

## Mental Capacity Act (MCA, 2005), including Deprivations of Liberty (DoLS, 2007)

Issue Date	Review Date	Version
September 2019	September 2024	1.5

### Purpose

To ensure implementation of the MCA within the acute hospital Trust.

### Who should read this document?

All staff (clinical) working with adults and young adults between the ages of 16-17 years

### Key Messages

The Mental Capacity Act 2005 (MCA) provides a statutory and quality framework to empower and protect some of the most vulnerable people in society. It clarifies who can take decisions, in which situations and how they should go about this in respect of people who lack capacity to make particular decisions for themselves.

The Deprivation of Liberty Safeguards 2007, an amendment of the MCA, provide a legal framework to protect the interests of vulnerable persons in a care home or hospital who lack capacity and are deprived of their liberty in order to keep them safe from harm.

### Core accountabilities

<b>Owner</b>	MCA Lead
<b>Review</b>	Safeguarding Steering Committee
<b>Ratification</b>	Executive Lead/Chief Nurse
<b>Dissemination (Raising Awareness)</b>	MCA Lead
<b>Compliance</b>	MCA Lead

### Links to other policies and procedures

Safeguarding Adults at Risk Policy  
 Management of Non-Physical & Physical Intervention for Adults Policy  
 Restraining Therapies Standard Operating Procedure  
 Safeguarding Children's Policy

### Version History

1	June 2016	First developed
1.1	September 2016	Appendix update
1.2	September 2016	Appendix update
1.3	September 2016	Appendix Update
1.4	September 2016	Updated
1.5	November 2019	Updated

*The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.*

**An electronic version of this document is available on Trust Documents. Larger text, Braille and Audio versions can be made available upon request.**

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## **1.0 Introduction**

1.1 The Mental Capacity Act 2005 (MCA) is the legal framework covering:

- How to assess whether a person can make a decision
- How people should be supported to make decisions
- How care and treatment can be provided if a person lacks mental capacity to consent to that treatment (best interests)
- How to ensure protection from liability for care or treatment where it is necessary to restrict a person`s rights and freedoms
- How to work with Lasting Power of Attorney`s and Deputies
- How to apply Advance Decisions to refuse treatment
- How to work with Independent Mental Capacity Advocates

1.2 Everyone who works in health and social care has a duty to have regard to the MCA Code of Practice.

1.3 The Act applies to everyone from the age of 16.

1.4 This Policy guides the practice of staff employed by University Hospitals Plymouth Trust (UHPNT) describing their roles and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

1.5 The Deprivation of Liberty Safeguards (DoLS) are:

- A framework, separate to the Mental Health Act (MHA) by which a person who lacks capacity to consent to being in hospital can be lawfully detained when it is necessary for their own safety

- An independent check on whether any deprivation is necessary
  - A process to ensure access to advocacy and a right of appeal for those who are deprived of their liberty whilst in a hospital or Registered Care Home.
- 1.6 The DoLS apply to adults aged 18 years and over and are covered in further detail in Section 21.0
- 1.7 Deprivation of Liberty can occur in any setting. When it is necessary for a person who lacks mental capacity to consent to their care and residence to be deprived of their liberty for their own safety in any setting other than a Registered Care Home or hospital, the deprivation must be authorised by the Court of Protection.

## **2.0 Purpose, including legal or regulatory background**

2.1 The purpose of this document is to describe the process and good practice required to ensure that all staff within the Organisation are compliant with the law as set out in the Mental Capacity Act 2005. This includes procedures to:

- assess mental capacity
- make decisions in the best interests of patients including patients who appear to have no family or friends to consult with
- use restraint
- follow valid and applicable advanced decisions
- makes it clear who can take decisions in which situations
- enable people to plan ahead (Advanced Decisions and Lasting Power of Attorney) for a time when they may lack capacity

2.2 Implementation of this Policy will ensure that:

- All clinical staff are able to recognise when there is a need to assess a patient/client's ability to make decisions based on their mental capacity and can act on this assessment
- Clinical staff are aware of and acknowledge Advance Decisions for Refusal of Treatment and act correctly
- Independent Mental Capacity Advocates are appointed appropriately
- There is consistency in reporting and procedure across health, social care and other partner agencies locally
- The Trust is compliant with the CQC essential standards relating to mental capacity

## **3.0 Ownership and Responsibilities**

### **Chief Executive**

3.1 The Chief Executive and wider Trust Board have key roles and responsibilities to ensure the Trust meets requirements set out by statutory and regulatory

authorities such as the Department of Health, Commissioners and the Care Quality Commission. The Trust's Chief Executive has overall responsibility to have processes in place to:

- Ensure that clinical staff are aware of this policy and adhere to its requirements
- Ensure that appropriate resources exist to meet the requirements of this policy

### **Executive and Non-Executive Directors**

3.2 The Executive Directors are responsible for ensuring that all Operational Managers in their area are aware of this policy, understand its requirements and support its implementation.

### **Role of Non- Executive and elected leads**

3.3 The Non-Executive and elected leads are responsible for:

- Championing & maintaining focus on mental capacity
- Providing independent scrutiny
- Holding Executive Directors and the Board to account

### **Medical Directorate/Consultants**

3.4 The Medical Director (delegate Mental Capacity Lead for the Trust) and Lead Consultants (Clinical Service Leads or equivalents) are responsible for ensuring legal frameworks and procedures detailed in this policy are understood and adhered to by medical staff.

### **Ward/Unit Managers**

3.5 Ward/Unit Managers are responsible for implementing the policy and ensuring that relevant assessment tools are readily available to allow staff to carry out the duties prescribed in this policy.

### **Members of Clinical Teams**

3.6 Clinical team members have responsibility to comply with the requirements of this and associated policies and have a legal duty to adhere to the Act and Code when working with, or caring for, adults who may lack capacity to make decisions for themselves.

### **Quality, Safety and Compliance Team**

3.7 The Quality, Safety and Compliance Team (Implementation Team) are responsible for informing the Care Quality Commission (CQC) of the outcome of all DoLS applications; this is a statutory requirement.

### **Role of Mental Capacity Act and Safeguarding Adults Leads**

3.8 The Mental Capacity Act Lead is responsible for:

- Ensuring the process and procedures are consistent for recording mental capacity and applying the MCA.
- Attending local and regional Mental Capacity Act Groups and Networks.
- Developing internal structures to provide assurance to the Organisation that mental capacity issues are considered and dealt with in a consistent and effective way.
- Provide systems and structures to support MCA implementation e.g. procedures, training.

3.9 The Safeguarding Adults Executive Lead is responsible for:

- Ensuring the Trust fulfills its responsibilities in protecting vulnerable adults within UHPNT.
- Ensuring that the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007 are fully implemented within the Trust, to ensure that the rights of person`s lacking capacity are respected.

### **Role of the Clinicians/Health professionals and Healthcare Assistants**

3.10 The member of staff carrying out the procedure or intervention is responsible for ensuring that consent to treatment is valid and that full discussions are recorded in the patient record.

3.11 Where the patient may lack mental capacity for that treatment decision the health professional must carry out a mental capacity assessment and subsequent best interest decision before carrying out the intervention.

## **4.0 Staff Development and Training**

4.1 The Trust is responsible for ensuring all staff are given Mental Capacity training that supports their role and responsibilities with regard to the Act. There are different levels of Mental Capacity training required for UHPNT employees:

- Level 1 Training-all frontline staff receive safeguarding training which includes MCA as part of mandatory training
- Level 2 Training-all frontline staff must complete the in-house 3 hour safeguarding session as a mandatory requirement

## **5.0 Monitoring Compliance and Effectiveness**

- 5.1 Auditing of the implementation of the Mental Capacity Act and the use of the Independent Mental Capacity Advocate across clinical areas will be undertaken to monitor the effectiveness and usage of this policy on a minimum of an annual basis.
- 5.2 The monitoring of compliance with this policy will be overseen by the UHPNT Safeguarding Steering Committee.
- 5.3 Elements to be monitored include:
- Documented evidence of consideration and assessment of mental capacity for specific decisions
  - The use of the Mental Capacity Assessment Tool when serious medical decisions, long term accommodation changes and any other significant decisions are required
  - The use of the Best Interest meeting record where applicable
  - The views and participation of the patient and carers as appropriate
  - The accurate use of the Independent Mental Capacity Advocate referral process where applicable

## **6.0 Standards/Key Performance Indicators**

- 6.1 Key performance indicators comprise:
- Percentage of staff completing Mental Capacity Training
  - Number of IMCA referrals
  - The number of DoLS applications made

### **Process for Monitoring Compliance and Effectiveness**

- 6.2 This policy and its implementation will be monitored through the Safeguarding Steering Committee.

### **Equality and Diversity**

- 6.3 This document complies with the UHPNT service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.
- 6.4 The Initial Quality Impact Assessment Screening Form is at Appendix 3.

## **7.0 Dissemination and Implementation**

- 7.1 This Policy is to be implemented and disseminated through the Organisation immediately following ratification and will be published on the Organisation`s intranet site document library; access to this document is open to all.
- 7.2 The Policy will be launched via the UHPNT daily communication network. Dissemination plan can be found in Appendix 1.
- 7.3 The Policy will be available to all external stakeholders via the Documents Library on the intranet.
- 7.4 This Policy document will be held in the public section of the Documents Library with unrestricted access, replacing the previous version which will be archived in accordance with the Trust Information Lifecycle and Corporate Records Management Policy.

## **8.0 Consultation and Ratification**

- 8.1 The design and process of review and revision of this Policy will comply with the Development and Management of Trust Wide Documents.
- 8.2 The review period for this document is set as a default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedure described.
- 8.3 This document will be approved by the Safeguarding Steering Committee and ratified by the Chief Nurse.
- 8.4 Non-significant amendments to this document may be made, under delegated authority from the Chief Nurse, by the nominated author. These must be ratified by the Chief Nurse and should be reported, retrospectively, to the approving Safeguarding Steering Committee.
- 8.5 Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades that are directly affected by the proposed changes.

## **9.0 Updating and Review**

This process is managed via the document library; review will be undertaken in September 2020 unless best practice dictates otherwise.

## 10.0 Mental Capacity Act Standards and Practice

10.1 Within the MCA there are 5 principles that underpin the entire Act and provide a safeguard for people whose mental capacity is called into question.

1. A person must be assumed to have capacity unless it is established that they lack capacity

If there is any reason to doubt the person's ability to make a decision or if it has been called into question, then there is an expectation that it will be assessed. It is for the assessor to demonstrate on the balance of probabilities that the person cannot make the decision by applying the statutory test of capacity.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success.

It is necessary to consider what might help or support the person to make the decision and provide whatever support is practicable in the circumstances. For example, it may be relevant to consider the best time and place to speak to the person where the person will feel at ease, whether the person has any communication needs and whether a friend or relative could help the person feel at ease or help the assessor understand the person's method of communication

3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.

It is important to acknowledge the inherent subjectivity of decision-making. It is not legally possible to conclude that a person lacks mental capacity to make a decision solely on evidence of decisions or actions that seem to place the person at increased risk of harm. These, in addition to a known or suspected impairment of the mind or brain may indicate the need for further assessment. Assessment of capacity and conclusions must make reference to the functional test (see section 10.8)

4. An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in the person's best interests.

The legal principle of "best interest" under the MCA only applies when it has been established that a person lacks mental capacity to make the relevant decision. Best interest is to be interpreted holistically and must take into account the ascertainable wishes of the person as well as the views of anyone else interested in the care and treatment of the person.

5. Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Whenever care or treatment is proposed that conflicts with the wishes of the person, it is important to consider whether the measures are necessary and proportionate to the risk, including consideration of any negative effect on the person from having their wishes over-riden. It is also essential to consider the right to respect for private and family life.

10.2 Nothing in the Act permits a decision to be made on someone else`s behalf on any of the following matters:

- Consenting to marriage or a civil partnership
- Consenting to having sexual relationships
- Consenting to a decree of divorce on the basis of two years separation
- Consenting to the dissolution of a civil partnership
- Consenting to a child being placed for adoption or the making of an adoption order
- Discharging parental responsibility for a child in matters not relating to the child`s property
- Giving consent under the Human Fertilisation and Embryology Act 1990

## **Mental Capacity Assessment**

### **When to assess capacity?**

10.3 Practitioners should think about decision-making capacity every time a person is asked for consent, or to make a decision, during care planning.

10.4 Capacity should be assessed whenever there is reason to doubt whether the person is able to make a decision (that needs to be made ie.decision-specific). This may be due to the person`s behaviour or circumstances, a cognitive impairment which may affect decision-making or a concern raised by another professional, carer or family member. There may also be a concern if a person repeatedly makes unwise decisions that put them at significant risk of harm or exploitation, or a particular unwise decision which is obviously irrational or out of character. This would not, in itself be evidence the person cannot make the decision, but would be a reason to assess capacity. Practitioners should also be aware that a person may have decision making capacity even if they are described as lacking insight into their condition. Capacity and insight are two distinct concepts; if a practitioner believes a person`s insight/lack of insight is relevant to their assessment of the person`s capacity they must clearly record what they mean by insight/lack of insight in this context and how they believe it affects /does not affect the person`s capacity.

### **Who assesses capacity?**

10.5 The MCA does not lay down professional roles nor require certain qualifications to undertake capacity assessments. Any competent health or social care professional can undertake a capacity assessment as long as they follow the

process outlined in the MCA Act. The capacity assessment should usually be undertaken by the person who is the decision maker as long as they are competent to do so although this may mean that the assessor is not the person who knows the person the best in which case the assessor may wish to consult with someone who knows the person better which may include other professionals and/or the person's relatives or friends. The decision maker does have to be satisfied that the person lacks capacity so they may wish to obtain additional expertise to help determine this in certain scenarios, for example, a speech and language therapist or someone with a particular expertise in the mental disorder of the person. They may also wish to consult with family or friends of the person unless it is contrary to the best interests of the person to do so or breaches their confidentiality.

10.6 Usually, professionals are the assessors for actions for which they are responsible. This means that a doctor will likely be the assessor of someone's capacity for the treatment they are prescribing; a nurse will likely be the assessor for activities of daily living such as washing and dressing.

10.7 As a general rule the more complex the decision the more experienced the assessor should be. There may be times when the multi-disciplinary team will discuss the person's capacity together however, it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed and whether they have reasonable belief on the balance of probabilities that the person lacks capacity to make the decision.

### **Assessing capacity**

10.8 The assessor must have reasonable belief that the person lacks capacity to commence the assessment. If you do not have reasonable belief then you must assume that the person has capacity. Any assessment of capacity is time and issue specific, for example, an individual may have capacity to choose where they live but not have the capacity to make a decision about their care and treatment. If there is more than one decision to be made then it may be necessary to undertake more than one assessment. The assessor should inform the person being assessed why they are assessing their capacity and what they can do if they do not agree with the outcome.

### **Completing the assessment**

10.9 There are two stages in the test of capacity:

#### **Stage one is the Diagnostic Test:**

Is there an impairment of, or disturbance in, the functioning of the person's mind or brain and is that impairment or disturbance sufficient to cause the person to be unable to make that particular decision.

This can be a confirmed diagnosis or signs and symptoms to indicate a diagnosis. Examples of an impairment or disturbance include Brain Injury, Dementia, Physical

or Medical conditions that cause confusion, drowsiness, or loss of consciousness etc. (refer to MCA Code of Practice 4.12)

Stage two would normally only progress if the criteria in stage one is met, although there may be other behavioural reasons to assess capacity at the onset.

### **Stage two is the four step Functional Test:**

Can the person:

- **Understand** the information relevant to the decision?

The assessor should determine nature of the decision, the purpose for which it is needed and the consequences, risks or outcomes of making the decision. In determining risks the person needs only to consider the reasonably foreseeable risks.

Prior to completing the capacity assessment, the assessor should determine what amounts to the relevant information for each particular decision. Generally, relevant information includes the nature of the decision, the reason why the decision is needed and the likely effects of the deciding one way or another or not making a decision at all. Relevant information will include the key factors /issues and where the decision is determining between a range of options the risks and benefits of each option. It is not necessary for the person to comprehend every detail of the issue but needs to comprehend the salient or most important details. It is important not to assess someone's understanding before they have been given the relevant information about a decision.

The assessor should document a description of the information they consider to be relevant for the person to understand. All practical and appropriate steps must be taken to help a person make a decision for themselves, information must be tailored to an individual's needs and abilities. It must be in the most appropriate form of communication for the person concerned. Use simple language and pause to check understanding. Where appropriate, use pictures, objects or illustrations to demonstrate ideas.

- **Retain** the information long enough to make the decision?

It is necessary to retain information for long enough to use it in making the decision. It may be helpful to consider in advance, given the nature of the decision, how long it would reasonably take the person to consider and reach a decision and proceed accordingly. It is not necessary for the person to spontaneously recall information or to retain information long enough for the decision to be implemented, although this may have other practical implications.

- **Weigh** or use the information as part of the process of making the decision?

Keep in mind that individuals may give different weight to different factors. For example, a person may legitimately value independence and familiarity over physical

safety or comfort. The MCA does not rely on “lack of insight” and this phrase does not feature in the functional test or Code of Practice.

- **Communicate** their decision using any method i.e. hand signals, gestures, writing etc?

If the person is unable to do **any** one of these four steps because of an impairment of, or disturbance in, the functioning of the mind or brain then they lack capacity to make the decision.

## **Recording the assessment**

10.10 If a capacity assessment has been carried out, records should include, at a minimum, the following information:

- The specific decision to be made and how the person wishes to be supported to make the decision.
- Details of the impairment of/or disturbance in, the functioning of the mind or brain and how it affects the person`s ability to make the decision
- Steps taken to maximise the person`s ability to make the decision
- the information relevant to the decision and how it was explained to the person
- Whether the person could understand, retain, weigh up the relevant information and communicate their decision, giving examples

There is a capacity assessment template in Appendix A. If this is not used then the assessor must ensure they record a clear and thorough account of the assessment in the medical/nursing records which is proportionate to the decision that is being made. The record should be shared with the person and with their consent other appropriate people.

As a general rule the more complex the decision and the risks associated with the decision the more detailed the assessment should be.

10.11 A detailed formal assessment of capacity should always take place where reasonable and practical to do so when the decision relates to:

### A) Serious Medical Treatment.

Serious Medical Treatment is defined in the Mental Capacity Act 2005 as treatment which involves withdrawing or withholding treatment in circumstances where one or more of the following apply:

- In a case where a single treatment is being proposed, there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail for them
- In a case where there is a choice of treatments, a decision as to which one to use is finely balanced

- What is proposed would be likely to involve serious consequences for the patient such as serious and prolonged pain, distress or side effects.
- Have potentially major consequences for the patient such as major surgery or stopping life sustaining treatment
- Have a serious impact on the patient`s future life choices

The MCA Code of Practice lists the following examples of possible serious treatments:

- Chemotherapy
- Electro-convulsive therapy
- Therapeutic sterilisation
- Major surgery such as open heart surgery or brain/neuro surgery
- Major amputations such as loss of an arm or leg for example
- Treatments that will result in permanent loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration
- Termination of pregnancy

B) A dispute as to what is in the person`s best interests with the person themselves or the person who has Lasting Power of Attorney or Deputyship for Health and Welfare for the person, family member or friend who is being consulted with, IMCA, or other professionals involved in the care /treatment of the person

- The person`s capacity may be subject to challenge
- If the case is in legal proceedings or likely to be in the future
- The person is making decisions that put him/her or others at risk or that result in preventable suffering

This list is not exhaustive and professional judgement must be used

## **Fluctuating Capacity**

10.12 An individual`s capacity may fluctuate over the course of time. If it is possible and reasonable and practical to do so the decision should be delayed until such time when the person has regained capacity. If the decision cannot be delayed then a decision on capacity, or lack of it, can be taken on the balance of probability but this will require a number of assessments over a period of time in order to determine this.

## **Executive Function, Executive Capacity and Self Neglect**

10.13 It may be more difficult to assess mental capacity in people with `executive dysfunction` – for example people with traumatic brain injury. `Executive dysfunction` develops when mental processes involving the completion of multi-step tasks or decisions do not develop normally or are damaged by brain injury or illness. It involves a range of difficulties in everyday planning and decision-making, which can be sometimes hard to detect. Assessments of capacity for

individuals in this group may need to be supplemented by real world observation of the person's functioning and decision-making ability in order to provide the assessor with a complete picture of an individual's decision-making ability. It is important to consider whether the inability to make the decision is caused by the 'executive dysfunction' arising from the impairment or disturbance of the mind or brain.

Whenever there are concerns of serious self-neglect, it is best practice to consider 'executive capacity' in addition to mental capacity and 'executive dysfunction.' 'Executive capacity' refers to the ability to carry out decisions and intentions, especially in relation to one's own welfare. This is different than 'executive dysfunction' because it is not necessarily caused by impairment of the mind or brain. Like 'executive dysfunction,' 'executive capacity' may be assessed through real world observation and contextual information from those who know the person well. Unlike lack of mental capacity caused by 'executive dysfunction', identifying that a person lacks 'executive capacity' would not enable professionals to rely upon the legal framework of the MCA to intervene without consent to bring about a person's best interest. There is no separate legal framework for intervention without consent for someone who lacks 'executive capacity.' Identifying the deficit can inform risk management. Planning should proceed in accordance with serious self-neglect policies. Other legal frameworks such as the Mental Health Act, Environmental Health or inherent jurisdiction of the high court may be considered.

### **Challenge to the finding of a lack of capacity**

10.14 A challenge to a mental capacity assessment could come from the patient, their family or from others involved in their care. If the challenge comes from the patient they may need support from others to assist in their challenge. The assessor will need to make use of the information recorded on the capacity assessment form to explain why a particular decision has been made. They must be able to provide reasons why they believe that the patient lacks capacity to make the specific decision and provide objective evidence to support this.

In some situations it may be helpful to obtain a second opinion from another professional who has not been involved in the person's care (see further information on disputes in section 12).

### **Making a decision in the person's best interests**

10.15 Having decided on and documented that the person lacks capacity to make the specific decision, if there is no Advanced Decision, Lasting Power of Attorney or Court Appointed Deputy for health and welfare (see section 15) a decision must be made in the person's best interests by the decision maker who must have reasonable belief that the decision is in the best interests of the person who lacks capacity. One of the key principles of the MCA is that any act

done, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's best interests. As long as these acts or decisions are in the best interest of the person who lacks capacity to make a decision for themselves, then the decision-maker or carer will be protected from liability.

A person's best interests may be different to what is in the best clinical interest of the person.

The MCA cannot be used to take a decision for someone that a person with capacity could not take for themselves. In other words, best interest decisions are limited to options that a person would have if they could make the decision themselves.

Working out what is in the best interests of the person must include consideration of the following:

- If there is a chance the person will regain capacity to make a particular decision, then it may be possible to put off the decision until later
- Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition or behaviour
- Every effort should be made to encourage and enable the person who lacks capacity to take part in the making the decision
- All relevant circumstances should be considered including:
  - 1) The person's past and present wishes and feelings
  - 2) The person's beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question
  - 3) If the decision involves life-sustaining treatment then the decision must not be motivated by a desire to bring about the person's death
  - 4) The decision maker should not make any assumptions about the person's quality of life
  - 5) The views of anyone involved in the persons care or interested in the welfare of the person or named by the person as someone to be consulted with, any Lasting Power of Attorney or Court Appointed Deputy for health and welfare, the person's Independent Mental Capacity Advocate (IMCA) if one is required (see section 13 on the role of the IMCA)

Whenever care or treatment is proposed that conflicts with the wishes of the person, it is important to consider whether the measures are necessary and proportionate to the risk, including consideration of any negative effect on the person from having their wishes and feelings over-ridden. It is essential to consider the right to respect for private and family life. Any interference with a person's right to privacy, autonomy or family life must be necessary, reasonable and proportionate (even in the context of safeguarding).

For young person`s aged 16-18 it is important to also consider alternative legal frameworks, such as the Children`s Act, where parental consent or Gillick competency may apply.

## **Best Interests Meeting**

10.16 A best interest meeting is a formal meeting that takes place with those involved in the care/treatment/support of the person who lacks capacity to consider what is in the person`s best interests. Careful consideration should be given as to who should attend so as not to exclude people who may have an interest. Those people may include:

- The person assessed as lacking capacity if this is appropriate and will not cause unnecessary distress to the person (if it agreed by those involved in their care /treatment/support that it is not in their best interest to attend in person, the reason should be recorded and a discussion and agreement take place about how, who and what should be fed back to the person who lacks capacity). The feelings and wishes of the person should be ascertained wherever possible, although they may lack capacity to make the decision their wishes and feelings need to be taken into consideration.
- Any person with Power of Attorney or a Court Appointed Deputy, even if they only have this for finance and property and not health and welfare
- Family members, parents, carers, and other people involved or interested in the welfare of the person who lacks capacity
- Any advocate who is involved including any statutory Independent Mental Capacity Advocate (IMCA)
- Any professional person who can contribute to the outcome of the best interest meeting

Best interest meetings should be held, wherever reasonable and practicable to do so, when deciding on serious medical treatment or long term accommodation moves or any significant life changing decision or where the person concerned is repeatedly making decisions that are placing themselves at risk or could result in preventable suffering.

A formal best interest meeting should be held when reasonable and practical to do so if there is a dispute from any person involved in the care/treatment/support of the person as to what is in the person`s best interests. A formal best interest meeting can take place but is not always necessary if it is only the person that lacks capacity that is in dispute as long as all others involved are in agreement as to what is in that person`s best interests. (Also see section 12 on Disputes).

In circumstances where the decision is not involving serious medical treatment, long term accommodation moves or a significant life changing decision or it is not practical or reasonable to hold a formal meeting then a best interest discussion can take place as an alternative to a formal meeting as long as the decision maker records who they consulted with the views given, the factors taken into account and the rationale for the decision made.

A Best Interest Meeting Checklist and Record is recommended for documenting the meeting (Appendix A). If the Best Interest Meeting Checklist and Record is not utilised the chair must ensure contemporaneous records are maintained and filed in the person's notes.

Before a best interest meeting commences it should already be established that the person lacks capacity. If an involved person cannot attend in person they should be given the opportunity to give their views by way of a consultation before the meeting or by alternative communication such as a letter or by way of someone else attending.

It should be established who the decision maker is.

It is best practice that the chair should not be the decision maker or someone directly involved in the person's care where it is practical and reasonable to have a chair who is independent from the decision that needs to be made.

Ensure that the meeting is person centered and focuses on the individual who lacks capacity and not what might best for Organisations or other family necessarily.

## **11.0 Decision maker**

11.1 This is not always obvious as it will depend on a number of factors and the specific circumstances of each case. For day to day non-life changing decisions this will often be the carer most involved in the persons care. However, for more complex or life changing decisions involving health professionals it is often the person prescribing the treatment or health intervention or the person responsible for the care plan or commissioning onward care, in some circumstances in can be a family member.

If there is a Lasting Power of Attorney or Court Appointed Deputy for Health and Welfare then they would be the decision maker but they are under the same obligations to consult with others involved in the person's care and apply the principles of the MCA.

## **12.0 Disputes**

12.1 If there is disagreement over what is in the person who lacks capacity best interests the decision maker can weigh up all the views and come to a decision as long as they record and/or share their rationale with those others involved in the person's care/treatment/support.

If the decision maker is a health or social care professional further advice should be sought from the MCA lead or the legal team as it is possible that in certain circumstances it may not be lawful to proceed with the decision and the decision needs to be delayed or an interim decision needs to be made with the final decision being made by the Court of Protection. In regards to DoLS applications the person who lacks capacity or an involved relative has the right of appeal to the Court of

Protection (Section 21A of the MCA) if they are objecting (see section 21.14 on Deprivation of Liberty).

### **13.0 Role of the Independent Mental Capacity Advocate (IMCA)**

13.1 An IMCA is a statutory advocate that must be involved in certain best interest decisions if there is no-one else willing or appropriate (on an unpaid basis) to be consulted as part of a best interest decision.

An IMCA must be involved in decisions about:

- serious medical treatment
- moving into care for more than 28 days or in a hospital for 8 weeks or more
- during an assessment for deprivation of liberty safeguards authorisation

Deciding whether a person's friend(s) or family members are "appropriate to consult" involves considering whether there is any reason that speaking to them would be harmful to the person. There is an expectation that friends and family members whom are willing to be involved will be consulted as part of best interest decisions.

13.2 An IMCA would not usually be involved merely because there is a dispute about what is in the person's best interests or because there is a disagreement between family and professionals. However, an IMCA may become involved even if the person has family or friends in a safeguarding investigation or to assist a person appointed as a DoLS representative.

13.3 The IMCA does not make best interest decisions but the professional making the best interest decision must take into account any information provided by the IMCA who can take steps to challenge the decision on behalf of the person.

13.4 NHS bodies must instruct and then take into account information from an IMCA where decisions are proposed about 'Serious Medical Treatment' (SMT), long term changes in accommodation or other significant life changing decisions where the person lacks the capacity to make the decision and there is no family or friends who are willing and able to support the person.

Examples of treatments where IMCAs have been involved include surgery, treatment for cancer, insertion of a PEG, amputation, dental treatment, blood tests, cataract operation, withdrawal of antibiotic treatment and Do Not Attempt Resuscitation (DNAR) orders.

13.5 The IMCA's have the right to interview the person in private, the right to examine, and take copies of, any records that the person holding the record thinks are relevant to the decision (for example, clinical records, care plans, social care assessment documents). Although clinicians and practitioners should be prepared to give access to records, those responsible for patient records should ensure that the third party information and other sensitive information not relevant to the decision at hand remain confidential. Trust

information application processes should be considered when access to records is sought.

- 13.6 The person responsible for making the relevant best interest decision should make a referral for an IMCA as soon as it becomes clear that one will be required. For Deprivation of Liberty Safeguards, all IMCA referrals will be made to the relevant Local Authority. For any other IMCA referrals the relevant professional should contact the IMCA Service in the area where the person is residing (including temporary hospital stays) regardless of ordinary residence, (or initially this can be done via the Trust Safeguarding Team).
- 13.7 The only exception for the need to instruct an IMCA is if there is an emergency situation requiring an urgent decision to be made, for example, to save a person's life. However, once the emergency has passed, there is a duty to instruct an IMCA for any subsequent serious medical treatment decisions.

UHPNT guidance to the involvement of an IMCA is shown in Appendix B. The IMCA referral form can be found in Appendix C.

#### **14.0 Advanced Decisions to refuse Medical Treatment**

- 14.1 An advance decision to refuse medical treatment enables someone aged 18 and over to refuse specified medical treatment for a time in the future when they may lack capacity to consent or refuse that treatment. The person can cancel their decision, or part of it, at any time while they have capacity to do so. An Advance Decision can set out what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent to this treatment for themselves in the future. It can be about any treatment even if it may result in the person's death.
- 14.2 If an Advance Decision is valid and applicable it must be followed as it is legally binding and has the same force as when a person with capacity refuses treatment (see below for the requirements for Advance Decisions). An Advance Decision does not need to be in writing; except for decisions relating to life-sustaining treatment (see below) but it is helpful if it is.

#### **What are the requirements for Advance Decisions?**

- 14.3 The following list gives a very brief summary of some of the main requirements for Advance Decisions (if you are involved in such a decision you should consult the Code of Practice): Advance decisions may be written or verbal, but must state precisely what treatment is to be refused, in medical or everyday language. It may also set out circumstances where the refusal should apply including possible future changes. Healthcare professionals should record verbal advance decisions in a person's healthcare record; however, they must also advise the person that there are additional requirements for recording

Advance Decisions to refuse life sustaining treatment. There is no set form for a written Advance Decision.

- People cannot make an Advance Decision to ask for medical treatment - they can only say what types of treatment they would refuse
- People cannot make an Advance Decision to ask for their life to be ended
- An Advance Decision can only refuse a particular specified treatment. It cannot refuse treatment by a specified healthcare provider or treatment at a specified hospital or place
- An Advance Decision can only relate to treatment, not personal care or procedures essential to keep the individual comfortable e.g. warmth, shelter, actions to keep a person clean and the offer of food and water by mouth.

### **Advance Decisions to refuse life-sustaining treatment**

14.4 If someone has made an Advance Decision to refuse life-sustaining treatment, specific rules apply.

- It must be in writing
- Be signed by the maker in the presence of a witness who must also sign the document. It can also be signed on the maker's behalf at their direction if they are physically unable to sign it for themselves
- Include a statement saying that it applies even if life is at risk

If you are satisfied that a decision is both valid and applicable then you will have to abide by the decision as a valid and applicable Advance Decision should be treated as if it were a contemporaneous refusal of treatment.

Any advanced decision that is shared or known about should be recorded in the patient's medical notes (making use of the safeguarding chapter card/file-divider) and then logged on iPM/SALUS and EDIS under alerts and/or appropriate patient data system that is used.

14.5 It will not be valid if:

- It has been withdrawn while the person had capacity to do so
- A LPA for health and welfare was appointed after the Advance Decision was made ( it will still be valid if the Advance Decision was made after the LPA was appointed)
- The person has acted in a way that is clearly not consistent with the decision (for example, consenting to the treatment while they had capacity

14.6 It will not be applicable if:

- The person still has mental capacity to make the decision in question
- It does not specifically refer to the treatment in question

- Any other circumstances specified in it are absent
- There are reasonable grounds for believing that circumstances exist currently that the person would not anticipate at the time of making the decision which would have affected the decision had they able to anticipate them (e.g. changes in the person's personal life or developments in medical treatments)

If an Advance Decision is not valid or applicable then it could still be considered as an indication of a person's feelings and wishes which although not legally binding should be taken into account and recorded in the same way as we record advance decisions to refuse treatment (see 14.4 on recording).

14.7 Where a person is detained under the Mental Health Act 1983 there are circumstances in which an Advance Decision can be overruled. Further guidance is available in the Mental Health Code of Practice.

### **Disputes and disagreements about Advance Decisions**

14.8 You will have to form a view about whether or not an Advance Decision is valid and applicable, if there is a dispute or uncertainty, then you should seek advice.

A healthcare professional is not required to act on an Advance Decision if they object to it on religious or moral grounds. The professional must make this known as soon as possible and arrangements must be made for the management of the patient's care to be transferred to another health professional.

If any of the people you provide care or treatment for had an Advance Decision (sometimes known as a 'Living Will') before the MCA came into force then it may still be valid. However, you should check that it meets the new rules, particularly if it deals with life-sustaining treatment. More detailed guidance on this is available at [www.dh.gov.uk/consent](http://www.dh.gov.uk/consent).

## **15.0 Lasting Power of Attorney (LPA)**

15.1 Having decided on and documented that the person lacks capacity to make the specific decision ascertain if there is a Lasting Power of Attorney or Court appointed Deputy with authority to make the decision in question.

A Lasting Power of Attorney lets an individual with capacity to do so appoint someone to make decisions on their behalf. There are two types

- Health and Welfare

- Property and financial affairs

Enduring Power of Attorney, available before 2008, may still be valid but would only relate to decisions about the donor's financial affairs.

If a person no longer has mental capacity to appoint an LPA, the Court can appoint a Deputy to make decisions. These can be for individual decisions, property and affairs or health and welfare, subject to limitations set by the Court.

The individual can choose to make one type of Lasting Power of Attorney or both. An LPA must be registered with the Office of the Public Guardian before it can be used.

15.2 Only people aged 18 or over can make a LPA

15.3 Attorney's must always follow the MCA's principles and make decisions in the donor's best interests.

15.4 Not all Lasting Power of Attorney's for health and welfare will have been given the power to make decisions about life sustaining treatment. The Lasting Power of Attorney form must clearly state this authority.

15.5 If a record of LPA or Deputyship is shared or confirmed then it should be recorded in the patient's medical notes (making use of the safeguarding chapter card/file divider) and logged on iPM/SALUS and EDIS under alerts and/or other appropriate patient data system that is being used.

## **Disputes and Disagreement**

15.6 If healthcare staff disagree with an attorney's assessment of best interests, they should discuss the case with other medical experts and / or get a formal second opinion. Then they should discuss the matter further with the Attorney.

If they cannot settle the disagreement, then the Trust's Legal Department should be contacted as there may be a need to make an application to the Court of Protection to make the decision.

If there are concerns that the Attorney is not acting in the best interests of the person then the concerns can be reported to the Office of the Public Guardian.

## **16.0 Research**

16.1 The MCA sets out the rules for research involving people who lack the capacity to consent. Details can be found in Chapter 11 of the Code of Practice. The MCA sets out parameters for research which may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees it is safe,

relates to the person's condition, and produces a benefit to the person that outweighs risk, or burden.

Carers or nominated third parties must be consulted and agree. If the person shows any signs of resistance or indicates in any way that they did not want to take part they must be withdrawn from the research project.

## **17.0 The application of the MCA to children and young people**

17.1 Within the MCA's Code of Practice, 'children' refers to people aged below 16 'Young people' refers to people aged 16–17. This differs from the Children Act 1989 and the law more generally where the term 'child' is used to refer to people aged under 18.

### **Children under 16**

The Act does not generally apply to people under the age of 16 but there are two exceptions:-

- i. The Court of Protection can make decisions about a child's property or finances (or appoint a deputy to make these decisions) if the child lacks capacity to make such decisions and is likely to still lack capacity to make financial decisions when they reach the age of 18.
- ii. Offences of ill treatment or willful neglect of a person who lacks capacity can also apply to victims younger than 16.

### **Young people aged 16–17 years**

17.2 Most of the Act applies to young people aged 16–17 years, who may lack capacity to make specific decisions but there are three exceptions:-

- i. Only people aged 18 and over can make a Lasting Power of Attorney
- ii. Only people aged 18 and over can make an advance decision to refuse medical treatment
- iii. The Court of Protection may only make a statutory will for a person aged 18 and over

### **Care or treatment for young people aged 16–17**

17.3 People carrying out acts in connection with the care or treatment of a young person aged 16–17 who lacks capacity will generally have protection from liability, as long as the person carrying out the act:

- has taken reasonable steps to establish that the young person lacks capacity

- reasonably believes that the young person lacks capacity and that the act is in the young person's best interests, and
- follows the principles of the MCA.

When assessing the young person's best interests, the person providing care or treatment must consult those involved in the young person's care and anyone interested in their welfare – if it is practical and appropriate to do so, this may include the young person's parents. Care should be taken not to unlawfully breach the young person's right to confidentiality.

### **Legal proceedings involving young people aged 16-17**

17.4 Sometimes there will be disagreements about the care, treatment or welfare of a young person aged 16 or 17 who lacks capacity to make relevant decisions. Depending on the circumstances, the case may be heard in the family courts or the Court of Protection. The Court of Protection may transfer a case to the family courts, and vice versa. This means that the choice of court will depend on what is appropriate in the particular circumstances of the case.

### **Children's Act (1989)- Applies to ALL those under the age of 18.**

#### **17.5 REMEMBER THE CHILD'S WELFARE IS PARAMOUNT – Children's Act (1989)**

You must consider safeguarding in ALL cases when undertaking a mental capacity assessment on young people aged 16-17. Whilst the MCA applies to those 16 and above the Children's Act must be considered in all cases. Seek expert guidance from the safeguarding team and/or legal department if required. The safeguarding of a child is paramount and children must be kept safe and free from harm: if safeguarding concerns exist escalate immediately through children protection processes and consider Court of Protection.

## **18.0 Interface of the Mental Capacity Act with the Mental Health Act 1983**

18.1 Detention of a person under the Mental Health Act (MHA) is not an indicator that they are unable to make decisions about their care and treatment. If a detained person requires treatment for a physical illness or condition, that is unrelated to their mental health, and they have been assessed as lacking capacity to make the required decision, then this UHPNT MCA policy and process must be followed.

The MHA is primarily about patients who are diagnosed as having a mental disorder that requires them to be detained and treated for that disorder or resultant physical symptoms in the interests of their own health or safety, or with a view to protecting other people.

18.2 Mental Health Act should be considered if:

- It is not possible to give the person the care or treatment they need without carrying out an action that might deprive them of their liberty
- The person needs treatment that cannot be given under the MCA (for example, because the person has made a valid and applicable advance decision to refuse all or part of that treatment)
- The person may need to be restrained in a way that is not allowed under the MCA
- It is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might then refuse to give consent)
- The person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so, or
- There is some other reason why the person might not get the treatment they need, and they or somebody else might suffer harm as a result.

18.3 Compulsory treatment under the MHA is not an option if:

- The patient's mental disorder does not justify detention in hospital, or
- The patient needs treatment only for a physical illness or disability

Before making an application under the MHA, decision-makers should consider whether they could achieve their aims safely and effectively using the MCA instead.

The interaction of the MHA and the MCA is a complex area of law. Where necessary, decision-makers are encouraged to contact the MCA/MHA Lead or UHPNT Legal Team for further advice.

## **19.0 Section 49 Court reports**

19.1 Section 49 of the Mental Capacity Act makes provision for the Court to require a Local Authority or NHS body to arrange for a report to be made by one of its officers or employees, or by such other person as the Authority, or the NHS body considers appropriate.

19.2 The Court rules and practice direction refer to a “senior officer” who can receive the court order on behalf of the Organisation. In this context, the senior officer will be the Chief Nurse or another member of the Executive Team.

19.3 The “nominated person” is the person with appropriate experience/knowledge nominated by the Trust to complete the report. This person may be employed by the hospital or be someone who has agreed to complete the report in accordance with the order on behalf of the hospital.

19.4 Where a nominated person has made a report they should be aware that they may also be called as a witness.

19.5 Further advice in relation to Section 49 reports can be sought from the UHPNT MCA Lead or Legal Team.

## **20.0 Restraint**

### **Restraint**

For a definition of restraint refer to the UHPNT Restraint Policy.

### **When is Restraint Permitted?**

20.1 The MCA permits the use of restraint or physical intervention which are in the best interest of the person and necessary to protect the person from harm. The action must also be the least restrictive intervention necessary to protect the person from harm and proportionate to the risk of harm in type and duration.

20.2 Where there are objective reasons for believing that restraint is necessary to prevent the person from coming to any harm, only the minimum necessary force or intervention may be used and for the shortest duration possible. Therefore, physical restraint can be used but only as a last resort.

Using excessive restraint could leave staff and the Trust liable to a range of civil and criminal penalties.

## **21 Deprivation of Liberty**

21.1 Article 5 of the Human Rights Act states that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'.

21.2 Best interest decision-making under the MCA is not a sufficient procedure to protect lawful justification for a deprivation of liberty. Protection from liability under the Act does not extend to protection from liability for unlawful deprivation of liberty.

21.3 The Mental Health Act does contain procedures by which a person may be deprived of their liberty in order to receive treatment for a mental disorder.

a. A person aged 18 or over who is deprived of their liberty outside the Mental Health Act in an acute hospital should be subject to the Deprivation of Liberty Safeguards (DoLS).

b. It is vital that an assessment of a person's capacity is made and documented that identifies that a person lacks capacity in order to apply for a DoLS.

21.4 A person aged under 18 who is deprived of their liberty outside of the Mental Health Act is not covered by DoLS, however, a deprivation of liberty cannot be

taking place if there is valid consent by way of parental responsibility for those person`s aged under 16. For those person`s aged 16 to 18 a recent Supreme Court Ruling, (“Re. D a Child (2019) UKSC 42”) has ruled that a deprivation of liberty cannot be authorised under parental responsibility, therefore if a deprivation of liberty is taking place of a young person aged 16 to 18 who lacks capacity, court authorisation will need to be sought. Further advice can be obtained if necessary from the UHPNT MCA Lead, Safeguarding Team or Legal Team.

## **Identifying a Deprivation of Liberty**

21.5 Deprivation of Liberty is another term for detention or confinement. It does not refer to an individual restriction or incidence of restraint. In 2014, the UK Supreme Court clarified the definition of deprivation of liberty. This is known as the acid test and is:

A person is deprived of their liberty if:

- The person is subject to continuous supervision and control

(if someone needs to know where the person is and what they are doing at all times for their own safety-this is considered continuous control)

And

- The person is not free to leave

(the person does not need to be actively trying to leave, it is the principle that it is the important factor, i.e. would they be allowed to leave on their own should they wish to?)

And

- The person has not given valid consent to the arrangements

(A person who lacks capacity to make a decision is not able to give valid consent)

Whether a person is deprived of their liberty does not depend on whether they are aware of or objecting to the arrangements.

## **Ferreira Ruling**

21.6 In the case of R (Ferreira) V HM Coroner for inner south London (2015) EWHC 2990, the UK Courts indicated that for patients receiving critical care there is one situation where the definition of deprivation of liberty may be different to that given by the UK Supreme Court (above). This is in the context of a person who lacks capacity to consent to receiving treatment for a physical

disorder in hospital. In this context only, the situation may not be considered a deprivation of liberty if:

- It is unavoidable as a result of circumstances beyond the control of professionals
- The treatment is necessary to avert a real risk of serious injury or damage
- The treatment is not materially different from that which would be given to a person of sound mind (according to medical evidence) in the same condition

The Courts have since clarified that in non-mental health wards where critical care is being delivered there is in general no need in the case of physical illness for a person of unsound mind to have the benefit of safeguards against a deprivation of liberty where the treatment is given in good faith and is materially the same treatment as would be given to a person of sound mind with the same physical illness. Therefore, as long as the person is not objecting to that treatment there is no need to seek authorisation; (the person would be seen to be objecting if there are additional restrictions put in place that would not normally be in place for someone who has capacity to consent with the same physical illness i.e. 1:1 staffing, bedrails, hand mittens, locked doors etc.). The law has clarified that DoLS does not apply to patients in Intensive Care Units, however, these patients still have rights under Article 5 of the Human Rights Act. Therefore, in cases where restraint being used may be seen as exceptional and/or excessive, either physically or chemically, there is a risk that this would amount to a deprivation of liberty, therefore would require a procedure set out by law to authorise this. As DoLS would not apply then authorisation from the Court of Protection may need to be considered if such restraint was beyond a negligible period of time. Further advice can be sought from the UHPNT MCA Lead or Safeguarding Team if necessary.

If the Ferreira Ruling has been applied then a note in the person's medical records should be made that it was felt the acid test criteria for DoLS has been met but that it was felt that the Ferreira ruling applied. The situation should be kept under review so that the DoLS process can be initiated if any of the criteria above no longer apply.

### **Who can be covered by DOLS?**

21.7 The deprivation of liberty safeguards can be used when a person:

- Is aged 18 years and over
- Has a mental disorder as defined in the Mental Health Act 1983
- Lacks capacity to consent to being in hospital and receiving treatment
- Needs to be deprived of their liberty for their own safety, where these arrangements are in the best interests of the person and proportionate to the risk of harm to the person if the arrangements were not in place.

The deprivation of liberty safeguards can only be used in hospitals and registered care homes. If a person is deprived of their liberty in any other setting, the deprivation of liberty must be authorised by a separate process involving a Court of Protection application.

### **Who is not covered by DoLS?**

DoLS cannot be used where;

- The person is under 18 years of age
- The person has made a valid and applicable Advance Decision refusing a necessary element of treatment for which they were admitted to hospital
- The use of the safeguards would conflict with a decision of the persons Attorney or Deputy of the Court of Protection
- The person is in hospital for the purpose of receiving treatment for mental disorder, they are objecting to that treatment and they meet the criteria to be detained under section 2 or 3 of the Mental Health Act.

### **Authorising a Deprivation of Liberty**

21.8 Hospitals and Care Homes, known as “Managing Authorities” must apply to the responsible Local Authority, known as the “Supervisory Body” for the deprivation of liberty to be authorised.

UHPNT geographically serves four Local Authorities. The Supervisory Body will usually be the Local Authority where the person is ordinarily resident (this will sometimes be dependent on which Local Authority is funding the package of care).

The Local Authority DoLS office will arrange for the necessary assessments that are required as part of the process and if satisfied will authorise the deprivation of liberty.

There are two types of authorisation: Standard and Urgent. A Managing Authority must request a Standard Authorisation when it appears likely that, at some time during the next 28 days, someone will be accommodated in its hospital or care home in circumstances that amount to a deprivation of liberty. The application form is shown in Appendix E.

Whenever possible an authorisation should be obtained in advance. Where this is not possible and the deprivation of liberty has already begun or where it is necessary for it to begin before Local Authority assessments are complete the Managing Authority must use the Urgent Authorisation process. This has the legal effect of a Self-Authorisation for a 7 day period. The hospital must apply for a Standard Authorisation at the same time as granting itself an Urgent Authorisation (usually this can be done on one form by completing two different sections). A copy of the Urgent Authorisation and request for a Standard Authorisation must be sent to the responsible Local Authority at the time that it is completed, it is not acceptable to rely on an Urgent Authorisation that has not be sent to the responsible Local Authority.

If the Standard Authorisation has not been granted within 7 days of applying then then it is possible to apply to the responsible Local Authority for an extension of the Urgent Authorisation. This application must be made before the end of the 7<sup>th</sup> day. The Urgent Authorisation will not be extended unless the responsible Local Authority grants the extension. The Urgent Authorisation can only be extended once and only for a further period of 7 days.

Once the Urgent Authorisation period and any extension that was granted has elapsed, it is not possible for the hospital to grant itself another Urgent Authorisation during the same hospital admission. The hospital must wait for the responsible Local Authority to grant the Standard Authorisation.

At the point when the Urgent Authorisation elapses (either after 7 days or 14 days if extended) a DATIX form must be completed as this enables a record of the unauthorised deprivation of liberty to be recorded and appropriate further action to be considered. The UHP process for application for DoLS can be found in Appendix E.

21.9 Deprivation of liberty authorisation, whether Urgent or Standard, relates solely to the issue of deprivation of liberty. It does not give authority to treat people, nor to do anything else that would normally require their consent. The arrangements for providing care and treatment to people in respect of whom a deprivation of liberty authorisation is in force are also subject to the wider provisions of the MCA.

21.10 If a person is being discharged from Hospital to a Registered Nursing or Residential Care Home and might require a DoLS then it is the responsibility of that Care Home to make the application as they may well be the Managing Authority, however, this should be discussed with the Care Home as part of the discharge planning. If the person is objecting to moving to the Care Home it may be necessary for the Care Home to make an application in advance and wait for it to be authorised in advance of the move to ensure that any deprivation of liberty is lawful.

### **Statutory Notification**

21.11 All DoLS applications are subject to statutory notification to the Care Quality Committee via Regulation 18(2), Care Quality Commission (Registration) Regulations 2009. Currently advice received from CQC is that they only require notification of those DoLS applications that have a Standard Authorisation in place.

### **Relevant Person's Representative**

21.12 Everyone subject to an authorisation issued by the Local Authority will have a person appointed as their representative. The representative will normally be a family member or friend but where this is not possible or appropriate the Supervisory Body will arrange for a paid representative to be appointed

(usually from the IMCA Service). The person's representative should be included in all decisions about the person's care and treatment.

21.13 Anyone who has a family member or friend as a representative also has the right to an IMCA. The representative also has the right to request an IMCA at any point. An IMCA supporting a person subject to a DoLS authorisation has a specific role and may not become involved in all care and treatment decisions unless they are relevant to the deprivation of liberty. It may be best to contact the DoLS IMCA regarding any decisions about care or treatment and ask whether they would like to be involved in the discussion.

21.14 One role of the representative is to support the person to exercise their right of appeal against the deprivation of liberty (Section 21A of the MCA). This may include requesting a review of the authorisation or an application to the Court of Protection.

21.15 If a person is subject to a deprivation of liberty safeguards authorisation, the authorisation may have conditions. Any condition of a DoLS authorisation should form part of the person's care/treatment plan. If it is considered unsafe or impossible to comply with the condition, the DoLS office who issued the authorisation should be informed immediately. The DoLS office should also be informed if the person's circumstances change so that the authorisation can be reviewed.

## **22.0 Criminal Offences under the Act**

22.1 The MCA introduced a new criminal offence of ill treatment or willful neglect of a person who lacks capacity to make relevant decisions.

- Ill-treatment covers both deliberate acts of ill-treatment and also those acts which are reckless and result in ill-treatment.
- Wilful neglect requires a serious departure from the required standards of treatment and usually means that a person has deliberately failed to carry out an act that they knew they were under a duty to perform.

A person found guilty of such an offence may be liable to a fine and/or imprisonment of up to five years.

## **23.0 Law of necessity**

23.1 Although there is provision for emergency treatment in the MCA and protection from liability provided under section 5(6) within the MCA for persons who lack capacity as in all situations, in all environments, in an emergency situation, health professionals can also undertake a vital act under the law of necessity which the health professional undertaking it believes it is necessary to prevent a serious deterioration in the person's condition even if they have capacity.

## **24.0 Access to Information and Confidentiality**

24.1 Where a person lacks mental capacity to decide whether to share information with a relative or other interested party, and there is no health and welfare power of Attorney or Deputy, a decision will need to be taken as to whether it is the best interests of the person for the information to be shared. Making this best interest decision should involve considering the person`s wishes and feelings (as far as they can be known) and considering the views of others that are involved in the care of the person.

When making a decision about whether a person should have a specific treatment, there is an expectation that the matter will be discussed with others involved in their care (including family and friends). It will be necessary to share enough information with family or friends to enable them to express their view of what is in the person`s best interest. There is an expectation that information relevant to the decision will be shared with those interested in the person`s care unless there is a clear reason not to do so.

If it is thought to be in the best interest of the person to share confidential information with the relative or other interested party outside of the best interest consultation process, the information shared should be relevant and proportionate in that situation.

There should be a record of what was shared and why, in accordance with the code of practice on confidentiality.

When a person has been granted finance and property Power of Attorney or Deputyship, this does not grant the right of access to health information in the same way; although it is relevant in the sense that it is an indication of the person having a sufficiently close relationship to act on the person`s behalf, for example, making a complaint on the person`s behalf. Information may still be shared if it is in the person`s best interests.

## **25.0 References and associated documentation**

1. Advanced Decision to Refuse Treatment: A Guide for Health and Social Care Professionals. The National Council for Palliative Care.
2. Care Act Standards Act (2000)
3. Children Act (1989)
4. Data Protection Act (1998)
5. Deprivation of Liberty Code of Practice (2007).
6. Equality Act (2010)
7. Human Rights Act (1998)
8. Involvement of Independent Mental Capacity Advocates (2007) PHNT
9. Mental Capacity Act Code of Practice (2005)

10. Ministry of Justice (2007) Mental Capacity Act (2005) Code of Practice: The Office of the Public Guardian.
11. Mental Capacity Act (2005)
12. Mental Health Act (1983)
13. Mental Capacity NICE Social Care Guidance NG108 ( 2018)

## **Definitions and Glossary of Terms used**

**Advance decision:** This is a decision made by an adult with capacity to refuse specific medical treatment in advance. The decision will apply at a future date when the person lacks the capacity to consent to or refuse the treatment specified in the Advance Decision. It has the same effect as a contemporaneous refusal of the specified medical treatment.

**Best Interests:** Any decision made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out someone's best interests. These are set out in Section 4 of the MCA, and in the non-exhaustive checklist in 5.13 of the MCA Code of Practice.

**Code of Practice:** People acting in a professional capacity for, or in relation to a person who lacks capacity are legally required to have regard to the Code of Practice which was written to support the understanding and application of the MCA.

**Consent:** Agreeing to a course of action –specifically in this document, to a care plan or treatment regime. For consent to be legally valid the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress, undue influence or inappropriate pressure.

**Court of Protection:** The specialist Court for all issues relating to people who lack capacity to make specific decisions.

**Decision maker:** The person who is most appropriate to make a particular decision or who has specific authority to make the decision. Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred throughout the code of practice as the 'decision maker', and it is the decision maker's responsibility to work out what would be in the best interests of the person who lacks capacity.

**Deprivation of Liberty Safeguards (DoLS):** Deprivation of Liberty Safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment, but for whom receiving care or treatment in circumstances that

amount to a deprivation of liberty may be necessary to protect them from harm and appears to be in their best interests

**Independent Mental Capacity Advocate (IMCA):** This is a person who supports and represents a person who lacks capacity to make a specific decision, where that person has no-one else who can support them. They make sure that major decisions for a person who lacks capacity are made in accordance with the Mental Capacity Act 2005. IMCA`s appointed under DoLS are required to have additional DoLS specific training. See DoLS Code of Practice 7.34 - 7.41 for details of the role of the DoLS IMCA.

**Lack of capacity:** The MCA defines a `lack of capacity` as an inability to make a particular decision at a particular time due to an `impairment of or disturbance in the functioning of the mind or brain.

**Lasting Power of Attorney (LPA):** This is a power of attorney created under the MCA 2005. It enables a person initially with capacity to appoint another person to act on their behalf in relation to decisions about the donor`s financial and/or personal welfare (including healthcare) at a time when they no longer have capacity. An LPA must be registered with the Office of the Public Guardian before it can be used.

**(Least) Less restrictive option:** This is a guiding principle underpinning the MCA. Before an act is done or a decision is made on behalf of a person who lacks capacity it should be considered whether these purposes can be achieved in a way that is less restrictive of that person`s rights and freedoms.

**Managing Authority:** The person or body with management responsibility for the hospital or care home in which a person is, or may become deprived of their liberty.

#### **MCA (Mental Capacity Act 2005):**

**Restraint:** The use of threat or force to undertake an act which the person resists, or the restriction of the person`s liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect that person from harm and it is proportionate to the risk.

**Serious Medical Treatment:** Providing, withholding or withdrawing treatment where there is a fine balance between the risks and benefits of a single treatment, a choice of treatments which are finely balanced or the proposed providing, withholding or withdrawing of treatment is likely to involve serious consequences for the patient.

**Standard Authorisation:** This is the formal authorisation to deprive a person of their liberty, given by the Supervisory Body, after completion of the statutory assessment process.

**Statement of wishes and feelings:** A person with capacity may express their wishes and feelings about their future medical treatment, where they would

Name Of Decision Making Officer: Designation: Signed:	
--	--

choose to live, how they would wish to be cared for, in the event they lose capacity in the future. These are non-binding but should be used by relevant professionals for consideration when making best interests decisions for a person who lacks capacity.

**Supervisory Body:** A Local Authority that is responsible for considering deprivation of liberty requests, commissioning the assessments, scrutinising the assessments and authorising deprivation of liberty.

**Appendix A – Record of Mental Capacity and Best Interest (MCA 2005)**

TRW.SAF.POL.1033 1.5 Mental Capacity Act (MCA, 2005) Liberty (DoLS, 2007) Policy

Surname: First Name: Hospital Number: NHS Number: DOB: <i>Affix patient label here</i>
---

<b>Date process started:</b>	
<b>Ward:</b>	
<b>Who is Representing Patient (NOK, Friend, IMCA)</b>	Include Level of Authority: (i.e. Power of Attorney for Health and welfare )

**Please give the name and status of anyone who assisted with making this best interest decision:**

Name	Status	Contact Details

**Details of the decision to be made on behalf of person who lacks capacity: e.g. medical intervention / DoLS**

**PART 1 DETERMINING LACK OF CAPACITY**

	Response		Comments
	Yes	No	
1. Is there an impairment of, or disturbance in the functioning of the Patient mind or brain?			
2. Do you consider the Patient <b>able</b> to understand the information?			
3. Do you consider the Patient <b>able</b> to retain the information?			
4. Do you consider the Patient <b>able</b> to use or weigh that information?			
5. Do you consider the Patient <b>able</b> to communicate their decision?			
6. Has the Service User been determined as lacking capacity to make this particular decision at this moment in time?			

If you have answered **NO** to Q1 that there is no such impairment or disturbance of the mind/brain, then unless there are other behavioural reasons to assess capacity at the outset there is no need to continue any further as this must be present for the assessment to continue to the next steps and thus **THE PATIENT HAS CAPACITY** within the meaning of the Mental Capacity Act 2005. Sign/date this form above, record the outcome within the patient's records. **Do not proceed any further.**

If you have answered **Yes** to Q1 and **No** to any of Q2 to Q5, the Patient is considered on the balance of probability, **NOT to have the capacity to make this particular decision at this time**. Please complete **Part 2** with a least one other individual who knows the person/circumstances best (this may not necessarily be NOK).

The MCA (2005) applies to those 16 years and over - you must consider the need for an advocate to be present for all young people aged 16 and 17 years and particularly where children are known to have a neurodevelopmental or mental health disorder. Remember **the safety of the child is paramount** and irrespective of whether the young person does or does not have mental capacity appropriate measures should be taken to ensure the young person's safety.

**PART 2 – DETERMINING BEST INTERESTS**

**All steps and decisions taken for someone who lacks capacity must be taken in their best interests.**

	Response		Details of Actions
	Yes	No	
Q1. <b>Avoid Discrimination – Guidance</b> Have you avoided making assumptions merely on the basis of the Patient’s age, appearance, condition or behaviour?			
Q2. <b>Relevant Circumstances – Guidance:</b> Have you identified all the things the Patient would have taken into account when making the decision for themselves?			
Q3. <b>Regaining Capacity – Guidance:</b> Have you considered if the Patient is likely to have capacity at some date in the future and if the decision can be delayed until that time?			
Q4. <b>Encourage Participation – Guidance:</b> Have you done whatever is possible to permit and encourage the Patient to take part in making the decision?			
Q5. <b>Special Considerations – Guidance:</b> Where the decision relates to life sustaining treatment, have you ensured that the decision has not been motivated in any way, by a desire to bring about their death?			
Q6. <b>The Persons Wishes – Guidance:</b> Has consideration been given to the Patient past and present wishes and feelings, beliefs and values that would be likely to influence this decision including written statements?			
Q7. <b>Consult Others – Guidance:</b> Have you where practicable consulted and taken into account the views of others including those engaged in knowing or caring for the Patient, Attorney under a Lasting or Enduring Power of Attorney or Deputy of the Court of Protection? In cases of serious medical treatment including <b>DNR</b> decisions or changes to accommodation and there is no one identified here you must consider instructing an Independent Mental Capacity Advocate.			
Q8. <b>Avoid Restricting Rights – Guidance:</b> Has consideration been given to the least restrictive option for the Patient?			
Q9. <b>Other Considerations – Guidance:</b> have you considered factors such as emotional ties, family obligations that the Patient would be likely to consider if they were making the decision?			
<b>Q10. Having considered all the relevant circumstances, what decision/action do you intend to take whilst acting in the Best Interests of the Patient?</b>			
<b>Signature:</b>			<b>Date:</b>

## Appendix B – Best Interest Meeting Template

Individual's Name	
DOB	
NHS No	

Date	Venue
------	-------

Attendees:	Name	Signature	Designation	Email or Address	Minutes Dissemination

Brief introduction to the individual:	
---------------------------------------	--

Decision to be made (Focus of meeting):	
---	--

Decision maker:	
-----------------	--

Current wishes of individual, if known:	
---	--

How was capacity assessed (in accordance with the Mental Capacity Act 2005) and what is the outcome:	
--	--

Is the person likely to regain capacity (Risks involved with waiting)	
---	--

Have professionals met the individual to ensure reports are up-to-date?	
---	--

What has been done to assist the individual to take part in the decision? E.g, supported communication, chance to visit the venue ahead of time (if attending)	
--	--

If individual is present	If individual is not present
<ul style="list-style-type: none"> <li>• All information available in an accessible format, or a client-friendly version is produced</li> <li>• Large name badges</li> <li>• Profession explanation document</li> <li>• To help reduce anxieties, Chair should ensure:               <ul style="list-style-type: none"> <li>- There is water on table</li> <li>- That attendees know where the toilets are, etc.</li> <li>- That regular breaks are allocated</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Is there a visual representation of the individual in the room? For example A4 picture of individual in middle of meeting table (Helping to keep the meeting person-centred)</li> </ul>

Any indications from the past as to the likely wishes of the individual? (Verbal/Writing)	
---	--

What would/does the individual think are the important factors here?	
--	--

Views and involvement of others, e.g: <ul style="list-style-type: none"> <li>• Health professionals</li> <li>• IMCA</li> <li>• Lasting Power of Attorney</li> <li>• Independent Advocate</li> </ul>	

Views of family members following professionals' opinions		
Any other contributing factors e.g, individual's compliance?		
List possible options being considered in regard to decision being made and their impact on the individual's health, welfare, social and emotional well-being:		
What decision has been made?		
Is the decision the least restrictive/intrusive? If not, then give rationale		
Outcome Plan: (inc. dates and person(s) responsible)	Action by NAMED individual(s)	By whom? By when?
Is there any dispute? How will this be managed? What options are available?		
How will decision be communicated to the individual and by whom?		
Professionals offer to meet individual after BIM to further explain if necessary and to repair relationship if damaged.		
Date of next meeting if required.		

PLYMOUTH HOSPITALS NHS TRUST

Involvement of Independent Mental Capacity Advocates (IMCA)

*The five underpinning principles - You must:*

1. Assume the person has capacity unless proved otherwise
2. Undertake all practical steps to enable a person to make a decision before a lack of capacity is formally assessed
3. Allow people to make what may seem to you an unwise decision
4. Always do things, or take decisions for people without capacity, in their best interest
5. Ensure that when doing something to someone, or making a decision on their behalf you choose the least restrictive option for rights and freedom

*The two-stage test of capacity*

1. Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?  
**and**
2. Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

*The person is able to make a decision and therefore has capacity if they:*

- a. Understand the information relevant to the decision
- b. Retain the information
- c. Use or weigh that information as part of the process of making the decision
- d. Communicate his/her decision either by talking, signing, or any other means

*Best Interest Checklist*

Where a person lacks capacity all decisions must be made in the best interest of that person.

When making decisions on behalf of a person who lacks capacity

- Involve the person
- Be aware of the person's past and present wishes and feelings
- Consult with others who are involved in the care of the person
- Do not make assumptions based solely on the person's age, appearance, condition or behaviour
- Consider that the person may regain capacity to make decisions in the future

*Record your decision and rationale in the patients clinical record*

For more information on the Mental Capacity Act contact your named lead or visit

<http://www.dce.gov.uk/legal-policy/mental-capacity/index.htm>

Involvement of IMCA service

1. Does the person have a condition which is affecting their ability to make decisions? ✓
2. Is the person 16 years or older? ✓
3. Does the person lack capacity to make the particular decision? ✓
4. Is there nobody (other than paid workers) whom the decision maker considers are willing and able to be consulted about the decision? ✓  
(This does not apply for Adult Protection cases – people can have family and still be eligible)

**If the above criteria applies**

An IMCA must be consulted for Decisions relating to

- Serious Medical Treatment (Serious Medical treatment is defined as treatment which involves giving new treatment, stopping treatment or withholding treatment that could be offered) where there is a fine balance between benefits and burdens, choice of treatments and serious consequences to the patient
- If the proposal is that the person is to be placed in a Care Home or moved to another Care Home for a period likely to be longer than 8 weeks  
(Including Supported Living/Sheltered Accommodation)
- An NHS Organization proposes to place a person in a Hospital or move them to another Hospital for a period exceeding 28 days

An IMCA may be consulted

- Adult Protection Cases
- Care Reviews

An IMCA may not necessarily be involved

- For urgent decisions for Serious Medical Treatment eg life saving procedures
  - Under certain circumstances when a person is detained under the Mental Health Act
- If you would like to discuss whether a person is eligible or make a referral please contact the IMCA Service by: email [info@seap.org.uk](mailto:info@seap.org.uk) or phone 0300 343 5719**

To download the seAp IMCA referral form please click below.

## IMCA REFERRAL

### What is the Independent Mental Capacity Advocate (IMCA) Service and how does it work?

The purpose of the IMCA service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about these decisions, or about care reviews or Adult Protection proceedings.

#### The IMCA service safeguards the rights of people aged 16 years and over who:

- **lack capacity to make a specified decision at the time it needs to be made**

The Mental Capacity Act 2005 (MCA) says everyone has the right to make their own decisions and must be given all practicable help to do so before they are deemed as lacking capacity. The person's capacity must be assessed in relation to the decision to be made. Generic assessments of capacity are not sufficient.

*and*

- **have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests, other than paid staff**

NHS and Local Authority Decision Makers need to determine if there are family or friends who are willing and able to be consulted about the proposed decision. If not, an IMCA will work with and support people who lack capacity, and represent their views to those who are considering their best interests in accordance with the MCA.

If a decision needs to be taken about a Care Review or Safeguarding case, there is now a statutory duty to refer under the Care Act 2014, and an ICAA referral should be made for an Independent Care Act Advocate.

**Please complete a SEPARATE referral PER DECISION**



**IMCA**

**This referral form is designed to be used with Nitro or Adobe Acrobat Reader DC. If you have trouble using this form with your PDF reader and require a different format, or have any questions, please contact us on: 0330 440 9000 or at: [info@seap.org.uk](mailto:info@seap.org.uk)**

To contact your local seAp office [click here](#).

## Process for application for Deprivation of Liberty Safeguards

For people who lack mental capacity to consent to treatment which requires them to be in hospital in their best interest, with restraint or care which amounts to deprivation of their liberty

PLEASE ENSURE A 'RECORD OF CAPACITY AND BEST INTEREST (MCA 2005)' FORM IS COMPLETED AND THE RESTRAINING CARE PLAN IS BEING USED

### DISCUSS & REVIEW CARE PLANNING WITH MDT, NOK, FAMILY/ MAIN CARER / IMCA

DAILY

STEP 1

COMPLETE DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1 – pages 1-7  
(Request for standard authorisation and urgent authorisation)

STEP 2

SEND COPY OF FORM 1 TO:  
(Keep original form in medical notes)

Safeguarding Team DoLS inbox - [plh-tr.DOLS@nhs.net](mailto:plh-tr.DOLS@nhs.net)

STEP 3

Prior to the end of first 7 days self-authorisation [urgent] and if there is no allocation of Best Interests Assessor from responsible Local Authority OR there is an allocated assessor but outcome is not known prior to self-authorisation [urgent] expiring complete:

- a) Section relating to extension of self-authorisation in Form 1 (original in clinical notes) – page 8
- b) Send copy as listed in STEP 2

Prior to end of extension expiring – if no allocation of Best Interest Assessor from responsible Local Authority

- c) Complete DATIX IF request for extension is not granted, or
- d) IF extension IS granted complete DATIX once extension has expired and there is still no Best Interest Assessor allocated
- e) Clinical teams must refer to the risk guidance on the reverse for next steps.

STEP 4

Inform relative/NOK using these suggested words – “As you know because your relative lacks capacity and is not free to leave the ward on their own the ward has followed a legal process called ‘Deprivation of Liberty Safeguards’ – due to significant demand the responsible Local Authority has not been able to arrange the necessary assessments within legal timescales. This should not affect your relatives care or treatment, but we wanted to inform you. We believe that the current Deprivation of Liberty is in the best interests of your relative, is the least restrictive option and proportionate to their care needs. We are using the hospitals care plan for restraint and restriction to review regularly. If you have any questions you can contact the ward or the responsible Local Authority DoLS Office.

STEP 5

If a Local Authority Standard authorisation deprivation of liberty expires then the process needs to start again by completing a FORM 1 as described in STEP 1 and STEP 2 – you do not complete page 7 & 8 as these are for an urgent application (once a standard authorisation has been in place a further self-authorisation cannot be put in place).

For people who lack mental capacity to consent to treatment which requires them to be in hospital in their best interest, with restraint or care which amounts to deprivation of their liberty

## **Risk Assessment guidance for expiring/not granted extension**

### **Applications - Deprivation of Liberty Safeguards**

Please use guidance below to review all medium/high risk triggers.

- Is the patient hospital stay likely to be more than 7 days?
- Have relatives expressed any concern? If Yes, escalate now to local authority/safeguarding team/legal team for advice
- Is the patient non-compliant with nutritional needs and medication and any other treatment necessary?
- Does the patient appear to be objecting with the care plan and treatment and for the need to be in hospital?
- Is the patient asking or attempting to leave the ward?
- Is the patient on a locked ward or has a locked door policy been implemented as a direct result of the patients presentation?
- Is the patient under regular monitoring or frequent checks (check at least every hour using the restraint care plan)?
- Is the patient subject to any restraint or any addition restrictions?

If **Yes** to any of the above medium/high risk triggers - **Clinical Teams MUST:**

**Prior to extension expiring or not being granted a written request via email should be made to responsible Local Authority to highlight high risk triggers identified above so that they can re-prioritise allocation of Best Interest Assessor – document this conversation in notes. Please copy in [plh-tr.DOLS@nhs.net](mailto:plh-tr.DOLS@nhs.net)**

The MDT must consider and document daily in medical notes the below:

- 1) Continue to evaluate the need for DoLS and the level of restraint /restriction required which is proportionate to the risks of the patient if these restraint/restrictions were not in place – use the restraints care plan throughout period of time PHNT believe they are depriving a patient of their liberty under best interest principles.
- 2) Maintain daily contact with patient’s representative (NOK, friend, IMCA).
- 3) Consider daily the need for an application to the Court Of Protection.
- 4) Inform Local Authority when patient is discharged.
- 5) If the patient is being discharged to another care facility UHPNT must inform them that a DoLS will need to be considered by them.

Case ID Number:

**Appendix F – Deprivation of Liberty Safeguards form 1(ADASS)**

**DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1**

**REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION**

<b>Name Of Decision Making Officer:</b> <b>Designation:</b> <b>Signed:</b>		Surname: First Name: Hospital Number: NHS Number: DOB:
<b>Ward:</b>		
<b>Ward Manager:</b>		
<b>Ward Contact Details:</b>		
<b>Who is Representing Patient</b> (NOK, Friend, IMCA)		
<b>Contact Number for Patient Representative:</b>		
<b>Please confirm DoLS information given to Patient and Representative:</b>		
<b>Date 7 day Urgent authorisation expires:</b>  .....	<p>Remember to request an extension prior to urgent expiring by (place date below when extension should be requested, day 5 of the Urgent application submission date.)</p> <p>Request Extension On:           .....</p>	

FRONT PAGE

**DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1  
REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION**

Request a <b>Standard Authorisation</b> only ( <i><b>you DO NOT need to complete pages 7 or 8</b></i> )				
Grant an <b>Urgent Authorisation</b> ( <i><b>please ALSO complete pages 7 and 8</b></i> )				
Full name of person being deprived of liberty				Sex
Date of Birth ( <i>or estimated age if unknown</i> )				Est. Age
Relevant Medical History				
Sensory Loss			Communication Requirements	
Name and address of the care home or hospital requesting this authorisation				
Telephone Number				
Person to contact at the care home or hospital, (including ward details if appropriate)	Name			
	Telephone			
	Email			
	Ward (if appropriate)			
Usual address of the person, (if different to above)				
Telephone Number				
Name of the Supervisory Body where this form is being sent				
How the care is funded	Local Authority <i>please specify</i>			
	NHS		Local Authority and NHS (jointly funded)	
	Self-funded by person		Funded through insurance or other	

## REQUEST FOR STANDARD AUTHORISATION

### THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED:

*If standard only – within 21 days*

*If an urgent authorisation is also attached – within 7 or 14 days*

### PURPOSE OF THE STANDARD AUTHORISATION

- *Please describe the care and / or treatment this person is receiving day-to-day and attach a relevant care plan.*
  - *Please give as much detail as possible about the type of care the person needs, including personal care, mobility, medication, support with behavioural issues, types of choice the person has and any medical treatment they receive.*
- 
- *Explain why the person is not free to leave and why they are under continuous or complete supervision and control.*
  - *Describe the restrictions you have put in place which are necessary to ensure the person receives care and treatment. (It will be helpful if you can describe why less restrictive options are not possible including risks of harm to the person.)*
  - *Indicate the frequency of the restrictions you have put in place.*

**INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT**

Family member or friend	Name	
	Address	
	Telephone	
Anyone named by the person as someone to be consulted about their welfare	Name	
	Address	
	Telephone	
Anyone engaged in caring for the person or interested in their welfare	Name	
	Address	
	Telephone	
Any donee of a Lasting Power of Attorney for Health and Welfare granted by the person	Name	
	Address	
	Telephone	
Any Deputy for Health and Welfare appointed for the person by the Court of Protection	Name	
	Address	
	Telephone	
Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005	Name	
	Address	
	Telephone	

**WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED**

*Place a cross in EITHER box below*

Apart from professionals and other people who are paid to provide care or treatment, this person has no-one whom it is appropriate to consult about what is in their best interests

There is someone whom it is appropriate to consult about what is in the person's best interests who is neither a professional nor is being paid to provide care or treatment

**WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION**

*Place a cross in one box below*

The person has made an Advance Decision that may be valid and applicable to some or all of the treatment

The Managing Authority is not aware that the person has made an Advance Decision that may be valid and applicable to some or all of the treatment

The proposed deprivation of liberty **is not** for the purpose of giving treatment

**THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT (1983)**

Yes  No  *If Yes please describe further*

**OTHER RELEVANT INFORMATION**

Names and contact numbers of regular visitors not detailed elsewhere on this form:

Any other relevant information including safeguarding issues:

**PLEASE NOW SIGN AND DATE THIS FORM**

Signature		Print Name	
Position			
Date		Time	

**I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION** *(Please sign to confirm)*

<b>RACIAL, ETHNIC OR NATIONAL ORIGIN</b> <i>Place a cross in one box only</i>			
White		Mixed / Multiple Ethnic groups	
Asian / Asian British		Black / Black British	
Not Stated		Undeclared / Not Known	
Other Ethnic Origin ( <i>please state</i> )			
<b>THE PERSON'S SEXUAL ORIENTATION</b> <i>Place a cross in one box only</i>			
Heterosexual		Homosexual	
Bisexual		Undeclared	
Not Known			
<b>OTHER DISABILITY</b>			
<p><i>While the person must have a mental disorder as defined under the Mental Health Act 1983, there may be another disability that is primarily associated with the person. This is based on the primary client types used in the Adult Social Care returns.</i></p> <p><i>To monitor the use of DoLS, the HSCIC requests information on other disabilities associated with the individual concerned. The presence of "other disability" may be unrelated to an assessment of mental disorder or lack of capacity.</i></p> <p style="text-align: right;"><i>Place a cross in one box only</i></p>			
Physical Disability: Hearing Impairment		Physical Disability: Visual Impairment	
Physical Disability: Dual Sensory Loss		Physical Disability: Other	
Mental Health needs: Dementia		Mental Health needs: Other	
Learning Disability		Other Disability (none of the above)	
No Disability			
<b>RELIGION OR BELIEF</b> <i>Place a cross in one box only</i>			
None		Not stated	
Buddhist		Hindu	
Jewish		Muslim	
Sikh		Any other religion	
Christian (includes Church of Wales, Catholic, Protestant and all other Christian denominations)			

**ONLY COMPLETE THIS SECTION IF YOU NEED TO GRANT AN URGENT AUTHORISATION BECAUSE IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS ALREADY OCCURRING AND ALL THE FOLLOWING CONDITIONS ARE MET**

**URGENT AUTHORISATION**

*Place a cross in EACH box to confirm that the person appears to meet the particular condition*

The person is aged 18 or over	
The person is suffering from a mental disorder	
The person is being accommodated here for the purpose of being given care or treatment. <b>Please describe further on page 2</b>	
The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment	
The person has not, as far as the Managing Authority is aware, made a valid Advance Decision that prevents them from being given any proposed treatment	
Accommodating the person here, and giving them the proposed care or treatment, does not, as far as the Managing Authority is aware, conflict with a valid decision made by a donee of a Lasting Power of Attorney or Deputy for Health and Welfare appointed by the Court of Protection under the Mental Capacity Act 2005	
It is in the person's best interests to be accommodated here to receive care or treatment, even though they will be deprived of liberty	
Depriving the person of liberty is necessary to prevent harm to them, and a proportionate response to the harm they are likely to suffer otherwise	
The person concerned is not, as far as the Managing Authority is aware, subject to an application or order under the Mental Health Act 1983 or, if they are, that order or application does not prevent an Urgent Authorisation being given	
The need for the person to be deprived of liberty here is so urgent that it is appropriate for that deprivation to begin immediately	

**AN URGENT AUTHORISATION IS NOW GRANTED**

This Urgent Authorisation comes into force immediately.

It is to be in force for a period of:  days

**The maximum period allowed is seven days.**

This Urgent Authorisation will expire at the end of the day on:

Signed	<input type="text"/>	Print name	<input type="text"/>
Position	<input type="text"/>		
Date	<input type="text"/>	Time	<input type="text"/>

**REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION**

*If Supervisory Body is unable to complete the process to authorise the deprivation of liberty*

A Standard Authorisation has been requested for this person and an Urgent Authorisation is in force.

The Managing Authority now requests that the duration of this Urgent Authorisation is extended for a further period of  DAYS (*up to a maximum of 7 days*)

It is essential for the existing deprivation of liberty to continue until the request for a Standard Authorisation is completed because the person needs to continue to be deprived and exceptional reasons are as follows (*please record your reasons*):

**Please now sign, date and send to the SUPERVISORY BODY for authorisation**

Signature		Date	
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**RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED**

This part of the form must be completed by the **SUPERVISORY BODY** if the duration of the Urgent Authorisation is extended. **The Managing Authority does not complete this part of the form.**

The duration of this Urgent Authorisation has been extended by the Supervisory Body.

It is now in force for a **further**  days

**Important note: The period specified must not exceed seven days.**

This Urgent Authorisation will now expire at the end of the day on:

<b>SIGNED</b> (on behalf of the Supervisory Body)	Signature			
	Print Name			
	Position			
	Date		Time	

<b>Core Information</b>				
<b>Document Title</b>	Mental Capacity Act (MCA), including Deprivations of Liberty (DoLS) (2007)			
<b>Date Finalised</b>	October 2019			
<b>Dissemination Lead</b>	Ian Stevenson			
<b>Previous Documents</b>				
<b>Previous document in use?</b>	Version1.5			
<b>Action to retrieve old copies.</b>				
<b>Dissemination Plan</b>				
<b>Recipient(s)</b>	<b>When</b>	<b>How</b>	<b>Responsibility</b>	<b>Progress update</b>
All staff	ASAP	Email / Vital Signs and Daily Briefing	Document Control	

<b>Review</b>		
<b>Title</b>	Is the title clear and unambiguous?	Yes
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Yes
	Does the style & format comply?	Yes
<b>Rationale</b>	Are reasons for development of the document stated?	Yes
<b>Development Process</b>	Is the method described in brief?	
	Are people involved in the development identified?	
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Yes
	Is there evidence of consultation with stakeholders and users?	No
<b>Content</b>	Is the objective of the document clear?	Yes
	Is the target population clear and unambiguous?	Yes
	Are the intended outcomes described?	Yes
	Are the statements clear and unambiguous?	Yes
<b>Evidence Base</b>	Is the type of evidence to support the document identified explicitly?	Yes
	Are key references cited and in full?	No
	Are supporting documents referenced?	Yes
<b>Approval</b>	Does the document identify which committee/group will review it?	Yes
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A
	Does the document identify which Executive Director will ratify it?	Yes
<b>Dissemination &amp; Implementation</b>	Is there an outline/plan to identify how this will be done?	Yes
	Does the plan include the necessary training/support to ensure compliance?	No
<b>Document Control</b>	Does the document identify where it will be held?	No
	Have archiving arrangements for superseded documents been addressed?	Yes
<b>Monitoring Compliance &amp; Effectiveness</b>	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	No
	Is there a plan to review or audit compliance with the document?	Yes
<b>Review Date</b>	Is the review date identified?	Yes
	Is the frequency of review identified? If so is it acceptable?	No
<b>Overall Responsibility</b>	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes

<b>Core Information</b>	
<b>Manager</b>	Ian Stevenson
<b>Directorate</b>	Professional Practice
<b>Date</b>	28 <sup>th</sup> October 2019
<b>Title</b>	MCA Lead
<b>What are the aims, objectives &amp; projected outcomes?</b>	This document sets out PHNT’s system for applying the Mental Capacity Act (MCA 2005) in practice and ensuring staff are aware of their responsibilities as defined by the Act.
<b>Scope of the assessment</b>	
The policy applies to all adults within Trust services.	
<b>Collecting data – Impact of policy on equality</b>	
<b>Race</b>	There is no evidence to suggest that there is an impact on race regarding this policy
<b>Religion</b>	There is no evidence to suggest that there is an impact on religion regarding this policy.
<b>Disability</b>	Positive Impact – as the policy describes processes and procedures to safeguard those individuals who are at risk due to their disability
<b>Sex</b>	There is no evidence to suggest that there is an impact on sex/gender regarding this policy
<b>Gender Identity</b>	There is no evidence to suggest that there is an impact on gender identity regarding this policy
<b>Sexual Orientation</b>	There is no evidence to suggest that there is an impact on sexual activity regarding this policy
<b>Age</b>	Positive Impact – as the policy describes processes and procedures to safeguard those individuals who are at risk due to frailty from age
<b>Socio-Economic</b>	Positive Impact – as the policy describes processes and procedures to safeguard those individuals who are at risk due to their life-style
<b>Human Rights</b>	This policy will safeguard Human Rights of individuals; will enable Trust to meet its legal duties of equality The policy will promote compliance with Mental Capacity Act (2005).
<b>What are the overall trends/patterns in the above data?</b>	

<b>Specific issues and data gaps that may need to be addressed through consultation or further research</b>	<p>The Safeguarding Steering Committee monitor regular incidents and Serious Case Reviews re application of MCA, including DoLS.</p> <p>Specific issues and gaps are addressed via the Safeguarding Steering Committee.</p> <p>There is an action plan to ensure compliance with National CQC standards are maintained.</p>			
<b>Involving and consulting stakeholders</b>				
<b>Internal involvement and consultation</b>	<p>This policy is a significant redrafting of the original policy - Safeguarding Steering Committee and medical service line leads have been involved and consulted; this includes</p> <ul style="list-style-type: none"> <li>• Matron representative</li> <li>• Service line manager representative</li> <li>• Emergency Department clinical lead</li> <li>• Safeguarding/vulnerable adult clinical nurse specialist</li> <li>• Head of Midwifery</li> <li>• Learning Disabilities Liaison team</li> <li>• Safeguarding children team – Named Clinicians</li> </ul>			
<b>External involvement and consultation</b>	Legal consultation.			
<b>Impact Assessment</b>				
<b>Overall assessment and analysis of the evidence</b>	This policy will have a positive impact on all service users.			
<b>Action Plan</b>				
<b>Action</b>	<b>Owner</b>	<b>Risks</b>	<b>Completion Date</b>	<b>Progress update</b>