

Title

Mental Capacity and Best Interests Policy and Procedure

Principle

Homekare Community Services is committed to:

- Presuming capacity for every adult at all times unless it is established otherwise;
- Supporting every individual to make their own decisions wherever possible;
- Respecting the right of individuals with capacity to make decisions that others may consider unwise;
- Ensuring that where a person lacks capacity, all decisions are made in their best interests using the least restrictive option; and
- Maintaining rigorous documentation of all capacity assessments, best interests decisions, and related actions.

Objectives

This policy and procedure establish the framework within which Homekare Community Services will apply the Mental Capacity Act 2005 (MCA) and the principles of best interests decision-making in all aspects of community care delivery. It ensures that every client's right to make their own decisions is upheld, and that where a person lacks capacity, all care and support decisions are made lawfully, in their best interests, and in the least restrictive way.

Homekare Community Services recognises that respecting mental capacity is not merely a legal obligation but is fundamental to delivering person-centred, dignified, and rights-respecting care. This policy reflects the organisation's commitment to the autonomy of every client.

Scope

This policy applies to:

- All Homekare Community Services employees, including the Registered Manager, Care Manager's, Senior Care Team, Care Team, and any team member carrying out regulated activities.
- All bank, agency, and contracted staff working on behalf of Homekare Community Services.
- All client's receiving domiciliary care from Homekare Community Services.
- All decisions made in the course of planning, delivering, reviewing, or changing care.

Responsibilities

Role	Responsibilities
Registered Manager	Overall accountability for MCA compliance across the service Authorises all significant best interests decisions. Ensures all staff are trained in MCA. Oversees all documentation and governance. Notifies CQC where required. Leads or approves all DoLS/LPS referrals. Maintains oversight through the audit programme.
Care Manager	Completes capacity assessments for care planning decisions Leads best interests decision processes for care package decisions. Ensures MCA documentation is on the care file. Escalates complex MCA issues to the Registered Manager. Coordinates involvement of family, carers, and advocates.
Senior Care Team	Supports capacity assessments in the field. Identifies and reports changes in a client's capacity to the Care Manager without delay. Provides information to care workers on MCA requirements at care delivery level. Documents concern contemporaneously.
Care Team	Presumes capacity at every visit. Takes all practicable steps to support the person to communicate their choices. Reports any capacity concerns to the Care Manager or Senior Care Team at the earliest opportunity. Records relevant observations in the visit notes. Does NOT make formal capacity assessments — this is the Care Manager's role.
Director / Nominated Individual	Strategic oversight and governance accountability. Reviews MCA compliance data in governance reports. Ensures adequate resource for training. Ensures the policy is reviewed on schedule.

Procedure

1 — THE FIVE STATUTORY PRINCIPLES OF THE MCA 2005

STATUTORY REQUIREMENT

All five principles of the MCA 2005 (Section 1) are legally binding. Every act or decision made under the MCA must be consistent with all five principles. These are not guidelines — they are the law.

No.	Statutory Principle	Application at Homekare
1	Assume capacity — a person must be assumed to have capacity unless it is	Team member's must not assume that a person lacks capacity because of their age, appearance, behaviour, diagnosis, or learning disability. Every

	established that they lack capacity.	adult is treated as capacitated unless a formal assessment establishes otherwise.
2	Supported decision-making — a person is not to be treated as unable to decide unless all practicable steps to help them have been taken without success.	Before any capacity assessment is initiated, team members must take all practicable steps to support the person to decide: simplify information; use pictures or visual aids; choose the right time and place; involve a trusted person; use an interpreter if needed. All steps must be recorded.
3	Unwise decisions — a person is not to be treated as unable to decide merely because they make an unwise decision.	Client's may make decisions that family or team member's consider unwise. This is not evidence of incapacity. The right to make unwise decisions is protected by the MCA. Team member's must not override a decision purely because they disagree with it.
4	Best interests — any act done or decision made for a person who lacks capacity must be done in their best interests.	Where incapacity is established, all decisions must be made in the person's best interests following the MCA Section 4 checklist. Best interests decisions must be documented and reviewed.
5	Least restrictive option — regard must be had to whether the purpose can be achieved in a less restrictive way.	Before any best interests decision is implemented, team member's must consider whether there is a less restrictive option that achieves the same outcome. The most restrictive option must only be used where there is no viable alternative.

2 — CAPACITY ASSESSMENT PROCEDURE

2.1 When to Assess Capacity

A capacity assessment must be carried out whenever there is reasonable doubt about whether a client can make a specific decision. This includes:

- Before starting a new care package or significantly changing an existing one.
- When a care worker or care coordinator observes behaviour suggesting the person may not understand or remember key information about their care.
- When a client's health changes (e.g. following hospital admission, diagnosis of dementia, medication change, or acute illness).
- When a client makes a decision that is significantly out of character or could cause serious harm, and there is doubt about capacity.
- Before any best interests decision is made.
- At each care plan review where capacity status may have changed.

Important

Capacity must be assessed in relation to the specific decision at the time it needs to be made. A person may have capacity to decide some things but not others. A past lack of capacity does not mean the person currently lacks capacity.

2.2 The Two-Stage Capacity Assessment Test

The two-stage test (MCA 2005, Section 2) must be applied in full. Both stages must be satisfied for a finding of incapacity.

Stage	Test	Guidance
Stage 1 Diagnostic Test	Is there an impairment of, or a disturbance in the functioning of, the person's mind or brain?	Includes: dementia; learning disability; brain injury; mental illness; effects of alcohol, drugs or medication; delirium; or any other condition affecting the brain or mind. The impairment can be temporary or permanent. Stage 1 alone does not establish incapacity.
Stage 2 Functional Test	Does the impairment or disturbance cause the person to be unable to: (a) understand the relevant information; (b) retain it; (c) use or weigh it; or (d) communicate a decision?	All four abilities are tested. Inability to satisfy any ONE of them satisfies Stage 2. The person need only retain information long enough to make the decision — they do not need to remember it afterwards. Communication can be by any means (gesture, eye contact, AAC device).

2.3 Supporting Decision-Making Before Assessing Capacity

Before concluding that a person lacks capacity, the assessor must document all steps taken to support the person's decision-making; NICE NG108 recommendation 1.2):

- Simplify information — use plain language; avoid jargon; break information into small steps.
- Use communication aids — pictures, written summaries, easy-read materials, objects of reference.
- Choose the right time — consider time of day, medication effects, pain levels, or fatigue.
- Choose the right environment — quiet, familiar, comfortable, free from distraction or pressure.
- Involve a trusted person — a family member, carer, advocate, or friend who can assist communication.
- Use an interpreter or translator where English is not the first language or where signing is needed.
- Give the person adequate time — do not rush; allow for processing time.

- Try more than once — if a decision can wait, re-attempt after rest or at a different time.

Documentation Requirement

All steps taken to support the person's decision-making must be documented before a formal capacity assessment is recorded. If the assessor cannot evidence that these steps were taken, the assessment process is incomplete.

2.4 Completing a Capacity Assessment

- The Care Manager (or Registered Manager for complex decisions) completes the capacity assessment.
- The assessment must be completed on the HomeKare Community Service Capacity Assessment Record.
- The assessment must be decision-specific — it must name the specific decision being assessed.
- The assessment must be dated — and re-dated for each subsequent assessment.
- The assessment must not be based on diagnosis alone. It must evidence the application of both stages of the two-stage test.
- Where appropriate, the assessor should seek input from the GP, mental health services, or specialist health professionals.
- A copy of the completed assessment must be filed in the client's care file and the care plan updated to reflect the capacity status.

3 — BEST INTERESTS DECISION-MAKING

3.1 When to Make a Best Interests Decision

A best interest's decision must be made whenever a person has been assessed as lacking capacity to make a specific decision and that decision needs to be made. It is not lawful to defer making a decision simply because the person lacks capacity.

3.2 Who Makes a Best Interests Decision

- The decision-maker is the person most closely involved in the act or decision in question.
- For day-to-day care delivery decisions: the Care team member, guided by the care plan.
- For significant changes to the care plan, or decisions with serious consequences: the Care Manager, with input from the Registered Manager.
- For decisions involving medical treatment, accommodation changes, or serious risk: the Registered Manager, involving the commissioning authority and relevant health professionals.
- The Registered Manager must be informed of and sign off all formal best interests decisions.

3.3 The Best Interests Checklist (MCA 2005, Section 4)

Legal Requirement

The decision-maker must work through each item on the best interests checklist before making a decision. Failure to do so renders the decision potentially unlawful. The checklist must be documented on the Best Interests Decision Record.

Checklist Item	Homekare Requirement
1. Consider whether and when the person may regain capacity.	Could the decision wait until the person may have or regain capacity? If not, document why the decision must be made now.
2. Encourage participation — the person must, so far as is reasonably practicable, be involved in the decision.	Involve the person even if they lack capacity. Their views, feelings, and non-verbal responses must be sought and recorded.
3. Past and present wishes — consider what the person would have wanted.	Review any written statements made when the person had capacity. Ask family and carers what the person previously expressed. Consider the person's life history, values, and preferences.
4. Beliefs and values — consider what beliefs or values would be likely to influence the decision.	Cultural, religious, and personal values must be taken into account. These may affect decisions about diet, personal care, contact, end-of-life wishes.
5. Other factors the person would be likely to consider if they had capacity.	Consider relationships, impact on family, financial implications, quality of life. Include anything relevant to that individual.
6. Consult others — family members, carers, anyone named by the person, any LPA holder, any deputy appointed by the Court of Protection.	All relevant people must be consulted (unless there are specific reasons not to — e.g. risk of harm or estrangement). Views must be recorded alongside the weight given to them.
7. Consider whether an IMCA must be instructed.	An IMCA referral must be made to Nottinghamshire County Council where the person lacks capacity for a serious medical treatment or accommodation decision and there

	is no appropriate person to consult other than paid professionals.	
8. Least restrictive option — choose the option that is least restrictive of the person's rights and freedom of action.	Document why the chosen option is the least restrictive. If a more restrictive option is selected, document the justification in full.	

3.4 Documenting a Best Interests Decision

- All best interests decisions must be recorded on the HomeKare Community Service Best Interests Decision Record.
- The record must capture: the decision made; the process followed; who was consulted; what their views were; why the decision made is in the person's best interests; and the least restrictive option analysis.
- The completed record must be signed by the Registered Manager and filed in the care file.
- The care plan must be updated to reflect the decision and its implications for care delivery.
- All care team delivering care under a best interests decision must be informed of the decision and its rationale.

3.5 Reviewing Best Interests Decisions

- All best interests decisions must be reviewed at the 6-monthly care plan review (minimum).
- Decisions must be reviewed immediately following any significant change in the person's condition, circumstances, or available evidence of their wishes.
- If the person regains capacity (including temporarily), they must be involved in any decision about their own care as soon as practicable.

4— LPA, ADRT AND IMCA

4.1 Lasting Power of Attorney — Health and Welfare

Where a client has executed a Lasting Power of Attorney (LPA) for Health and Welfare, HomeKare Community Services must:

- Request and verify a certified copy of the registered LPA at the pre-service assessment stage.
- Confirm the LPA is registered with the Office of the Public Guardian (OPG) — an unregistered LPA has no legal effect.
- File a copy of the registered LPA in the care file.
- Ensure all team members involved in the client's care are aware of the LPA and the identity of the attorney.
- Involve the attorney in all best interests decisions where the client lacks capacity for health and welfare decisions.
- Note: an attorney may only make decisions that fall within the scope of the LPA and may not override a valid refusal made by the client while they had capacity.

Verification — OPG

The LPA must be verified as registered with the Office of the Public Guardian before acting on any instruction from an attorney. Do not act on an unregistered LPA. OPG: Tel 0300 456 0300 | publicguardian.gov.uk

4.2 Advance Decisions to Refuse Treatment (ADRT)

A valid and applicable ADRT is legally binding and overrides a best interests decision where it applies. HomeKare Community Services must:

- Check whether an ADRT exists at the pre-service assessment stage.
- Obtain a copy and file it in the care file.
- Ensure the Registered Manager reviews the ADRT to confirm it is valid (in writing, signed and witnessed for life-sustaining treatment) and applicable to the decision in question.
- Communicate the existence and content of the ADRT to all care team member's involved in the service user's care.
- Contact the GP and Registered Manager immediately if care team member's are asked to take action that may conflict with an ADRT.
- Not override a valid and applicable ADRT — to do so may constitute unlawful battery.

4.3 Independent Mental Capacity Advocate (IMCA)

An IMCA must be instructed by the responsible authority (not by HomeKare Community Service's independently) where the person lacks capacity and there is a decision about:

- Serious medical treatment — where the decision is proposed by an NHS body.
- Long-term accommodation change — where the decision is made by a local authority or NHS body and there is no appropriate person to consult other than paid staff.

HomeKare Community Service's role in IMCA referrals:

- Identify where an IMCA may be required and notify the Care Manager and Registered Manager.
- Refer to Nottinghamshire County Council Adult Social Care for IMCA instruction: Tel 0300 500 8080.
- Document the referral date and any response on the care file.
- Ensure the IMCA's report and recommendations are considered in the best interests decision.

5 — RESTRAINT AND DEPRIVATION OF LIBERTY IN DOMICILIARY CARE

5.1 Restraint

Restraint includes any use of force, or threat of force, to make a person do something they are resisting, or restricting the person's liberty of movement.

Restraint is only lawful under the MCA 2005 (Section 6) where:

- The person lacks capacity for the specific decision; AND
- The restraint is necessary to prevent harm to the person; AND

- The restraint is a proportionate response to the likelihood of harm and its seriousness.

Zero Tolerance

Restraint without satisfying all three conditions above is unlawful — it may constitute assault or false imprisonment. Any use of restraint must be documented immediately and reported to the Registered Manager. Unlawful restraint is a safeguarding concern and will be referred to NSAB MASH.

5.2 Deprivation of Liberty in Domiciliary Care

The Deprivation of Liberty Safeguards (DoLS) apply only in registered care homes and hospitals. HomeKare Community Service's, as a domiciliary care provider, does not operate DoLS authorisations.

However, a care arrangement in the home can constitute a deprivation of liberty if:

- The person is under continuous supervision and control; AND
- The person is not free to leave.

Where HomeKare Community Service's believes a care arrangement in the home may amount to a deprivation of liberty, the Registered Manager must:

- Document the concern on the care file.
- Consult with the commissioning local authority (Nottinghamshire County Council) without delay.
- Consider whether an application to the Court of Protection is required.
- Not implement or continue any care arrangement that deprives a person of their liberty without lawful authority.

With the planned introduction of Liberty Protection Safeguards (LPS), community settings — including domiciliary care — will be brought within the authorisation framework. The Registered Manager must monitor government implementation guidance and update this policy accordingly.

6 — INTERFACE WITH SAFEGUARDING

6.1 When an MCA Breach Becomes a Safeguarding Concern

Under the Care Act 2014, care provided without valid consent — and without a lawful best interests process — can constitute abuse. The following MCA failures must be treated as potential safeguarding concerns and referred to NSAB MASH:

MCA Failure	Safeguarding Category (Care Act 2014)
Care delivered without consent and without a best interests decision	Psychological abuse / Physical abuse
Medication administered covertly without a best interests process	Physical abuse / Psychological abuse
Unlawful restraint	Physical abuse

Deprivation of liberty without authorisation	Unlawful detention / Psychological abuse
Care decisions made for financial, organisational, or staff convenience rather than the person's best interests	Psychological abuse / Neglect
ADRT overridden without lawful basis	Physical abuse
LPA holder making decisions outside their authority or against the person's interests	Financial abuse / Psychological abuse — report to OPG and MASH
Staff making capacity assessments without following the two-stage test and documenting the process	Governance failure — potential neglect or risk of harm

6.2 Safeguarding Referral Pathway

- Any MCA concern that meets the safeguarding threshold must be referred to the NSAB MASH within 24 hours of identification.
- The referral must be made by, or with the knowledge of, the Registered Manager.
- The Registered Manager must also notify CQC where required under Regulation 18 (Notification of other incidents).
- All documentation relating to the concern — capacity assessments, best interests records, care notes — must be preserved and available for inspection.
- Team member's must not destroy, alter, or withhold any documentation relevant to a safeguarding concern.

Contact	Details
NSAB MASH — Nottinghamshire County Council (Homekare's primary referral route)	Tel: 0300 500 8080 Monday–Friday, office hours
Nottinghamshire Emergency Duty Team (Out of Hours)	Tel: 0300 456 4546 Evenings, weekends, bank holidays
Emergency Services	999 — where there is immediate risk of serious harm
CQC Notification	Where required under Regulation 18 — via CQC portal
Office of the Public Guardian (LPA/deputy concerns)	Tel: 0300 456 0300 publicguardian.gov.uk

Homekare Community Service Location —Blyth Worksop, Nottinghamshire

All safeguarding referrals — including those arising from MCA concerns — route to Nottinghamshire County Council MASH (Tel: 0300 500 8080), NOT to Nottingham City Safeguarding Adults Board.

7— TRAINING, COMPETENCY AND SUPERVISION

Training Requirement	Detail
MCA induction training — all new team members	All team members must complete MCA awareness training as part of induction before delivering care unsupervised. This must include the five principles, the two-stage test, and the importance of documentation.
Care Certificate Standards 7, 9 & 10	All new care team member's must complete these standards within 12 weeks of start date. Standards 7 (Privacy/Dignity), 9 (Dementia/Mental Health Awareness), and 10 (Safeguarding) all contain MCA components.
MCA refresher training	Minimum every 3 years, or following any significant MCA-related incident, a safeguarding concern arising from a capacity consent issue, or a material change in legislation or guidance.
Registered Manager — Level 5 Diploma	The Registered Manager must hold or be working towards a Level 5 Diploma in Leadership for Health and Social Care, which includes advanced MCA competency, best interests decision-making, and governance.
Supervision and appraisal	MCA practice must be discussed in regular supervision. New staff: monthly. Care Team: 6-weekly. MCA issues arising in practice must be reflected on in supervision. Appraisals must include competency evidence for MCA.
Training records	All MCA training must be recorded in the training matrix. Training completion rates are a KPI reported to governance.

8 — DOCUMENTATION AND RECORD-KEEPING

Good documentation is essential for MCA compliance. The MCA Code of Practice and CQC Regulation 11 both require that decisions affecting people who may lack capacity are recorded contemporaneously and in detail. The following documentation standards apply:

Document	Requirement
Capacity Assessment Record	Completed for each specific decision where capacity is in doubt. Includes: the decision being assessed; steps taken to support the person; Stage 1 and Stage 2 findings; conclusion; date and signature. Filed in care file.

Best Interests Decision Record	Completed for every best interests decision. Covers the full MCA Section 4 checklist. Records: who was consulted; what their views were; what decision was made and why; least restrictive option analysis; review date. Signed by Registered Manager.
Care Plan	Must be updated to reflect: current capacity status; any best interests decisions in effect; any ADRT or LPA in place; communication needs relevant to capacity; any DoLS/LPS considerations.
Visit records / daily notes	Care team member's must document in visit notes any observations relevant to capacity — unusual responses, confusion, distress, withdrawal. These observations provide the evidence base for capacity reviews.
ADRT and LPA copies	Certified copies of any registered LPA or ADRT must be filed in the care file. The care plan must note their existence and any implications for care delivery.
Training records	Team MCA training records held in the training matrix; must be available to CQC on inspection.

Retention

Capacity assessment records and best interests decision records must be retained for a minimum of 7 years (or indefinitely where the decision is linked to a safeguarding concern or legal proceedings). Records must be stored securely in accordance with the UK GDPR and HomeKare Community Services Data Protection Policy.

9 — AUDIT, KPIs AND GOVERNANCE

KPI / Audit Item	Standard / Target	Frequency
% of care files with documented capacity assessment where capacity is in doubt	100%	Quarterly file audit
% of best interests decisions with completed Best Interests Decision Record (Appendix B)	100%	Quarterly file audit
% of LPAs and ADRTs verified and filed where known to exist	100%	At assessment; verified at 6-monthly review

Team Member's MCA training completion (induction)	100% before first unsupervised care delivery	Ongoing; reported monthly
Team Member's MCA refresher training compliance	100% within 3 years; no overdue records	Quarterly; reported in governance report
Safeguarding referrals arising from MCA concerns made within 24 hours	100%	Following any referral; reported in governance report
Best interests decisions reviewed at 6-monthly care plan review	100%	At each care plan review
Supervision records evidencing MCA discussion where relevant	100% of staff with live MCA-related decisions	Reviewed in quarterly audit

All MCA audit findings must be reported to the Registered Manager and Director and included in the quarterly governance report. Any compliance gaps identified must result in a documented improvement action with a named lead and deadline.

Linked Legislation and Guidance

Legislation / Guidance	Relevance
Mental Capacity Act 2005 (MCA)	Primary legislation governing capacity assessment and best interests decision-making. All care decisions involving potential incapacity must comply with the MCA.
MCA 2005 Code of Practice	Statutory Code to which all care workers must have regard. Sets out detailed guidance on applying the MCA five principles, conducting assessments, and making best interests decisions.
Mental Capacity (Amendment) Act 2019	Introduces Liberty Protection Safeguards (LPS) to replace DoLS when implemented. Domiciliary care providers will be within scope. Current status: monitor implementation.
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 — Regulation 11	Fundamental Standard: Consent. Providers must not deliver care without valid consent. Where a person lacks capacity, care must comply with the MCA 2005.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 — Regulation 9	Person-Centred Care. Care must meet individual needs and preferences; where capacity is absent, best interests decisions must be made and documented.		
Care Act 2014 — Section 1 (Wellbeing Principle)	Providers must promote wellbeing including the individual's right to participate in decisions. Informs best interests decision-making.		
Human Rights Act 1998	Article 5 (Right to Liberty), Article 8 (Private and Family Life), and Article 3 (Freedom from Degrading Treatment) are directly engaged by MCA compliance requirements.		
NICE NG108 — Decision-Making and Mental Capacity (2018)	Comprehensive national guidance on assessing capacity, supported decision-making, best interests decisions, and workforce training.		
Skills for Care — Care Certificate Standards 7, 9 & 10	Minimum competency standards for all care workers in privacy/ dignity, awareness of dementia/mental health, and safeguarding — all linked to MCA practice.		
SCIE — Mental Capacity Act Resources	Evidence-based practice guidance for social care providers, including domiciliary care applications.		
NSAB Multi-Agency Safeguarding Procedures (Nottinghamshire)	Defines the safeguarding referral pathway where an MCA breach reaches the safeguarding threshold. Routes to NCC MASH: 0300 500 8080.		
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References and Appendices

- Appendix A:
- Appendix B:
- Appendix C: