Decision making and mental capacity

Quality standard
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This standard is based on NG108.

This standard should be read in conjunction with QS187, QS184, QS154, QS140, QS101, QS85 and QS200.

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Quality statement 1: Supported decision making

Quality statement

People aged 16 and over who may lack capacity to make decisions are supported with decision making in a way that reflects their individual circumstances and meets their particular needs.

Rationale

People using health and social care services should be empowered to make decisions for themselves wherever possible. They may experience difficulty and need support with a range of decisions, including those about their care and treatment, financial matters and day-to-day living. Having the mental capacity to make decisions can change, depending on the person's circumstances and the type of decision that needs to be made.

To support people in a way that is appropriate to their circumstances and meets their needs, practitioners need to understand what is involved in a particular decision, and which aspect of decision making people may need support with and why. The support may include help with communication such as involving significant and trusted people (including family members, carers and independent advocates or specialist services) in line with the person's needs and wishes. It may also include identifying a location where the person feels more at ease or times of day when the person's understanding is better.

Quality measures

Structure

a) Evidence of local policy and guidance about which interventions, tools and approaches should be used to support decision making in people aged 16 and over who may lack capacity to make decisions.

Data source: Local data collection, for example evidence of providers implementing locally tools and approaches described in chapter 3 of the Mental Capacity Act Code of Practice.

b) Evidence of local arrangements to ensure that people aged 16 and over who may lack capacity to make decisions are supported to do so in a way that reflects their individual circumstances and meets their particular needs.

Data source: Local data collection, for example evidence of significant and trusted people, advocacy service or specialists such as occupational therapists, psychologists, or speech and language therapists being involved in supporting the decision-making process.

Process

Principles of supported decision making should be applied to all decisions made by people who may lack capacity. However, the recording of the decision-making process should be proportionate to the decision being made. For measurement purposes, commissioners may wish to focus on decisions that have significant consequences.

a) Proportion of decisions made by people aged 16 and over who may lack capacity where the decision-making process reflected their communication needs.

Numerator – the number in the denominator where the decision-making process reflected the person's communication needs.

Denominator – the number of decisions made by people aged 16 and over who may lack capacity.

Data source: Local data collection, for example local audit of patient records or care plans.

b) Proportion of decisions made by people aged 16 and over who may lack capacity where the decision-making process involved the person's significant and trusted people.

Numerator – the number in the denominator where the decision-making process involved the person's significant and trusted people.

Denominator – the number of decisions made by people aged 16 years and over who may lack capacity.

Data source: Local data collection, for example local audit of patient/client records or care plans.

c) Proportion of decisions made by people aged 16 and over who may lack capacity and had no significant or trusted people, that involved an advocate.

Numerator – the number in the denominator that involved an advocate.

Denominator – the number of decisions made by people aged 16 and over who may lack capacity and had no significant or trusted people.

Data source: Local data collection, for example local audit of patient/client records or care plans.

Outcome

a) Proportion of people who may lack capacity who feel supported to make their own decisions.

Numerator – the number in the denominator who feel supported to make their own decisions.

Denominator – the number of people who may lack capacity.

Data source: Local data collection, for example surveys of people's experience of supported decision making in health and social care, feedback gathered by voluntary sector organisations supporting people who may lack capacity, and their families and carers.

b) Proportion of carers of people who may lack capacity who think that the person they care for is supported well to make their own decisions.

Numerator – the number in the denominator who think that the person they care for is supported well to make their own decisions.

Denominator – the number of carers of people who may lack capacity.

Data source: Local data collection, for example surveys of family members and carers on their experiences of supported decision making in health and social care, feedback gathered by voluntary sector organisations supporting people who may lack capacity, and their families and carers.

What the quality statement means for different audiences

Service providers(such as community services, local authorities, private care providers, general practices and hospitals) ensure that appropriate support with decision making forms part of care planning processes for people receiving health or social care services. They develop local policy and guidance about which interventions, tools and approaches should be used and ensure that practitioners undergo training to help them apply the Mental Capacity Act 2005 and its Code of Practice. They ensure that training is available and tailored to the role and responsibilities of the practitioners and the specific needs of the individuals. They also ensure that the training covers new staff and pre-registration, and the continuing development and practice supervision for existing staff.

Health and social care practitioners (such as social workers, care staff, GPs, doctors, nurses and therapists) take a personalised approach to supporting people who may lack capacity. This includes making any reasonable adjustments and considering the wide range of factors that can affect a person's ability to make a decision. They support effective communication by allowing sufficient time for discussions and by using a range of tools such as inclusive communication, visual materials, visual aids, communication aids and hearing aids. These help people to take an active part in decision making. Health and social care practitioners also include family members, carers, and significant and trusted people in supporting decision making, in line with the person's needs and preferences, and involve an advocate when needed.

Commissioners (such as local authorities, clinical commissioning groups and NHS England) commission services that require practitioners to apply the Mental Capacity Act 2005 and its Code of Practice. Specifically, they commission services that have arrangements for competency-based training and assessment of relevant communication skills, as well as sufficient capacity within advocacy services available to people in need of support.

People aged 16 and over who may need help with making decisions are given support that is tailored to their own needs and circumstances. This might include help with communication or understanding information and what the different choices might mean for them, or allowing them sufficient time to consider the options. They may be given information in a range of media including 'easy read' or visual format. They may also have help from their family members, carers or advocates when they need to make a decision.

Source guidance

Decision-making and mental capacity. NICE guideline NG108 (2018), recommendations 1.2.4 and 1.2.11

Definitions of terms used in this quality statement

People who may lack capacity

People who are experiencing difficulties making decisions due to health conditions or particular circumstances they are in at the time a specific decision needs to be made. These include decisions about their care and treatment, financial matters and day-to-day living. Examples of health conditions or particular circumstances include, but are not limited to, those with:

- dementia
- a severe learning disability
- a brain injury
- a mental health problem
- a stroke
- unconsciousness caused by an anaesthetic or sudden accident.

[Adapted from Mental Capacity Act Code of Practice and expert opinion]

Individual circumstances and particular needs

This should include understanding and taking account of:

- the person's physical and mental health condition

- the person's communication needs
- the person's previous experience (or lack of experience) in making decisions
- the involvement of others and being aware of the possibility that the person may be subject to undue influence, duress or coercion regarding the decision
- situational, social and relational factors
- cultural, ethnic and religious factors
- cognitive (including the person's awareness of their ability to make decisions), emotional and behavioural factors, or those related to symptoms
- the effects of prescribed drugs or other substances.

This knowledge should be used to develop a shared and personalised understanding of the factors that may help or hinder a person's decision making, which can be used to identify ways in which the person's decision making can be supported. It should also be recorded in the person's written care plan. [NICE's guideline on decision-making and mental capacity, recommendation 1.2.4]

Independent advocacy

Independent advocates can have a role in promoting social inclusion, equality and social justice and can provide a safeguard against the abuse of vulnerable people. Independent advocates help people say what they want, help them secure their rights, represent their interests and help them obtain the services they need. Together with their provider organisations they work in partnership with the people they support, helping the person to speak out for themselves or speaking out on their behalf.

Independent advocates most likely to be involved in decision-making are Independent Mental Capacity Advocates (IMCAs), Independent Mental Health Advocates (IMHAs) and Care Act Advocates. [Adapted from NICE's guideline on decision-making and mental capacity, terms used in this guideline]

Quality statement 2: Advance care plans

Quality statement

People aged 16 and over at risk of losing capacity to make decisions, and those with fluctuating capacity, are given the opportunity to discuss advance care planning at each health and social care review.

Rationale

Advance care planning involves offering people opportunities to consider and discuss their future care and support needs and make plans while they have capacity to make decisions. It may involve appointing an advocate, which can increase the chances of the person's wishes being known and respected.

Opportunities to discuss advance care plans should be offered to people at risk of losing capacity (for example through progressive illness), as well as those who have fluctuating capacity (for example through mental illness). If people do not want to speak about their future needs and care arrangements, this should be respected and clearly recorded. However, people should know that they can discuss these whenever they wish. Reviewing and updating existing advance care plans regularly ensures that the recorded wishes stay valid, applicable and true to the person.

The quick guide to advance care planning on the NICE website can provide more information.

Quality measures

Structure

Evidence of local arrangements to ensure that people aged 16 and over at risk of losing capacity to make decisions, and those with fluctuating capacity, have ongoing opportunities to discuss their advance care plans while they have capacity.

Data source: Local data collection, for example local protocols or recording templates.

Process

Everyone who is at risk of losing capacity or has fluctuating capacity should be offered an opportunity to discuss advance care planning. For measurement purposes, the reviews that should be included are significant reviews of the care and support provided to the person and those carried out as a result of substantial changes to the person's health or circumstances. It does not mean every appointment the person has with a health or social care practitioner.

a) Proportion of health and social care reviews for people aged 16 and over who are at risk of losing capacity, with a documented discussion about advance care planning.

Numerator – the number in the denominator with a documented discussion about advance care planning.

Denominator – the number of health and social care reviews for people aged 16 and over who are at risk of losing capacity.

Data source: Local data collection, for example local audit of individual care plans.

b) Proportion of health and social care reviews for people aged 16 and over with fluctuating capacity, with a documented discussion about advance care planning.

Numerator – the number in the denominator with a documented discussion about advance care planning.

Denominator – the number of health and social care reviews for people aged 16 and over with fluctuating capacity.

Data source: Local data collection, for example local audit of individual care plans.

c) Proportion of people aged 16 and over at risk of losing capacity who have a documented discussion about making advance statements.

Numerator – the number in the denominator who have a documented discussion about making advance statements.

Denominator – the number of people aged 16 and over at risk of losing capacity.

Data source: Local data collection, for example local audit of patient records or care plans.

d) Proportion of people aged 16 and over with fluctuating capacity who have a documented discussion about making advance statements.

Numerator – the number in the denominator who have a documented discussion about making advance statements.

Denominator – the number of people aged 16 and over with fluctuating capacity.

Data source: Local data collection, for example local audit of patient records or care plans.

e) Proportion of people aged 18 and over at risk of losing capacity who have a documented discussion about making advance decisions or lasting powers of attorney.

Numerator – the number in the denominator who have a documented discussion about making advance decisions or lasting powers of attorney.

Denominator – the number of people aged 18 and over at risk of losing capacity.

Data source: Local data collection, for example local audit of patient records or care plans.

f) Proportion of people aged 18 and over with fluctuating capacity who have a documented discussion about making advance decisions or lasting powers of attorney.

Numerator – the number in the denominator who have a documented discussion about making advance decisions or lasting powers of attorney.

Denominator – the number of people aged 18 and over with fluctuating capacity.

Data source: Local data collection, for example local audit of patient records or care plans.

Outcome

a) Proportion of people aged 16 and over at risk of losing capacity who feel supported to make decisions about their health and social care support.

Numerator – the number in the denominator who feel supported to make decisions about their health and social care support.

Denominator – the number of people aged 16 and over at risk of losing capacity.

Data source: Local data collection, for example a survey of people with a long-term condition, or a progressive or life-limiting illness.

b) Proportion of people aged 16 and over with fluctuating capacity who feel supported to make decisions about their health and social care support.

Numerator – the number in the denominator who feel supported to make decisions about their health and social care support.

Denominator – the number of people aged 16 and over with fluctuating capacity.

Data source: Local data collection, for example a survey of people with progressive illness or mental health problems.

What the quality statement means for different audiences

Service providers (such as community services, local authorities, private care providers, GPs and hospitals) ensure that systems are in place to offer support to people at risk of losing capacity (for example through progressive illness) or people with fluctuating capacity (for example through mental illness) to make decisions, and to develop and review their advance care plans regularly. Service providers also develop standard protocols and plans for joint working and, with the person's consent, the sharing of information on advance care plans between practitioners, advocates, trusted people and families. Protocols and plans developed by service providers should reflect the optional nature of advance care planning.

Health and social care practitioners (such as social workers, care staff, GPs, doctors, nurses and therapists) offer people who are at risk of losing capacity or have fluctuating capacity opportunities to discuss, make and regularly review advance care plans. They support them in a sensitive manner to consider their decisions about future care and support. They also respect that some people do not wish to have these discussions. For people aged 18 and over this can include making advance decisions or lasting powers of attorney. The practitioners provide the person with clear and accessible information to help them consider these decisions. With the person's consent, they involve carers, family, friends or advocates in regular reviews of advance care plans.

Commissioners (such as local authorities, clinical commissioning groups, NHS England) develop standard protocols and plans for joint working and sharing of information on advance care plans between practitioners, advocates, trusted people and families, if this is what the person's wish is. They ensure that protocols and plans reflect the fact that people have a choice about whether and how to participate in advance care planning. They commission training on advance care planning, including advance decisions to refuse treatment and lasting powers of attorney for people aged 18 and over. They also demonstrate that protocols are in place and that training is available by including the offer of advance care planning in their performance monitoring frameworks.

People aged 16 and over who may not be able to make decisions in the future are offered help with making a plan for their future care, called an 'advance care plan', if they want to have one. They can update this plan every time their treatment or support is reviewed.

Source guidance

Decision-making and mental capacity. NICE guideline NG108 (2018), recommendation 1.3.15

Definitions of terms used in this quality statement

Advance care planning

Advance care planning with people who may lack mental capacity in the future is a voluntary process of discussion about future care between the person and their care providers. If the person wishes, their family, friends, legal representative or advocate may be included in the discussion. With the person's agreement this discussion is documented, regularly reviewed and communicated to key persons involved in their care. [NICE's guideline on decision-making and mental capacity, terms used in the guideline]

Health and social care review

A health and social care review includes scheduled reviews carried out by health and social care practitioners and reviews carried out as a result of substantial changes in the person's health or circumstances to ensure that the person's care and support continue to meet their needs. It does not mean every appointment the person has with a health and social care practitioner. [Expert opinion]

Mental capacity

The concept of capacity under the Mental Capacity Act 2005 is relevant to many decisions including care, support and treatment, financial matters and day-to-day living. Capacity is decision-specific, and an individual is assumed to have capacity unless, on the balance of probabilities, it is established otherwise. To lack capacity within the meaning of the Mental Capacity Act 2005, a person must be unable to make a decision because of an impairment or disturbance in the functioning of the mind or brain. The inability to make a decision must not be due to other factors, for example because of undue influence, coercion or pressure.

A lack of capacity can only be established if the condition prevents the person from understanding, retaining, using or weighing information about the decision, or communicating their decision. It cannot be established unless everything practicable has been done to support the person to have capacity, and it should never be based merely on the basis that the decision made is unwise. [Adapted from NICE's guideline on decision-making and mental capacity, section 1.4 on assessment of mental capacity]

People with fluctuating capacity

People who have a problem or condition that gets worse occasionally and affects their ability to make decisions. For example, someone who has manic depression may have a temporary manic phase which causes them to lack capacity to make financial decisions, leading them to get into debt even though at other times they are perfectly able to manage their money. A person with a psychotic illness may have delusions that affect their capacity to make decisions at certain times but disappear at others. [Mental Capacity Act Code of Practice]

Quality statement 3: Assessment of capacity

Quality statement

People aged 16 and over who are assessed as lacking capacity to make a particular decision at the time that decision needs to be made, have a clear record of the reasons why they lack capacity and the practicable steps taken to support them.

Rationale

A person's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made. Capacity must not be determined on the basis of age, appearance, condition or an aspect of the person's behaviour. The starting assumption must always be that the person has the capacity, until there is proof that they lack capacity. Anyone who concludes that a person lacks capacity should be able to provide evidence. They also need to be able to demonstrate that they have taken all practicable steps to help the person make a decision for themselves. Capacity to make specific decisions may change over time. This means that, if possible, a decision may need to be postponed and the person's capacity reviewed and reassessed.

Quality measures

Structure

a) Evidence of local protocols to record practicable steps taken during the decision-making process to support people aged 16 and over who may lack capacity.

Data source: Local data collection, for example local protocols or recording templates.

b) Evidence of local protocols to ensure mental capacity assessments are collaborative, person centred, thorough and aligned with the Mental Capacity Act 2005 and its Code of Practice.

Data source: Local data collection, for example an audit of the quality of mental capacity assessments.

c) Evidence of local arrangements to ensure that assessors can seek advice from people with specialist knowledge to help them assess whether there is evidence that the person lacks mental capacity.

Data source: Local data collection, for example service level agreements and partnership arrangements between services.

Process

a) Proportion of mental capacity assessments with the outcome stating that the person lacks capacity to make a particular decision, with a record of the practicable steps taken to help the person make the relevant decision.

Numerator – the number in the denominator with a record of the practicable steps taken to help the person make the relevant decision.

Denominator – the number of mental capacity assessments with the outcome stating that the person lacks capacity to make a particular decision.

Data source: Local data collection, for example local audit of patient records or individual care plans.

b) Proportion of mental capacity assessments carried out with people aged 16 and over with an outcome of the assessment stating that the person lacks capacity to make a particular decision, with a record of:

- the impairment/disturbance of the mind or brain that has been identified
- the reasons why the person is unable to make a decision (with reference to section 3 of the Mental Capacity Act 2005)
- the fact that the person's inability to make a decision is a direct consequence of the impairment or disturbance identified.

Numerator – the number in the denominator with a record of:

- the impairment/disturbance of the mind or brain that has been identified
- the reasons why the person is unable to make a decision (with reference to section 3 of the Mental Capacity Act 2005)
- the fact that the person's inability to make a decision is a direct consequence of the impairment or disturbance identified.

Denominator – the number of mental capacity assessments carried out with people aged 16 and over with an outcome of the assessment stating that the person lacks capacity to make a particular decision.

Data source: Local data collection, for example local audit of patient records or individual care plans.

What the quality statement means for different audiences

Service providers (such as community services, local authorities, private care providers, GPs and hospitals) develop policies, guidance and tools that support good quality mental capacity assessments. They monitor and audit the quality of the assessments, taking into account the degree to which they are collaborative, person centred, thorough and aligned with the Mental Capacity Act 2005 and its Code of Practice. They include people's views and experiences in data collected for monitoring an organisation's mental capacity assessment activity.

Health and social care practitioners(such as social workers, care staff, GPs, doctors, nurses and therapists) take a collaborative approach to assessing capacity. They work with the person and other practitioners involved in the person's care to produce a shared understanding of what may help or hinder the person's communication and decision making. If the person is assessed as lacking capacity, they record what impairment or disturbance of the mind or brain caused the inability to make a decision, the practicable steps taken to help the person make a decision for themselves and why the practitioner considers this to be an incapacitous decision as opposed to an unwise decision.

Commissioners (such as local authorities, clinical commissioning groups, NHS England) ensure that they commission services that follow the principles and requirements of the Mental Capacity Act 2005 and assume capacity unless it is established that the person lacks capacity. They commission necessary training to facilitate person-centred capacity assessments aligned with the Mental Capacity Act. They also ensure that people have sufficient access to advocacy services and that assessors have access to people with specialist condition-specific knowledge, such as psychologists or speech and language therapists, to help assess the person's mental capacity.

People aged 16 and over who have an assessment of their mental capacity to make a decision have an assessor who is able to communicate with them as clearly as possible. The assessor explains what is involved in the decision, finds out what the person's wishes and preferences are and makes a record of these. If the assessor decides that the person is not able to make this decision, they make a record of the evidence supporting this conclusion.

Source guidance

Decision-making and mental capacity. NICE guideline NG108 (2018), recommendations 1.4.27 and 1.4.28

Definitions of terms used in this quality statement

Mental capacity

The concept of capacity under the Mental Capacity Act 2005 is relevant to many decisions including care, support and treatment, financial matters and day-to-day living. Capacity is decision-specific, and an individual is assumed to have capacity unless, on the balance of probabilities, proven otherwise. To lack capacity within the meaning of the Mental Capacity Act 2005, a person must be unable to make a decision because of an impairment or disturbance in the functioning of the mind or brain. The inability to make a decision must not be due to other factors, for example because of undue influence, coercion or pressure.

A lack of capacity can only be established if the condition prevents the person from understanding, retaining, using or weighing information about the decision, or communicating their decision. It cannot be established unless everything practicable has been done to support the person to have capacity, and it should never be based on the perception that the decision made is unwise. [Adapted from NICE's guideline on decision-making and mental capacity, section 1.4 on assessment of mental capacity]

Assessing capacity

The Mental Capacity Act 2005 sets out the process of assessing mental capacity to determine if a person lacks capacity to make a particular decision. [Mental Capacity Act 2005 section 2 and section 3].

Practicable steps

'Practicable steps' links to principle 2 of the Mental Capacity Act (and chapter 3 of the Code of Practice), which states that 'all practicable steps' should be taken to help a person make a decision before being treated as though they are unable to make the decision. There are obvious steps a person might take, proportionate to the urgency, type and importance of the decision. These might include the use of specific types of communication equipment or types of languages such as Makaton, or the use of specialist services, such as a speech and language therapist or psychologist. Practicable steps could also involve ensuring the best environment in which people are expected to make often life-changing decisions – for example giving them sufficient time, privacy and peace and quiet, or ensuring they have a family member or other trusted person to provide support during decision making, if this is their wish. [NICE's guideline on decision-making and mental capacity, terms used in this guideline]

Quality statement 4: Best interests decision making

Quality statement

People aged 16 and over who lack capacity to make a particular decision at the time that decision needs to be made have their wishes, feelings, values and beliefs accounted for in best interests decisions.

Rationale

When a person lacks capacity to make a particular decision at the time the decision needs to be made, all actions and decisions taken by practitioners must be in the person's best interests. This principle covers all aspects of financial, personal welfare and healthcare decision making and actions.

The person must be placed at the heart of the decision-making process and supported to be involved in the decision-making process as far as possible. Wherever possible this means finding out about the person's past and present wishes, feelings, values and beliefs that would have influenced the decision if the person had capacity. It also means using information included in care plans and advance care plans, consulting with the person's family, carers and advocates and seeking to establish the person's wishes, preferences and values.

For adults (aged 18 and over) particular attention should be paid to advance decisions, lasting power of attorney and court order, including any court-appointed deputy.

Quality measures

Structure

a) Evidence of local protocols to ensure that best interests decisions are being made in line with the Mental Capacity Act 2005.

Data source: Local data collection, for example an audit of the best interests decision-making processes.

b) Evidence of systems and protocols that support the decision maker to identify and locate any relevant written statements made by the person when they had capacity, at the earliest possible time.

Data source: Local data collection, for example service level agreements and partnership arrangements between services.

c) Evidence of systems and protocols that ensure the decision maker reviews any relevant written statements made by the person before they make a best interests decision.

Data source: Local data collection, for example an audit of the best interests decision-making processes.

d) Evidence of systems and protocols that ensure carers, family, friends or advocates are involved in the best interests decision-making process.

Data source: Local data collection, for example an audit of the best interests decision-making processes.

Outcome

Proportion of significant and trusted people, including family members, carers and independent advocates, who feel included in making best interests decisions for the person who lacks capacity.

Numerator – the number in the denominator who feel included in making best interests decisions for the person they support.

Denominator – the number of significant and trusted people, including family members, carers and independent advocates, for a person who lacks capacity.

Data source: Local data collection, for example a survey of trusted people including family members, carers and independent advocates.

What the quality statement means for different audiences

Service providers (such as local authorities, private care providers, GPs, hospitals and community services) ensure that best interests decisions are being made in line with the Mental Capacity Act 2005. They implement processes and protocols, and provide toolkits, to support staff to carry out and record best interests decisions. They also have clear systems in place to support practitioners to identify and locate any relevant written statement or advance care plan made by the person when they had capacity to make decisions.

Health and social care practitioners (such as social workers, care staff, GPs, doctors, nurses and therapists) are responsible for deciding what course of action would be in the person's best interests. They ensure that any best interests decision made reflects the person's wishes, feelings, values and beliefs as far as reasonably practicable. They use a range of approaches to gather information about the person informally, as well as through formal meetings, and to identify any relevant advance care planning documents that may support making the decision. They work with carers, family and friends, advocates, attorneys and deputies to find out the person's wishes, feelings, values and beliefs in relation to the specific decision and to understand the person's decision-making history.

Commissioners (such as local authorities, clinical commissioning groups, NHS England) ensure that they commission services in which decisions are being made in line with the Mental Capacity Act 2005. They ensure that people aged 16 and over who lack capacity remain involved in the decision-making process. They also ensure that health and social care practitioners have the skills, facilities and resources that allow them to establish the person's wishes, feelings, values and beliefs.

People aged 16 and over who are not able to make decisions are involved as much as possible when decisions are made about their care and support. Health and social care staff use the information they have about their wishes, feelings, values and beliefs when making a decision about their care and support.

Source guidance

Decision-making and mental capacity. NICE guideline NG108 (2018), recommendations 1.5.6 and 1.5.14

Definitions of terms used in this quality statement

Best interests decision

When a person does not have capacity to make a decision, all actions and decisions taken by practitioners, or their attorney or court-appointed deputy must be done or made in the person's best interests. Any relevant written statements expressing the individual's views about the decision in question should be taken into account and given appropriate weight. Health and social care organisations should provide toolkits to support staff to carry out and record best interests decisions. These toolkits should include:

- how to identify any decision-making instruments that would have an impact on best interests decision making occurring (for example a lasting power of attorney, advance decisions to refuse treatment, court orders)
- when to instruct an independent mental capacity advocate
- a prompt to consult interested parties (for example families, friends, advocates and relevant professionals) and a record of who they are
- guidance about recording the best interests process and decision. This may include, for example, a balance sheet, which may assist in documenting the risks and benefits of a particular decision
- instructions on what information to record, ensuring this covers:
  - a clear explanation of the decision to be made
  - the steps that have been taken to help the person make the decision themselves
  - a current assessment concluding that the person lacks the capacity to make this decision, evidencing each element of the assessment
  - a clear record of the person's wishes, feelings, cultural preferences, values and beliefs, including any advance statements
  - the concrete choices that have been put to the person
  - the salient details the person needs to understand
  - the best interests decision made, with reasons.

[NICE's guideline on decision-making and mental capacity, section 1.5 on best interests decision making]

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standard advisory committees for details of standing committee 1 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- people being enabled to make decisions about their own lives
- people being enabled to participate as fully and effectively as possible in a decision made in their best interests
- dignity, human rights and rights under the Mental Capacity Act 2005
- independence and social inclusion.

It is also expected to support delivery of the following national frameworks:

- Adult social care outcomes framework
- NHS outcomes framework
- Public health outcomes framework for England
- Quality framework for public health.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact statement for the NICE guideline on decision-making and mental capacity to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by The Department of Health and Social Care, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- British Psychological society
- Skills for Care
- Royal College of Physicians (RCP)
- Royal College of Occupational Therapists (RCOT)
- Royal College of Nursing (RCN)
- Royal College of Speech and Language Therapists (RCSLT)
- Royal College of Paediatrics and Child Health