishes and feelings, in so far as these can be determined.
- Remember that best interests are not simply based on medical matters, but must take full account of the person's values, wishes, feelings and beliefs and the way they lived their life.

Patient	<i>Give full name, address, &amp; NHS no</i>
Question or situation being considered	<i>What is/are the decision(s) that need to be made?</i>
Mental Capacity	<i>Confirm that (a) the person does not have the capacity to make the decision and (b) it is not possible to delay action until capacity is regained. State where the assessment is documented.</i>
Advance Decision	<i>Is there a valid and applicable Advance Decision (to refuse treatment) If so it must be followed.</i>
Can someone else decide?	<i>Is there an attorney or Court appointed Deputy with powers over welfare decisions able to make the decision? If so they become the decision maker.</i>

## Best Interests Decision form

(Page 2 of 3)

Process details	<i>Place meeting held, date, chair person (and decision maker if different)</i>
People present	<i>Name, role/relationship of each person</i>
People also consulted	<i>Name, role/relationship of each other person contributing</i>
Should an IMCA be present?	<p><i>An Independent Mental Capacity Advocate must be appointed and involved if a person does not have any friend or relative to advocate for them and if the decision concerns</i></p> <ul style="list-style-type: none"> <li><i>• a major medical intervention or</i></li> <li><i>• a transfer to a nursing home for longer than eight weeks or a hospital for more than four weeks or</i></li> <li><i>• an 'unbefriended' person who is being assessed for a Deprivation of Liberty Safeguards (DOLs) authorization.</i></li> </ul> <p><i>Note: An Independent Mental Capacity Advocate <u>may</u> be appointed by any party if this is believed to be beneficial in ensuring that the patient's own views are represented as full as possible.</i></p>

Person's views	<i>What are or might be the views of the person? Consider (a) existing stated or implied views (b) previously stated or implied views. Facilitate their participation as far as possible.</i>
Person's values and beliefs	<i>What was the person's overall set of values and beliefs, and what other factors might they have considered in relation to this decision?</i>
Options considered	<i>Give a brief summary of options considered</i>
Decision made, and why	<i>Specify the choice made and confirm that this decision:</i> <ul style="list-style-type: none"> <li>• <i>is the least restrictive option available</i></li> <li>• <i>maximizes risk/benefit ratio</i></li> <li>• <i>is concordant with known or reported views and values of the patient (If not, you must document why not)</i></li> </ul>
Chair	<i>Give name, role/relationship, contact details</i>

**Author:** Dr Derick Wade, Consultant and Professor of  
Neurological Rehabilitation

With help from:  
Professor Jenny Kitinger and Professor Celia Kitinger  
Co-Directors of the Cardiff-York Chronic Disorders of  
Consciousness Research Centre

**Email:** *derick.wade@ntlworld.com*

V. 7/17

Copyright © This booklet may be printed, photocopied and reproduced in  
any quantities necessary. Please acknowledge source; not to be sold.

Further copies of this leaflet are available online from the Coma  
and Disorders of Consciousness Research Centre.



