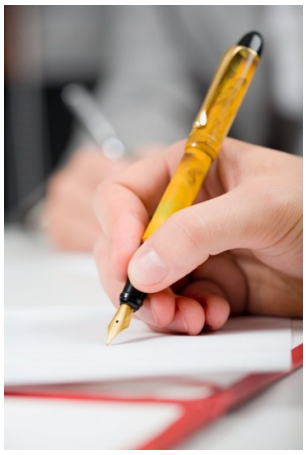
IMCA REPORT WRITING

BEST PRACTICE GUIDANCE



action for advocacy

IMCA Support Project

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Preface

When the IMCA support project first started in August 2009, we ran an online survey which asked IMCAs and their managers what priority areas the project should focus on in the first year. This included asking what issues IMCA providers currently face, what support and resources we could offer. We also asked some key questions about how providers responded to different factors at the initial stage of IMCA instruction, report writing and aspects of the MCA 2005 Code of Practice. A wide range of responses were received, including concern about the variance in IMCA practice which has emerged over the past three years and the need for practice guidance in a number of areas.

After analysing the survey feedback, discussion with IMCAs at network meetings and with individual IMCA providers, we decided to firstly write best practice guidance that focuses on the beginning and the end of the IMCA process and have therefore produced best practice guidance on instruction and report writing. This guidance aims to offer a suggested way forward to ensure that the statutory service being delivered offers quality and consistency.

An advisory group was formed which consisted of a wide range of IMCA providers. We would like to thank participants for their input, which contributed significantly to the content of this guidance.

Jakki Cowley **Sue Lee**

IMCA Support Project Managers

July 2010

Endorsement by the

Association of Directors of Adult Social Services

The Association of Directors of Adult Social Services (ADASS) is the national organisation in England and Northern Ireland representing directors of social care in local social services authorities. ADASS members are responsible for providing or commissioning, through the activities of their departments, the well-being, protection and care of hundreds of thousands of people, as well as for the promotion of their well-being and protection wherever it is needed. Close formal and informal links are maintained with the NHS and with central government in helping to shape and implement policy and social care legislation.

Within ADASS the work on supporting the implementation of the Mental Capacity Act 2005, including the additional Deprivation of Liberty Safeguards, is located within our Mental Health Drugs and Alcohol Network. Greg Slay (West Sussex County Council) has been our lead officer in this work since 2005, recently and ably assisted by Lindsay Smith (Halton Council) and Richard Smith (Telford and Wrekin Council).

We are pleased to work in partnership with Action for Advocacy, the Social Care Institute for Excellence, and many other organisations in improving practitioner awareness of the Mental Capacity Act 2005.

We commend this IMCA guidance to IMCA Service advocates and managers and hope it will be well used – it deserves to be!

We also commend this IMCA guidance as a reference document to commissioners of statutory advocacy services as well as those staff who have a legal duty to refer to the IMCA Service in their local areas.

Richard Webb (Sheffield Council) **Jonathan Phillips** (Calderdale Council)

Co-chairs, ADASS Mental Health Drugs and Alcohol Network

July2010

Introduction

It is evident that whilst the IMCA service is a statutory one, individual IMCAs come from diverse and varied backgrounds. Some have a wealth of advocacy experience, for example, in mental health, learning difficulties, working with older people or another aspect of social care. Other IMCAs may have a social work, nursing, health or legal background resulting in a workforce, which is varied in professional experience and is quite unlike many other sectors. Each IMCA accesses initial training and then undertakes the demanding and at times challenging role. It is inevitable that in this new area of work, interpretation of the role and the legislation within which people are working will mean that IMCAs will practice differently.

This guidance looks at how a report can be tailored to reflect the individual client through different styles of writing. Two main descriptions of reports are provided. The guidance describes how reports are often written from either a person centred or an audit perspective and suggests that these styles can be combined effectively. We wanted to acknowledge that reports are written differently, that there is not a 'one size fits all' approach but there is however a way to ensure the report has the required impact on behalf of the client and the way this is communicated will be different for each person. There is a template for a report and a suggested way of concluding a report that we hope will demonstrate how the guidance marries up with the reality of writing a report.

We have offered suggestions as to what to include in a report as well as what not to and we hope this will support IMCAs to advocate more confidently within their reports if only by way of articulating to decision makers the rationale for their reports.

The guidance details more closely how non-instructed advocacy is played out in the role of the IMCA and how this relates to the question of 'do IMCAs make recommendations?' We have included the legal position for IMCAs with respect to 'who has access to the report' and who actually owns the report that now clarifies the position on this and therefore we hope IMCAS will feel more confident in their knowledge around this area.

We have included suggested guidance on when IMCAs should close a case, current practice is varied on this issue, but we hope this demonstrates that whilst there is not always a clear and definite answer there can be a common way that still recognises the individual whom the decision is about.

We conclude with some frequently experienced scenarios that IMCAs face with respect to report writing including what to do if the IMCA has never met the client, if the client moves out of area or a decision no longer needs to be made. We hope the guidance reflects current practice as well as offering suggestions to a standard approach so that the IMCA service is viewed as a professional one, delivering quality advocacy by ensuring the client is at the heart of the decision making process. Ultimately we want to ensure that when a report is submitted on behalf of a client their history, wishes, beliefs and values are fully present in the current decision and we hope this ensures their future care is also impacted by the IMCA report.

What's covered in this guidance?

This guidance covers the report writing process for Independent Mental Capacity Advocates including what constitutes a report, what information should and should not be included in a report and how IMCAs can best represent their client. It clarifies information in the Code of Practice that has been interpreted variously by IMCA providers and identifies good practice in relation to report writing. It also includes a template for reports that IMCA providers can use and/or adapt to suit their individual service.

The statutory responsibility to write a report for the decision maker

The Mental Capacity Act 2005 states that an IMCA *must* prepare a report for the authorised person who instructed them (typically the decision maker) and that this may include submissions that are considered appropriate in relation to the client and the act or decision that is proposed. The decision maker *must* take this report into account when determining what is in the person's best interests in that specific decision. Where IMCAs receive an instruction (referral) on behalf of the responsible body e.g. junior doctor, nurse, psychologist etc but not from the named decision maker it is important that the report goes to the person that is ultimately responsible for carrying out the decision for them to consider. Decision makers will vary for each decision but generally will be the following professionals:

Serious medical treatment – will always be the person that is providing the treatment (usually the doctor).
Accommodation - care manager/social worker
Safeguarding - adult safeguarding lead
Care reviews – care manager/social worker

In regard to Serious Medical Treatment decisions the Code of Practice advises that whilst a decision maker is awaiting an IMCA's report they must still act in the best interests of the person e.g. to give treatment that stops the person's condition getting worse. This ensures that the person is still treated in their best interests but that the IMCA is also able to carry out their role and provide appropriate representation until a final decision is made.

What constitutes a report?

A written report is required in terms of making a formal representation about the decision proposed and it is important that the decision maker receives this prior to making the decision given their responsibility under the Act. Whilst an IMCA is continually representing their client by way of meeting with them, ascertaining their wishes, gathering information and views of others, examining relevant records, attending meetings and communicating with the decision maker it is important that this is summarised within a report.

Aspects of reports

Evidence based

All reports must be evidence based. Reports need to be factual, providing only evidence and information that's been gathered either from medical or social care records, consulting with professionals, family and/or friends of the client or from meeting with the client themselves. The purpose of a report is to build up a picture of the client as if they were able to do so themselves based on the proposed decision (the best interests checklist is one of the closest guides to non instructed advocacy there is). It is important reports do not reflect the personal opinion of the IMCA. This same basic requirement is no different for this statutory advocacy task to the well established position in respect of non statutory advocacy, i.e. to provide independent support, representation and assistance in putting forward the person's own views, feelings and ideas; ensuring they are not excluded because they do not express their views in ways that others understand.

However the report may contain others personal opinions providing they are relevant to the decision. For example a neighbour reporting the client keeps themselves to themselves and therefore they don't think they'd like to live with others, a nurse reporting a client will only accept treatment from female staff and coming to the conclusion they would be better suited in a predominately female environment. Of course it's important not to interpret a client's actions too much or place more weight on one person's opinion. The report should acknowledge that these opinions are formed out of the nature of trying to determine what a person would have wanted were they in a position to self advocate.

A paid carer of 20 years may know the client better than a family member who visits twice a year however both views are equally valid and form part of the process of determining a best interest decision, it is the information gathered from all parties (on top of what the client expresses) that becomes paramount in this.

Person centred

Aspects of a person centred report focus very clearly on the person at the heart of the decision making process, the emphasis is on their wishes, their views and ways they have communicated their feelings on the issue. Each client will have a different level of both understanding the decision and how to communicate this and it is important that the report demonstrates how this has been identified. This report is a reflective account of what the IMCA has done in order to ascertain the client's wishes and whilst still contains important information about the pros and cons of the decision, the risks and benefits, its focus is on the client. This report clearly evidences the advocacy role.

Auditing

Auditing is an aspect of reports and focuses more on the process of the decision making, whether it is compliant with the Mental Capacity Act and should reflect how the decision meets the requirements of the best interest checklist and the principles of the Act therefore has a more legalistic aspect to it than the person centred style of report. It may be appropriate to use this style of report writing when the IMCA is unable to submit a written report (due to time restrictions for example) before the decision is made or it can be written by way of detailing why the decision is being challenged (as often a challenge will result from an aspect of either the Act or the best interests checklist not being considered e.g. the person's wishes or feelings, least restrictive option or issues around capacity of the client). It can also be used to positively reflect the whole process and highlight how much the client, options, risks and benefits were considered within this but also the role the IMCA played.

A good report by a statutory advocate i.e. one that best represents the client, will feature aspects of both person centred and audit reports. Depending on the actual decision, how well the advocate knows the client, the stage in the process the report is being submitted and the actions taken so far by the IMCA may mean that some reports will be more person centred with a small level of auditing and vice versa but it is important to consider the differences and adapt to suit. Examples below offer some further guidance on this:

Where IMCA unable to ascertain the client's wishes or views

For example, where a client has led an isolated life, an audit report i.e. reflecting just on the principles of the Act and detailing how well the best interest checklist has been adhered to where possible is likely to be submitted.

Where IMCA knows the client extremely well and has been able to gather how the decision proposed would impact on them and what their views are about this, a report submitted can be more person centred and reflective of the interactions between client and IMCA.

Where the Decision is quite urgent and whilst the IMCA met with the client and determined their views as well as those of professionals involved but was unable to submit a report, e.g. the decision was made at a best interests meeting which the IMCA was part of and advocated on behalf of the client, this report is more likely to be an audit report focusing on the process that took place.

Where the *IMCA ascertained the client's views and circumstances* and *also wishes to highlight certain aspects of the checklist and principles of the Act* for example detailing the least restrictive option and issues about supporting the client further to make a decision. The IMCA can therefore submit a report that demonstrates the balance between representing the person's views and wishes as well as ensuring the decision making process is adhering to the MCA.

How can the IMCA report best represent the client?

Ultimately given that the decision maker is required to take into account any report the IMCA submits before they make their decision can they identify the following when they receive an IMCA report?

What does the client want; what are their wishes, views, feelings, are they established?

What decision would the client make if they were able to? Being deemed to lack capacity does not negate a person's ability to express themselves, have a view or inform others about what has been important in their life or is currently.

What actions did the IMCA take in order to reach a conclusion i.e. what evidence supports the above?

Is it balanced? Have they looked at and then submitted the pros and cons of the decision from all involved (doctor, social worker, family, friends) i.e. have questions been asked as if the client were able to?

Is there anything else the decision maker should consider:

Relevant case law

Aspects of the MCA 2005 - for example will the decision result in a DOL?

Best Interests Checklist - are there components of it that need highlighting e.g. consideration of the least restrictive option; is the proposed decision reflective of it?

Finally if a certain course of action is proposed, does the report conclude with a statement by the IMCA as to whether this reflects the best interests checklist or outline how an alternate course of action may more appropriately represent the best interests of the client? Note it is the decision makers responsibility to decide ultimately what is

in the person's best interests but the role of the IMCA[1] is to ensure they communicate their understanding of the process and articulate what they are advocating for based on the best interests checklist and the principles of the Act.

Where the report indicates serious concerns about the proposed decision complying with the MCA, does it identify what actions the IMCA may consider? It is important to highlight that the IMCA has a responsibility if they are identifying factors within the report that impact negatively on the client (be it the actual decision or issues such as training for staff on the MCA) to progress this through the appropriate channels such as complaints procedure or legal route.

[1] paragraph 10.20 in the MCA 2005 Code of Practice

What should be in a report?

As already stated reports need to be factual, evidence based, reflective of the client's wishes and feelings and detail a formal representation that includes consulting with the client, family, friends and professionals, seeking alternative options, gathering information and finding out how the client can best be supported to be involved in the decision making process.

Reports should include the following:

Client details including their name, DOB, current address and any other relevant identifiable information e.g. NHS number or IMCA Service Client ID.

- Details of the IMCA service including who the report has been written by and the commissioned service
- Referral details including date received, outcome of eligibility criteria (capacity assessment, reasons family or friends deemed inappropriate).
- Decision proposed including options being considered.
- Actions undertaken by the IMCA.
- Discussions with and observations of the client.
- Discussions with the decision maker, carers and other people consulted.
- Details from health and social care records.
- Visits to services including relevant information such as CQC reports and recommendations.
- Researched information, for example about a particular medical condition or service.

The report should have a conclusion that articulates the findings and how these impact on the decision proposed. It should be evident whether the IMCA is advocating for one option to be more highly regarded based on the evidence gathered from the framework above (the best interests checklist and the principles of the Act). The conclusion should also outline what factors the IMCA would like to be considered on the clients behalf if the decision maker believes an alternative option is in the clients best interests.

To expand further, if the client has made clear they wish to return home and there is scope for a care package at home a rule of thumb is that the IMCA would be advocating for this to occur. If the decision maker ultimately believes residential care is in the client's best interests, the IMCA should provide in their report an outline of what would be important for the client in this instance e.g. geographical location of a home, activities available, cultural issues and/or highlight key concerns as to why the MCA may not be complied with.

It is important the report is balanced even if it is advocating for one option to be more highly regarded than another i.e. the IMCA must demonstrate how they have considered all options available by way of discussion with the client, accessing notes and discussions with professionals involved and ensure that the clients wishes are still considered in whatever option is considered to be the in their best interests by the decision maker.

Where further advocacy would benefit the person either because of ongoing or outstanding issues or because the client has requested this and the IMCA is able to signpost/or refer on it is important that they highlight this within their report. Given the client is likely unable to do so themselves it is important that the sharing of information (i.e. referring to another advocacy service) is done in that persons best interests. Where there is no known advocacy available for the client in the locality it is important that the need for advocacy is still articulated in order for the decision maker to ensure suitable arrangements are put in place e.g. spot purchasing of advocacy from another locality/provider.

If the IMCA is aware of other issues not directly related to the decision these should be highlighted in the report.

Finally, good practice would be for the report to have a statement/paragraph at the end or for a covering letter that outlines the decision maker's responsibilities within the Act in regards to the IMCA report.

How do IMCAs gather information?

The IMCA's role is of a ***non-instructed advocate***. Non-instructed advocacy (NIA) means that the client has not instructed the advocate to work on their behalf, it may be that they are unable to do so due to communication or comprehension issues either due to a learning difficulty, mental illness, dementia, brain injury or other impairment. All IMCAs work in a non-instructed capacity as it is a professional that instructs them and determines that the client lacks capacity to make a specific decision therefore requires an independent person to support them express their wishes and ensure their rights are upheld. Whilst the IMCA is acting in a non-instructed way this does not mean that the client is not able to articulate their views, wishes, feelings and beliefs, indeed the IMCAs role is to ensure that the client's voice is at the heart of the work they do. Non-instructed advocacy uses a range of models:

Rights based approach:

Begins with the fundamental premise that we all have human rights, the advocate's role is to promote and defend these rights and take action where appropriate and necessary.

Observation approach:

The role of the advocate in this approach is to merely be an observer or witness to a person's life, this can include noticing what they like, their dislikes, interactions with others, stimulants round them, routines etc and report on this.

Person Centred approach:

The advocate will build up a picture of a person by getting to know them, spending time with them to learn their likes and dislikes, their lifestyle, preferences and represent these as if they were the advocate's own.

Watching Brief:

This approach uses 8 quality of life domains which serve as a base from which a series of questions the advocate can use on behalf of the client they're working with. The questions will focus on a particular decision or situation that the client is in or used in a more general way to ensure they are represented when discussions are taking place about them.

The role of IMCA uses all of these approaches, often combining the 4 together, at times focusing on one more than the other depending on the individual themselves and the decision/situation. The IMCA has an added system in place by the fact they are working within the Mental Capacity Act, which means they need to understand and promote the 5 principles of the Act, and the best interest checklist which are fundamental aspects in the decision making process within the Mental Capacity Act. An IMCA does not make decisions but is there to ensure that those who are making decisions do so according to these principles and the best interests checklist. This checklist is also used as a form of non-instructed advocacy (within the Act).

Do IMCAs make recommendations in their report?

IMCAs are not making recommendations in the formal sense of the word; they are not giving a professional opinion the way a doctor or occupational therapist might. Using all of the approaches detailed above the IMCA is submitting information that they ask to be considered, this will include advocating for both what they understand the clients decision would have been and what the Act states is required to be considered. At times the IMCA will be advocating a course of action based on all of these approaches, which the Act makes clear, is their role. The IMCA is not advocating for what they wish to occur but attempting to represent their client as close as if this were an instructed advocacy relationship as possible. Non-instructed advocacy can never determine exactly what informed instruction a person would make if they could but the report will attempt to represent this as much as possible.

Different reports for different decisions?

Each report should be of the same standard by using a report template and what's included within it in terms of the IMCA's actions and the bearing of these on the individual client. However it is important to recognise that each decision type and decision maker may require particular considerations that another one wouldn't. For example, the type of questions asked are likely to differ when advocating for someone on serious medical treatment decisions as oppose to accommodation, or safeguarding.

Not all reports are required to be lengthy and there will be times particularly if there has been previous IMCA involvement on the same issue for the client that an addendum to the original report will be more appropriate rather than another detailed report, ultimately the report should reflect the work the IMCA has done, their contribution to the decision and the issues the client is facing within this. With this in mind, it may be useful to reflect on the following to either add to report templates as additional headings or to help consider how to address particular issues within a report.

Accommodation decisions:

- Current living situation and rationale for proposed move
- Options being considered
- The wishes, feelings, beliefs and values of the person and how these have been determined.
- The views of other people who have been consulted
- Consensus of opinions/differing opinions
- Factors to be considered for the client in where they live (e.g. geography, staff, family, presence in the community, long standing relationships).
- Any Deprivation of Liberty considerations
- Other matters the IMCA wishes to raise

Serious medical treatment decisions:

- The different options being considered.
- Risks, benefits and potential burdens of proposed treatment
- The wishes, feelings, beliefs and values of the person and how these have been determined

- What the IMCA has done since receiving the instruction
- The views of other people who have been consulted
- Consensus of opinions/differing opinions
- Whether a second medical opinion is being requested by the IMCA
- Any Deprivation of Liberty considerations

Care reviews:

- Purpose of review (annual review, client's needs have changed, registration issues, recent best interests decision made)
- Factors to be considered
- The wishes, feelings, beliefs and values of the person and how these have been determined.
- The views of other people who have been consulted
- Consensus of opinions/differing opinions
- Any Deprivation of Liberty considerations
- Other matters the IMCA wishes to raise including whether a subsequent referral is necessary e.g. change in accommodation, or referral to IMHA if client to be placed under the MHA 1983

Adult safeguarding:

- The alleged abuse
- Protective measures being considered or applied
- Main work undertaken by the IMCA
- The person's views and wishes related to the protective measures and how these have been determined
- Other factors to consider in making decisions about protective measures
- Consensus of opinions/differing opinions
- Any Deprivation of Liberty considerations
- Other matters the IMCA wishes to raise

What should not be in a report?

The IMCA report is a formal document that the Act requires the decision maker to take into account when deciding what is in the person's best interests. With this in mind the following should not be included in a report:

Personal opinions of the IMCA – for example "I don't think the care home are providing the type of care that is conducive to a relaxing environment that is needed by the client". More appropriate would be "on visiting the care home there was a lot of activity and the manager informed me that their ethos of care is very focused on learning experiences so a high level of engagement is expected from residents"

Personally attacking or slanderous comments – for example "the Doctor was particularly abrupt and rude and seemed uninterested whether the patient received any further treatment". Information about how someone responded can still be conveyed in a more factual manner, "The Doctor's response was to walk out the room when I asked about alternative treatment"

> ***Abbreviations should be avoided unless they are commonly used and recognised e.g. DOLS or MCA 2005.***

Third party confidential information (this may be particularly relevant in safeguarding issues) – if the IMCA has received information of another safeguarding issue that the client was involved that also discloses the nature of the abuse and the other person, it may paramount to the decision making process therefore appropriate to be aware of this but not appropriate to then provide details within the IMCA report, an overview is only required.

Incorrect quotations – if the report quotes either a document or what someone has said it is important this is accurate and correct. If it is not possible then the IMCA should paraphrase what information they have received.

Out of date information – if the report was written several weeks ago it may no longer reflect the current situation.

Personal opinion about the decision – e.g. saying what the IMCA believes is in the person's best interests, making a recommendation or saying they agree with the proposed decision – this is not the same as the IMCA saying they understand this would satisfy the MCA, there is an important distinction between this and agreeing.

Who has access to the report?

Many IMCA providers have worked to the principle that the report they write is owned by the decision maker given it is written for them and must be taken into account by them when making a best interests decision. Following this principle many providers have then directed anyone wishing to access the report to the decision maker to determine whether it is in the person's best interests for the report to be accessed by a third party. However whilst the IMCA service is commissioned by the Local Authority or NHS body to provide a service they are not commissioned by and for the decision maker to write a report in the same way an independent social worker is for example that is asked to complete and submit a professional assessment on behalf of the Local Authority. This means that the organisation the IMCA is employed by is the holder of the IMCA report therefore it is up to that individual organisation to ensure there are policies and procedures in place that govern who has access to the report, these need to be in line with the Data Protection Act 1998.

The only requirement under the Act is for the report to be sent to the decision maker so that they may take into account the information submitted when deciding what is in the client's best interests. If others are asking for this report, the IMCA service has a responsibility to determine whether this request is in line with Section 7 of the Data Protection Act; which gives everyone the right to see personal information that an organisation holds about them. They may also authorise someone else to access their information on their behalf. The person holding the information has a legal duty to release it[2].

What this means is if the client is requesting this information they have a right to see it, as does their authorised representative. If someone lacks the capacity to give

[2] *Para 16.4, Code of Practice, MCA 2005*

consent, someone else might still be able to see his or her personal information. This will depend on:

- Whether the person requesting the information is acting as an agent (a representative recognised by the law, such as a deputy or attorney) for the person who lacks capacity
- Whether disclosure is in the best interests of the person who lacks capacity, and
- What type of information has been requested?[3]

With this in mind the IMCA service needs to determine why someone other than the decision maker needs access to the information that is in the report, it may be appropriate to offer part of the report that relates to him or her but not the whole of the report. The most common scenario is that another professional requests the report, in which case the same key questions need to be considered before any information is disclosed and these need to be reflected within the organisations policies.

The decision maker is a representative of the responsible body therefore once they are provided with the report it will become part of the records held by the responsible authority, and therefore available to anyone within that organisation and may be disclosed accordingly. IMCA services may want to consider specifically identifying anything that should not be disclosed, if that's appropriate.

Feedback from Decision Makers

Good practice is for IMCA providers to request feedback from decision makers as to the quality of the IMCA report, below are some suggested questions that can be sent along with the report:

- Were you satisfied with the response time of the service?
- Throughout the process, did the IMCA adopt a professional approach?
- Did the report arrive in time to inform your decision?
- Did the report influence your decision?
- Overall did you find the service helpful?
- Any further comments or feedback?

[3] Para 16.8 of the Code of Practice, MCA 2005

Closing cases once a report is submitted

For many providers this raises the question as to when the case should be closed in relation to this submission and the subsequent decision made by the responsible body. All cases will need to be judged on an individual basis but providers need to identify how they can ensure policies and practice reflect the varying ways the IMCA's role stops or provide a rationale for remaining involved after submitting a report:

Case remains open or closed?

Instruction is withdrawn

Case is closed

When instruction is withdrawn the case is closed automatically. Instruction can be withdrawn for a variety of reasons that will include the person now being deemed to have capacity, family or friends being appropriate, no longer a decision to be made that requires IMCA involvement or the decision is moved to another locality. This is particularly common where the person moves to another hospital/locality whilst a decision is being made and it is more appropriate for another IMCA service to take the case on. The IMCA case should be formally closed as it for the decision maker to determine eligibility criteria for the IMCA service.

Should the IMCA wish to challenge the withdrawal of instruction they may do this but only as a non statutory advocate and as such would lose any powers such as access to records until instruction given again (where applicable). They are still able to act as a non instructed advocate however for the client.

The decision is made with no review by the Local Authority for 3 months

Case is closed

The local authority social services Act 1970 requires local authority's to conduct a review of the care they provide for someone on an annual basis or within 3 months of a major change in provision of care (an example being an accommodation move) for further information go to:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113154

If a decision is made and it is deemed by the decision making body that there is no requirement for a review until this 3 month period this would suggest that they do not have any immediate cause for concern and feel it appropriate to wait to conduct this.

The IMCA challenges the decision.

Case remains open

If the IMCA is challenging the decision then the case will remain open until there is resolution either through the complaints procedure, a review, further best interest meeting or Court of Protection decision (depending on the route taken). The IMCA can indicate in their report the route of challenge if it is deemed likely to occur (for example the decision maker has been clear as to the decision they are going to make).

The decision is made but is reviewed prior to the 3 month closure.

Case remains open

When a decision is made and it is felt appropriate for those involved in this process to meet to review for example it has been a complex decision making process or because the IMCA asked for several considerations to be made to a person's care within their report that can only known to have occurred at a review then the case will remain open until it is documented that a best interest decision and a review of this has occurred.

It is important to stipulate that this review needs to be arranged/decided by the decision maker or requested by the IMCA with the rationale for holding a review

Some local authorities will have in place a review process that occurs prior to 3 months e.g. it is standard practice that a review is conducted every 2-4 weeks after a person moves, if this is the case it allows IMCAs to remain involved whilst still being relatively close to the decision making process in terms of timeframes. If this is local practice then the IMCA should refer to point 2 with regards to their involvement as it will not be necessary to attend each review just because the local authority hold one.

IMCAs should therefore feel confident in closing the case unless they are challenging the decision or have concerns that a wait of 3 months to review is too long, both of which can be indicated within the IMCA report (these 2 points are discussed further below).

IMCA services need to ensure there are appropriate policies and procedures in place to ensure referrals (instructions) for care reviews are made once there has been IMCA involvement, IMCAs can highlight this within their reports to the decision maker.

Frequently Asked Questions

What if the decision needs to be made quickly and I don't have time to write a report?

When an urgent decision is needed e.g. to save a person's life then there is no requirement to make a referral to the IMCA service however this needs to be recorded by the NHS body with the reasons why. If further Serious Medical Treatment is required after urgent treatment there is a still a duty to instruct an IMCA where the criteria are met. There will be many situations where a decision needs to be made quickly but is not urgent that allows for an IMCA to be involved (IMCA services will need to ensure they have a process in place for managing and prioritising referrals). If time is extremely limited it is important that there is representation in one or more of the following ways:

- Attending a best interests meeting and making a verbal representation
- Communicating with the decision maker (e.g. verbally or via email/letter) indicating your understanding of the proposed decision, your actions and points you wish to be considered (based on the best interests checklist, principles of the Act and the client's views).
- Writing a report/comments directly into the patient's file at the hospital.
- Submitting a report after the decision is made detailing actions you took, outlining the best interests checklist in terms of your understanding with respect to the options discussed and outcome of the decision and concluding with any further considerations you would like to be made or issues you are raising/challenging.

If the client dies; am I still required to write a report?

It is important there is still a record of what actions you carried out and the representation you made, however this need only be a brief summary to be kept in the clients file and sent to the decision maker.

There may be times you wish to challenge an element of the decision making process in which case a summary of actions, issues raised and final outcome may be beneficial in terms of instigating the relevant complaints procedure.

What if the client is transferred to another IMCA service?

There is no requirement to produce a report if you are not inputting into the decision. However it is important to consider the client and to ensure that any actions you have completed, wishes or views you've ascertained from the client or others, or significant events you might have been party to e.g. best interests meeting, initial safeguarding meeting are handed over. This can be done in a summary. Depending on the stage the decision making process is at, it may be more appropriate to write a report for the attention of the decision maker to ensure that this is taken into account.

What if I've yet to meet the client and the case is then closed?

(e.g. because the client dies or is transferred to another IMCA service)

There may be times that you don't have an opportunity to meet the client. This may be because the client dies or they are transferred out of area (from one hospital to another for example) meaning the case is transferred to another service. Where there is no longer a decision to be made that you are required to input into there is no requirement to complete a report, unless you believe you have made significant representation that needs to be formally submitted. If you have been unable to meet someone or ascertain any relevant information, best practice would be that you submit a statement to the decision maker and IMCA service (where applicable) briefly stating a referral was received and no action taken. This can at the very least ensure there is a paper trail on the client's behalf.

Is it necessary to complete a post decision report / provide a closing statement?

There is no legal requirement to complete a post decision report or provide a closing statement. Each case will need to be judged individually in terms of whether a challenge is being made, the complaints process is instigated, a safeguarding adult alert or an unlawful Deprivation of Liberty alert is made. However it is important that the IMCA service establishes a standard when closing cases. Best practice would be to submit a closing statement that briefly outlines the view of the IMCA with respect to auditing the best interest process and confirms the final decision and rationale for the decision maker ending the instruction i.e. decision made, client moved out of area. It also provides an opportunity for the IMCA to alert a future referral e.g. care review. Whilst there is a legal requirement for decision makers to inform the IMCA of the final decision this does not need to be written therefore this approach can ensure there is a formal record within the IMCA case file of this and also on the client's file held by the relevant responsible body.

IMCA REPORT PRO FORMA

Client details:

Name:

DOB:

Address:

Client ID:

IMCA Caseworker:

Service Manager:

Decision details:

Serious Medical Treatment ☐

Change of residence ☐

Adult Safeguarding ☐

Care review ☐

Date of Instruction:

Report No:

Date report submitted:

Summary of decision to be made (including options being considered)
Decision maker:

Eligibility Criteria
Outcome of capacity assessment: Reason NHS/LA has deemed family/friends inappropriate to consult with (if applicable):

Actions undertaken by IMCA
Medical Records accessed ☐ Social Care records accessed ☐

The wishes, feelings, beliefs and values of the client:
Information obtained (from discussions with people who know the client & written records)
Conclusion

Signed:

Date:

This report is being sent solely to you as the Decision Maker in this case.

The Mental Capacity Act 2005 specifies that you are required to take this report into consideration when making the decision.

When the decision has been made, please complete and return the attached form by post or fax. In the meantime if there are any reviews/best interest meetings related to this decision please could you let the named IMCA worker on this case know.

Decisions maker's response to the IMCA's report

When the decision has been made, please complete and return this form by post or fax.

IMCA Service
123 IMCA Street
Anywhere
Tel:
Fax:

Name of client:

Name of Decision Maker:

Decision Maker's Position:

Date Decision Made:

Details of decision made:

Signed:

Date

IMCA REPORT

Client details:	Decision details:	
Name: Eleanor Louise Tanner	Serious Medical Treatment	☐
DOB: 10/07/65	Change of residence	✓
Address: Currently resident on Cherry Ward at Orchard Psychiatric unit.	Adult Safeguarding	☐
	Care review	☐
	Date of Instruction: 17/01/2010	
	Report No: 1	

IMCA Caseworker: Daniel Brown

Service Manager: Rob Langdon

Summary of decision to be made (including options being considered)
Eleanor is currently on Cherry ward, Orchard Psychiatric Unit where she was admitted on a section 3 of the Mental Health Act 1983 18 months ago. Having recently been discharged from her section a decision needs to be made as to where she lives. Eleanor would like to return home but the clinical team has concerns as to how she'll manage once there so are proposing 24hr residential care. Decision maker: Anne Walker, AMHP, Team A, Ribble Valley CMHT.

Eligibility criteria
Outcome of capacity assessment: Dr Phillip has assessed Eleanor's capacity to make the decision about where to live and deems she is unable to fully comprehend and weigh up the risks of returning home. Dr Phillip states that Eleanor is unable to weigh up and understand the treatment plan which includes medication and CMHT involvement required to keep her well at home in the community and as such subsequently becomes non-compliant and self medicates with alcohol which places her at risk of deterioration and self neglect. **Reason NHS/LA has deemed family/friends inappropriate to consult with (if applicable):** Eleanor has several brothers and sisters but she believes they are instrumental in her admissions to hospital therefore it has been deemed it is not appropriate for them to be part of the decision making process (although they have asked to be kept informed of any outcomes and stress they will help where possible).

Actions undertaken by IMCA
Medical Records accessed ✓ Social Care records accessed ✓
• Met with Eleanor on several occasions including attending her ward rounds on 3 occasions. • Spoken to Anne Walker with regards to options available. • Met with Dr Phillip, Eleanor's Responsible Clinician • Met with 3 of Eleanor's siblings.

The wishes, feelings, beliefs and values of the client:
I met with Eleanor initially on 22nd January and explained my role as an IMCA and why Anne Walker had asked me to visit her, Eleanor said she was pleased I was there as was keen to leave the ward and hoped I could help her with that. Eleanor told me she had her own house (her parents lived there all her life and the rent agreement was handed on to Eleanor when they passed away) and described being "desperate" to be back there, stating she'd missed being able to clean it, and that she was extremely house proud. Eleanor talked about the fact she'd not been back to visit it with staff and that this was because she needed to go with the Occupational Therapist (who is currently on long term sick leave). Eleanor said staff had told her she couldn't go on her own because they were concerned she might not return and that they had concerns about her living there until a meeting had been held to discuss this further and they were unable to offer any other staff member to accompany her. I spoke to Eleanor about how much she understood of her rights given she is no longer detained, Eleanor explained she understands she is not on a section anymore but that she still has to seek permission in ward rounds the way she always has in order to be allowed to leave the ward. Eleanor explained she'd been informed a home assessment is required to make sure she's safe enough to return home but doesn't feel this is necessary as believes once she returns with a care package she will settle in quite quickly although would be happy to go with Anne to sort through the mail. Eleanor talked about the fact she's never left the local area although described feeling quite lonely at times, stating most of the local residents are elderly and she misses having people to talk to her own age, the way she does on the ward. Eleanor said she often starts drinking once she's back home because she gets bored and it helps her sleep. I asked Eleanor about her family and she says it's their fault she's always ended up in hospital as they want the house back, Eleanor says her siblings once arranged for a group of nurses to pretend they were lawyers and there to help her leave hospital once but actually they injected her with poison, which made her "go mad", she states she's never forgiven them for this and so doesn't want to see them. Eleanor described looking after her parents when they became frail and elderly and knows they would have wanted her to stay in the house, she remains consistent with this view whenever we meet.

I asked Eleanor whether she had considered living anywhere else e.g. residential home or sheltered accommodation but Eleanor said she didn't need extra help, just some more company which is an aspect of the ward she enjoys, Eleanor described being able to cook and shop for herself so wouldn't need to be somewhere that did all of this although visited one home with the OT a few months ago and described it as "awful" and that "everyone was asleep", Eleanor also stated it was in an area she didn't know therefore she'd hardly ever go out.

I asked Eleanor how much she goes out in the community once she's at home and she explained she goes to the local shop but gets quite anxious being out on her own and would prefer to have someone go with her, Eleanor informed me she used to have a support worker - Eddie - but that when he left he wasn't replaced. Eleanor also used to walk her neighbours' dog some years ago before he died which she loved doing as said she got to meet other people this way. Lastly I spoke to Eleanor about her medication and whilst she feels she doesn't require it as disputes her diagnosis of schizophrenia, she does feel better for taking it (Eleanor was unable to describe how she feels better when I asked her about this) and is happy to continue with this although often forgets about it until staff give it to her.

Information obtained (from discussions with people who know the client & written records)

I've spoken to Anne Walker, AMHP on 3 occasions and also had access to her assessment of Eleanor's needs that included care package options. Anne has worked with Eleanor for 10 years and described her as being treatment resistant although the medication she has been prescribed has kept her mental health reasonably stable for some time, Dr Phillip concurred with this and described Eleanor's "mental health quality of life at it's optimum" hence his rationale for removing her section. Anne explained Eleanor has often presented with conspiracy theories as to how and why she is admitted to hospital but that on each occasion it has been at crisis point and because she has become non compliant with her medication due to alcohol consumption. Anne informed me that Eleanor is a very independent woman but without 24-hour supervision she is unlikely to continue with her medication regime and therefore be admitted to hospital again.

Anne also explained that Eleanor appears not to recognise how unwell she was prior to this admission and that the 'cleaning up' she's talked about doing in her house requires professional input due to the neglectful state it's in. Anne is concerned that the longer this cycle goes on the more she loses her basic daily living skills and becomes institutionalised to the point she won't be able to live at home. Anne discussed options and said she felt that ideally Eleanor would go to a rehabilitative community setting where she could have 24-hour supervision but also have rehabilitative treatment, which could be reviewed with the plan to eventually move Eleanor into more independent living.

Dr Phillip explained he is not going to alter Eleanor's medication to a depot as this would be less effective, highlighting Eleanor has no issues with taking it on the ward therefore he feels as long as she is encouraged once back at home she will continue to remain well. Dr Phillip is concerned about Eleanor's reluctance to return home however with the staff and believes this is her way of demonstrating she would rather be in a 24 hour staffed environment although given Eleanor's age there are few homes that are available, Dr Phillip feels sheltered accommodation may be more appropriate as this would allow for staff to be there during the day to at least provide prompts with medication but again Eleanor's age may be a factor - although there are properties 7 miles from where Eleanor's house is now. Lastly Anne expressed concern about how vulnerable Eleanor is in the community from local youths whom she says have taken advantage of her in the past by befriending her and stealing from her.

I met Eleanor's siblings who informed me Anne had spoken to them about their views on this decision, they describe Eleanor as a very independent woman but that she's always been very close to their parents, Stanley (Eleanor's older brother) told me that when Eleanor first became ill she had been taken into hospital after being visited by her GP and 2 members of staff from the CMHT, he states she was never the same after this nor forgave them for alerting the GP to how unwell she'd become (he explained she had stopped eating but started drinking heavily which he knew was because she was hearing voices, believing she was "going mad" and had started boarding up the windows and had destroyed all the electrical items in the house as they were "sending messages" to her). Eleanor's siblings expressed a great deal of concern for her and said they just wanted her to be well and were keen for residential care to be considered as whilst Eleanor won't interact with them when she's at home (they live in the same street) they described the fact that the period before her last admission had become quite stressful as when Eleanor is at home they take it in turn to make sure someone is looking out for her i.e. one person is always at home so they can watch Eleanor's house and make sure she's okay.

Conclusion

In terms of the options, they are as follows:

Eleanor is placed in 24hr residential care

In terms of the Act, given that Eleanor has resided in her current home all her life, for her to move to an area she is not familiar with would not appear to be the least restrictive option. As Eleanor is also only 45 there are few providers that would be able to specifically cater for her age range given that its felt general supervision and prompts are required rather than a specific nursing type care package. Eleanor has visited one care home so far and did not wish to be placed there due to the age range of the clients and that she saw the majority of residents being asleep rather than engaging in activities.

Were this option to be considered, at this stage I would express concern as to how this met Eleanor's best interests given the exploration that has yet to done with a home care package. However as it's possible that a care package at home would fail in the future I would ask for consideration be given to the following factors at that point:

- Geographical area of any care home given Eleanor has resided in Wellsworth for most of her life.
- The opportunity for Eleanor to be around residents that have a similar level of independence with regards to shopping, accessing the community, engaging in activities both within a care home and outside of it but also for her to build relationships with other residents given Eleanor talks enthusiastically about being in the company of others her age.
- For Eleanor to be afforded the opportunity to visit several homes given the possible implications of deprivation of liberty, particularly in light of the fact that on the ward Eleanor has believed she's not allowed to access the community without the formal authorisation from her RC highlighting she does not fully understand her rights under the Mental Capacity Act.

Eleanor returns home with a high package of care

With regards to this option this would appear to at least afford Eleanor the right for the least restrictive option to be considered as required by the Act. The previous care package Eleanor had was also the minimum and Eleanor identifies this is not what she benefits from and that she needs someone to actively engage her in activities, it is important to note that on reading Eleanor's social care records, she remained well in the community for a period of 5 years when she had 3 weekly visits from the support worker, this was also the same period of time that Eleanor walked her neighbours' dog once a day. Elsie describes

drinking alcohol to ease boredom and aid sleep and that were she able to access the community more freely she would feel less isolated.

Eleanor has yet to return home for an assessment. This appears to not have occurred due to a combination of staff taking leave. Eleanor has shown no reluctance, in fact she has asked on a regular basis whether she can go home for the day and this has not been facilitated. Eleanor has also explained she would be happy to return home with Anne. Eleanor has remarked that she feels she benefits from taking Clozapine although forgets to take it unless prompted (this occurs on the ward) and it has been identified that a maximum care package could provide Eleanor with prompts and supervision regarding her medication and this has yet to be tried, I would therefore ask for consideration to be given to this.

Given Eleanor is a keen pet lover I would ask whether a referral can be made to Carers for Dogs, a charity that specialises in providing pet therapy for isolated or vulnerable adults, this would allow Eleanor to walk a dog several times a week and also access their befriending service. Eleanor has also identified wanting a support worker again and I'd ask for consideration for Eleanor being able to purchase this through direct payments again given these are all factors Eleanor has stated are important to her remaining well in the community. Although Eleanor's family have expressed concern and shared their levels of stress in being informal carers for Eleanor it's important to highlight that they have carried out this role due to the lack of stimulus Eleanor has had which has resulted in her drinking heavily which has then made her a vulnerable target amongst the local youths. Given the principles of the Act and the best interest checklist this option would appear to be more reflective in terms of Eleanor's best interests before consideration is given to a more restrictive environment.

Signed:

Date:

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When the decision has been made, please complete and return the attached form by post or fax. In the meantime if there are any reviews/best interest meetings related to this decision please could you let the named IMCA worker on this case know.

The above is an example of how a report may be presented to a decision maker in respect of language used and method of delivering information i.e. using both person centred and audit aspects of report writing.

The report is not a real case although based on several real life IMCA scenarios. The length and detail in the main body of the report (the person's wishes, views and feelings) is provided for illustrative purposes in order to give the conclusion some context therefore it is not advocating that all reports be this lengthy in terms of detail. However it is important to note that reports should always ensure that the central part conveys crucial information about the person and what's important to them therefore it will be necessary and important at times that the person's wishes, feeling and beliefs are this comprehensive. This can then allow for the actual conclusion to be succinct and to the point.

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