Thematic Review of South West Safeguarding Adult Reviews (SAR):

Mental Capacity

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Please note that this version should be considered the final version of this document. Previous versions dated 15/08/2023 and 24/10/2023 should be considered draft and not the final published ADASS SW version.

EXECUTIVE SUMMARY

This thematic review of South West Safeguarding Adult Reviews (SAR) looks at practice issues identified in relation to the Mental Capacity Act 2005. SARs are statutory enquiries under s.44 of the Care Act 2014 carried out when persons or services could have worked better together, and the individual has either died as a result of experiencing abuse or neglect or is alive but experienced serious abuse or neglect. The Mental Capacity Act 2005 provides a statutory framework to support decision making and human rights for individuals who may find it difficult to make decisions due to a cognitive impairment. Published and publicly available documents pertaining to 62 SARs were eligible for informing this review covering all 12 Safeguarding Adult Boards (SAB) from the region. These 62 also mention mental capacity.

Over-arching themes were identified in relation to omission of completing mental capacity assessments when one is indicated, executive function, misapplication of the Act, safeguarding and risk management, and specific concerns in relation to care providers and health settings. Sub themes discuss various examples of practice concerns identified including:

- Practitioners not completing mental capacity assessments – not taking responsibility or feeling it is not their responsibility. This is potentially a confidence issue resolvable by training and support mechanisms.
- Practitioners relying on the assumption of mental capacity without documenting evidence of their decision making or making sufficient enquiry. Practitioners also relying on 'informal mental capacity' resulting in provisions of a documented assessment (with associated legal framework) not being applied.
- Managers not assuring themselves that mental capacity assessments are happening when actions are set around this.
- Various misinterpretations of the five principles of the Act and other aspects may be preventing mental capacity assessments from taking place e.g., 'right to unwise decisions'.
- One of the biggest, if not the largest area of practice concern, is practitioners finding it difficult to work with and understand executive function and how to assess mental capacity with individuals with potential executive dysfunction. This includes the specific impacts that some contexts and conditions have on executive function such as self-neglect and substance misuse.
- The decision and time specific nature of decisions under the Act are often not accurately reflected in practitioner approaches to mental capacity and best interests.
- Practitioners can also find working with fluctuating capacity difficult. More confidence would be beneficial for practitioners to take a longitudinal approach to capacity in such cases. Practitioners also need to be mindful to work with the individual to remake or revalidate decisions when they regain or lose mental capacity in their fluctuations. Delay in this area can result in a lack of legal framework and boundaries for supported decision making.
- Non-application/non-completion of mental capacity assessments when practitioners struggle with applying the Act to practice results in a lack of legal framework for decision making and prevents multi-disciplinary best interest and risk management discussions as well as preventing access to advocacy and Court remedy for the individual.

- Discussions and reflections on mental capacity and its relationship to risk are not necessarily happening in all relevant multi-disciplinary meetings and safeguarding enquiries.
- Practitioners can be unclear about the application of the Mental Capacity Act in safeguarding enquiries. There is evidence in SARs of it not being fully considered and discussed in enquiries.
- Practitioners can find it difficult to navigate the impact on mental capacity and decision making for individuals experiencing coercion, duress, and domestic abuse.
- Some SARs established concerns over the level of knowledge and awareness that care provider staff and registered professionals had of the Deprivation of Liberty Safeguards, its role, and limits. This may mean that individuals are not being referred for the safeguards when they are eligible to benefit from human rights protection.
- One theme included concern around practitioner knowledge and importance of the role of independent advocacy and the Court of Protection in the best interests process and support for the individual.
- Specific issues in relation to care providers were found including lack of staff awareness and knowledge.
- Gaps included commissioning needing to monitor Mental Capacity Act compliance in their contract auditing, quality assurance and monitoring functions to support practice and identify concerns.
- Concerns were also identified in respect to hospitals facilitating discharge without a mental capacity assessment. This resulted in individuals being discharged or self-discharging to risky or unsafe environments in some cases repeatedly despite doubts on capacity being well established.
- Informal peer support to discuss aspects of complex cases and interplay with mental capacity as well as access to legal support were all cited as helpful ways to enhance practitioner practice confidence and knowledge.
- Examples of best practice in this area were also identified including having robust SAB policies around self-neglect and hoarding linked to mental capacity, practitioner determination to maintain engagement in the face of non-compliance and aggression and positive examples from care providers and health settings.

Recommendations have been made to support practice and help prevent the practice issue themes identified re-occurring, support practitioner confidence and provide assurance. ADASS South West have highlighted ten recommendations as a priority included at page 29. Further author recommendations have been included at Appendix 1.

Checklists to help map the findings from this review against agency learning and development offers, and agency policies and processes has also been included at Appendix 3 and Appendix 4 respectively. A practitioner summary has been included at Appendix 5.

directors of adass adult social services South West

INTRODUCTION

This thematic review looks at the theme of the Mental Capacity Act 2005 in Safeguarding Adult Reviews (SAR) that have taken place across the South West region. It collates relevant learning in this specific area of adult social care and groups them into core themes each with its own subthemes.

Safeguarding Adult Reviews

Section 44 of the Care Act 2014 places a statutory requirement for Safeguarding Adult Boards (SAB) to arrange SARs to take place when an adult in its area with needs for care and support dies and/or other circumstances are met as detailed in the Care Act:

s.44 (1) An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met

s.44 (2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

s.44 (3)Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

s.44 (5) further outlines the purpose of SARs to identify lessons learnt from the adult's case and apply those lessons to future cases.

Mental Capacity Act 2005

The Mental Capacity Act is a law designed to protect and support the decision making of vulnerable adults. It applies to everyone aged from 16 years. Every adult has a right to make their own decisions wherever possible. The Act promotes that support is given to support an individual to make decisions such as accessible information and explaining things in different ways. If the decision is too large for the person and the difficulties in making the decision are linked to a cognitive impairment, the Act stipulates how best interests decisions can be made by appropriate people around the individual instead.

A mental capacity assessment is required to establish if the person is unable to make the decision themselves. The Act is also clear that any decisions should be considered time and decision specific. This allows the possibility for individuals to regain mental capacity later and to retain mental capacity for all decisions other than the one assessed as not having the mental capacity to make.

A fundamental part of the Act are the five statutory principles of the Mental Capacity Act:

1. *"A person must be assumed to have capacity unless it is established that they lack capacity."*
2. *"A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success."*
3. *"A person is not to be treated as unable to make a decision merely because he makes an unwise decision."*

4. *"An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests."*
5. *"Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action."*

The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act designed to protect the human rights of vulnerable adults who receive their care through a restrictive care plan perhaps with 24/7 care resulting in constant supervision or requiring restraint. DoLS applies to CQC registered settings such as care homes and hospitals. Since 2014, case law has meant that those living in all other care settings require a process of authorisation via the Court of Protection to provide legal safeguards to their deprivation of liberty.

For further information please see the Mental Capacity Act 2005 Code of Practice[1] and the many guides available including the Social Care Institute for Excellence (SCIE) webpages[2]. The Deprivation of Liberty Safeguards has its own Code of Practice[3].

Although the Ministry of Justice and Department for Health and Social Care announced in June 2023 that they are making some changes to the Code of Practice, the current legislation, Codes of Practice etc. must be followed until such time that revisions are made.

Thematic Review

A thematic review of SARs will highlight the areas of learning in relation to mental capacity and deprivation of liberty from when practice did not go as it potentially should have. Collation of learning specifically about the Mental Capacity Act will help consolidate learning from across the whole region which can be themed in terms of recommendations but can also feed into other wider sector improvement for example ensuring that learning and development offers and content include the areas identified in this review. This will help ensure that practitioners in health and social care have the knowledge and experience required to help prevent the events looked at by these SARs from occurring again as best as possible.

This report will detail the findings of this review by theme divided into relevant sections. It will focus on where things could have potentially gone better and may have been established as contributory factors as part of the SARs. Relevant examples from the SARs have been included across the themes. Good practice in relation to the Mental Capacity Act cited in SARs are also included towards the end of the report. ADASS South West have selected 10 priority recommendations from this review which have been included at page 29. The author has also provided recommendations based on the review findings which agencies are free to adopt and adapt as they see appropriate. These have been included at Appendix 1.

As well as the recommendations contained within this report, support for the themes of practice identified as concerns in this report can be found in the myriad of protocols,

[1] Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk)
[2] Mental Capacity Act (MCA) and DoLS | SCIE
[3] [ARCHIVED CONTENT] Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice : Department of Health - Publications (nationalarchives.gov.uk)

guidance, webinars and reports available online, on local authority and SAB websites, SCIE and NICE websites[4] and others.

Method

This analysis reviewed findings and recommendations from all relevant published reports from the region's Safeguarding Adults Boards (SAB):

- Bath and North East Somerset
- Bristol
- Cornwall and the Isles of Scilly
- Devon and Torbay
- Dorset
- Gloucestershire
- North Somerset
- Plymouth
- Somerset
- South Gloucestershire
- Swindon
- Wiltshire

The documents reviewed were published on the websites of the SABs above. All SARs considered in this review were therefore publicly available at the time the review was undertaken. There was some variety in the extent of SAR documentation published on websites. Where the full report was published, this was reviewed otherwise executive summaries or practitioner learning briefs were reviewed if this was all that was available and published on SAB websites. Safeguarding Adult Reviews were included but pre-Care Act Serious Case Reviews were not because not all SABs have published these online and they predate 2015 when the Care Act came into effect. Published SAB learning reviews for cases which did not meet the criteria for a SAR are omitted from this review as although they may provide relevant learning, not all SABs may decide to complete such reviews and/or publish them.

ADASS South West commissioned Michael Preston-Shoot to complete an analysis of some regional case reviews which was published in 2017[5]. There is some coverage in that report in relation to mental capacity which mentions some similar themes to the current report based on enquiries that largely pre-date the sample of this current report. A national repository of SARs is available at https://nationalnetwork.org.uk/search.html.

A key word search for 'capacity' was used in the SAR documents, learning and recommendations were noted, collated and then analysed for themes to inform this report. Not all the published SARs mention issues of capacity or Mental Capacity but those that do were included for review and inclusion in this report. A total number of 62 SARs were eligible for inclusion in this review. This includes all SARs with documents published online and publicly available up to and including 13 July 2023. Every SAB is represented in this number

[4] For example, NICE guideline NG108. *Decision-making and mental capacity.* Available from: Overview | Decision-making and mental capacity | Guidance | NICE

[5] Available from: SW-SCRs-SARs-Report-Final-Version-2017.pdf (safeguardingsomerset.org.uk)

with a range of 2 to 9 SARs included. A full list of these eligible SARs is included at Appendix 2.

Checklists to support the implementation of recommendations have been included at Appendix 3 for learning and development content and Appendix 4 for a policy/process review.

A practitioner quick read summary has been included at Appendix 5.

FINDINGS

SECTION ONE – OMISSION OF ASSESSMENT

This section discusses themes in relation to decisions and occasions where practitioners should have completed mental capacity assessments but for whatever reason did not.

1.1 Not Completing Mental Capacity Assessments

A major theme across all SARs related to a failure of professionals, unregistered staff, and support staff of not completing a mental capacity assessment when one was required. Non-completion (and recording) of an assessment means there is potentially no legal framework for actions and decisions to be undertaken under. This is particularly pertinent if there is some doubt about the individual's mental capacity to make the decision whether that be from what they have said, their communication or a disconnect between verbal responses and physical actions (see executive capacity/function later).

This concern was reported in a variety of settings in SARs and events too numerous to analyse in detail here, so a summary is provided with specific issues being examined further in the rest of the report. Despite several clear triggers or reasons to doubt mental capacity being evident in several SAR enquiries, no mental capacity assessment was completed in such contexts as financial mismanagement or finances to purchase alcohol, fire risks and self-neglect, documented decline in cognition and refusal of care, services and/or support.

Concerns in health settings related to no mental capacity assessment taking place around attendance at an appointment to examine a pressure ulcer or a hospital noting the individual 'lacks insight' but not completing a mental capacity assessment around these critical decisions. No documented assessment to support statements like an individual having mental capacity for discharge were also found as well as more generalised concerns that a hospital did not adhere to the Mental Capacity Act. Concerns around medication compliance and adherence to physical health treatment were also identified across the SARs reviewed.

Concerns in social care included an example of consent to a review in which an assessment of mental capacity may have acted as a gateway to an independent advocate referral to support the individual through a statutory process. Issues of referrals being made to social care without consent, or a legal framework also appeared in two other SARs. Failure to complete a mental capacity assessment was also seen in one SAR as a missed opportunity to challenge unwise decision making at appropriate junctures.

The gap in application by the police led a to a missed opportunity to potentially convey an individual away from harm for hospital treatment but the police incorrectly at the time presumed they could not convey under the Mental Capacity Act so no documented assessment was completed.

Practice issues in relation to the application of the Mental Capacity Act by care providers is analysed in a separate section of this report.

One of the reasons that mental capacity assessments did not take place in some SARs was an absence in either confidence or responsibility from practitioners to take ownership over completing it. Several instances were recorded of practitioners and support staff looking to each other to complete the mental capacity assessment/s resulting in a gap of it not being done. Formally referring to another party to complete the assessment instead of acting and

taking responsibility oneself was also found to be a concern. This practice also introduces delays into a person's care pathway.

In one SAR this included health professionals deferring to each other including the GP expecting the psychiatrist involved to complete a mental capacity assessment when the care provider did not believe it was their role. In a further instance, care provider staff looked to a social worker to complete and record mental capacity assessments which although true of bigger decisions, was not true of smaller day to day decisions needed to keep the adult safe. Ultimately, these decisions made on the individuals' behalf would not have been lawful without the legal framework the Act provides. There is also evidence in SARs of no mental capacity assessment taking place around pertinent decisions before the unfortunate death of vulnerable adults despite professionals recognising or agreeing that there was evidence to doubt mental capacity around decisions.

There was also a re-occurring theme of relying on another's opinion of mental capacity where there is potential need for a more specific local assessment and best interests' decisions. For example, one SAR identified a care home relied on a GP's assessment of mental capacity around eating concerns rather than produce their own decision and time specific assessments and best interest decisions that they could review when required locally. A further SAR identified authorities relying on family members to inform them about mental capacity of their loved one as a 'trusted assessor' rather than visiting themselves despite care being refused by the individual and doubt over mental capacity being raised by a GP. These concerns are potentially due to staff confidence and ability to feel responsible for these decisions.

Concerns in relation to information sharing between agencies and professionals about mental capacity were also identified across some SARs. Some services were working in silo and therefore not sharing important information which would impact views on mental capacity in one SAR whilst another SAR felt it was unclear how decisions and information about mental capacity were being shared between professionals and meetings that appeared to happen in isolation to each other. This lack of information sharing may also have been contributory to professionals not following up on doubts raised in meetings on mental capacity despite these opinions being expressed in forums.

1.2 Assumption of Mental Capacity

A major theme across SARs is the over assumption of capacity without sufficient enquiry. The first principle of the Mental Capacity Act states that "A person must be assumed to have capacity unless it is established that they lack capacity." It means you cannot assume someone can't make a decision for themselves on the basis of their diagnosis or condition (SCIE, 2022[6]). It does not mean that you should not make attempts to establish a lack (or presence) of mental capacity if you have concerns about decision making – the diagnosis in itself is not a reason to attribute a lack of mental capacity to that individual. However, SARs highlight many examples where practitioners have not explored risky behaviour and decisions, exerted professional curiosity sufficiently and not challenged decision making because they have cited the assumption of capacity as a reason not to.

Often SARs raised that the notion of 'assumption of capacity' was relied upon even if there were doubts on capacity expressed by practitioners, professionals, family members or in one

[6] Social Care Institute for Excellence, SCIE, *Mental Capacity 2005 at a Glance* - Mental Capacity Act 2005 at a glance | SCIE

case recorded in an Ombudsman ruling. It is important that mental capacity is fully tested before assumptions are taken at face value but relying on this principle inaccurately has in SARs resulted or come about from a lack of professional curiosity and challenge. Not only did this result in no legal framework for decision making in these scenarios but opportunities for professionals and informal carers to meet with the individual to formulate risk management and best interest decisions are lost. It also prevents access to other support and protections for the individuals such as the Deprivation of Liberty Safeguards and access to the Court of Protection. These combined may exacerbate any risk presented in the decision making and behaviours of the individual. This was evidenced in one SAR where an assumption of capacity was relied upon but there was no evidence of discussions between professionals of capacity and risks presented by the individual and the interplay between the two. Three further SARs reflected that practitioners assumed capacity when there was evidence to doubt it, but no recording was evident of how their view was formed. It is perfectly reasonable that practitioners may not have had sufficient course to doubt mental capacity, but it should be considered on an ongoing basis and decision making documented with clear rationale. Similarly, SARs also found that assumption of mental capacity was not backed up with or supported by documented mental capacity assessments sometimes even if doubts on capacity were not documented but backdropped against contexts of cognitive diagnoses, self-neglect, and/or substance misuse.

SARs also reflected on the need to revisit mental capacity when an individual is assumed to have it and to continue with engagement. It is possible that cognition may decline (or improve) and with life experience, an individual's ability to draw on that experience and knowledge can support evidencing mental capacity or a lack of. If a vulnerable adult continues with unwise decisions, it is helpful for a level of monitoring and multi-disciplinary discussion to take place to continue to support the individual and help mitigate the risks as well as ensuring they have all the information pertinent to the decisions in line with the second principle of the Mental Capacity Act.

Practitioners also need to be mindful of some of the other themes identified in this review related to an assumption of capacity. For example, ensuring that their assumption of mental capacity and not completing an assessment is not hiding problems with executive function that may be compounding risks to or from the vulnerable adult. As one SAR reflected, service user views around their refusal of services and non-compliance being taken at face value by practitioners under the notion of 'assuming capacity' is an over simplified model of mental capacity and consent.

Practitioners and care staff having more knowledge and awareness of the Mental Capacity Act not just about the act per se but its application to practice should help them be more enquiring and manage complexities and interplay with mental capacity with other areas like safeguarding and risk management. One SAR furthered this by reflecting whether practitioners are 'wandering enough' about mental capacity in their work and this is resulting in limits to curiosity in practice and supporting vulnerable adults with these highlighted concerns.

1.3 'Informal Capacity'

Three SARs established concerns around the reliance on something practitioners report as being 'informal mental capacity assessments'. These perhaps refer to the practitioner having had a conversation with the individual and/or completed a desktop review around the decision but no actual assessment has been completed and documented. One SAR

established in the chronology that there were multiple reflections on mental capacity and whether informal or actual assessments had taken place but only one assessment was formally recorded. A second SAR found reference to 'informal mental capacity assessment' but no associated reference as to which decision or with associated formal documentation. Another SAR reflected on the potential failings that come from a lack of completed and documented mental capacity assessments. No recorded assessment means no legal framework to support interventions around risk management and meeting needs. It also potentially means collaborative best interest decisions do not take place nor support from Independent Mental Capacity Advocates (IMCAs) being accessed. If there are doubts about someone's mental capacity, informal judgement is not sufficient, and a documented assessment is required. This may be indicative of a training need in the sector to re-enforce the importance of not only the protective factors that come from application of the legal Mental Capacity Act framework but also the empowering nature to support the individual to take decisions for themselves.

1.4 Lack of Audit on MCA Allocations

A more directly 'managerial' theme identified across several SARs relates to the completion of mental capacity assessments when they are directed or set as actions for practitioners to complete. For example, in one SAR chronologies indicated a mental capacity assessment for discharge was required but this was never allocated or completed. This is potentially indicative of a wider concern explored elsewhere in this report about practitioners leaving completion of a mental capacity assessment to each other perhaps not feeling confident to complete it themselves. A similar finding was established in a different SAR in which best interests conversations did not happen around medication and nutrition despite direction to do so.

One SAR established that even though hospital teams had a note on their system to prompt them to consider mental capacity for an individual who regularly appeared and self-discharged with fluctuating mental capacity, it is unclear as to whether this was followed or factored into work when he presented. One SAR found little in the way of management follow up to audit and check requests to complete mental capacity assessments and this may have been a contributory factor in the SAR.

These examples, although few, are sufficient to raise concern around the theme of managerial checks and auditing that assessments that are requested to provide a legal framework for interventions and protect vulnerable individuals are carried out. It may be appropriate for managers to record such actions in supervision notes for example to be checked at the subsequent session and/or between sessions through case auditing.

SECTION TWO – EXECUTIVE FUNCTION AND FLUCTUATING MENTAL CAPACITY

This section reports on themes in relation to executive function and the difficulties in assessing mental capacity with those with suspected executive dysfunction as well as that of fluctuating mental capacity. These are recognised as areas where practitioners can struggle to access and apply knowledge and skills in their mental capacity work both within the SARs reviewed but also the wider narrative in relation to practice improvements required against the Mental Capacity Act[7].

Executive Function

Executive function relates to the ability to put into practice knowledge and information about a decision in the moment that a decision or action is required. It is a clinical term and relates to a set of cognitive skills pertaining to working memory, planning, attention focus, remembering instructions, self-control and juggling multiple tasks. It can impact individuals with a wide range of diagnoses including dementia, acquired brain injury, and autism. These issues sometimes come to the fore in relation to mental capacity assessments when there is a disconnect between rational verbal answers and in the moment functioning. For example, an individual may be able to verbally detail the risks of a decision and that they would make a 'wise' decision but when in the moment they take an alternative risky decision.

When working within the Mental Capacity Act, one needs to be mindful of the third principle and the not treating the individual as lacking mental capacity because they have made an unwise decision/s but repeated unwise decisions within a context of verbal reports to the contrary may be an indication of difficulties with executive function. In an assessment this would typically be considered as part of the 'sufficiently weigh up and use information to make a decision' assessment criteria.

Practice concerns in relation to executive function were reported in SARs both in a general sense but also in relation to specific aspects of concern. These concerns typically centred around issues of self-neglect and issues where there was the presence of substance misuse. These are explored below.

2.1 Executive Function: General

This section covers some general comments and practice issues in relation to executive function that were raised by regional SARs. SARs found several examples of vulnerable individuals providing cogent answers to questions during assessment or interview, but they were unable to put this into practice or appeared to be more cognitively able than they actually were. This was sometimes indicative of practitioners taking things at face value and going along with discussions or dialogue during assessments. Practitioners in these scenarios were assuming mental capacity but without sufficient enquiry. This is indicative of comments elsewhere in this report of practitioners needing to implement professional curiosity and go deeper and further with their enquiries particularly when someone is making unwise and risky decisions. In one SAR a clear change in an individual's routine was evident around key and risky decisions post hospital discharge which is potentially illustrative of an

[7] The Autonomy Project recently produced a webinar on this subject which is a helpful overview. Slides can be found here: 2023-04-25 NMCF S2E4 Exec Dysf FINAL (essex.ac.uk) and the recorded webinar here: NMCF Events - Essex Autonomy Project.

executive dysfunction and could have prompted questions and assessment/s of mental capacity.

In terms of specific practice gaps, one SAR identified that practitioners were over reliant on a 'tell me' approach to considering mental capacity rather than also considering a 'show me' approach in combination. Practical observations and recording of in moment decisions have the potential to be important aspects of considering mental capacity and completion of mental capacity assessments for someone who potentially has an executive function impairment. The same SAR posed a reflective question of whether mental capacity quality assurance also looks for reflections on executive function as well as decisional capacity. This is evident in another SAR which found that executive function was not brought into any case discussion despite being a factor in the case. Practitioner confusion or low understanding of the Mental Capacity Act around a misinterpretation of the Act and believing there is a 'right to make unwise decisions' was also found resulting in the individual being able to continue putting themselves at risk (see section 3.1 for more on this). Instead, this should have been seen as a trigger point for a mental capacity assessment to provide a legal framework around decision making.

Some further SARs reflected that even though practitioners raised or recorded concern that a vulnerable adult did not understand risks in action or was making repeated unwise or risky decisions, no documented mental capacity assessment was carried out. Often it can be difficult to engage with such individuals or provide a means to accurately assess their in the moment decision making to inform a judgement of mental capacity but practitioners should continue to attempt engagement regardless and record such engagement and observations to support defensible and supportive decision making.

There were also reflections in SARs around wider needs and diagnoses that may impact on executive function which practitioners should be considering if it appears they are present. These includes the impact of those with acquired brain injuries particularly with impairment to the frontal lobe. The understanding of executive function or capacity is so important that one SAR strongly advocated for practitioners to consider it in all mental capacity assessments.

2.2 Executive Function: Self-Neglect

Concerns in relation to executive function in the context of self-neglect were identified in four SARs reflected on in this section. One SAR commented on professional recognition and observation at a Care Programme Approach (CPA) meeting that the service user was unable to cope without a carer. This was in the context of self-neglect and the service user reporting that they did not need support. Despite the professional acknowledgement, and in a formal forum, that the individual's expressed opinions differed to the observed behaviour, no mental capacity assessment took place. The same SAR commented that although the wishes of the service user were being respected by those around him, this resulted in it being unclear as to whether he had mental capacity to make decisions that amounted to self-neglect. The absence of a documented assessment and a legal decision-making framework prevents exploration with others and via best interests to support management of risks. Completion of a mental capacity assessment can also provide a framework to build challenges to unwise decisions around at appropriate junctures potentially reducing risk of harm.

A similar finding of relying on and adhering to the wishes of the individual was established in a further SAR. Amid self-neglect and a refusal to accept support there was an over-reliance on a misinterpretation of the Mental Capacity Act's principle three by professionals believing the individual had a right to make unwise decisions. Repeated unwise decisions should have in this instance triggered a mental capacity assessment as it is potentially indicative of problems with executive function. The SAR identified that a deeper understanding by staff of the Mental Capacity Act was required to improve practice.

A further SAR, in which there was also a presence of substance misuse, discussed a cyclical pattern from the service user in compliance and non-compliance as well as the presence of compulsive behaviours. Conversations to discuss these unwise decisions that may be indicative of impaired executive functioning were not held by any professionals working with him. A fourth SAR commented that there was no consideration of mental capacity recorded in any case notes in a situation of self-neglect.

These four SARs indicate the importance of professional curiosity around perceived unwise decision making in the context of self-neglect which is potentially indicative of executive dysfunction. Completion of a mental capacity assessment provides a legal framework and has the potential to bring all parties together in the best interests of the individual to plan a way forward and help manage risks.

2.3 Executive Function: Substance Misuse

Substance misuse concerns appeared in multiple SARs and most of these link to mental capacity in some form due to the nature of drug and alcohol misuse. Given the biological impact of substances on the brain, many of these concerns related to executive function.

Although this section is examining a more nuanced area, it is pertinent to reflect the point raised in one SAR that mental capacity should always be considered when an individual is intoxicated. There will invariably be an impact on cognitive function in those that misuse substances even if momentary and this should naturally lead to consideration of mental capacity by all professionals and care staff working with that individual. There is concern across many of the SARs that consideration of mental capacity did not take place in such circumstances. For example, in one SAR it was established that mental capacity was never assessed during the review period despite evidence of the individual leading a chaotic lifestyle and misusing substances with queries around self-neglect and potential cuckooing. Further SARs have established that consideration of mental capacity, executive dysfunction, and mental capacity assessments in the context of chaotic decision making from substance misuse is not necessarily commonplace.

Where mental capacity assessments have been considered, practitioners have sometimes not properly considered the impact of alcohol on cognitive function and risks particularly in respect to executive function. Four SARs recognised the need for practitioners to have a deeper knowledge of the impact of alcohol misuse particularly on the frontal lobe and how this may impact decision making and executive function. As well as the substances themselves impacting cognitive function, other factors around substance misuse such as coercion from peers or the possible 'cuckooing' of vulnerable people can also impact decision making. Where these other environmental factors are present, it is important for professionals working with the individual to come together to share this information to help formulate whether a mental capacity assessment is required and to support risk assessment.

However, this sort of planning and discussion did not take place routinely across different SARs.

The issue of fluctuating capacity in relation to individuals who misuse substances was also explored by SARs. Individuals may present as capacitated when concerns are discussed with them but when misusing substances, their decision making and risk taking may be different to that stated when not under the influence. These SARs all established concerns that mental capacity assessments were not completed with these cases despite the vulnerable adult displaying gaps in memory and confusion and practitioners articulating they were unsure on decision making capacity when the individual misuses substances even if they had mental capacity when not misusing.

2.4 Fluctuating Mental Capacity

Fluctuating capacity can be difficult for practitioners to work with particularly in relation to the interaction with the decision and time specific nature of decisions under the Mental Capacity Act.

Three SARs considered the problems that practitioners in their enquiries had engaging with this subject. There was commonality in all three in the focus on requiring a legal framework to be in place to support decision making that was absent. Concerns were expressed in relation to practitioners delaying decision making in the hope that mental capacity would be regained. This would be appropriate if the decision could be delayed but against a context of fluctuating capacity, it resulted in no legal framework being in place for required decisions including boundaries to work within in the individual's best interests which was problematic.

SARs reflected on two different approaches to this. One could establish a longitudinal framework for mental capacity and fluctuating decision making that guides best interest decisions for times when mental capacity is impaired (sometimes referred to as *macro decision making*). One could also complete decision specific mental capacity assessments and review these at each point the decision is to be made again as it may not be possible to rely on previous time specific assessments again (or a series of *micro decisions*). In either case it is important to keep decisions on mental capacity under review as well as consider any potential changing expression or communication of wishes by the person to ensure that best interest decisions when required are as robust and person centred as possible.

One SAR recognised that training availability in fluctuating capacity was limited and recommended that this be enhanced to ensure practitioners have the advanced skills, knowledge, and experience to work with fluctuating capacity and unwise decision making.

SECTION THREE – MISAPPLYING OTHER AREAS OF THE ACT

This section refers to themes identified in SARs in relation to misapplication of other parts of the Mental Capacity Act not outlined in detail already.

3.1 Time and Decision Specific

Further to the reflections contained at section 2.4 on fluctuating mental capacity, the Mental Capacity Act is clear that decisions for the purpose of the Act are time and decision specific. This means that a determination of mental capacity needs to be for a decision as narrow and specific as possible whilst also being specific to the time the assessment takes place. This opens the possibility for individuals to retain mental capacity over some decisions but not others and for people to regain or lose mental capacity over time.

There is a reoccurring narrative in some SAR chronologies around mental capacity as being something either an individual had or did not have. The lack of specificity around decision making or the idea that it could fluctuate was problematic in the approach of some practitioners. It was also apparent in written records and chronologies examined by SAR reviewers. For example, three SARs found mention of the individual having mental capacity but with no rationale or specific decision reported. A fourth SAR found practitioners referring to the individual as having 'fluctuating capacity' but without associated notes to define what this may mean, the scenarios and limits etc. that practitioners working with the individual may need to know. This would make it hard for any professional relying on these notes to work accordingly with the individual and the absence of rationale makes it difficult to evidence defensible decision making if rationale and evidence cannot be pointed to. The absence of a documented mental capacity assessment as re-iterated in other parts of this report, may mean that best interest meetings are not convened as a way of bringing together the individual, family, formal care, health and social care to support the individual and manage/mitigate any risks for the specific decision in question as well as opening up the potential avenues of IMCA support and Court of Protection involvement.

A further practice concern raised by SARs in this area is when a mental capacity assessment does take place, but the decision is not sufficiently well defined making it not necessarily compliant with the legislation. In the case of one SAR enquiry, only one recorded mental capacity assessment was completed around some serious risks, but this was not decision specific referring instead to more general concepts. This was replicated by a second SAR which found a practitioner used the decision of "care needs" which lacked the specificity and nuance required to assess for mental capacity and provide a related functional legal framework to support decision making against. A separate concern was also raised in a different SAR finding that although health settings were stating mental capacity assessments were taking place – they were not recorded and so the evidence base and nature of the decisions assessed for was not clear.

3.2 Best Interests

The fourth principle of the Mental Capacity Act states "An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests". A best interests decision is made following a mental capacity assessment

establishing the individual themselves is unable to make the decision. The best interests checklist contained within Section 4 of the Act details the factors and process that should take place when making a best interests decision. The issue for many SARs in this area of practice is not enough mental capacity assessments are being completed at pertinent times to trigger a best interest process. However, when best interest decision making is triggered, limited but significant practice concerns were raised across some SARs.

One concern is linked to a lack of recording and evidencing that a best interest meeting or consultation had taken place and how a decision was reached. The other concerns centred around how consultation took place. For example, a care home not engaging with others for views before making decisions on an individual's behalf. There were also concerns that best interest meetings may occur without all the professionals having a chance to express their views about care. One SAR commented on a large time gap between the mental capacity assessment and the best interest decision raising concern about the understanding of the decision and time specific nature of the assessment and decision-making process. In addition, formal best interest meetings and decisions are highly significant, and one SAR commented about the need to provide written and other information to informal carers supporting the decision so they were clearer on their role and what to expect during the meeting and decision making process. A further SAR expressed concern that family views (without a registered Lasting Power of Attorney) were over-relied upon and not sufficiently challenged during what was meant to be a collaborative process.

As discussed at section 3.1, decisions under the Mental Capacity Act are time specific and therefore any best interests decision should be revisited periodically, particularly if circumstances change, to make sure it accounts for any new information. This was raised as a practice concern in two SARs. In the first, there was a commitment from practitioners to review the decision, but this did not happen despite the individual lapsing into substance misuse again – a change in circumstance that would impact cognition and options available. Not reviewing the best interests decision meant that practitioners were not necessarily still working in the best interests of the individual. A similar scenario happened in a second SAR where the individual was deemed to not have the mental capacity to make decisions about his finances but when he refused to hand over to his appointed representative a large amount of money stored at home, the best interest decision around financial risk management was not revisited or reviewed.

SECTION FOUR – SAFEGUARDING, RISK AND DOLS

This section discusses thematic concerns raised in SARs directly related to the safeguarding process and risk management. Other themes in this report are relevant to safeguarding, particularly self-neglect and omission to complete and document mental capacity assessments but this section focusses on the theme of safeguarding itself. This section also covers practice concerns in relation to the deprivation of liberty safeguards (DoLS), access to advocacy and the Court of Protection.

4.1 Safeguarding Enquiries

A prominent theme across many SARs related to the consideration and application of the Mental Capacity Act during safeguarding enquiries themselves. A theme in some SARs related to safeguarding enquiries not initiating due to interpretations around the Act and issues of consent to the enquiry. One SAR identified that safeguarding enquiries did not happen for the individual as the person did not want one despite the significant harm present. A further SAR identified that both police and adult social care failed to provide a safeguarding service to the vulnerable individual experiencing harm as they felt she 'had capacity'. This was also against a backdrop of apparent domestic abuse and potential coercion. A distinction needs to be made by practitioners between consent to a safeguarding enquiry and taking steps to support the person to manage their own risks. A third SAR reflected that under the Care Act, a safeguarding enquiry can still be explored under s.42 if the individual is self-neglecting regardless of mental capacity and practitioners should be aware of this. As the Care and Support Statutory Guidance states at 4.17 "*A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support*". A further SAR commented on the importance of trying to manage risk for someone with mental capacity who is not engaging or is declining support through engagement with family and other informal support to understand the situation and try to influence via those mechanisms.

These examples all highlight the importance of considering requirements and support that can be offered to an individual experiencing, alleged to have experienced or at risk of experiencing harm through safeguarding responses regardless of views on mental capacity. This is particularly true for some cohorts of vulnerable individuals with one SAR reflecting that those who experience multiple exclusion homelessness are often excluded from assessments of mental capacity and referrals to statutory safeguarding teams. As one SAR considers, a safeguarding referral can open discussions around mental capacity – bringing people together and ascertaining the wishes of the person in relation to desired outcomes should lend itself to multi-disciplinary approaches and considerations of mental capacity.

Some SARs also identified that when safeguarding enquiries did take place considerations of mental capacity did not always occur. One SAR found the safeguarding enquiry failed to take account of any aspect of mental capacity, the individual's wishes as well as ignoring consent and mental capacity concerns. A second SAR established several concerns and raised a reflection that they were unsure of how well-established safeguarding literacy was in practice and the interplay with the Mental Capacity Act. A third SAR established that the safeguarding enquiry potentially mis-recorded that there were no concerns about the individual's mental capacity to make decisions as in wider notes the GP and other professionals raised concerns around diminishing mental capacity. Bringing MDT thoughts

on capacity together under the umbrella of safeguarding can provide helpful discussions on actions to undertake mental capacity assessments and information sharing that perhaps would have not been undertaken otherwise. Separately, a safeguarding enquiry examined in another SAR found that although the individual was found to lack mental capacity to understand the safeguarding process, no independent advocate was appointed to support him. This would have limited the involvement he had in the process which was meant to be person centred around him. This in turn may have limited the potential influence the safeguarding enquiry had in supporting him to manage the risks causing harm.

There were also reflections around the interplay of mental capacity with certain causes of harm/risks of harm. For example, one SAR felt that in relation to an individual with fluctuating mental capacity, the safeguarding enquiry was closed too early – time was not allowed to see if measures set were effective particularly in the context of the potential for engagement to fluctuate with the individual's mental capacity. Two other SARs reflected on the difficulty in separating out mental capacity from potential coercion in matters of domestic abuse and mate crime. An individual may be presenting as making 'unwise decisions' and able to give rationale for this during a verbal assessment but responses may be influenced by another. This is also where access to specialist legal advice as reflected in section 6.1 is helpful for practitioners to look at how to work with this issue within a legal framework and potentially consider the inherent jurisdiction of the High Court if necessary to help find a way to intervene.

These are nuanced areas, and any safeguarding training would benefit from considering covering not just the key role and interplay of the Mental Capacity Act in safeguarding enquiries but also the more complex areas raised in SARs such as fluctuating capacity and the impact of coercion and domestic abuse on decision making and mental capacity.

4.2 Risk Formulation and Management

As discussed in the previous section on safeguarding, mental capacity and related best interests and multi-disciplinary discussions can be very helpful and effective in sharing information and co-ordinating approaches to help formulate and manage risk within a legal framework. As one SAR reflected, best practice should be that mental capacity is considered at all risk meetings alongside mental health. The completion of mental capacity assessments around high-risk activities to evidence mental capacity (or trigger best interest decision making) can also help empower the individual to live their life as they wish whilst giving confidence and assurance to practitioners in their practice.

Multiple SARs commented on the need for practitioners to be more curious around mental capacity in their consideration of risk. There were repeated instances of individuals at risk or experiencing harm refusing offers of support and intervention or non-compliance with support and medication. These gaps in engagement or compliance were taken at face value by practitioners and potentially considered 'unwise' decisions without the completion of a mental capacity assessment or reflecting on executive function (see section 2). This over simplified model of mental capacity meant that the legal framework that stems from a documented assessment and offers protection to the individual and practitioners was not put into place.

Issues around this were reported across some SARs in relation to medication compliance. In one SAR, critically there was no evidence of a mental capacity assessment around taking/refusing medication despite the GP reporting that not taking medication will likely

result in a decline of mental capacity. In a separate SAR there was no record of mental capacity being assessed around taking medication, the care staff assumed the individual had mental capacity to decline and therefore did not raise this as a concern.

Several SARs commented on the missed opportunity of professionals from different backgrounds coming together to discuss risk and not sharing information and/or formulating risk management plans based around mental capacity. One SAR found that despite the individual's mental capacity for decisions relating to the areas of risk being tested, this was not formally recorded nor included in the risk management plan. A similar event was found in two other SARs – mental capacity was not included in the risk management plan. In one of these, it was well established that the individual lacked the mental capacity to make relevant decisions around accepting support and therefore a risk management plan should have been in place to pre-empt and provide contingencies for future refusals to help minimise harm.

Additional comments in SARs related to the theme of practitioners needing to consider the possible impact of physical health concerns stemming from risks around the person on mental capacity. There were also comments in relation to ensuring there is engagement through the best interests process to help manage risks and to consider all options with the person.

4.3 The Impact of Coercion

One specific dynamic relating to safeguarding and mental capacity that came from some SARs was that of the impact of duress or coercion on mental capacity. Four SARs identified that practitioners believed the vulnerable adult to have mental capacity and was making unwise decisions but did not sufficiently enquire into the potential coercion of family members or others in the individual's network and the influence that this may be having on their decision making.

When there seems to be coercion or duress that may be causing an individual to appear to make unwise decisions it is important to explore this further within the context of mental capacity. It is in line with principle two of the Act to ensure that capacity is maximised, and this includes trying to reduce and remove any potential coercive influence that could be causing harm and/or negatively impacting decision-making ability. It is beneficial to view coercion alongside re-evaluations of risk and unwise decision making on an ongoing basis. Mental capacity assessments can be helpful here as they can support open and targeted discussions and evaluation to work out if coercion or duress is impacting as well as providing a legal framework for decision making.

Practitioners should be aware of the potential role of the inherent jurisdiction of the High Court in such cases to be able to potentially support intervention and decision making when an individual is being coerced or under duress. The Court of Protection may also be able to offer support in its remit of being able to make judgements on whether an individual has mental capacity or not for a decision based on available and requested evidence[8].

4.4 Deprivation of Liberty Safeguards

[8] Ripfa's guide on inherent jurisdiction is helpful here. Available from: inherent_jurisdiction_pg_web.pdf (eastsussexsab.org.uk)

The Deprivation of Liberty Safeguards (DoLS)[9] were introduced as an amendment to the Mental Capacity Act 2005. DoLS came into being as it was raised that the country did not have a legal process in place for the infringement of article 5 rights of The Human Rights Act. It ensures that there is authorisation for any deprivation of liberty where the individual is unable to consent to it through a thorough process involving independent support for the person and a right to appeal to Court. DoLS originally applied to Care Quality Commission (CQC) registered settings (principally residential care homes and hospitals), but case law has subsequently expanded this to all care settings. Multiple SARs looked at individuals who were resident in CQC registered care homes or in hospital settings as well as some thematic SARs being site specific. These identified several areas of concern in relation to DoLS.

The most common concern was the lack of referrals to the managing authority when mental capacity to consent to a care or treatment plan was in doubt and the plan contained restrictions that amounted to a deprivation of liberty. This included those residing in care homes as well as hospitals. Two SARs also referenced the potential of deprivation of liberty to apply to community settings, but no referral or authorisation appeared to be in place.

In some cases a lack of application of the Mental Capacity Act and assessments unfortunately led to a lack of referral for DoLS as well. One SAR reported concerns that care home staff had no understanding of the Mental Capacity Act and DoLS resulting in lack of application. An incorrect reliance on the assumption of mental capacity (see section 1.2) or overlooking/not considering capacity serves to prevent access to legal frameworks that can help maintain safety and protect human rights. These all indicate a requirement for a better level of knowledge and application for care home staff.

One SAR also raised concerns around the knowledge of registered professionals in this area as well. One professional misunderstanding resulted in no mental capacity assessments being completed in hospital as the ward falsely believed that because the DoLS referral was declined as not eligible, the individual could not be found lacking mental capacity for anything including medication administration. It is also important for all settings to consider the potential role of the Court of Protection, to provide legal authorisations and resolve disputes which is accessible if the Mental Capacity Act is applied appropriately. One SAR identified that professionals immediately ruled out remote technology as a restrictive breach of human rights without discussing with the person, potentially providing a missed opportunity to manage and monitor risks. This reflects an over-simplified approach to mental capacity, best interests, and deprivation of liberty.

Some nuanced aspects of care plans that are indicative of a deprivation of liberty were also picked up in SARs. These aspects in themselves may have been sufficient to have required a referral for a DoLS authorisation. For example, the presence of restraint in a care home, physical intervention, and the management of complex needs. There was also a misunderstanding in one SAR in respect to fluctuating mental capacity and the care home not making a DoLS referral when the individual who had regained mental capacity lost it again. There were some reflections that perhaps due to a reduced knowledge base, DoLS was not considered in MDT or multi-agency meetings when it really should have. This also limited the possibility of a discussion around less restrictive options in these cases. DoLS is an important part of pre-planning for individuals with restrictive care plans particularly when considering discharge from hospital to other settings and transition/conveyance plans which

[9] See SCIE's At a Glance webpage for more details on DoLS. Available from: Deprivation of Liberty Safeguards (DoLS) at a glance | SCIE

may require additional authorisation from the Court of Protection. One SAR recognised that discussions around DoLS to support highly restrictive care and restraint happened too late after an emergency placement happened rather than before/in the planning of. This resulted in unauthorised article 5 infringements due to the absence of a legal framework.

4.5 Advocacy and Court of Protection Access

One of the many benefits of having a legal framework such as the Mental Capacity Act to help support decision making by vulnerable individuals is the wider support the enactment of the framework can provide. This could be access to advocacy for example to strengthen the voice of the individual at the centre and to support them to navigate their decisions. It could also be access to the Court of Protection when resolution cannot be obtained through a best interests process.

There are statutory requirements where access to an Independent Mental Capacity Advocate (IMCA) is required but advocacy can also be referred for on discretionary criteria to support the individual with decision making[10]. Independent advocacy is also available to support with other statutory processes e.g. Care Act advocacy for support with statutory needs assessments and safeguarding enquiries.

For best interest decision making to be as robust as possible, consultation with as many of those who know the person well is essential to get a good sense of what the person may have chosen to have done if they could make the decision themselves. In one SAR there was no attempt to contact the individual's brother for a decision as he was abroad and no attempt to contact the care provider and no IMCA was referred for either (despite the decision being one of the statutory decisions). The gap in professionals referring for an IMCA to support around decision making was also evidenced in a SAR examining the issues around a failed care home where IMCA and Relevant Person's Representative (RPR) support may have been beneficial to residents. A further SAR also commented on the lack of consideration of advocacy being a reflection and impact of a lack of application of the Mental Capacity Act by all stakeholders.

The possibility of a discretionary referral for an IMCA is important as it may be helpful to have an individual who is independent supporting and amplifying the voice of the individual particularly if there is a difference in views, history with family members and to seek resolution locally before going to the Court of Protection. This was also true in two SARs which reflected on the benefits an IMCA would have potentially had for the individual to understand the options before them rather than relying on family members who may have different motivations. In addition, an IMCA in these cases was felt appropriate in supporting dispute resolution.

It is also important to reflect on the role of advocacy in other statutory processes reflected in themes elsewhere in this report. In reference to safeguarding, one SAR established that the individual was not appointed an advocate despite lacking the mental capacity to make decisions around the safeguarding process. This potentially may have limited his engagement in the process which may have afforded him additional protections. A further

[10] Statutory decisions are; Serious medical treatment, or a change in accommodation with a stay longer than 28 days in hospital or 8 weeks in a care home. An IMCA *may* be instructed in care reviews where there is no-one available to be consulted or in adult protection cases whether or not family, friends or others are involved.

SAR reflected on the importance of a mental capacity assessment being a potential gateway to independent advocacy for statutory schemes if the individual lacks mental capacity.

A further reason to complete mental capacity assessments and associated best interests decisions is that it provides for a potential application to the Court of Protection where there are disagreements that cannot be resolved. However, practitioners do need to know about this as an option and the steps that should be taken in the best interests of the person. This was unfortunately found not to be the case in three SARs from the region. In one SAR, a disagreement that would normally trigger a referral to Court did not happen preventing the individual from having the independent judicial oversight that they were entitled to. The Court was also seen as a potential option that was not taken to enforce a plan to support a vulnerable adult's wellbeing during a separate SAR. A third SAR reflected that legal options may or may not have been helpful in the case examined but at no point was there evidence of this being considered as a means of supporting the individual. These indicate a lack of consideration of the role of the Court of Protection to support interventions as well as making decisions with best interests disagreements.

SECTION FIVE – CARE PROVIDERS AND HOSPITALS

This section brings together learning from the region's SARs explicitly related to care providers and hospital admission and health processes.

5.1 Care Providers

SARs reflect the practice of all stakeholders involved in the person but there are also SARs that have looked at a specific service or care home where things have not gone as they should have done. These have included learning around the application of the Mental Capacity Act. For example, one SAR found a care provider did not record any mental capacity assessments despite concerns raised in this area and a second found very little evidence in care home documentation.

Further concerns around care provider staff awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards and principles of least restrictive practice and proportionality were raised in several SARs. One SAR highlighted the contribution that commissioning may have made to the serious situation by not including this in their monitoring of the care home in question. This highlights the importance of commissioning colleagues being aware of what to look for in respect to practice, documentation, and procedures in care providers in relation to the Mental Capacity Act when completing quality assurance and contract monitoring visits as well as the potential consequence if practice is deemed concerning and unsafe.

One aspect relating to care home staff that was raised in one SAR reflected on the 'ownership' of completing a mental capacity assessment. As a result of care provider staff feeling it was not their responsibility to complete mental capacity assessments and expecting a social worker to do it no documented assessment took place. As the SAR report reflects, this may be true of some large decisions where the local authority or health body may be the decision maker but there were many small decisions day-day that were required to keep the adult safe that had to be taken by the care provider. These should have been accompanied by mental capacity assessments and best interests decisions as appropriate in order to ensure that these decisions were lawful. In a separate SAR it was established that many key workers did not have mental capacity training that covered issues of consent.

Lack of ownership over decision making may also have contributed to a care provider in a different SAR not completing a mental capacity around wound care which became a crucial component of the individual's care regime – perhaps seeing this as a health responsibility. One can analyse this issue in several ways (or a combination), either staff and managers do not have sufficient knowledge and training in the Mental Capacity Act and their responsibilities, they do not have care planning tools that may prompt and facilitate reflection around these requirements or there are mixed and potentially confusing communication messages between professionals and care providers about expectations on completing mental capacity assessments.

5.2 Hospital Admission/Discharge and Treatment Escalation

Several SARs reflected on areas of practice that would benefit from improvement in relation to hospital admission, discharge and around Do Not Attempt Resuscitation (DNAR) and treatment escalation plans.

In relation to DNAR, a mental capacity assessment was missing in some cases looked at by SARs when there was sufficient information to doubt decision making. This resulted in an inadequate legal framework being in place for such a sensitive and life critical decision. Clarity over how the end-of-life escalation plan is formed and ensuring it is legally robust is also important to avoid doubt and problems of clarity that appeared in a further SAR. For these individuals the missing assessment of capacity also misses an opportunity for the individual to express their wishes and for a best interests meeting with all those who care for the person to provide their views. This provides for a more robust decision. Similarly, a lack of engagement with formal support providers around the person by medical practitioners was also noted by one SAR. Often care providers work with an individual for several years with the same dedicated staff who can offer a lot of expertise and knowledge on the person and their likely wishes and preferences if they are contacted and consulted with.

SARs identified several areas of concern in relation to hospital admissions. There were several queries around mental capacity and decisions on admission and receiving hospital care where there was doubt on the individual's decision-making cognitive ability, but no mental capacity assessment was documented. These included acute and mental health settings as well as the use of ambulance transport. One SAR recognised the lost opportunity that came from not completing a mental capacity assessment on admission as it would have enabled risk management discussions around complex elements of care for the vulnerable individual at an earlier stage. This would have potentially supported the individual better at the hospital.

Mental capacity should be an important part of decision making around discharge from hospital and has implications for deprivation of liberty considerations. Multiple SARs in the region found instances of vulnerable at-risk individuals where there was doubt around mental capacity discharging themselves from hospital without a decision specific mental capacity assessment being completed. These individuals were potentially making an impaired decision to return to a risky situation which they potentially did not have the mental capacity to make. This included two SARs in which the vulnerable adult repeatedly discharged themselves without a mental capacity assessment being completed. Repeated self-discharge to risky environments should in itself be considered a trigger for examination of mental capacity as it may be indicative of executive dysfunction (see Section 2.1). Time can be highly pressurised on hospital wards with high demand for bed space but where there is evidence of impaired mental capacity it is important that staff are allowed to complete work towards what is a legal requirement. Mental capacity should be a consideration in all discharge planning decisions.

SECTION SIX – OTHER THEMES AND GOOD PRACTICE

This section brings together themes from the across the region's SARs and that don't neatly fit into the previous five sections as well as a collation of best practice examples in mental capacity cited in the SARs.

6.1 Practitioner Access to Legal and Peer Support

The absence of consideration of legal avenues as discussed in Section 4.5 to help support the individual potentially at risk may be indicative of a lack of access or confidence by practitioners. This was reflected across three different SARs. One SAR commented positively on the access Council employed practitioners have to specialist legal advice and reflected that not all statutory agencies involved with the individual had that access. The importance of frontline staff being able to discuss issues of mental capacity with legal colleagues was also recognised as vital to support confidence in a second SAR.

As well as legal support, practitioners can obtain confidence from talking to their peers, a point highlighted in one SAR which pointed to practitioners having a named and safe space to discuss complex issues such as mental capacity, mental health, safeguarding, and high-risk situations as important to help practitioners feel supported.

6.2 Wider Mental Capacity Support

Deviating slightly from the direct application of the Mental Capacity Act, some SARs reflected on the gaps in provision and support for individuals who may lack mental capacity in terms of accessing services. One SAR reflected on an issue of access to community services such as mental health support and the additional support and information those with impaired capacity may require when deciding on engagement with such services. There is potential consideration here of ensuring easy read and accessible information is easily and readily available to such individuals by statutory agencies, care providers and third sector community support agencies.

A further SAR reflected on the issue of perpetrators with declining mental capacity particularly in the context of those individuals who are on the sex register as a previous offender but due to impairments of cognition may neglect to inform others of this. This highlights a very specific area of support this cohort requires and the importance of agencies to talk to each other about important information that is necessary to help prevent harm to others and reduce risks.

6.3 Good Practice

It should be noted that as well as identifying areas where practice could be improved SARs also found some areas of recognised good practice in relation to mental capacity.

In one SAR, the practitioner was commended for exploring apparent executive dysfunction appropriately, comparing cogent verbal answers with the visual evidence of self-neglect apparent in the environment to determine the individual did not have mental capacity for the decision in question. It was one of several actions that resulted in the individual not passing away alone at home. One SAR recognised that the mental capacity of an individual was constantly considered and regularly tested at appropriate junctures when capacity was doubted. This was despite the individual being assessed as having mental capacity in all recorded assessments evidencing the practitioners were following the 'time and decision

specific' basis of the Act. SARs also identified good practice in terms of maintaining engagement with the individual despite non-compliance, non-engagement or aggression directed at practitioners. This supports the individual to try and make informed decisions through regular information provision as well as supporting oversight and management of risk. This good practice around difficult areas of self-neglect and hoarding that impact or inter-relate with mental capacity was also recognised as being supported by robust SAB protocols, policies, and processes accessible to practitioners. In a further SAR, practitioners were commended for going to get expert advice on difficult areas of mental capacity after recognising the complexities involved.

Positive practice in respect to care providers was also identified, in one SAR it was recognised that the domiciliary care agency had a care plan linked to mental capacity assessments for all relevant sections. In another, the care home staff felt able and did challenge the implementation of a Do Not Resuscitate document when they felt it was not in the individual's best interests. Positive practice was also identified in health settings with mental capacity assessments and best interests being used well and effectively in one SAR in relation to medical healthcare intervention. In a further SAR, doctors relied on and utilised section 4B of the Mental Capacity Act as they had reasonable belief to doubt mental capacity. This resulted in the provision of life sustaining treatment to keep the individual alive and within a legal framework to do so.

ADASS SOUTH WEST RECOMMENDATIONS

ADASS South West have endorsed the following 10 priority recommendations from this thematic review for stakeholders to focus their Mental Capacity Act practice improvement and assurance work around. These priorities are in no set order and were selected following working groups of the region's Principal Social Workers, commissioning and Mental Capacity Act/Deprivation of Liberty Safeguards leads.

1. Local authorities to collaborate with care providers, NHS, and connected stakeholders through its commissioning, learning and development and other networks to support the embedding of improved Mental Capacity practice including the themes in this report across the Integrated Care System. Local authority practitioners including those in commissioning can support Mental Capacity Act (including deprivation of liberty) compliance across stakeholders as part of provider visits, contract monitoring and networking meetings.

2. Local authorities (including agencies with delegated functions) to assure themselves that their own Mental Capacity Act learning and development offer covers the themes of this review such as executive function and 'dispels' some of the current misapplications of the Act's principles such as the over reliance on an 'assumption of capacity'. An additional 'add on' module/session may be appropriate to deliver learning to focus on the more complex areas of mental capacity that practitioners find difficult; executive function, fluctuating capacity, and working with unwise decision.

3. Mental Capacity, and particularly more complex elements such as executive function and fluctuating capacity including relevant case law, to be a regular subject for professional development and reflected in supervision discussions about case work where appropriate. Case supervision actions set should be followed up on. This normalising of the conversation can encourage confidence, ownership, professional curiosity and raise practice levels. This can be further supported through internal quality assurance processes of practitioner work that includes executive function, engagement around mental capacity when this may be difficult, and whether best interest decisions have been taken appropriately.

4. For professional curiosity and the importance of making enquiries to be included in mental capacity training particularly if the individual is repeatedly making unwise decisions. This will support practitioners to be confident to be curious and ask questions relating to mental capacity and not to always accept what they are told on face value. Practitioners can be supported to develop the knowledge and skills to do this through supervision, observations and learning and development.

5. Multi-disciplinary meetings and teams to ensure mental capacity is considered and information shared where relevant and recorded on client data records to support sharing. Multi-disciplinary meetings should consider evidence and concerns where appropriate around executive function and allocate someone to complete a mental capacity assessment around relevant decision/s if concerns warrant this particularly in the context of potential harm or self-neglect.

6. All health and social care staff should be either competent and confident to complete a mental capacity assessment within their area of expertise and/or employment or

know someone who can and is available to complete a documented mental capacity assessment within a reasonable timeframe for the decision in question e.g., care provider staff deferring to a team leader or manager.

7. Practitioners should be encouraged to record their evidence base for decisions around mental capacity in appropriate case records even if capacity has been presumed. Recording of decisions around mental capacity should include consideration of executive function where relevant. This should also be reflected in relevant case audits of practitioner recordings.

8. For agencies to assure themselves that their safeguarding protocols and forms prompt for consideration of mental capacity and that this is embedded into safeguarding and induction training. Mental capacity considerations should be a feature of any safeguarding activity including the individual's ability to make related and relevant decisions in the context of any possible coercion and duress.

9. Where there is reason to doubt a person's ability to decide on their temporary or permanent place of residence including tenancy arrangements, a mental capacity assessment must be undertaken and documented. This includes hospital discharge as well as a change in placement.

10. Commissioners of care and support should assure themselves through contract monitoring and quality assurance activities that care and support providers have in place relevant training to support their staff in MCA and best interest decision making practice, and that relevant managers are competent in the application of the Deprivation of Liberty Safeguards, including deprivation of liberty in community settings, and know the steps that need to be taken to refer for authorisation.

It is recognised that different agencies will have different types of interactions with the Mental Capacity Act and each agency should determine the level of training and awareness that its staff requires. ADASS South West and its members recognise the importance of developing their own local authority staff as well as supporting commissioned care providers and connected stakeholders to develop the practice of their own staff groups.

APPENDIX 1 – AUTHOR RECOMMENDATIONS

This appendix contains author recommendations extending beyond the ten ADASS South West priority recommendations. This list is not endorsed by ADASS South West but are suggestions based on the collated findings the author has established in the course of completing this thematic review. It is recognised that not all recommendations will be appropriate for all agencies. Agencies and practitioners can use this list to identify recommendations that are pertinent to them should they wish to follow them.

Recommendation 1: Mental capacity awareness and assessment requirements to be covered in induction courses and competency sign off across social care, health bodies, care providers and connected stakeholders. Agencies may be able to access support from DHSC, Skills for Care, SCIE etc. and should feedback training support requirements to them if not readily available. *REVIEW SECTIONS 1.1, 5.1, 5.2*

Recommendation 2: Mental capacity training to be clear about the decision and time specific nature of decisions made under the Mental Capacity Act. *REVIEW SECTION 3.1*

Recommendation 3: All health and social care staff should be either competent to complete a mental capacity assessment within their area of expertise and/or employment OR know someone who can and is available to complete and document an assessment within a reasonable timeframe for the decision in question e.g., care provider staff deferring to a team leader or manager. *REVIEW SECTIONS 1.1, 5.1, 5.2*

Recommendation 4: Multi-disciplinary meetings and teams to ensure mental capacity is considered in every meeting where appropriate and recorded on client data records to support sharing. Any MDT discussion around risk should include a discussion of mental capacity as part of the conversation. *REVIEW SECTIONS 1.1, 4.2*

Recommendation 5: For multi-disciplinary meetings and teams to consider evidence and concerns around executive function when relevant and allocate someone to complete a mental capacity assessment around relevant decision/s if concerns warrant this particularly in the context of potential harm or self-neglect. *REVIEW SECTIONS 2.2, 2.3*

Recommendation 6: Practitioners should record their evidence base for decisions around mental capacity even if assuming capacity without assessment in appropriate case records. Recording of decisions around mental capacity should also include consideration of executive function where relevant. Audits of case recordings, client records, patient records or similar should also include checking there is evidence of practitioner decisions around whether to complete a mental capacity assessment or not. *REVIEW SECTIONS 1.2, 2.2, 3.1*

Recommendation 7: Mental Capacity to be a regular subject for professional development and reflected in supervision discussions about case work when relevant. This normalising of the conversation should encourage confidence, ownership, professional curiosity and raise practice levels. Any actions set by supervisors and managers should be recorded on supervision and system notes in line with agency procedures and checked if complete at subsequent supervision sessions or via auditing. *REVIEW SECTIONS 1.2, 1.4, 6.1*

Recommendation 8: Mental Capacity training to stress that ‘informal mental capacity assessments’ do not have a legal basis. If there is sufficient doubt of someone’s mental capacity, a documented assessment must be carried out to ensure legal compliance as well ensuring appropriate support for the individual is in place. *REVIEW SECTION 1.3*

Recommendation 9: For mental capacity training to include a focus on dispelling misinterpretations of the Act’s principles including a ‘right to make unwise decisions’.

Agencies to also assure themselves that their training on mental capacity stresses the time and decision specific nature of the decisions made under the Act including the need to review best interest decisions if circumstances change. *REVIEW SECTIONS 2.1, 2.2, 3.2*

Recommendation 10: For mental capacity assessment forms to include prompts and places to evidence all considerations of mental capacity including executive function (or lack of) and fluctuating mental capacity when these are relevant potential concerns. *REVIEW SECTIONS 2.1, 2.4*

Recommendation 11: For quality assurance mechanisms to include consideration of executive function when appropriate and ongoing attempts to engage the individual around mental capacity when assessment may be difficult. *REVIEW SECTION 2.1*

Recommendation 12: For quality assurance mechanisms to include consideration of whether best interest decisions have been taken appropriately including consultations with others. *REVIEW SECTION 3.2*

Recommendation 13: For mental capacity training to include content on the different potential impacts on mental capacity and executive function of different diagnoses and conditions. This should also include the impacts of substance misuse. *REVIEW SECTIONS 2.1, 2.3*

Recommendation 14: For professional curiosity and the importance of making enquiries to be included in mental capacity training particularly guidance on what to do if the individual is repeatedly making unwise decisions. *REVIEW SECTION 2.2*

Recommendation 15: For mental capacity considerations to be a key component of any safeguarding, self-neglect or working with substance misuse policies, protocols, and training. For such documents to be readily available and accessible to staff. These policies should encourage practitioners to maintain ongoing engagement to support risk management and help the individual with mental capacity make informed decisions. Policies where appropriate should encourage practitioners to reflect on the potential impact of coercion on decision-making ability. *REVIEW SECTIONS 2.3, 4.1*

Recommendation 16: For discussions around risk and mental capacity to include reflections of the mental capacity, experience, and presentation of the alleged perpetrator. *REVIEW SECTION 6.2*

Recommendation 17: Mental capacity training to reflect how to work with someone with fluctuating capacity and the importance of completing mental capacity assessments at appropriate times. *REVIEW SECTION 2.4*

Recommendation 18: For agencies to consider provision of a separate module or training session to focus on the more complex areas of mental capacity that practitioners find difficult; executive function, fluctuating capacity, working with unwise decision making including self-neglect and substance misuse. *REVIEW SECTION 2.4*

Recommendation 19: For agencies to be assured that mental capacity training expresses the importance of including evidence for decisions and views on mental capacity in client notes (or agency equivalent). *REVIEW SECTION 3.1*

Recommendation 20: Agencies should assure themselves that they are able to formally record best interest consultations and decision making. *REVIEW SECTION 3.2*

Recommendation 21: Agencies to consider publishing details on what best interests decisions, meetings and consultations may entail on their websites. Accessible documents

and information should be readily available for practitioners to give to those they are consulting with ahead of time. *REVIEW SECTION 3.2*

Recommendation 22: For agencies to assure themselves that their safeguarding enquiry protocols and forms prompt for consideration of mental capacity and that this is embedded into safeguarding and induction training. Mental capacity considerations should be a featured consideration of any safeguarding activity including the individual's ability to make related and relevant decisions in the context of any possible coercion and fluctuating capacity. *REVIEW SECTIONS 4.1, 4.3*

Recommendation 23: For agencies to assure themselves that practitioners are aware of the requirements for Independent Mental Capacity Advocates, the benefit of their role and how to refer to the local advocacy agency for one. This includes statutory decisions as well as the benefits of supporting the individual in other best interests decisions. This information as well as details of the role of the Court of Protection and local processes for referrals should be included in training offers. *REVIEW SECTION 4.5*

Recommendation 24: For agencies to be assured that there are triggers and prompts for practitioners to refer for independent advocates to support with safeguarding enquiries particularly if the individual lacks mental capacity to consent to the enquiry and understand the alleged harm. *REVIEW SECTION 4.1*

Recommendation 25: For practitioners to be encouraged to be professionally curious and to be supplied with the knowledge and skills to do this through supervision, supported observations and learning and development. *REVIEW SECTION 4.2*

Recommendation 26: For practitioners to be able to access expert knowledge and legal advice when appropriate when working with complex areas of mental capacity and with individuals whose decision-making ability is being impacted by duress, coercion, or related context. *REVIEW SECTIONS 4.3, 6.1*

Recommendation 27: For care providers to be assured that care home, supported living service, domiciliary and other community support managers can recognise a deprivation of liberty and know the steps that need to be taken in respect to referring for authorisation, mental capacity and best interests and the local means to do so. *REVIEW SECTIONS 4.4, 5.1*

Recommendation 28: For health and social care professionals to understand deprivation of liberty from induction and ongoing training particularly in respect to its human rights basis and the principles of least restriction. *REVIEW SECTION 4.4*

Recommendation 29: For agencies to assure themselves that practitioners are aware of the role of the Court of Protection and how to seek legal advice in respect to whether there is a role for the Court in cases if and as appropriate. *REVIEW SECTIONS 4.5, 6.1*

Recommendation 30: For commissioning agencies to assure themselves that commissioning, contract monitoring, and quality auditing frameworks and enquiries include looking at compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards. *REVIEW SECTION 5.1*

Recommendation 31: For agencies to assure themselves that mental capacity is a consideration in discussions around a change in location for the person such as hospital discharge or a change of placement to include tenancy considerations. *REVIEW SECTION 5.2*

Recommendation 32: For agencies to consider setting up mental capacity peer support forums, peer champions or similar to encourage practitioners to talk to each other about complex case issues including mental capacity in an informal but supportive way. *REVIEW SECTION 6.1*

Recommendation 33: For all agencies and stakeholders to consider and assure themselves if its accessible and easy read information is sufficient to support decisions on engagement with those with impaired mental capacity to make such a decision. *REVIEW SECTION 6.2*

APPENDIX 2 – LIST OF SARS CONSIDERED IN THIS REVIEW

The following SARs were included for consideration in this review. These were all published on SAB websites up to and including 13 July 2023 and eligible for inclusion based on the criteria outlined in the methodology section.

SAB	Title	Year of Publication
Bath and North East Somerset	Elley	2020
Bath and North East Somerset	Martin Evans	2021
Bath and North East Somerset	Cooper	2022
Bath and North East Somerset	Angus	2022
Bath and North East Somerset	Mr Swaby	2022
Bristol	Thematic Mate Crime Review	2018
Bristol	Christopher	2018
Bristol	Martyn	2021
Bristol	Self-neglect Thematic Review	2022
Cornwall and the Isles of Scilly	JK	2009
Cornwall and the Isles of Scilly	Paul	2018/2019
Cornwall and the Isles of Scilly	Jack	2020
Cornwall and the Isles of Scilly	Margaret/Joint Domestic Homicide	2021
Cornwall and the Isles of Scilly	Thematic Carers Analysis	2022
Cornwall and the Isles of Scilly	Ken	2023
Cornwall and the Isles of Scilly	Anthony and Mary	2023
Devon and Torbay	T	2016
Devon and Torbay	Sally	2018
Devon and Torbay	Rita	2019
Devon and Torbay	Atlas Care Homes	2019
Devon and Torbay	Charles	2019
Devon and Torbay	Ben	2020
Devon and Torbay	Self-neglect Thematic Analysis	2023
Devon and Torbay	Hermione	2023
Dorset	JT	2012
Dorset	Highcliffe Nursing Home	2016
Gloucestershire	SJ	2015
Gloucestershire	KH	2016
Gloucestershire	Ted	2017
Gloucestershire	Hannah	2017
Gloucestershire	Danny	2018
Gloucestershire	Z	2019
Gloucestershire	Nick	2020
Gloucestershire	Peter	2021
Gloucestershire	Five Women	2021
North Somerset	Stan, Charlotte and Philip/Self-Neglect Thematic Review	2023
North Somerset	Abi and Kim	2023
Plymouth	Ruth Mitchell	2017
Plymouth	DP	2020
Somerset	Mendip House	2018
Somerset	Luke	2020
Somerset	Damien	2021
Somerset	Matthew	2022

Somerset	Susan	2022
Somerset	Robert	2023
South Gloucestershire	Nightingale Homes	2018
South Gloucestershire	Family Z	2019
South Gloucestershire	Adult A	2020
South Gloucestershire	Mr D	2022
Swindon	Honor	2018
Swindon	Terry	2020
Swindon	Kieran	2021
Swindon	Alison	2022
Swindon	Brenda	2023
Swindon	Brian	2023
Wiltshire	Adult A	2018
Wiltshire	Adult B	2018
Wiltshire	Adult D	2018
Wiltshire	Adult C	2019
Wiltshire	Adult E	2019
Wiltshire	Adult H	2020
Wiltshire	Adult L	2021

APPENDIX 3 - LEARNING AND DEVELOPMENT OFFER CHECKLIST

The following checklist has been developed by the author to support mapping of findings from this regional SAR review against current learning and development offers by the agency completing the checklist. Items can be deleted/adapted to suit agency needs, requirements and views. A further checklist has been produced in relation to policies and procedures (see page 39).

#		✓?
1	Is content on mental capacity delivered as part of any new staff induction?	
	Does mental capacity training…….	
2	…stress the importance of completing and documenting mental capacity assessments rather than relying on 'assumption of capacity', an 'informal capacity assessment' or similar?	
3	…dispel some common misinterpretations of the Act found in this review e.g. 'right to make unwise decisions'.	
4	…stress the time and decision specific nature of decisions under the Act including best interest decisions?	
5	…cover executive function and how to complete mental capacity assessments for those with suspected executive dysfunction?	
6	…cover the impact on executive function and related mental capacity of different diagnoses and conditions e.g., substance misuse, frontal lobe damage?	
7	…cover fluctuating mental capacity and how to work with this including the completion of mental capacity assessments and best interests decisions?	
8	…inform practitioners of the importance of recording their thoughts and evidence in relation to decisions around mental capacity? This should include rationale of why a mental capacity assessment has not been completed if there is potential doubt about an individual's mental capacity or they are making repeated unwise decisions.	
9	…cover the role and remit of Independent Mental Capacity Advocates (IMCA)?	
10	…highlight the benefits of a multi-disciplinary approach to co-ordinating information on mental capacity, risks, unwise decision making and executive function?	
11	…encourage professional curiosity and maintaining engagement around repeated unwise decisions?	
12	…make it clear what individual responsibilities are re: mental capacity particularly on completing mental capacity assessments and who within the agency/team has this responsibility if not everyone?	

13	…cover deprivation of liberty (Deprivation of Liberty Safeguards [DoLS] and/or community deprivation of liberty)? This should include a human rights perspective, and a focus on principles of proportionality and least restriction. Training should also cover how legal and/or expert advice can be obtained on this subject if it is required.	
14	…cover the role of the Court of Protection?	
15	Does safeguarding training cover consideration of mental capacity within the safeguarding enquiry process including in relation to coercion, executive function, and fluctuating capacity?	
16	Consideration of a separate module to explore in detail issues in relation to fluctuating mental capacity, executive function, self-neglect and substance misuse in relation to mental capacity.	
17	Consideration of wider tools and learning and development offers to enhance practitioner professional curiosity skills and confidence.	

APPENDIX 4 - POLICY AND PROCESS CHECKLIST

The following checklist has been developed by the author to support mapping of findings from this regional SAR review against current policy and processes by the agency completing the checklist. Items can be deleted/adapted to suit agency needs, requirements and views. A further checklist has been produced in relation to learning and development (see page 37).

#		✓?
1	Do all staff have sufficient competency and confidence to complete and document a mental capacity assessment?	
2	If not all staff have responsibility to complete and document a mental capacity assessment, are you assured that they know who in their team does have this responsibility and how to request an assessment?	
3	Do MDT focussed policies/procedures comment on the importance of considering mental capacity?	
4	Do MDT focussed policies/procedures comment on executive function and the importance of taking responsibility for completing and documenting mental capacity assessments within individual practitioners' specialist areas?	
5	Do change of residence/placements, hospital admission and discharge focussed policies/procedures comment on requirements in relation to the Mental Capacity Act including Deprivation of Liberty Safeguards?	
6	Do you have a mental capacity assessment template?	
7	Do you have a best interests decision template?	
8	Do mental capacity assessment forms prompt for consideration and have space for recording of evidence around executive function and fluctuating capacity?	
9	Do mental capacity forms prompt for consideration of referral for an Independent Mental Capacity Advocate (IMCA)?	
10	Do mental capacity forms remind/prompt practitioners of the role of Court of Protection if this is required?	
11	Do audits of practitioner work and client records include looking at whether mental capacity has been considered appropriately and the thought process and evidence for completing or not completing a mental capacity assessment is clear?	
12A 12B	Does any audit also look at whether the practitioner has considered executive function? Does any audit also look at how best interests decisions were made and those who contributed to it?	
13	Is mental capacity discussed as part of supervision sessions and case discussions when appropriate? Is this included in any supervision framework/policy?	

14	Are actions set by managers/seniors in relation to mental capacity documented and then followed up on to check they were completed?	
15	Do safeguarding referral and enquiry forms prompt for consideration of mental capacity?	
16	Do safeguarding enquiry forms prompt for consideration of referral for an Independent Mental Capacity Advocate (IMCA)?	
17	Do safeguarding enquiry forms include consideration of the mental capacity of the alleged perpetrator to make related decisions?	
18A 18B 18C 18D	Do you have safeguarding policies/procedures in relation to hoarding, self-neglect and substance misuse? Do these include consideration of mental capacity? Do these reflect the impact of coercion on mental capacity and decision making? Are these readily available and accessible to practitioners?	
19	Do you have accessible information in relation to best interest decision making and contributions published on your website? Is this type of information readily available for staff to share with others?	
20	Are you assured that practitioners have access to an appropriate level of expert and/or legal advice to discuss issues relating to mental capacity and know how to access this?	
21	Do you have tools and mechanisms in place beyond a learning and development offer to encourage confidence and raise skills in relation to professional curiosity?	
22	Do staff have access to informal peer support to discuss complex areas of practice such as those relating to mental capacity?	
23	Do commissioning contract monitoring and quality assurance visits of care providers look at compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their framework?	
24	Is information on the services that you offer available and accessible to individuals who may have an impaired mental capacity to decide to engage with you/your service?	

APPENDIX 5 – PRACTITIONER SUMMARY

Mental Capacity Act 2005:

Messages from South West SARs

directors of adass adult social services South West

Safeguarding Adult Reviews (SARs)

A SAR is a statutory enquiry under s.44 of the Care Act which needs to be completed by Safeguarding Adults Boards when they are made aware that a vulnerable individual has either died or experienced serious harm in their area and board stakeholders e.g. LAs, NHS, providers etc. could have worked together better. The SAR aims to identify learning from such events. A thematic review was completed for themes related to mental capacity from SARs published 2016-2023 from across the South West region. This is a summary quick read for practitioners.

Mental Capacity Act

The Mental Capacity Act 2005 is a law designed to protect and support the decision making of vulnerable adults. It applies to everyone aged from 16 years when the age of consent is reached. If following a formal mental capacity assessment it is established that the person is unable to make the decision themselves, and the difficulties in making the decision are linked to a cognitive impairment, the Act stipulates how best interests decisions can be made by appropriate people around the individual instead. The Act contains five statutory principles that need to be followed:

- *"A person must be assumed to have capacity unless it is established that they lack capacity."*
- *"A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success."*
- *"A person is not to be treated as unable to make a decision merely because he makes an unwise decision."*
- *"An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests."*
- *"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."*

Formal Assessments and Recording

As well as covering big decisions such as where to live or managing finances, the Mental Capacity Act also applies to smaller day to day decisions. It is therefore important that all staff working in health and social care understand the Act and they and their teams have the capability to complete formal mental capacity assessments for relevant decisions.

A formal mental capacity assessment is required to establish if someone does not have mental capacity to make a decision. This should be recorded on a separate form along with any best interests decision. The forms should contain the evidence for any decision reached.

A formal assessment should be completed if there is sufficient doubt about an individual's ability to make a certain decision.

An 'informal assessment' does not have any legal validity.

In addition, if there is some doubt about mental capacity but a decision to not assess is made, the rationale for this should be included in care recordings/client notes.

Managers should ensure that actions to complete mental capacity assessments set for others are fulfilled to prevent delays in care pathways

Barry Graves—LPS Implementation Lead—ADASS South West. Date: 15/08/2023

Mental Capacity Act 2005:

Messages from South West SARs

directors of adass adult social services South West

Executive Function

Executive function pertains to a set of cognitive skills including working memory, planning, attention focus and remembering instructions. Problems with executive function can lead to individuals struggling to make decisions or making 'unwise' ones in the moment contrary to previous declarations. It can be difficult to assess mental capacity with individuals with executive dysfunction.

The SAR review identified some areas of learning that are helpful:

- Be professionally curious and ask questions to explore decision making with the individual.
- Don't necessarily take answers at face value during a formal assessment, compare with visual evidence and observations.
- Maintain engagement even if difficult—assess if any provision of new information makes a difference to decision making.
- Be aware of the potential impact of substance misuse and frontal lobe impairments on executive function.
- Be mindful of individual's self-neglecting following repeated unwise decision making—this could be an indicative of executive dysfunction.

Fluctuating capacity is when an individual loses and regains mental capacity over time depending on their health, treatment, the context and sometimes substance misuse. Practitioners need to work closely with the individual to ensure there is appropriate support for decision making at all times and formal mental capacity assessments are completed at times of suspected reduced mental capacity.

Safeguarding and Risk

There is a substantial interface between safeguarding and the Mental Capacity Act. A formal mental capacity assessment can provide a good framework to discuss the concerns and issues with the individual if the harm and risks relate to their own decision making e.g. self-neglect.

Safeguarding and other multi-disciplinary meetings are ideal places for everyone around the person to share information on risks and mental capacity to help establish if a formal assessment is required.

Coercion and duress can impact decision making—practitioners should be aware of this when considering mental capacity.

If an individual's care plan contains restrictions such as 24/7 or 1:1 support and they are not free to leave their residence without consequence, they may be deprived of their liberty and require these arrangements to be authorised. If you are a statutory colleague, or a care home, supported living, shared lives, domiciliary care etc. manager it is important you know who and how to refer a potential deprivation of liberty to.

Advocacy and Court of Protection

Individuals without a family member or friend to support them in a best interests decision may benefit from an Independent Mental Capacity Advocate (IMCA) to support them. There are some statutory decisions that require an IMCA but a discretionary referral can also be helpful in some cases.

If no agreement can be reached in a best interests decision, the Court of Protection can be asked to provide judgement. Individuals can also appeal to the Court if they are unhappy with their deprivation of liberty arrangements.

Barry Graves—LPS Implementation Lead—ADASS South West. Date: 15/08/2023