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Sample policy template, generated 2026-05-31

Mental Capacity and Consent Policy

Sample policy template. This is a Verivius-authored template based on the verbatim text of the statutory source. Tenants adapt the operational sections to their own organisation. Where this template and the live regulation diverge, the live regulation wins.

Statutory anchor: Mental Capacity Act 2005, sections 1 to 5 **Primary source:** https://www.legislation.gov.uk/ukpga/2005/9/contents **Last reviewed:** 2026-06-01 **Verivius pack version:** v1.1, 2026-06-01

1. What the regulation says

> A person must be assumed to have capacity unless it is established that he lacks 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.
>
> For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
>
> A lack of capacity cannot be established merely by reference to (a) a person's age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity.
>
> For the purposes of section 2, a person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means).

> He must consider, so far as is reasonably ascertainable, (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity), (b) the beliefs and values that would be likely to influence his decision if he had capacity, and (c) the other factors that he would be likely to consider if he were able to do so.
>
> He must take into account, if it is practicable and appropriate to consult them, the views of (a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind, (b) anyone engaged in caring for the person or interested in his welfare, (c) any donee of a lasting power of attorney granted by the person, and (d) any deputy appointed for the person by the court, as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).
>
> If a person ("D") does an act in connection with the care or treatment of another person ("P"), the act is one to which this section applies if (a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and (b) when doing the act, D reasonably believes (i) that P lacks capacity in relation to the matter, and (ii) that it will be in P's best interests for the act to be done.
>
> D does not incur any liability in relation to the act that he would not have incurred if P (a) had had capacity to consent in relation to the matter, and (b) had consented to D's doing the act.
>
> Nothing in this section excludes a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in doing the act.
>
> The full text of the Act is at https://www.legislation.gov.uk/ukpga/2005/9/contents. Where this policy and the Act diverge, the Act wins.

2. Plain British summary

The Mental Capacity Act 2005 sets the law on decision-making for people aged 16 and over in England and Wales who may lack the capacity to make a specific decision at a specific time. The Act starts from five statutory principles: a person is assumed to have capacity unless established otherwise; all practicable steps to help the person decide must be taken before treating them as unable to decide; an unwise decision is not the same as lacking capacity; any act done for someone who lacks capacity must be in their best interests; and the least restrictive option must be considered. Capacity is decision-specific and time-specific. When a person lacks capacity to consent to care or treatment, the responsible person follows the best interests determination in Section 4. Routine care and treatment is protected from liability under Section 5 if the person reasonably believes the person lacks capacity and that the act is in their best interests. Deprivation of Liberty Safeguards (DoLS, MCA Schedule A1) provide the legal mechanism for authorising any arrangement that deprives a person of their liberty in a

care home or hospital setting. DoLS is being replaced by Liberty Protection Safeguards (LPS); LPS implementation is deferred and DoLS remains in force as of the page review date.

3. Scope

This policy applies to all clinical and direct-care staff at <provider name>, every regulated activity that involves a decision about care or treatment for a service user aged 16 or over, every encounter where capacity may be in question (especially neurology, dementia, intensive care, end-of-life, mental health, learning disability, intoxication, post-anaesthesia). It covers capacity assessment, best-interests decision-making, Lasting Power of Attorney recognition, Court of Protection-deputy recognition, advance decisions to refuse treatment, IMCA referrals where required, and Deprivation of Liberty Safeguards applications where the service shape attracts them.

(Tenant updates the angle-bracket placeholder.)

4. Roles and responsibilities

- **Registered Manager:** accountable for the MCA framework operating across every site. Reviews any incident where capacity was in question. Signs off any best-interests decision that involves a service-user-restriction or a major treatment decision.
- **Mental Capacity Act Lead (named individual; in small services often the Clinical Lead or Registered Manager):** the day-to-day MCA-decision advisor. Reads capacity assessments quarterly for two-stage-test completeness. Holds Level 3 MCA training and refreshes annually.
- **Treating clinician:** for each decision, assesses capacity, runs the best-interests process where required, and records both. The treating clinician is the named decision-maker.
- **DoLS Lead (where the service shape attracts DoLS):** prepares and submits standard authorisation requests to the supervisory body, tracks the outcome, and records the authorisation against the service user's care plan.
- **All staff:** know the five statutory principles, raise concerns where they suspect capacity is in question, do not make capacity calls outside their role's competence.

(Tenant updates the named role-holders.)

5. Procedure

The MCA procedure operationalises Sections 1 to 5 across every decision where capacity may be in question.

1. **Trigger.** A specific decision arises (consent to a procedure, refusal of food or fluids, refusal of safeguarding, change of accommodation, change of treatment plan). The treating clinician identifies that capacity may be in question.

2. **Presume capacity.** The MCA s1(2) presumption applies. The clinician supports the service user to make the decision with reasonable adjustments (timing, environment, communication aids, presence of supporter, plain-language explanation).
3. **Capacity assessment if needed.** Where doubt remains, the two-stage MCA test is applied. Stage 1: is there an impairment of mind or brain. Stage 2: does that impairment cause the person to be unable to (a) understand the relevant information, (b) retain it, (c) use or weigh it as part of the decision, (d) communicate the decision. The assessment is decision-specific and time-specific.
4. **Record the assessment.** The assessment is recorded in the clinical record with the assessor name, date, the specific decision in question, the support given to enable the person, the two-stage test result with reasoning, and the conclusion.
5. **Where the person has capacity:** the clinician records the person's decision and respects it, including the right to make an unwise decision per s1(4).
6. **Where the person lacks capacity:** the best-interests determination under s4 begins. The decision-maker (typically the treating clinician) considers all relevant circumstances per s4(2), considers the person's past and present wishes and feelings per s4(6), consults with anyone named by the person to be consulted, anyone caring for the person or interested in their welfare, any LPA donee, and any court-appointed deputy per s4(7), considers the least-restrictive option per s1(6), and records the decision with reasoning.
7. **Independent Mental Capacity Advocate (IMCA).** Where the decision involves serious medical treatment, accommodation change of more than 28 days in a hospital, or accommodation change of more than 8 weeks in a care home, and the person has no appropriate other person to consult, an IMCA is instructed.
8. **Lasting Power of Attorney check.** Before making a best-interests decision, the clinician checks the Office of the Public Guardian register for any registered LPA for health and welfare. Where one is in force and the decision is within its scope, the attorney's decision applies.
9. **Advance decision to refuse treatment.** Where a valid and applicable advance decision exists per ss24 to 26, the advance decision takes priority over best-interests decision-making for the treatment refused.
0. **DoLS authorisation where required.** Where the care plan involves any arrangement that may deprive the person of their liberty (continuous supervision and control plus not free to leave), the DoLS Lead prepares and submits a standard authorisation request to the supervisory body. The urgent authorisation procedure applies where the deprivation needs to start before the standard authorisation is in place. The Reg 18 (Registration Regulations 2009) notification to CQC follows when the standard authorisation request is made.

6. Training requirement

- All clinical and direct-care staff complete MCA awareness training (Level 1) at induction and every three years.
- Staff who regularly make capacity assessments or contribute to best-interests decisions complete MCA practice training (Level 2) at induction and every three years.
- The MCA Lead and any clinician likely to lead capacity assessments on complex decisions completes Level 3 MCA training, refreshed annually.
- The DoLS Lead (where the role exists) completes DoLS training at appointment and every two years.

Training records held in the tenant's training matrix register.

7. Audit

Compliance with this policy is monitored by the MCA Lead:

- **Quarterly capacity-assessment sample:** random sample of 5 to 10 assessments reviewed for two-stage-test completeness, reasoning quality, and decision-specificity.
- **Quarterly best-interests-decision sample:** random sample of best-interests decisions reviewed for s4 process compliance (relevant circumstances considered, person's wishes recorded, appropriate consultations completed, least-restrictive option considered).
- **Annual DoLS authorisation review (where the role applies):** every active DoLS authorisation reviewed against the supervisory-body-issued conditions and expiry date.
- **Annual policy review:** the policy is read against the live MCA 2005 text, the most recent MCA Code of Practice (statutory guidance), and any LPS implementation update.

Audit findings recorded in the tenant's audit register; actions logged in the improvement-actions register.

8. Record-keeping

MCA records (capacity assessments, best-interests decision records, IMCA referrals, LPA register checks, advance decisions, DoLS authorisations) form part of the clinical record and are held for a minimum of 8 years from the date of the last entry per the NHS Code of Practice on Records Management. Where the decision relates to a person under 18, retention follows until the child reaches the age of 25. DoLS authorisation records are retained for the duration of the authorisation plus the same NHS Code period.

Verivius preserves the per-record audit trail indefinitely while the workspace is active.

9. Related policies in this pack

- Person-Centred Care Policy (`hscra-reg-9-person-centred-care`)
- Consent Policy (`hscra-reg-11-consent`)

- Safeguarding Adults Policy (`hscra-reg-13-safeguarding-from-abuse`)
- Statutory Notifications Policy (`cqc-reg-18-notification-of-other-incidents`)

10. Document control

Version	Date	Author	Changes
v1	2026-05-19	Verivius (sample)	Initial sample template.
v1.1	2026-06-01	Verivius (sample)	Filled out Sections 3 to 8 with concrete content. Section 4 names the MCA Lead and DoLS Lead roles. Section 5 expanded to a 10-step procedure covering the five statutory principles, the two-stage capacity test, the s4 best-interests determination, IMCA referrals, LPA register checks, advance decisions, and DoLS authorisation. Section 6 names training tiers. Section 7 names the audit cadence. Section 8 references the NHS Code of Practice on Records Management.

This sample policy template was issued by Verivius as part of the Mock Inspection design partner onboarding pack. It is a template, not a substitute for legal advice or the tenant's own policy-development process. Where this template and the live regulation diverge, the live regulation wins.
