Lincolnshire Community Health Services NHS Trust

Mental Capacity Act including Deprivation of Liberty Safeguards Policy and Procedures

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Version Control Sheet

Version	Section / Para / Appendix	Version / Description of Amendments	Date	Author / Amended by
1		New policy merging P_CS_17 Mental capacity Act and P_CS_23 Deprivation of Liberty Policies	March 2015	Michelle Johnstone
1.1		Extension to allow for joint agency consultation	March 2017	Head of Safeguarding
1.2		Updated contact details	May 2017	Head of Safeguarding
2		Update P_CS_42	October 2017	Gemma Cross
3		Updated to include Respect, LPS and NICE guidance	January 2020	Gemma Cross
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				

Mental Capacity Act including Deprivation of Liberty Safeguards Policy and Procedures

Contents

Guidelines for Managers and Employees for staff experiencing or affected by Domestic Abuse

Procedural Document Statement

Background

The Mental Capacity Act 2005 (MCA) for England & Wales (The Act) received Royal Assent on 7thApril 2005. Parts of the Act were available from April 2007 – the introduction of Independent Mental Capacity Advocate (IMCA's) – but most of the Act came into force in October 2007. The Act will generally only affect people aged 16 and over, and provides a statutory framework for the protection of people who may lack capacity to make some decisions themselves, based on current best practice and common law principles. It also makes it clear who can take decisions in which situations and enables people to plan ahead (Advanced Decisions) for a time when they may lack capacity. Effective from 1 April 2009, the Deprivation of Liberty Safeguards (DOLS) have been added to the Act; these were introduced to provide a legal framework around the deprivation of liberty and the Guidance is to be used in conjunction with the Mental Capacity Act guidance 2005. DOLS apply to anyone aged 18 and over, who suffer from a mental disorder or disability of the mind-such as dementia or a profound learning disability; who lacks the capacity to give informed consent to the arrangements made for their care or treatment and for whom deprivation of liberty (within the meaning of Article 5 of the ECHR) is considered after and independent assessment to be necessary in their best interest to protect them from harm

Statement

The Act introduces new statutory responsibilities which apply to everyone who works in health and social care. The guidance in this policy is for staff working within, or on behalf of Lincolnshire Community Health Services NHS Trust and who are involved in the care and/or treatment of a patient who is 16 or over and may lack capacity in relation to a specific decision at the material time. To ensure the implementation of the Mental Capacity Act Code of Practice and Deprivation of Liberty Safeguards Code of Practice which provides legal protection for those vulnerable people who are deprived of their liberty otherwise than under the Mental Health Act 1983, to prevent arbitrary decisions to deprive a person of liberty and to give rights to challenge deprivation of liberty authorisations.

Responsibilities

Compliance with the policy will be the responsibility of the Chief Executive, Managing Directors, General Managers, Service managers and staff.

Training

Training will be provided by the Corporate Safeguarding Team.

Dissemination

Staff Intranet; Quality Assurance Groups; Safeguarding Supervision and Safeguarding Newsletter.

Resource implication

Within existing resource.

1.1 The Mental Capacity Act 2005 (MCA) introduced statutory responsibilities and applies to everyone who works in Health and Social Care and is involved in the care, treatment or support of people over the age of 16, living in England or Wales, who are unable to make all or some decisions for themselves. The MCA came fully into force on 1 October 2007. The Deprivation of Liberty Safeguards (MCA DOLS) came into force on 1 April 2009. The Mental Capacity (Amendment) Act 2019, will replace DoLS with Liberty Protection Safeguards in 2020.

1.2 Whilst the Act has significant implications for Health and Social Care, it is a very positive step towards protecting the rights of vulnerable people, whilst safeguarding practitioners and clinicians from liability.

1.3 The Deprivation of Liberty safeguards 2007 (DoLS) are an amendment of the Mental Capacity Act 2005. These safeguards came into force in April 2009 to protect the interests of an extremely vulnerable group. The Deprivation of Liberty safeguards are in addition to, and do not replace, other safeguards in the Mental Capacity Act 2005. This means that decisions made, and actions taken, for a person who is subject to a Deprivation of liberty authorisation must fulfil the requirements of the Mental Capacity Act first in the same way as for any other person. The Mental Capacity (Amendment) Act 2019, will replace DoLS with Liberty Protection Safeguards in 2020.

1.4 MCA and DoLS have been subject to Equality and Diversity Impact Assessment nationally by the Department of Justice, which included consultation with groups in Lincolnshire. Equality and Diversity is therefore implicit within the Policy.

1.5 **Principles of the Act**
The whole Act is underpinned by 5 principles. These are referred to throughout a Code of Practice and are a measure by which standards of best practice should be judged:

1.5.1. **Principle 1 Assume Capacity unless established that they lack capacity**
Every adult has the right to make their own decisions if they have capacity to do so.

1.5.2 **Principle 2 Practical steps to maximise decision making capacity**
A person is not to be treated as unable to make a decision unless all practicable steps to help him\her to do so have been taken without success.

1.5.2.1 Supported Decision Making (NICE Guidance 2018 NG108)

1.5.2.2 Principle 2 of the Mental Capacity Act 2005 requires practitioners to help a person make their own decision, before deciding that they are unable to make a decision. Supporting decision-making capacity effectively requires a collaborative and trusting relationship between the practitioner and the person. It does not involve trying to persuade or coerce a person into making a particular decision, and must be conducted in a non-discriminatory way. It requires practitioners to understand what is involved in a particular decision, and to understand what aspects of decision-making a person may need support with, and why.

1.5.2.3 This may mean helping a person with their memory or communication, helping them understand and weigh up the information relevant to a decision, or helping to reduce their distress. Various ways to support decision-making capacity are described in Chapter 3 of the Mental Capacity Act 2005 Code of Practice.

1.5.2.4 Find out from the person how they want to be supported in decision-making in accordance with principle 2 of the Mental Capacity Act 2005. If they would like someone to support them, find out from the person who needs support who this should be. Be aware of the possibility that the nominated person may be exercising undue influence, duress or coercion regarding the decision, and take advice from a safeguarding lead if there is a concern.

1.5.2.5 Practitioners should take a personalised approach, accounting for any reasonable adjustments and the wide range of factors that can have an impact on a person's ability to make a decision. These should include:

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

1.5.2.6 They should use this knowledge to develop a shared and personalised understanding of the factors that may help or hinder a person's decision-making, which can be used to identify ways in which the person's decision-making can be supported. Practitioners should be aware of the pros and cons of supporting decision-making and be prepared to discuss these with the person concerned. The benefits could include increased autonomy, being better informed and sharing decisions with people interested in their welfare. However, practitioners should also be aware that talking about potentially upsetting issues including declining health or end of life can be potentially distressing, and a person may feel overwhelmed with having to make a difficult decision at a difficult time and having to deal with possibly conflicting opinions.

Give people time during the decision-making process to communicate their needs and feel listened to. Be aware that this may mean meeting with the person for more than 1 session.

Health and social care practitioners should refer to other services (for example speech and language therapy, clinical psychology and liaison psychiatry) that could enable the person to make their decision when their level of need requires specialist input. This is especially important:

- when the person's needs in relation to decision-making are complex
- if the consequences of the decision would be significant (for example a decision about a highly complex treatment that carries significant risk).

1.5.3 **Principle 3 Unwise decisions**
A person is not to be treated as unable to make a decision because he or she makes what others may consider to be an eccentric or unwise decision.

1.5.4 **Principle 4 Best Interests**
Any act done or decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in his\her best interests.

1.5.5 **Principle 5 Least Restrictive Alternative**
Before an act is done, or a decision is 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 for the person's rights and freedom of action.

1.5.6 The Act also works on the basis that capacity is decision specific, which means capacity should be determined in relation to a specific decision a person is being asked to make. It is rare that a person will have no capacity for any decision making.

2. Purpose & Scope

2.1 This policy provides detail on how MCA and DoLS legal obligations will be met in Lincolnshire and more specifically within the NHS Trusts of Lincolnshire and St Barnabas.

2.2 The MCA addresses the duties of staff that provide care for individuals **who are 16 years and over** who may lack capacity to make some or all of their decisions.

2.3 The Deprivation of Liberty Safeguards will only apply to people who:

- **Are 18 years and over**
- Are being cared for in a hospital or registered care home for the purpose of care and/or treatment.
- Lack the capacity to consent to these arrangements for their care/treatment

- Are not detained (or able to be detained) under the MHA (Department of Health (2007) The Mental health Act 1983 as amended by Mental Health Act 2007)
- Have a mental disorder

2.4 **Excluded Decisions**

2.4.1 The MCA lists certain decisions that can never be made on behalf of a person who lacks capacity. There will be no question of an attorney consenting or the Court of Protection making an order appointing a deputy to provide the requisite consent.

2.4.2 The decisions that can never be made on behalf of someone who lacks capacity are:

- Consenting to marriage or civil partnership
- Consenting to sexual relations
- Consenting to a divorce
- Consenting to the dissolution of a civil partnership
- Consenting to a child being placed for adoption
- Consenting to the making of an adoption order
- Discharging parental responsibility to matters not relating to a child's property
- Giving consent under the Human Fertilisation and Embryology Act 1990
- Voting at an election for any public office or referendum

3. Duties

3.1 Duties within the Trust

Individual/Group:	**Responsibilities:**
Chief Executive	As Accounting Officer of the Trust the Chief Executive has ultimate responsibility for adherence to legislation and policy.
Board of Directors	Responsibility for ensuring compliance with appropriate legislation. To act as Managing Authority for DoLS.
Director of Nursing, AHP's and Operations	Executive Director for MCA & DoLS.
Safeguarding & Patient Safety Group	To ratify approval of policy. responsibility for development, implementation, review and monitoring effectiveness of these policy and procedures on behalf of the Board, receiving assurance via legislative committee, an annual report and annual safeguarding declaration.
Named Nurse for Safeguaridng	To ensure that advice is available to staff on the interpretation of the MCA and the Code of Practice To report on DoLS activity internally & externally as

	appropriate. Ensure appropriate training is available to staff on the MCA & DoLS. To provide reports to the SPSG on policy compliance and other related issues. Ensure that policies and procedures are in place to ensure that the MCA and DoLS including Managing authorities duties are carried out appropriately. To disseminate changes in case law and national guidance to appropriate staff. To provide regular reports to the appropriate committee and ensure that training compliance is on the agenda To lead for the Trust on the implementation of Liberty Protection Safeguards as per the Mental Capacity (Amendment) Act 2019.
Heads of Clinical Services	Ensure staff are released to attend training To promote best practice and ensure staff are aware of and adhere to this policy and the Act. Ensure compliance with conditions attached to DoLS authorisations.
Safeguarding Team	Provide advice to staff on interpretation of the MCA & DoLS and the Codes of Practice. To develop & deliver MCA & DoLS training to staff, including awareness raising of the new Liberty Protection Safeguards. Appropriately report non-compliance with policy and procedure. To advise on the requirement for legal advice
Clinical Team Leads	To ensure copies of the Code of Practice and other relevant guidance are available to staff. To ensure their staff are appropriately trained regarding mental capacity and to promote best practice in this area. Ensure that policies and procedures are followed and understood as appropriate to each staff member's role and function; and to appropriately report non-compliance with policy. To act as / or delegate the Managing Authority duties and responsibilities for completion of DoLS forms and liaison with the Supervisory Body Ensure compliance with conditions attached to DoLS authorisations.
Safeguarding Champions	Support other staff in identification of and appropriate reporting (form completion) of cases that may constitute a DoLS. Support other staff to follow local and national guidance in assessment of capacity and in making choices on behalf of people lacking capacity. Awareness raising of new Liberty Protection Safeguards. Assist with embedding the principles of the MCA within their service.

All Clinical Staff	To be familiar with the 5 statutory principles. To follow the legislation as set out in Trust Policy & Procedures To have regard to the Code of Practice Complete Mental Capacity Act & DoLS training as prescribed by the Mandatory Training matrix To undertake capacity assessments as appropriate To act as the decision maker when appropriate To alert their line manager and Trust Safeguarding policy & procedures if they believe anyone is responsible for ill-treatment or wilful neglect of someone who lacks capacity. Ensure capacity assessments and decisions made in the best interests of a Patients are clearly documented To understand Advance Decisions to Refuse Treatment and when they can be overridden. To assist Patients s in making Advance Decisions to Refuse Treatment if appropriate. To Understand and refer to Advance statements when decision making Appropriately report non-compliance with policy. Refer to Advocacy services.
Learning and Development	Ensure facilities & resources are available to provide appropriate training, and recording & reporting compliance with this. Promote MCA & DoLS training

3.2 Duties of Agencies external to NHS Trusts:

Lincolnshire County Council (Supervisory Body)	To commission Independent Mental Capacity Advocate (IMCA) services for Patients s who lack capacity including those who are deprived of their liberty To act as a Supervisory Body, receiving applications from care homes and wards for authorisation of a deprivation of liberty To ensure relevant person's (paid) representatives are available for those deprived of their liberty who do not have suitable family or friends to act in this role To commission the six assessments to be done following receipt of an application To grant or refuse applications within the statutory time frames To provide a Best Interest Assessor service. To provide a Mental Health Assessor service.
Court of Protection	Make declarations about whether or not a person has capacity to make a particular decision. Make decisions on serious issues about healthcare and treatment on behalf of a person who lacks capacity if necessary. Make decisions about the property and financial affairs of a person who lacks capacity if necessary.

	Appoint deputies to have ongoing authority to make decisions. Make decisions in relation to Lasting Powers of Attorney (LPAs) and Enduring Powers of Attorney (EPAs). Make declarations about whether an Advance Decision to Refuse Treatment is valid and applicable. To hear appeals regarding deprivation of liberty as requested by the individual themselves or their representative
Person appointed under Lasting Power of Attorney	Make decisions in the best interests of the Patients within their remit of authority. Make decisions regarding whether information can be disclosed.

4. Definitions

4.1 **Advance Decision to Refuse Treatment:** At a time when a patient has the capacity to make the decision they may decide that if they lack capacity at some point in the future they do not want to receive specific treatments. If an advance decision relates to life sustaining treatment (such as resuscitation) it must be in writing and witnessed – ideally by a carer or relative or if this is not appropriate an advocate or independent third party- but not by a member of Trust staff unless there are special circumstances.

4.2 Advance Decisions to Refuse Treatment must satisfy these 7 criteria:

- The person had mental capacity when it was made
- The person was 18 or over when it was made
- It was not made under conditions of undue influence or compulsion
- The person has made an informed choice which is the result of having relevant information and of careful thought
- It is clear so that there is no doubt about the individual's intentions
- It is applicable to the person's condition at the time it comes into force
- It does not request anything that is against the BMA’s code of ethics

4.3 The interaction between the Mental Capacity Act and the Mental Health Act means that there are now 3 levels of Advance Decisions:

4.3.1. **Level 1:** An advance decision to refuse treatment for physical disorders (e.g. resuscitation, chemotherapy, certain medications such as antibiotics, PEG feeding). These are always legally binding (if valid and applicable) and MUST be followed if staff are aware of them.

4.3.2. **Level 2:** An advance decision to refuse Electro-Convulsive Therapy (ECT). This can be overridden if the Patients is detained under the Mental Health Act 1983 and the ECT is to be given because it is immediately necessary to save the Patients ’s life or prevent a serious deterioration in the Patients ’s condition (see section 58A(5) and 62 (1A) of the Mental Health Act 1983). Clinicians are advised

though that going against an advance decision may lead them open to challenge so documentation of the justification for overriding must be clear.

4.3.3. **Level 3:** An advance decision to refuse specific forms of treatment for mental disorder (e.g. certain medications such as Clozapine). These can be overridden if the patient is detained under the Mental Health Act 1983. Clinicians are advised that alternative forms of treatment should be considered first in line with the Guiding Principles of the Mental Health Act 1983.

4.4 Advance Decisions cannot be made to refuse 'basic care', defined by the British Medical Association (BMA) as procedures essential to keep the individual comfortable e.g. warmth, shelter, personal hygiene, pain relief and the management of distressing symptoms.

4.5 **ReSPECT** (Recommended Summary Plan for Emergency Care and Treatment). The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Such emergencies may include death or cardiac arrest, but are not limited to those events. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not CPR should be attempted if the person's heart and breathing stop. For more information relating to ReSPECT conversations and processes please see the Lincolnshire Health System policy: https://www.lincolnshirecommunityhealthservices.nhs.uk/application/files/8815/5247/9431/P_CS_54__ReSPECT_Policy.pdf

4.6 **Advance Statement:** An Advance Statement details a patient's wishes and feelings should they lack capacity in the future but is not legally binding.

4.7 **Advanced Care Planning & Collaboration:** Advance care planning involves helping people to plan for their future care and support needs, including medical treatment, and therefore to exercise their personal autonomy as far as possible. This should be offered to everyone who is at risk of losing capacity (for example through progressive illness), as well as those who have fluctuating capacity (for example through mental illness).Some approaches involve the production of legally binding advance decisions, which only cover decisions to refuse medical treatment, or the appointment of an attorney. Others, such as joint crisis planning and advance statements, which can include any information a person considers important to their health and care, do not have legal force, but practitioners must consider them carefully when future decisions are being made, and need to be able to justify not adhering to them.

4.8 **Best Interest Assessor (BIA) for Deprivation of Liberty only:** The Best Interests Assessor must be a social worker, nurse, occupational therapist or psychologist registered appropriately and with at least 2 years post-qualification experience. They must have undertaken the relevant BIA training.

4.9 **Best Interests:** If, following a capacity assessment, an individual is found to lack the capacity to make the specific decision; the decision maker should decide what action is in the Patient's best interests.

4.10 **Causative Nexus:** It has been established in case law that in all capacity assessments it is vital to consider whether this third question – the 'causative nexus' – is proven. In other words, you must be satisfied that the person's inability to make a decision is because of an impairment of, or a disturbance in the functioning of, the mind or brain, and you must evidence in your assessment that:

- you are satisfied;
- why you are satisfied;
- how there is a causal link between the disturbance or impairment of the person's mind or brain and the person's inability to make the decision(s) in question.

4.11 **Court Appointed Deputy:** In certain situations where an individual does not have an LPA but a series of decisions needs to be made the Court of Protection may appoint a deputy who then take on the same functions as an attorney either for a specified period or indefinitely.

4.12 **Court of Protection:** The specialist court for all issues relating to people who lack capacity to make specific decisions. The Court of Protection is established under s.47 of the MCA.

4.13 **Deprivation of Liberty Safeguards (DoLS):** The Deprivation of Liberty Safeguards provide legal protection for people who are, or may become, deprived of their liberty in a hospital or care home. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears unavoidable. There are some circumstances where depriving a person, who lacks capacity to consent to the arrangements made for care or treatment, or their liberty is necessary to protect them from harm, and is in their best interests.

4.14 **Independent Mental Capacity Advocate (IMCA):** A specialist advocate who can represent the patient and their best interests if they have no family/friends to speak on their behalf. There is a statutory duty to refer to an IMCA in certain situations:

4.15 **Lasting Power of Attorney (LPA):** A Lasting Power of Attorney is a legal document which gives the attorney (or donee as it sometimes called) the authority to make decisions on the patients behalf. There are 2 types of LPA: Personal Welfare and Property & Affairs. To be valid an LPA must be registered with the Office of the Public Guardian.

4.16 **Managing Authority:** Managing Authorities under DoLS are hospitals or care homes.

4.17 **Mediation;** A process for resolving disagreements in which an impartial third party (the mediator) helps people in dispute to find a mutually acceptable resolution.

4.18 **Mental Capacity:** A person's ability to make a **particular** decision at a **particular** time.

4.19 **Mental Health Assessor:** For DoLS; The Mental Health Assessor must be a section 12(2) doctor or a registered medical practitioner with at least 3 years post registration experience in the diagnosis or treatment of mental disorder who has completed the necessary Mental Health Assessor training.

4.20 **Relevant Person's Representative (RPR):** Any individual deprived of their liberty under the safeguards need an RPR to support them in any appeal to the court themselves. 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.

4.21 **Restraint / Restriction / Force:** Section 6(4) of the Act states that someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or

- Restrict a person's freedom of movement, whether they are resisting or not.

4.22 **Supervisory Body:** Supervisory Bodies are those organisations that can authorise a DoLS. This will be the Local Authority where the patient is ordinary resident, for most patients this will be Lincolnshire County Council but could be other neighbouring Authorities.

Advanced Care Planning (NICE Guidance 2018, NG108)

Health and social care practitioners should help everyone to take part in advance care planning and co-produce their advance care plan if they choose to have one (including people with fluctuating or progressive conditions).

People can initiate advance care planning (such as advance statements) independently, without the input of practitioners. However, in some circumstances, professional input from a clinician with the appropriate expertise may assist a person to consider the matters they wish to address either by way of an advance care plan, an advance refusal of treatment and/or creation of a formal proxy decision-making mechanism such as a Lasting Power of Attorney. Skilled practitioners need to be able to have sensitive conversations with people in the context of a trusting and collaborative relationship, and provide the person with clear and accessible information to help them make these important decisions.

Providing information about advance care planning

Offer people accessible verbal and written information about advance care planning, including how it relates to their own circumstances and conditions. All information sharing must fulfil the requirements of the NHS Accessible Information Standard.

If a person has recently been diagnosed with a long-term or life-limiting condition, give them information on their condition, the process of advance care planning, how they can change their minds or amend the decisions they make while they retain capacity to make them, the impact that a subsequent loss of capacity may have on decisions made, services that will help in advance care planning.

Developing advance care plans collaboratively

All health and social care practitioners who come into contact with the person after diagnosis should help them to make an informed choice about participating in advance care planning. If the person wishes to engage in advance care planning, enable them to do so.

Offer the person a discussion about advance care planning:

- at the most suitable time once they receive a diagnosis likely to make advance care planning useful and
- at other times, allowing people to think through and address different issues in their own time.

Practitioners involved in advance care planning should ensure that they have access to information about the person's medical condition that helps them to support the advance care planning process. It is the practitioner's responsibility to identify what information they need.

When approaching discussions about advance care planning, practitioners should:

- be sensitive, recognising that some people may prefer not to talk about this, or prefer not to have an advance care plan
- be prepared to postpone discussions until a later date, if the person wishes
- recognise that people have different needs for knowledge, autonomy and control
- talk about the purpose, advantages and challenges of this type of planning
- consider the use of checklists to support discussions.

Joint crisis planning

Practitioners and individuals may wish to consider the use of advance care planning in the context of joint crisis planning. Offer joint crisis planning to anyone who has been diagnosed with a mental disorder and has an assessed risk of relapse or deterioration, and anyone who is in contact with specialist mental health services. The offer should be documented and, if the person accepts it, the plan should be recorded.

5. Undertaking Capacity Assessment (Appendix 1 Mental Capacity Process)

5.1 A lack of capacity cannot be established merely by reference to a person's age or appearance or condition, or an aspect of their behaviour which might lead other to make unjustified assumptions about their capacity.

5.2 For the purposes of the Act, a person lacks capacity in relation to a matter if at a material time he\she is unable to make a decision for him\herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

5.3 Whilst it is essential that health professionals recognise a person's right to safety and exercise their fundamental duty of care, the Act requires that every effort is made to encourage and support people to make their own decisions. Anybody who claims that an individual lacks capacity should be able to provide proof. The need to be able to show, on the balance of probabilities, that the individual lacks capacity to make a particular decision, at the time it needs to be made.

5.4 **Who should assess capacity?**
The individual who makes the decision or intends to undertake the action should assess the patient's capacity. Some assessments can be carried out by multi-disciplinary team members for example where an inpatient needs to access a different department for their treatment decision making should be jointly made by the referrer and the person undertaking the action, i.e. Radiology/Endoscopy.

5.4.1 The following factors may indicate the need for involvement of a more experienced professional with specialist skills and escalation to the Trusts MCA Lead:

- The gravity of the decision or its consequences
- Where the person concerned disputes a finding of incapacity
- Where there is disagreement between family members, carers and\or professionals as to the persons capacity
- Where the person concerned is expressing different views to different people, perhaps through trying to please each or tell them what she\he thinks they want to hear.
- Where the persons capacity to make a particular decision is subject to challenge, either at the time the decision is made or in the future
- Where there may be legal consequences of a finding of capacity
- The person concerned is repeatedly making decisions that put him\her at risk, or that result in preventable suffering or damage

5.5 Capacity Assessments (Appendix 2 Capacity Assessment)

5.5.1 A capacity assessment can be triggered in one of many ways, following the establishment of a need for a patient to make a specific decision, e.g.:

a) The persons behaviour/responses suggest they may lack capacity

b) The persons circumstances suggests they may lack capacity

c) Someone else has raised concerns over capacity

d) There have been capacity issues previously

e) An unwise decision causes concern over capacity

5.5.2 Capacity assessments should begin from the assumption that a person has capacity the member of staff needs to provide evidence of a lack of capacity.

5.6 The two stage functional test

A person will be found to be lacking capacity to make a decision if:

5.6.1 **Stage 1** is there is an impairment or disturbance of the function of the persons mind or brain - this could be due to long-term conditions such as mental illness, dementia, or learning disability, or more temporary states such as confusion, unconsciousness, or the effects of drugs or alcohol. If so:

5.6.2 **Stage 2** is the impairment\disturbance is sufficient that the person lacks capacity to

make a particular decision. To establish stage 2 the following then needs to be considered:

5.6.3 **The relevant information**

It is not necessary that the patient understands every element of what is being explained to him: What is important is that the patient can understand the 'salient factors', this means that the onus is on staff to identify the specific decision, what information is relevant to that decision, and what the options are that the patient is to choose between. Further, one must not start with a 'blank canvas'.

5.6.4 **Can the person understand information relevant to the decision?**

In order to demonstrate 'understanding' a person needs to understand the nature of the decision, the reason why it is needed, and to have an element of foresight about the likely consequences of making or not making the decision?

5.6.5 **Can they retain that information long enough to make the decision?** Information

need only be held in the mind of the person long enough to make the decision?

5.6.6 **Can they weigh \ use the information to make a decision**?

This requires the person actually engage in the decision-making process itself and to be able to see the various parts of the argument and to relate them one to

another. The person must be able to consider and weigh the arguments for and against a proposed action and the likely consequences before making a decision.

5.6.7 **Can they communicate by any means the decision?**
Can the person communicate a decision?

If there is a NO answer in any of the above four domains above then the test indicates that the person lacks capacity in relation to that decision.

5.6.8 The Act requires only a 'reasonable belief' of the assessor that a person lacks capacity in relation to a decision but Clinicians / practitioners need to be able to identify objective reasons why a person lacks capacity based on the above test.

5.6.9 The capacity assessment should be revisited if the person's condition changes, to ensure it is still relevant and valid.

5.6.10 When assessing capacity the causative nexus must be incorporated in to the assessment and formulation of the written assessment and outcome.

5.7 Recording of the Capacity Assessments

5.7.1 Capacity assessments can be recorded in notes but must meet the minimal legal requirements. The forms provided will ensure the minimum legal requirements are met and LPFT has a capacity assessment tool on health clinical systems which meets these requirements and easily accessible.

5.8 Capacity Disputes

5.8.1 If an assessor is in any doubt after assessment, or their assessment is challenged, it is entirely proper for them to obtain a second opinion from other trained colleagues. Furthermore, assessments can be undertaken by teams of staff if this is found to be appropriate. In all circumstances this should be fully documented in the notes. Where uncertainties or significant dispute continue this should be escalated via your MCA leads.

5.9 Referral to Independent Mental Capacity Advocacy (IMCA) Service.

5.9.1 The Act places a legal duty on local authorities and the NHS to refer a person to an IMCA in certain circumstances, to support people who lack capacity to make important decisions:

1. Serious medical treatment (starting, withholding or stopping) or
2. Periods of accommodation in a hospital (28 days or more) or
3. Moving to a care home (8 weeks continuously or more) or
4. Where decisions with serious implications need to be made.

5.9.2 IMCAs must be involved when a person aged over 16 and has no family, friends or carers (who might contribute to best-interest decision-making)
AND
Has been evidenced as lacking capacity in relation to one or more important decisions as above.

5.9.3 If there is a need for urgent treatment or an urgent need for a move to hospital, care home or residential accommodation then an IMCA referral should be made with a follow up call regarding the urgency, but the care or treatment undertaken should not be delayed in urgent circumstances.

5.9.4 Properly appointed IMCAs have a statutory right of access to records that the record-holder believes to be relevant to the decision. Clinicians and practitioners should allow access to files and notes but only to information relevant to the decision. Those responsible for patient / user records should ensure that third-party information and other sensitive information not relevant to the decision remains confidential.

5.9.5 Following referral via the referral to Total Voice Lincolnshire: Voiceability on 01522 706580 or via https://www.totalvoicelincolnshire.org/adult-services/imca/ . IMCA involvement and receipt of an IMCA report, the referring staff will be expected to communicate the outcome of the case to the IMCA service.

5.10 Best Interests Decisions: Appendix 3 and 4. If a patient is found to be lacking capacity an action may be undertaken, providing that action is in their best interest.

5.10.1 To make a basic or day-to-day decision on behalf of someone lacking capacity, staff should use the Best Interest documentation for everyday decision making, contained within **Appendix 3** of this document which should be appropriately uploaded onto the clinical system for future reference. For more complex decisions staff should refer to the Best Interest Meeting complex decisions documentation in **Appendix 4.**

5.10.2 The person making the decision is referred to as the “Decision Maker” and it is their responsibility to work out what would be in the best interests of the person who lacks capacity. For most day to day actions or decisions, the decision maker will be the carer most directly involved with the person at the time. Where the decision involves provision of care and treatment, the most appropriate member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision maker. Ultimately it is up to the professional responsible for the person’s treatment to make sure that capacity has been assessed.

5.10.3 When working out what is in the best interests, decision makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacks capacity.

5.10.4 It is up to the decision maker to ensure that they have sufficient information in order to make the decision in the patient's best interests. They must arrange to talk to other professionals involved and the patient's family and friends. In situations where an IMCA is involved they will also receive a report from the IMCA as to what may be in the patient's best interests.

5.10.5 Best Interests is not purely what would be 'best' medically in terms of prolonging life but must take into account social, emotional and psychological factors as well as anything that the Patients may regard as important if they were making the decision themselves.

5.10.6 The best interest checklist ensures decision makers:

- **Encourage participation:** do whatever is possible to permit and encourage the person to take part or improve their ability to take part in making the decision

- **Identify all relevant circumstances:** try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.

- **Find out the person's views:** try to find out the views of the person who lacks capacity, including the persons past and present wishes and feelings; these may have been expressed verbally, in writing, or through behaviour or habits. Any beliefs and values, e.g. religious, cultural, moral or political that would be likely to influence the decision in question, any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

- **Avoid discrimination:** not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.

- **Assess whether the person might regain capacity:** consider whether the person is likely to regain capacity (e.g. after receiving medical treatment) if so, can the decision wait until then?

- **If the decision concerns life-sustaining treatment:** not be motivated in anyway by a desire to bring about the persons death, they should not make assumptions about the person's quality of life.

- **Consult others:** if it is appropriate and practical to do so consult other people for their views about the person's best interests to see if they have any information about the person's wishes and feelings, beliefs and values. In particular try to consult everyone previously named by the person as someone to be consulted on

either the decision in question or on further issues, anyone engaged in caring for person, close relatives, friends and others who take an interest in the persons welfare, an attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney, any deputy appointed by the Court of Protection to make decisions for the person.

5.11 **Consultation**

5.11.1 The Act promotes consultation and requires transparency in decision making processes in order to protect and empower people from random or unsound decision making.

5.11.2 Family and friends are not decision makers but they can provide important information about current and previously expressed wishes, values, beliefs, culture and how different options might impact on them to inform decision makers about the person.

5.11.3 Family and friends may not always agree about what is in the best interests of an individual. If you are the decision maker you will need to clearly demonstrate in your record keeping that you have made a decision on all available evidence, and taken into account all of the conflicting views.

5.11.4 Family and friends must be made aware of the pros and cons of the available options during consultation.

5.11.5 Consultation can be via a meeting for complex decisions or where there are lots of people to consult. Consultation can also be via direct discussions or telephone contact.

6.0 Confidentiality

6.1 A best interest decision may require the sharing of information amongst health and social care workers, family and friends. If a person lacks capacity to consent the disclosure information must be based on the determination of the person's best interests.

6.2 The Act places a duty to take into the account the wishes and feelings of others who may have an important role in a person's life but only share as much information as is needed.

6.3 Where an attorney under a Health and Welfare Lasting Power of Attorney (LPA) has been appointed, they will be entitled to access to health and social care information and may also determine if information can be disclosed. Staff must consult with an LPA before sharing any information with a third party.

6.4 Where it is not possible to consult more widely because, for example, urgent treatment is necessary, staff must still act in the patient's best interest.

7. Children and Young People Aged 16 to 17 Years

7.1 Most of the MCA applies to people aged 16 years and over, there is an overlap with the Children's Act 1989. For the Act to apply to a young person, they must lack capacity to make a particular decision (in line with the Act definition of lack of capacity described previously). In such situations, either this Act or the Children's Act 1989 may apply, depending on the particular circumstances.

7.2 There may also be situations when neither of these Acts provides an appropriate solution. In such cases it may be necessary to look to the powers available under the Mental Health Act 1983, or the High Court's inherent powers to deal with cases involving young people.

7.3 There are provisions in the MCA not available to 16 or 17 year olds. These are:

- Making a Lasting Power of Attorney
- Advance decisions to refuse treatment
- Making a Will

7.4 For very complex capacity cases, it is recommended that staff contact the Trust's Safeguarding & Mental Capacity Team and if necessary a specialist legal opinion can be obtained.

8. Safeguards for People who lack capacity

8.1 The MCA provides new options for people to plan ahead for a time when they may lose capacity. The new Court of Protection also has powers to appoint deputies to act for a person in complex situations. Potentially these new provisions will have an important implication for staff in health and social care, by requiring that attorneys and deputies are involved as decision makers for the person they represent:-

8.2 **Lasting Power of Attorney**

The MCA allows a person to appoint an Attorney to act on their behalf if they should lose capacity in the future. A Lasting Power of Attorney (LPA) is a formal legal arrangement which allows the Attorney the authority to make specified decisions on behalf of a person who lacks capacity. Existing Enduring Powers of Attorney are also still valid.

8.3 An LPA must be registered with the Office of the Public Guardian before use.

8.4 Property and Financial LPAs deal with finance, and Health and Welfare LPAs deal with personal care issues (including decisions on medical treatment where the LPA is the decision maker). Clinicians should consider discussing LPAs with patients, but must not use undue pressure.

8.5 An LPA can also be verified by an identified hologram on the LPA and unique reference number is intended as proof of validity. The contact details for the Office of the Public Guardian are as follows: https://www.gov.uk/find-someones-attorney-deputy-or-guardian .To confirm an LPA or Court Appointed Deputy complete search form and submit to customerservices@publicguardian.gov.uk

A copy of the LPA must be kept in the patients' healthcare records with an alert/flag placed on the record.

Concerns about an LPA should be communicated to your local safeguarding team but also concerns can be raised via the OPG safeguarding office.

9. Court of Protection

The Court of Protection is the ultimate arbiter for all matters relating to the MCA. The Court has powers of adjudication and will:

- Make declaration about whether or not a person has the capacity to make a particular decision

- Make declarations about the lawfulness, or otherwise, of an act done or yet to be done, including decisions on serious health care issues and treatment

- Make single orders, individual decisions about the property and financial affairs, or about the health and welfare of a person who lacks capacity.

- The court will has the authority to appoint deputies to make decisions for a person who lacks capacity in complex or disputed cases, and where a single determination is not possible.

9.1 Advanced Statement (Appendix 5)

A key principle of the MCA is that people should be encouraged to record their wishes and preferences with regard to the care and treatment they receive for a time in the future when they may lack capacity. This can include a wide range of treatments, or ways in which people would choose to be cared for if they lost capacity. The wishes should be taken into account when providing care and treatment in best interests but they are not legally binding.

9.2 Advance Decision to refuse treatment (see Lincolnshire Policy)

The MCA creates statutory rules so that people over 18 years of age may choose to make a decision in advance to refuse treatment (ADRT) if they should lack

capacity in the future. This section is designed to be a brief introductory guide to advance decisions. For more detailed information please consult the Trust's Advance Decisions to Refuse Treatment specialist guidance which is available on the intranet.

9.3 Healthcare professionals may not be protected from liability if they knowingly act against a valid ADRT. However, the Act does provide for staff to conscientiously object if, in the circumstances, they feel this is appropriate.

10. Criminal Offence

10.1 The MCA creates two new criminal offences, wilful neglect or ill treatment of an adult lacking capacity.

10.2 In all cases where there is a suspicion of an offence, members of staff should alert their line manager immediately and invoke Lincolnshire Safeguarding Adults procedures.

11. Interface with the Mental Health Act 1983 (as amended by MHA 2007)

11.1 The MCA section 28 provides that the MCA does not apply to any treatment for a medical disorder which is being given in accordance with the rules about compulsory treatment as set out in Part IV of the Mental Health Act 1983 (as amended by Mental Health Act 2007). Staff should be aware that the statutory safeguards which the Mental Health Act 1983 (as amended by Mental Health Act 2007) gives in relation to compulsory psychiatric treatment must always be afforded to those patients to whom the Mental Health Act 1983 (as amended by Mental Health Act 2007) applies.

11.2 However, the above does not preclude the use of the MCA in relation to a physical condition. If a patient has capacity to make decisions regarding their physical welfare or has an Advanced Decision regarding physical treatment this must be upheld. **Appendix 6** is an LPFT inpatient decision making process for MHA or MCA.

12. Clinical Holds - Restraint and Restriction – identification treatment and Management of people with challenging behaviour violence and aggression in Clinical Care Policy 1 (LPFT).

The Act makes provision for the restraint of an individual providing certain criteria are satisfied.

12.1 Restraint can take many different forms such as physical, verbal, mechanical, chemical, environmental, and can include restrictions on contact and privacy. Examples of these include using covert medication, the use of physical force to prevent someone doing something, the use of mechanical restrictions (e.g. bed sides) and the use of verbal threats. This may include having the external door to a unit locked to prevent a patients wandering off the ward into a potentially dangerous situation. Including the use, or threat, of force to do something that the

person concerned resists - for example, by using bed sides. If an assessment of capacity has been undertaken and found the person lacking capacity the restraint must be in the person's best interest.

12.2 Physical restraint/Clinical holds can be used but only as a last resort.

12.3 If any restraint is required an care plan must be completed in line with policy. Staff must also refer to the Trusts identification treatment and Management of people with challenging behaviour violence and aggression in Clinical Care Policy 1 (LPFT).

12.4 The MCA identifies two further conditions which must be satisfied in order for protection from liability for restraint to be available; staff must reasonably believe that it is necessary to undertake an action which involves restraint in order to prevent harm to the person lacking capacity AND any restraint must be a proportionate response in terms of both the likelihood and seriousness of that harm. Using excessive restraint could leave staff and the Trust liable to a range of civil and criminal penalties.

13. Deprivation of Liberty Safeguards in a hospital setting (Appendix 7)

13.1 The Deprivation of liberty safeguards will apply to people 18 and over who meet all of the following eligibility criteria:

- **Mental health assessment** - They suffer from mental disorder as defined in Section 1 of the Mental Health Act 1983, namely a mental disorder is any disorder or disability of the mind, and this excludes dependence on alcohol and drugs. This includes all patients with learning disabilities.

- **Eligibility** – the person must not be detainable under the MHA or If the proposed authorisation relates to a deprivation of liberty in a hospital wholly or partly for the purpose of treatment of a mental disorder, the relevant individual will be eligible unless:

  They object to being admitted to hospital, or to some or all the treatment, **and** They meet the criteria for an application for admission under section 2 or section 3 of the Mental Health Act 1983.

- **Age**- they are over the age of 18

- **No Refusals –** the care arrangements do not conflict with other existing authority for decision-making for that person, such as an advance decision to refuse treatment or LPA

- **Capacity;** They have been found to Lack the capacity to give consent to the arrangements made for their care and treatment, and

- **Best Interests** it has been determined that their care (in circumstances that amount to deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights) is considered, after independent assessments, to be a necessary and proportionate response in their best interests to protect them from harm.

13.2 **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 patient lacks capacity to make decisions on some elements of the care and treatment they need, but has capacity to decide about a vital element and has already refused it or is likely to do so.

- A DoLS authorisation cannot be used in order to force treatment or care on a person who has the mental capacity to a make a decision about the proposed treatment, care and the manner and location in which it is to be provided.

13.3 The Deprivation of liberty safeguards mean that the 'managing authority' the relevant hospital or care home must seek authorisation from the 'supervisory body' where there MAYBE a DoLS occurring.

14. **Avoiding DoLS**

Every effort should be made, in commissioning and providing care or treatment, to prevent Deprivation of Liberty. If deprivation of liberty cannot be avoided, it should be for no longer than is necessary.

14.1 Ensure you have you taken all practical and reasonable steps to avoid a deprivation
of liberty:

- Ensure all decisions are taken and reviewed in a structured way using the tools and information available and record all decisions on how they were made.

- Ensure good care planning - use other agencies and complex case managers and GP's to explore all other alternatives.

- Make a proper assessment of whether the person lacks capacity to decide whether or not to accept the care or treatment proposed in line with the principles of the Mental Capacity Act.

- Before admitting a person to hospital or residential care in circumstances that may amount to deprivation of liberty, consider whether the person's needs could be met in a less restrictive way.

- Take proper steps to help the relevant person to retain contact with family, friends and carers. Where local advocacy services are available, their involvement should be encouraged to support the person, their family, friends and carers.

14.2 Where the deprivation of liberty safeguards are applied to a person in a hospital the supervisory body will be the Local Authority where the person is ordinarily resident. Lincolnshire County Council will be the supervisory body for most patients.

15. Identification of a Deprivation of Liberty

15.1 Deprivation of liberty is determined on a case by case basis; therefore, there is no simple definition. Judgments of the European Court of Human Rights and the UK Courts inform decision making and when restraint may amount to a deprivation of liberty.

15.2 The Supreme Court has clarified that, for the purposes of Article 5 of the European Convention on Human Rights, there is a Deprivation of Liberty in the following circumstances: "**ACID TEST"**

- The person is under **continuous supervision** and **control**

  and

- is **not free** to leave,

  and

- The person **lacks capacity** to consent to these arrangements.

15.3 **The Supreme Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person's compliance or**

lack of objection and the reason or purpose behind a particular placement. It was also held that the relative normality of the placement, given the person's needs, was not relevant.

15.4 This means that the person should not be compared to anyone else in determining whether there is a deprivation of liberty.

15.5 In the situation where the person to be admitted is already subject to a DoLS authorisation in a Care Home, then it is very likely that the Trust will need to apply for DoLS authorisation in order to effect admission. For elective cases this should be applied for in advance of the planned admission date and it is the admitting Clinicians' responsibility to ensure this is completed.

15.6 Other factors for consideration of a potential Deprivation of Liberty are:

- Restraint, including sedation, is used to admit a person to an institution where that person is resisting admission.
- Staff exercise complete and effective control over the care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment, contacts and residence.
- A decision has been taken by the Institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the Institution consider it appropriate.
- A request by Carers for a person to be discharged to their care is refused –
- The person is unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control.
- It is important to remember that the above list is not exclusive; other factors may arise in the future in particular cases.

15.7 An additional factor in identification of a potential DoLS is the time frame. Courts have advised that "that the person is confined to a particular restricted place for a non-negligible period of time" We have concluded in most cases a non-negligible period of time will be above 6 days in an acute setting ward unless the restraints required amount to of a total and intense nature where case law has shown that several hours may meet the criteria

16. Authorisation of a Deprivation of Liberty

16.1 The hospital has responsibility for applying for authorisation of deprivation of liberty for any person who **MAY** come within the scope of the deprivation of liberty safeguards.

16.2 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 of a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights. The request must be made in writing to the supervisory body and a standard authorisation must be given within 21 days.

16.3 Whenever possible, authorisation should be obtained in advance. Where this is not possible, and the managing authority believes it is necessary to deprive someone of their liberty in their best interest before the standard authorisation process can be completed, the managing authority must itself give an urgent authorisation and then obtain standard authorisation within 7 calendar days.

16.4 An extension can be granted by the Supervisory body in exceptional circumstances for a further 7 days

16.5 The request is made using the Deprivation of Liberty Combined Form No 1 & 4 found on Lincolnshire County Council (LCC) Website www.lincolnshire.gov.uk or local Intranet DoLS sites this referral form will be stored.
Send Forms securely via NHS.net account to the DoLS Team at mentalcapacityresource@lincolnshire.gov.uk

16.6 LCC has established a DoLS office which provides a direct point of contact that can be contacted on 01522 554205. The office will be staffed from 9am-5pm Monday to Friday (except Bank Holidays) and supported by an answering machine for out of hours contact.

16.7 A Care Plan to reflect the DoLS must be completed whenever the DoLS is submitted.

16.7 The person and their family must be notified about the application; this can be done using leaflets in **Appendix 8.**

16.8 A 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 subject to the wider provisions of the Mental Capacity Act 2005.

16.9 LCC will currently automatically commission a reassessment 21 days prior to expiry but for other Supervisory bodies you will need to take the following steps to

assess whether to seek authorisation. Wards should ensure they are aware when the DoLS expires

17. Challenges

17.1 A decision to deprive a person of liberty may be challenged by the relevant person, or by the relevant person's representative, by an application to the Court of Protection. However, managing authorities and supervisory bodies should always be prepared to try to resolve disputes locally and informally. No one should be forced to apply to the Court because of failure or unwillingness on the part of a managing authority or supervisory body to engage in constructive discussion.

18.1 Process for DoLS (Appendix 7)

18.1.1 DoLS Authorisation is specific to the Managing Authority that applied for the authorisation. Therefore it is permissible to transfer a patient who is held under a DoLS to another ward within the same building and belonging to the same provider, however any movement should be undertaken in the person's best interest. It would be acceptable to move someone from MEAU to the relevant specialty ward or even to another ward for provision of a side room if this was deemed essential; however they should not be out lied without prior agreement from the safeguarding lead. A new DoLS application would be required to transfer a patient between sites.

18.1.2 Wards must notify the CQC once the outcome of each application is known.

18.2 What happens next?

18.2.1 The Supervisory Body (local authority) makes arrangements for the required assessments to be undertaken. Clinical staff should support this assessment process but do not undertake the assessments themselves. Access to the medical records will be required by the assessors.

18.2.2 The assessments will be undertaken by a Best Interest Assessor and should normally be within the 7-day period of the Urgent Authorisation. If for any reason the assessment process will take longer, then the Supervisory Body will advise the Trust and an Urgent Extension will be required. The clinical team caring for the patient will be given the required form and responsible for applying for any extension.

18.2.3 On completion of the assessment process, the Supervisory Body will either grant or deny the DoLS authorisation. The DoLS Office will send the outcome forms to the ward and these forms must be filed in the medical record. A copy forms will also be sent to the Trust Safeguarding Office.

19. A Standard DoLS Authorisation is granted

19.1 The care plan should include ongoing review of the treatment plan and the need for a continuing DoLS order.

19.2 A patient held under DoLS may be kept in hospital for the proposed treatment and care until:

- The course of treatment is completed and the patient no longer needs to remain in hospital and can return to their normal place of residence- ward must inform Supervisory Body

- Arrangements have been made for on-going care to continue in another location e.g. care home or specialist hospital

- The DoLS is judged to no longer be required. The clinical team must inform the Supervisory Body.

- The DoLS expires. If continuing treatment and care is required and this would mean that the person continues to be deprived of their liberty then an extension to the Standard Authorisation will be required. DoLS form 4 should be completed again and sent off to the DoLS Supervisory Body as above.

OR

- The person's mental capacity returns and they are able to make their own decision about continuing with treatment and care. In this circumstance the DoLS is no longer valid, even if the person decides to leave hospital or refuses to comply with treatment and care against medical advice.

- A DoLS Authorisation is specific to the Managing Authority that applied for the authorisation. Therefore it is permissible to transfer a patient who is held under a DoLS to another ward within the same location and belonging to the same provider, however any movement should be undertaken in the person's best interest. A move to another building or provider requires a new application.

19.2 As soon as possible and practical after a standard deprivation of liberty authorisation is given, staff will need to ensure that the relevant person and their representative understand:

- The effect of the authorisation their right to request a review.

- The formal and informal complaints procedures that are available to them.
- Their right to make an application to the Court of Protection to seek variation termination of the authorisation.
- Their right, where the relevant person does not have a paid 'professional' representative, to request the support of an IMCA.

19.3 **Relevant Person's Representative**

Where an authorisation is granted, a Relevant Person's Representative is Appointed based on the BIA's recommendations.
The Representative must be given information and has access to documentation in relation to the DOLS and the persons care and treatments to support to assist them in their role.

19.4 **A Standard DoLS Authorisation is refused**

If the authorisation is refused or cannot be granted because the qualifying criteria have not been met, then the treatment and care plan should be reviewed again to see if less restrictive alternatives can be put in place. In this way the patient may consent to remain in hospital and undergo treatment.

19.5 Alternatively consideration could be given to whether a different treatment option or care location can be arranged which would be acceptable to the patient e.g. change of antibiotics to allow administration to take place in the community, a less invasive or aggressive therapy, transfer to a facility closer to family.

19.6 If the patient refuses all options presented then clinical staff should take steps to reduce the risks of discharge e.g. Liaison with GP, social care and other community services, informing next of kin etc.

19.7 However, if there are major concerns about the patients safety should they leave hospital and fail to comply with what is deemed essential treatment and care, senior clinical and legal advice should be sought. In some cases application to the Court of Protection may be required. Requests for legal advice in regard to MCA and DoLS should go through your Safeguarding teams or via on call Managers out of hours.

20. Unauthorised Deprivations of Liberty

20.1 If staff are concerned that an unauthorised deprivation of liberty has occurred or is likely to occur within the Trust then a senior clinician should review the situation as a matter of urgency and steps taken to avoid any further, or prevent a potential

future deprivation of liberty. In order to achieve this it may be necessary to apply an Urgent Authorisation.

20.2 Any deprivation of liberty identified where an Application has not been submitted must be reported as an adverse incident using your incident reporting systems.

20.3 All unlawful DoLS will be reported to the Trust Board, the CQC and external Safeguarding partners. The Trust Adult Safeguarding office will coordinate these notifications.

20.4 If there is a concern that a deprivation of liberty may be occurring in non-Trust accommodation then staff should discuss the concerns with their line manager as soon as possible and the also the Managing Authority of the care home or hospital. The Supervisory Authority should also be notified.

21. Deprivation of Liberty in "Domestic" Settings (Appendix 9)

21.1 The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement in the community. Hence where there is, or is likely to be, a deprivation of liberty in such placements that must be authorised by the Court of Protection. Staff must familiarise themselves with the provisions of the Mental Capacity Act, in particular the five principles and specifically the "least restrictive" principle.

21.2 Where Trust staff become aware of a potential DoLS in a domestic setting, they must contact their safeguarding team for specialist advice on action to prevent the deprivation or to seek authorisation by the Court of Protection.

21.3 The Court has a streamlined process to authorise such deprivation. The Re X procedure is designed to enable the court to decide applications for a court-authorised deprivation of liberty on the papers only, without holding a hearing, provided certain safeguards are met: Those safeguards include ensuring that:

- The person who is the subject of the application and all relevant people in their life are consulted about the application and have an opportunity to express their wishes and views to the court.
- The person who is the subject of the application has not expressed a wish to take part in the court proceedings
- The person who is the subject of the application and all relevant people in their life do not object to the application.
- There are no other significant factors that ought to be brought to the attention of the court that would make the application unsuitable for the streamlined procedure.

22. Independent Mental Capacity Advocates (IMCA)

22.1 If there is nobody appropriate to consult, other than people engaged in providing care or treatment for the relevant person in a professional capacity or for remuneration, Lincolnshire County Council will instruct an IMCA straight away to represent the relevant person.

23. Further Information and Advice

23.1 For all MCA queries please contact your Safeguarding Team.

23.2 intranet safeguarding has links to all relevant forms and guidance.

24. Development of Policies and Procedures

24.1 This policy was originally developed by the Mental Capacity Act Working Group and composed by the Corporate and Legal Services Officer.

25. References

Advance Decisions to Refuse Treatment; A Guide for Health and Social Care Professionals. The National Council for Palliative Care. Available at: http://www.adrtnhs.co.uk/

Mental Capacity (Amendment) Act 2019
http://www.legislation.gov.uk/ukpga/2019/18/enacted/data.htm

Mental Capacity Act Code of Practice (2007)
www.dca.gov.uk/menincap/legis.htm#codeofpractice

Deprivation of Liberty Safeguards Code of Practice (2008) available at Trust intranet via http://sharon/lpft/mha-and-mca/Pages/MentalCapacityAct.aspx

The Mental Capacity Act Code of Practice**:** The Code of Practice is the key document to which paid staff have a legal duty to have regard. It can be downloaded at: www.dca.gov.uk/menincap/legis.htm#codeofpractice

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Department of Health (2014) Positive & Proactive Care; Reducing the need for restrictive intervention https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300291/JRA_DoH_Guidance_on_RH_Summary_web_accessible.pdf

Care Standards Act 2000 http://www.legislation.gov.uk/ukpga/2000/14/pdfs/ukpga_20000014_en.pdf

Health & Social Care Act 2012 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Police and Crime Act 2016 https://www.gov.uk/government/collections/policing-and-crime-bill

Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Two Stage Capacity Test to Assess Capacity

This procedure should be carried out every time a capacity assessment is required. The assessment begins with the recording of some personal information, then moves on to a two stage test for capacity and concludes with some final general questions.

All parts will need to be completed. The form must be signed at the end. If parts 1, 4, 5 and 12 are incomplete the assessment will not be valid.

1. PERSON'S NAME:

2. DATE OF BIRTH:

3. NHS Nos.

4. NAME OF ASSESSOR:

5. JOB TITLE:

6. DATE: _____

PLEASE SUMMARISE BELOW THE DECISION WHICH NEEDS TO BE MADE:

Please indicate the salient points the person will need to understand and use to make the decision:

ON WHAT GROUNDS DO YOU SUSPECT THERE MAY BE A REASON TO QUESTION THIS PERSON'S CAPACITY:

The person's behaviour suggests they may lack capacity	☐
The person's circumstances suggest they may lack capacity	☐
Someone else has raised concerns	☐
There have been capacity issues previously	☐
Other (please specify)	☐

<u>Test - Stage 1 -</u> Does the patient have an impairment of or disturbance in the functioning of the brain or mind?

Yes □□or No □□ (If the answer is NO then capacity is not an issue) If **YES** record nature of disturbance and move to test stage 2.

Neurological Disorder □□
Learning Disability □□
Mental Disorder □□
Dementia □□
Stroke □□
Head Injury □□
Delirium, Unconsciousness □□
Substance Use □□
Other (please specify) □□_____

Test - Stage 2. – a) Practical steps taken to support the patient with decision making.

_____
_____
_____
_____

b) Evidence objective reasons why a person lacks capacity based on the test elements below.

1. Understanding, Does the person understand the information relevant to the decision?

Yes / No. In each case provide evidence below

2. Retain; Can the person retain the relevant information long enough for the decision to be made?

Yes /No In each case provide evidence below

<u>3. Use / Weigh.</u> Can the person use or weigh the relevant information to make a decision?

Yes/ No In each case provide evidence below

4. Communication. Can the person communicate their decision? This could be talking, using sign language or other means.

Yes /No In each case provide evidence below

I therefore have a reasonable belief that the patient **has/has not** got capacity for this specific decision

(Please delete as appropriate)

Location of further evidence _____

(Please indicate where any further evidence is recorded if appropriate to support your answers

above. For example in 'case notes' or accompanying reports etc.)

Assessment completed by_____

Date and time completed

_____

Second opinion if required …….

Best Interest Decision form (non-meeting)

When making a decision on behalf of the person who lacks capacity, practitioners should use a range of approaches, as needed, to ensure that the person's best interests are served. This might include:

- a less formalised approach for day-to-day decisions – that is, recurring decisions to be recorded in support or care plans
- a decision-making approach appropriate to the circumstances and personalised to the individual, making all reasonable adjustments
- formal best interests meetings for significant decisions:
    - if this is the most appropriate way to undertake the required consultation **or**
    - if the outcome of the decision is likely to have a serious impact on the person's health or wellbeing **or**
    - if there are likely to be conflicting opinions about the person's best interests.

Name of service user: ……..
NHS Number ……..
Date of birth: …….

NHS Number: …….

Date/s of assessment ……...

For this decision a.. [dropdown] formal best interest meeting template/an informal decision making template [if this option is selected then below should pop up]…is being recorded

Ensure that everyone involved in the best interests decision-making process knows and agrees who the decision maker is.

Concrete options

Is there a relevant Advanced Statement/Advanced Decision to refuse treatment?

Minimum 100 characters

As part of the best interests decision-making process, practitioners must take all reasonable steps to help the person to provide their own views on the decision.

Record service user's views, wishes and feelings relevant to the decision and their beliefs and values that may be relevant to the decision. If person is unable to share their views record attempts made to gain these:

Minimum 100 characters

Unless it would be contrary to the person's best interests to do so, health and social care practitioners should work with carers, family and friends, advocates, attorneys and deputies, to find out the person's values, feelings, beliefs, wishes and preferences in relation to the specific decision and to understand the person's decision-making history.

Record views of all interested parties and if not spoken with record why not:

Minimum 100 characters

Option 1: [space to record option]

Benefits	Costs

Option 2: [space to record option]

Benefits	Costs

{additional options to be added}

Competency Decision Making Tool

Competency assessment (for children aged 15 and under)

Please note anyone aged 16 and over should be assumed to have capacity to make decisions unless they are assessed to lack capacity (see mental capacity act policy and assessment)

Any child under the age of 16 who is to make their own decision in a specific area should not be assumed to be competent and an assessment should be carried out to ensure their understanding, maturity and ability to use or weigh the information.

This assessment should be completed for any decision the child expresses a wish to make the decision themselves_____

3. PERSON'S NAME: _____
4. DATE OF BIRTH: _____
3. NHS No.
7. NAME OF ASSESSOR:
8. JOB TITLE:
9. DATE:

What is the decision that needs to be made?

What practicable steps have been taken to provide the child with the relevant information- consider what are the salient points, the available choices, has the information been given in age appropriate language, including their individual needs

Is the child willing to make a choice (including the choice that someone else (eg a parent) can make the decision)?

Does the child have the ability to understand that there is a choice and that choices have consequences? Consider their maturity in understanding the decision within this.

Does the child have an understanding of the nature and purpose of the proposed intervention and its risks and side effects?

Does the child have the ability to weigh the information and arrive at a decision including demonstrating an understanding of alternatives?

What steps have been taken to ensure the child is free from undue pressure?

I therefore have a reasonable belief that the patient **has/has not** got the required level of competency for this specific decision

(Please delete as appropriate)

Assessment completed by _____

Date and time completed

_____

Second opinion if required …….

Appendix 4

Monitoring Template

Minimum requirement to be monitored	Process for monitoring e.g. audit	Responsible individuals/ group/ committee	Frequency of monitoring/audit	Responsible individuals/ group/ committee (multidisciplinary) for review of results	Responsible individuals/ group/ committee for development of action plan	Responsible individuals/ group/ committee for monitoring of action plan
	Audit	SPSG Workforce	Two Yearly	Safeguarding Team SPSG	SPSG	SPSG

Appendix 5

Equality Analysis

Name of Policy/Procedure/Function*
Mental Capacity Act including Deprivation of Liberty Safeguards Policy and Procedures
Equality Analysis Carried out by: Gemma Cross
Date: October 2017
Equality & Human rights Lead: Rachel Higgins

Director\General Manager: Susan Ombler

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

Section 1 – to be completed for all policies

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	That all those working in the field of health comply with their commitment to protect children and vulnerable adults through their participation in inter-agency support to social service to ensure the safety, wellbeing and protection of vulnerable adults in their care		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	All trust staff either directly employed by or contract agreement and service users		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	No		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		X	
	Sexual Orientation		X	
	Sex		X	
	Gender Reassignment		X	
	Race		X	
	Marriage/Civil Partnership		X	
	Maternity/Pregnancy		X	
	Age		X	
	Religion or Belief		X	
	Carers		X	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Gemma Cross		
Date:		October 2017		

Section 2

Equality analysis

Title:
Relevant line in:

What are the intended outcomes of this work? *Include outline of objectives and function aims*
Who will be affected? *e.g. staff, patients, service users etc*

Evidence *The Government's commitment to transparency requires public bodies to be open about the information on which they base their decisions and the results. You must understand your responsibilities under the transparency agenda before completing this section of the assessment.*
What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, state what you will do to close them in the Action Plan on the last page of this template.*
Disability *Consider and detail (including the source of any evidence) on attitudinal, physical and social barriers.*
Sex *Consider and detail (including the source of any evidence) on men and women (potential to link to carers below).*
Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*
Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*
Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*
Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working,*

infant caring responsibilities.

Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*

Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*

• Engagement and involvement

Was this work subject to the requirements of the Equality Act and the NHS Act 2006 (Duty to involve) ? (Y/N)

How have you engaged stakeholders in gathering evidence or testing the evidence available?

How have you engaged stakeholders in testing the policy or programme proposals?

For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs:

Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services or expand their participation in public life.

Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups.

Eliminate discrimination, harassment and victimisation

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

Advance equality of opportunity

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

Promote good relations between groups

Where there is evidence, address each protected characteristic (age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation).

What is the overall impact?

Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact?

Addressing the impact on equalities

Please give an outline of what broad action you or any other bodies are taking to address any inequalities identified through the evidence.

Action planning for improvement

Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Actions to improve the policy/programmes need to be summarised (An action plan template is appended for specific action planning). Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.

Please give an outline of your next steps based on the challenges and opportunities you have identified. Include here any or all of the following, based on your assessment

- **For the record**

Name of person who carried out this assessment:

Date assessment completed:

Name of responsible Director/ General Manager:

Date assessment was signed: