1. Introduction

The Mental Capacity Act (MCA) 2005 provides a statutory framework to empower and protect people aged 16 years and over, who are temporarily or permanently unable to make some, or all of their own decisions. The MCA makes it clear who can take decisions, in which situations and how they should proceed. It also enables adults 18 or over to plan ahead for a time when they may lose capacity.

The Trust is committed to ensuring that all people using our health services are treated with dignity and respect and patients and their families/carers receive appropriate care and support. This includes consideration of gender, race, any disability, sexual orientation, age and religion or belief.

This policy outlines the responsibilities of the Trust and how it will meet the requirements of the MCA and the Deprivation of Liberty Safeguards (DoLS) and provides guidance for staff to follow in their everyday work. The policy applies to all clinical staff working within the West Suffolk NHS Foundation Trust (WSFT) and all services commissioned and contracted by the Trust will be expected to comply with the principles of this policy.

Guidance on the Mental Capacity Act is provided in the MCA Code of Practice (2007). This and other guidance can be found on the following useful websites:

www.suffolk.gov.uk/mca

www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

www.suffolkas.org

NHS Safeguarding App

The MCA Code of Practice has statutory force, which means that those working within Health and Social Care have a legal duty to have “regard to” it when working with or caring for adults who may lack capacity to make decisions for themselves.
This policy and guidance is devised to assist staff understand and apply the requirements of the Mental Capacity Act 2005 & the Deprivation of Liberty Safeguards 2009 within all aspects of their practice.

DoLS were introduced in response to the 2004 ‘Bournewood judgment’ in the European Court of Human Rights (HL v UK (Application No: 45508/99)). This case was brought by carers of a man with autism who was kept at Bournewood Hospital against his wishes. The Court found that the circumstances by which the person was admitted to and kept in hospital breached the human right to liberty (Article 5 (1) European Convention of Human Rights Deprivation of liberty) and also of Article 5 (4), the right to have the lawfulness of detention reviewed by a court.

The use of the DoLS Authorisation process can avoid similar breaches of human rights and provides a legal framework to protect adults who lack capacity to consent to the arrangements for their care or treatment, because they have a disorder or disability of the mind or brain (e.g. dementia, significant learning disability, brain injury etc) and where levels of restriction or restraint used in delivering that care for the purpose of protection from risk / harm are so extensive as to potentially be depriving the person of their liberty. The safeguards have been introduced to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities. The safeguards require that the deprivation of liberty be made lawful through ‘Urgent’ and ‘Standard’ Authorisation processes.

It is a requirement of our registration with the Care Quality Commission that they be notified of all applications for a DoLS authorisation and its outcome.

2. Context and Application

2.1. The MCA says that a person lacks capacity in relation to a specific matter at a particular time, if at the specific time s/he is unable to make a decision for him/herself because of impairment in the functioning of, the mind or brain. However, the Act states that every adult has the right to make his or her own decisions and must be assumed to have capacity unless it is proved otherwise. It is the primary key principle on which the MCA and this guidance are based.

2.2. Lack of capacity may arise at a particular point in an individual’s life e.g. as a result of dementia, brain injury, delirium, confusion, stroke, unconsciousness, severe pain/shock or mental health conditions, or where a condition has been present since birth e.g. significant learning disability. Lack of capacity may also arise from the symptoms of drug or alcohol abuse.

2.3. The MCA applies whenever decisions are being made on behalf of a person who lacks capacity (with the exception of treatment for mental disorder under the Mental Health Act 1983). This includes any assessment of their need for care, examination, treatment, services and support. The MCA governs very important decisions such as serious medical treatment or moving into a care home, as well as the more ordinary decisions that are part of daily life.

2.4. Some types of decision (such as consenting to sex, marriage, divorce, adoption, and voting etc.) can never be made by another person on behalf of someone who lacks capacity, even if they are an attorney or a deputy and the MCA does not change this.
2.5. The MCA also introduces the role of the Independent Mental Capacity Advocate (IMCA) who have a responsibility to help adults who lack capacity to make decisions about serious medical treatment or changes of accommodation, and who have no family or friends that it would be appropriate to consult about these decisions. Their role is explained in more depth later in Section 8 of this document.

3. Key Principles of the MCA

3.1. There are five key principles designed to provide a benchmark for decision-makers and carers. These principles can be summarised as follows:

1) **The presumption of capacity**: Every adult has the right to make his/her own decisions and must be assumed to have capacity to do so, unless it is proved otherwise.

2) **Help with decision making**: People have the right to be supported to make decisions themselves. All appropriate help must be given before anyone concludes that someone cannot make his or her own decisions.

3) **Unwise decisions**: Individuals must retain the right to make what might be seen as eccentric or unwise decisions.

4) **Best interests**: Anything done for, or on behalf of a person who lacks capacity must be in their best interests.

5) **Least restrictive alternative**: Where there is more than one possible option/decision, consideration should be given to the option that is least restrictive of a person’s future options, as long as this is in their best interests.

4. Helping people make their own decisions

4.1. **All practicable steps** must be taken to help someone make their own decisions, before they can be regarded as lacking capacity. All relevant information should be provided in a way that the person can understand. In doing this the member of staff involved needs to:

- Take time to explain anything that might be relevant or might help the person make the decision, including information about the alternatives;
- Try not to burden someone with too much detail. Provide a simple explanation, which includes all the key information;
- Describe the possible consequences of a decision, or of not making a decision;
- If there are a number of possible decisions, repeat the approach above for each option.

4.2. Attention to the most appropriate method of communication can help the person make a decision:

- Consult family or other carers about the best methods of communicating;
- Use simple language where required, focus on one piece of information at a time and where appropriate use pictures or objects as illustrations;
- Enlist the help of others who are known and trusted by the person;
- Ensure that any necessary communication aids are available e.g. The Hospital Communication Book (available on all wards), voice synthesizers or other computer equipment and consider the use of an interpreter where appropriate.
4.3. Assessors should be mindful of cultural, ethnic, religious, gender, age or sexual orientation issues, which may impact on specific decision-making.

4.4. Most people find it easier to make decisions when they are in an environment where they feel at ease:

- Choose the most appropriate location for the person to feel comfortable.
- Consider the timing of the discussion, as some people’s functioning may vary at different times of day, or may be affected by particular medication.
- Consider whether the decision can be delayed until the person regains capacity if this is a possibility.

5. People who lack capacity

5.1. If someone lacks capacity to make a decision on one occasion, it does not mean they will always lack capacity to make decisions in the future. Any assessment of a person’s capacity must be ‘time and decision-specific’, this means:

- The assessment of capacity must be about a particular decision that has to be made at a particular time;
- If a person cannot make complex decisions, this does not mean they cannot make simple decisions;
- Staff cannot decide that a person lacks capacity due to their age, appearance, condition or behaviour alone. An assessment of capacity will not normally be undertaken without involving family, carers, friends etc.

5.2. In order to decide whether someone has capacity to make a particular decision a two-stage test must be applied.

**Stage 1**

This is sometimes referred to as ‘The Diagnostic Test’.

Is there an *impairment of, or a disturbance in the functioning of the mind or brain?*

This could be due to a stroke or brain injury, delirium, confusion, severe pain, shock, a mental health condition, dementia, significant learning disability or substance misuse.

It does not matter whether the impairment or disturbance is permanent or temporary. **If there is no impairment or disturbance the individual cannot be assessed as lacking capacity.** If there is impairment or disturbance and doubt about the person’s capacity to make a decision, the second test must be applied:

**Stage 2**

This requires a decision about whether the impairment or disturbance is sufficient for the person to lack capacity to make a particular decision. In order to determine this, a further test has to be applied, which is sometimes referred to as ‘The Functional Test’.

Under the MCA, a person is regarded as being unable to make a decision if, at the time the decision needs to be made, he or she is unable to do **one or more** of the following:

- **Understand the information relevant to the decision** – Practitioners must make every effort to make this information clear and accessible.
• **Retain the information relevant to the decision for long enough to make a choice or effective decision** - This only needs to be long enough to use and weigh the information relevant to the decision.

• **Use or weigh the information as part of the decision making process** - The person must demonstrate that they are able to consider the benefits & burdens of the proposed care, intervention and/or treatment and the alternatives available.

• **Communicate his/her decision** – by any means (e.g. whether by talking, sign language, squeezing someone’s hand, blinking an eye and so on) - Practitioners must demonstrate that they have tried every method possible to enable this.

This two-stage test must be used and documented in the patient’s records. In addition, it is essential to document actions that have been taken to assist the person to make their own decision. A ‘Mental Capacity Assessment Record’ form to assist in documentation of the capacity assessment is located on EVOLVE within the ‘Patient Profile’ icon and clicking on ‘fill in a form’ in the drop-down box. A copy of this form can be found in Appendix 1 and an example of the completed form is located on the Trust Intranet in the ‘Safeguarding’ heading under the section titled ‘Safeguarding Adults’.

Some people, e.g. those in the early stages of dementia are able to retain information for a limited period only. The fact that someone can retain information for only a short period does not prevent him or her from making a decision.

5.3. When assessing a person’s ability to make a particular decision, the assessment must be made at the time that the decision is required. Where more than one decision is involved, each decision must be considered in turn as someone may be competent to make certain decisions, but at the same time lack the capacity to make complex decisions.

5.4. Everybody has their own values, beliefs, preferences and attitudes. A person should not be regarded as lacking capacity to make a decision simply because s/he makes an unwise or eccentric decision. This means that a person, who has the necessary ability to make the decision, has the right to make decisions that may appear unwise, irrational or eccentric. This applies even if family members, friends, health or social care workers are unhappy with a decision.

6. **Decision Makers (Assessors)**

6.1. The decision-maker is determined by the nature and complexity of the decision to be made. Day-to-day care decisions may be made by the carer most directly involved with the person at the time. Where nursing care is provided, the member of the healthcare team responsible for delivering the care will be the decision-maker. Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision-maker.

6.2. The decision-maker must involve an Independent Mental Capacity Advocate (IMCA) for decisions about Serious Medical Treatment or certain changes of accommodation where the person lacks capacity and there is no family member, friends or un-paid carers for the decision-maker to consult (see Appendix 2 for more information on the IMCA).
6.3. If a Lasting Power of Attorney (LPA) has been made and registered, or a deputy appointed under a court order, the attorney or deputy will be the decision-maker for decisions within the scope of their authority.

6.4. By making an assessment that an individual lacks capacity to make a decision, the person’s right to make that decision may be denied. It is therefore important that Assessors (referred to within the MCA and Code of Practice as “Decision Makers”) fully understand what they are being required to do and are able to justify their actions.

6.5. After an assessor has completed an assessment that someone lacks decision-making capacity with respect to a particular matter, the Assessor may then take the required action regarding the care and treatment of that person. At all times the Assessor must be acting in the “best interests” of the person who lacks capacity (see guidance on best interests in Section 7 overleaf). An assessment of capacity would not normally be made without involving family, friends and/or carers or an IMCA.

6.6. An IMCA must be appointed to support a person who lacks capacity and has no family, friends or un-paid carers to consult where it is proposed that the person:

- Needs Serious Medical Treatment;
- Is moved into long term care of more than 28 days in hospital;
- Is moved into long term care of more than eight weeks in a care home;
- Is moved (for more than eight weeks) to different accommodation, such as different hospital or care home;
- Where Safeguarding Adult measures are being taken either regarding a person who may have been abused or neglected or regarding a person alleged to be an abuser;
- Where there is disagreement between family members, carers and/or professionals regarding a person’s capacity;
- Where a person is repeatedly making decisions that put him/her at risk or result in preventable suffering or harm.

6.7. Where important care planning issues are involved, formal assessment must take place and the outcomes must be recorded in the patient’s notes. Prior to commencing any assessment of capacity, Assessors need to take reasonable steps to establish whether there is an existing Enduring Power of Attorney (EPA) [made before 1/10/07], Lasting Power of Attorney [made after 1/10/07] or deputy appointed by the Court of Protection and consult with them where they exist. It is important to note that there are two types of LPA responsible for making certain decisions on behalf of the person who lacks capacity to make decisions. The two types are:

- A Property and Affairs LPA – responsible for decisions relating to property and finances.
- A Personal Welfare LPA – responsible for decisions about both health and personal welfare.

6.8. Sometimes it will be necessary to consider whether other experts need to contribute to the assessment of capacity. In many cases an opinion from the person’s GP may be all that is needed in assisting the assessor to complete the process.

6.9. In some cases, e.g. where the person has been diagnosed with a particular condition it may be appropriate to seek an opinion from a specialist, such as a Consultant Psychiatrist or Psychologist with particular experience of the condition.
6.10. Whilst a specialist health professional’s opinion may help to justify a finding about capacity, the decision as to whether someone has, or lacks, capacity, must be taken by the Assessor. For example, an Assessor looking at the capacity of an older person with dementia to decide on moving into a care home may appropriately take an opinion from a Psychiatrist of old age in situations where there is potential for disagreement or a lack of clarity about the diagnosis. However, the Psychiatrist is acting in an advisory role and the Assessor will make the final decision about the person’s capacity to decide. Assessors should discuss all assessments of capacity with their Team Manager and/or Senior Practitioner.

6.11. An assessment must be “time and decision specific” and be made on the balance of probabilities, i.e. is it more likely than not that the person lacks capacity?

The recording of the assessment needs to demonstrate how the conclusion has been reached where someone is assessed as lacking capacity.

6.12. In an emergency situation treatment must take priority if it is clear this is in a patient’s best interests and that this treatment could be successful. If however there is an appropriate Personal Welfare LPA or an Advance Decision to refuse treatment in place which relates to the proposed treatment (is ‘Valid’ and ‘Applicable’) then these must be adhered to (unless it is felt by the health care practitioner/team that the LPA does not appear to be acting in the patient’s best interests).

If the health care practitioner/team disagrees with the decision of the LPA then they should seek a second opinion and speak to the LPA again.

If there is still no resolution then the decision would need to be made by the Court of Protection - In the meantime the health care professional can provide life-sustaining treatment to prevent a serious deterioration in the patient’s condition whilst clarification is sought from the Court of Protection.

Health care professionals relying on LPA’s, which subsequently turn out to be invalid are protected.

An Advance Decision overrides an LPA unless the LPA was made after the Advanced Decision and is both valid and applicable.

7 Best interests

7.1 The following key factors need to be taken into account in determining the best interests of a person lacking capacity:

- Do not make assumptions about someone’s best interests merely on the basis of the person’s age or appearance, condition or an aspect of his/her behaviour.
- Try to identify the issues and circumstances relating to the decision that are most relevant to the person lacking capacity and throughout make decisions which are as least restrictive and within the individuals best interest.
- Consider whether the person is likely to regain capacity. If so, can the decision wait?
- Do whatever is possible to enable and encourage the person to participate as fully as possible in making the decision.
- Try to find out the views of the person by reference to their past and present wishes and feelings, particularly any relevant written statements (including Advance Decisions – see Chapter 9 of the MCA Code of Practice) made when s/he had...
capacity. Consideration should also be given to any beliefs and values (faith based, cultural or moral) that would be likely to influence the decision.

- Consult other people where it is practicable and appropriate in the light of the person’s right to confidentiality. In particular try to consult with anyone previously named by the person as someone to be consulted (unpaid carers, close relatives and friends who take an interest in the person’s welfare, an Advocate or anyone holding Enduring or Lasting Power of Attorney or any deputy appointed by the Court of Protection).

- In situations where someone has been assessed to lack capacity, does not have any family, friends or un-paid carers to consult, then an IMCA must be instructed where serious medical treatment is being considered or a change of long-term accommodation is going to be discussed at a care review or a change of long-term accommodation is being planned.

7.2 In some cases involving Adult Safeguarding procedures or a Care Review an IMCA can be instructed even if the person has friends or relatives that can be consulted. See Section 13 of this document and Chapter 10 of the MCA Code of Practice for further reference regarding involving an IMCA.

8 The Independent Mental Capacity Advocate (IMCA) service

8.1 The IMCA service is a statutory advocacy service introduced for people who lack capacity to make their own decision. In Suffolk ‘VoiceAbility’ provide the IMCA service.

NB The IMCA service is not available out of hours and therefore any cases that meet the criteria for referral should be referred the next working day unless the situation needs urgent attention, in which case action should be taken in the patient’s best interests and decisions recorded.

8.2 An IMCA is an independent person instructed by a health or care professional, to support and represent a person who lacks capacity to make certain serious decisions. Their role is to gather information, provide support to the patient involved in the decision and make representations about that person’s wishes, feelings, beliefs and values (see Section 4 of this guidance).

The IMCA must also bring to the attention of the decision-maker all of the factors that are relevant to the decision. The IMCA is able to challenge the decision-maker if they feel that the decision-maker has not paid enough attention to their report and other relevant information.

The decision-maker does not have to adhere to an IMCA’s recommendations but must take them into account as part of the decision making process.

Situations where an IMCA should be instructed

8.3 Decision-makers in Suffolk County Council and responsible NHS organisations in Suffolk must instruct an IMCA where a person lacks capacity and does not have family, friends or un-paid carers whom it would be appropriate to consult, in the following circumstances:
8.4 A decision needs to be made about providing, withholding or stopping serious medical treatment provided by the NHS (but excluding treatment regulated under Part 4 of the Mental Health Act 1983).

8.5 The County Council or the appropriate NHS body propose that a person should be moved into or between long-term care accommodation (which is defined as more than 28 days in the case of a hospital and likely to be more than 8 weeks in the case of a care home), as long as the move to this accommodation is not a requirement of the Mental Health Act 1983.

8.6 In addition to the situations described above, the County Council or the appropriate NHS body may involve an IMCA in care reviews and adult protection cases where the person lacks capacity and where they “are satisfied that it would be of particular benefit to the person to be so represented” (the Expansion Regulations). In adult protection cases the requirement that the person has no family or friends does not apply.

9. **An IMCA cannot be instructed in the following circumstances:**

- Someone who now lacks capacity previously named a person who should be consulted about decisions affecting him or her and that person is willing and available to help.

- A person lacking capacity has appointed an attorney under an Enduring Power of Attorney (EPA) and the attorney continues to manage their affairs (but see 14.1 below).

- The Court of Protection has appointed a deputy who continues to act on behalf of the person lacking capacity.

- The person lacking capacity has appointed an attorney under a Lasting Power of Attorney (LPA) who continues to manage their affairs (but see also below).

10. **Proposed Serious Medical Treatment**

11.1 When a doctor or other healthcare professional is proposing to provide, withhold or stop serious medical treatment for someone who lacks capacity to give consent and there is nobody appropriate to consult, other than paid staff, an IMCA must be instructed.

11.2 For decisions about serious medical treatment, the responsible body is the NHS organisation providing the person’s healthcare or treatment.

11.3 The definition of serious medical treatment is set out in Regulations. It is defined as giving new treatment, stopping treatment that has already started or withholding treatment that could be offered, in circumstances where:

- if a single treatment is proposed there is a fine balance between the likely benefits/burdens to the patient and the risks involved, or

- a decision between a choice of treatments is finely balanced, or

- what is proposed is likely to have serious consequences for the patient
• The MCA Code of Practice defines serious consequences as those actions that “could have a serious impact on the patient, either from the effects of the treatment itself or its wider implications”.

This may include treatments which:

  o cause serious and prolonged pain, distress or side effects, or
  o have potentially major consequences (e.g. stopping life-sustaining treatment or having major surgery such as heart surgery), or
  o have a serious impact on future life choices (e.g. interventions for ovarian cancer)

11.4 Neither the MCA nor the Regulations provide a definitive list of procedures that may amount to serious medical treatment. The MCA Code of Practice provides the following examples of medical treatments that might be considered serious:

• chemotherapy and surgery for cancer
• electro-convulsive therapy
• therapeutic sterilisation
• major surgery (such as open heart surgery or brain/neuro-surgery)
• major amputations (e.g. the loss of an arm or leg)
• treatments that will result in permanent loss of hearing or sight
• withholding or stopping artificial nutrition and hydration
• termination of pregnancy.

The MCA Code of Practice emphasises that this list is illustrative and that there are “many more treatments which will be defined as serious medical treatments.”

11.5 Some decisions about medical treatment are so serious that the courts need to be involved and there is detailed guidance on such situations in Chapter 8 of the MCA Code of Practice. In particular 8.18 of the MCA Code of Practice says that cases involving any of the following decisions should be brought before a court:

• decisions about the proposed withdrawal or withholding of artificial nutrition and hydration from patients in a permanent vegetative state.
• cases involving organ or bone marrow donation by a person lacking capacity to consent.
• cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
• all other cases where there is a doubt or dispute about whether a treatment will be in the best interests of a person who lacks capacity.

11.6 Where an urgent decision is required about serious medical treatment the duty to instruct an IMCA need not be followed. Such urgent decisions must be recorded with the reason for the non-referral.
11.7 There is no requirement to instruct an IMCA for patients detained under the Mental Health Act 1983, if the proposed treatment is for mental disorder and it can be given without patient consent under that Act. If serious medical treatment proposed for a detained patient is not for their mental disorder, the patient has the right to an IMCA as long as they meet the IMCA requirements (i.e. no family, friends or un-paid carers who are appropriate to consult with and the patient lacks capacity).

12. Change of Accommodation

12.1 Where a person lacks capacity and there are no family, friends or un-paid carers whom it is appropriate to consult, the County Council or responsible NHS body must instruct an IMCA in the following circumstances:

- The responsible NHS body is proposing to place a person in long-term hospital accommodation for more than 28 days, or move them to a different hospital for more than 28 days.

- The County Council or the responsible NHS body are proposing to place a person in a care home for more than 8 weeks or move them to a different care home for more than eight weeks.

The right to an IMCA applies to long-term accommodation in a hospital or care home if it is:

- provided by or arranged by the NHS, or

- residential care provided by or arranged by the County Council or provided under section 117 of the Mental health Act 1983, or

- a move between such accommodation.

12.2 In situations where a placement or move is urgent, the NHS body or the County Council can put aside their duty to involve an IMCA. The person making the decision must involve an IMCA as soon as possible after making the emergency placement or move if:

- the person is likely to stay in hospital for longer than 28 days

- the person is likely to stay in a care home for longer than 8 weeks

12.3 Sometimes a person’s placement will be longer than expected. The NHS body or the County Council should involve an IMCA as soon as they realise that the person's stay will be longer than 28 days or eight weeks, as appropriate.

12.4 IMCA’s do not have to be instructed if the person in question is going to be required to stay in the accommodation as a result of the Mental Health Act 1983. This is different from the position where someone is discharged from hospital to long-term accommodation under section 117 of the Mental Health Act 1983, where an IMCA has to be instructed when the qualifying criteria are met.

12.5 People who pay their own care home fees (self-funders) have the same rights to an IMCA as people funded by the County Council, as long as the Council has:

- carried out an assessment under the NHS and Community Care Act 1990, and
• decided to provide or arrange residential care under the National Assistance Act or section 117 of the Mental Health Act

This means that a person who is self-funding is entitled to an IMCA if the County Council assess them as requiring accommodation in a care home, even when the person pays their own fees.

13. Other instances when an IMCA can be instructed

13.1 An IMCA may be instructed to represent a person in a care review or in an adult protection case even when the person has family or friends who can be consulted. For further information see the MCA Code of Practice 2007.

13.2 Where a person is to be detained or required to live in accommodation under the Mental Health Act 1983, an IMCA will not be needed as the safeguards under that Act will apply.

13.3 Where there is disagreement between family members an IMCA may be instructed to provide independent representation of the person’s views and wishes.

14. IMCA’s and Enduring or Lasting Power of Attorney or deputies of the Court of Protection

14.1 The MCA says that an IMCA cannot be instructed if the circumstances that are listed in Section 10 of this guidance apply. However, the MCA Code of Practice says that where a person has no family, friends or un-paid carers to represent them, but does have an attorney or deputy who has been appointed solely to deal with their property and financial affairs, they should not be denied access to an IMCA. This would enable an IMCA to be appointed to represent the person in decisions relating to serious medical treatment or long-term accommodation moves. The government is seeking to amend the MCA at the earliest opportunity to give force of law to this Code of Practice guidance.

15. Making a referral to the IMCA service

Referrals can be made by completing the IMCA referral form on EVOLVE. This can be found in the fill in a form drop down section.

Alternatively, direct contact can made to VoiceAbility:

**VoiceAbility Suffolk**

**Address:** Total Voice Suffolk, VoiceAbility, Unit 4, Delta Terrace, West Road, Ransomes Euro Park, Ipswich, IP3 9FH

**Tel:** 01473 857631

**Email:** tvspartnership@voiceability.org

16. Deprivation of Liberty Safeguards

The MCA DoLS provide legal protection for adults who lack capacity to consent to receive treatment and care in hospital and may be deprived of their liberty (within the meaning of article 5 of the European Convention on Human Rights).
DoLS only apply to people who lack the mental capacity to decide whether to remain in a hospital or a care home for treatment and care.

When a person has been assessed as lacking capacity a DoLS Authorisation application must be considered. When considering if a situation amounts to a deprivation of liberty the following need to be considered:

- Is the person most likely to regain capacity in the next 72 hours
- Is the person undergoing clinical assessments to determine medical diagnosis and treatment that need to be completed to inform a DoLS decision
- Is the person most likely to be discharged in the next 72 hours

If the answer to any of the above is yes - delay application of DoLS.
If the person s at the end of their life i.e. last two weeks, a DoLS referral is not required, however the decision must be documented.

In all other situations apply the DoLS ‘ACID Test’ to determine the requirement for a DoLS application:

**ACID TEST**

1. Is the person under continuous supervision and control? (all in-patients are)
2. Is the person free to leave? (whether they have expressed a wish to do so or are capable of, is irrelevant)

If the answer is yes to question 1 & no to question 2 - a DoLS application must be considered.

16.1 Applying for a DoLS Authorisation

**General Guidance on when to apply for a DoLS:**

The concept of ‘deprivation of liberty’ is not always straightforward and there are certain circumstances where staff need to decide if the care and treatment provided/proposed is ‘restraint / restriction of liberty’ or a ‘deprivation of liberty’.

**PATHWAY ONE - Restraint / Restriction of Liberty**

**IMPORTANT NOTE:** If the patient’s lack of capacity to make the decision to remain in hospital for a period of care and treatment is Permanent then a DoLS Authorisation must be applied for (see Pathway Two).

If the patient is likely to regain capacity to make decisions because their condition is Fluctuating or Temporary then the provisions in place to keep them safe and from harm can be provided for up to 72 hours under ‘Restrain / Restriction of liberty’. This is as long as they are considered to be in the patient’s best interests and adhere to the principles of the Mental Capacity Act 2005.

The provisions in place must be reviewed regularly (recommended daily) as should the patient’s mental capacity.

The following is an example of how to record in the patients notes ‘Restraint/Restriction of Liberty’.
PATHWAY TWO - DoLS Authorisation Application

If after this time period it is deemed that the provisions are still required and the patient still lacks the capacity to consent to them and he/she is likely to remain in hospital for up to a further seven days or more then both ‘Urgent’ AND ‘Standard’ DoLS Authorisation applications *must* be made (both these can be completed on the same form: ‘DoLS Form 1 – Standard and Urgent Authorisation Request’).

Please note that the Urgent Authorisation is only valid for up to seven days with day 1 being the day of application. We can ask for a further seven day extension which would allow up to fourteen days to deprive a patient of their liberty. The Standard Authorisation will come into place following the assessment process completed by the Best Interest Assessor (BIA) and the Section 12 MHA Doctor. These will 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 they can extend the Urgent for an additional 7 days. On completion of the assessment process, the Supervisory Body (County Council) will either grant or deny the DoLS authorisation.

It should be borne in mind that an authorisation for deprivation of liberty does not, in itself, give authority to treat people, nor do anything else that would normally require their consent. Treatment & decision making has to be considered every time a decision is required under the wider provisions of the MCA 2005.

The DoLS form *MUST* be filled in electronically on EVOLVE so it can be saved and sent directly to the appropriate Supervisory Body.

Once the DoLS form is completed and emailed it is legal to prevent the person leaving hospital.

Standard Authorisations can be granted for differing lengths of time, dependant on the individual circumstances.

The Managing Authority (WSFT) will be informed both directly to the person who made the application and the Safeguarding Adults Team.

Please see Appendix 3 for information Flowcharts on deciding if a DoLS is needed and the DoLS Process.

**16.2 Who completes the DoLS forms?**

It is the responsibility of the clinical team caring for the patient to apply for a DoLS authorisation.
Elective admissions

For where it is believed a deprivation of liberty will or is likely to occur on an elective admission to hospital then a Standard Authorisation can be applied for in advance.

16.3 What happens to the forms once completed?

The DoLS Authorisation form needs to be sent via EVOLVE to the relevant Supervisory Body depending on where the patient normally resides (or where their funding comes from). This form will also automatically be sent to the Safeguarding Adults Team at wsh-tr.DolsReferrals@nhs.net as this provides the trigger for the CQC notification. It is a requirement of our registration with the Care Quality Commission (CQC) that we inform them of all DoLS applications and outcomes.

The DoLS application must be recorded in the patient record once the application has been made.

The patient/carer must be informed and they must have it explained to them. It may not be appropriate to do this at the time of the application, however, they must be given this information prior to discharge and staff should document in the patient record that they have done so.

16.5 If a Standard DOLS Authorisation is granted

- The care plan should include on-going review of the treatment plan and the need for a continuing DoLS order.
- A patient held under DoLS may be kept in WSFT 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.
  - 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 if the patient has been discharged, the patient has regained capacity or they have died. The clinical team must inform the relevant DoLS Team and Safeguarding Adult Nurse.

16.5 If the DoLS expires

When 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 1 should be completed again and sent off to the relevant Supervisory Body.

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. The relevant DoLS Team should be informed if a DoLS is no longer required in this instance.

16.6 If 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.
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.

However if there are major concerns about the patient’s 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 should be made through the Trust Legal Services office ext. 2781 or via Hospital Site Managers out of hours.

17. USEFUL RESOURCES

17.1 The MCA Flowchart

The Trust has developed an MCA Flowchart for all staff to use to assist with the process of what to do when a patient appears to lack capacity to make decisions about care, examination and treatment. The Flowchart can be found on each ward and department within the MCA Resource Folder. A copy can also be found in Appendix 4 of this document.

17.2 The MCA Resource Folder

All wards and departments within the Trust have an MCA Resource Folder which contains detailed information on the Mental Capacity Act, the role of the IMCA and the Deprivation of Liberty Safeguards (DoLS). All staff should utilise this folder to guide them when working with patients who lack mental capacity to make decisions.

17.3 The MCA & DoLS Micro-site

There is a ‘Safeguarding Adults’ micro-site on the Trust Intranet for staff to access. As well as containing general information relating to Safeguarding Adults it also contains all the information in the MCA Resource Folder as well as further information such as; Frequently Asked Questions, case examples and a ‘Useful Resources’ section. The micro-site can be accessed by clicking on the word ‘Safeguarding’ (down the left-hand side of the page) on the first page of the staff intranet, then click on the ‘Safeguarding Adults’ button on the next page.

18. References


DEVELOPMENT OF THE GUIDELINE

Changes compared to previous document
This document includes additional guidance on the Mental Capacity Act 2005 decision making and updates the contact information for the IMCA service.

Statement of clinical evidence
As per the reference above.

Contributors and peer review
The guidance was produced in conjunction with the Suffolk County Council MCA Local Implementation Group. The original was approved by TEG.

Distribution list/dissemination method
This guidance will be circulated as per Trust policies and procedures and will also be available within Trust clinical guidelines.

Document configuration information

<table>
<thead>
<tr>
<th>Author(s):</th>
<th>Deputy Chief Nurse Learning Disability Liaison &amp; Safeguarding Adult Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other contributors:</td>
<td>Members of the Local Implementation Group (see above)</td>
</tr>
<tr>
<td>Approvals and endorsements:</td>
<td>Safeguarding Adults Committee</td>
</tr>
<tr>
<td>Consultation:</td>
<td>Suffolk County Council</td>
</tr>
<tr>
<td>Issue no:</td>
<td>3</td>
</tr>
<tr>
<td>File name:</td>
<td></td>
</tr>
<tr>
<td>Supercedes:</td>
<td>Issue 2</td>
</tr>
<tr>
<td>Equality Assessed:</td>
<td>Yes</td>
</tr>
<tr>
<td>Implementation:</td>
<td>Key stake holders</td>
</tr>
<tr>
<td></td>
<td>Intranet</td>
</tr>
<tr>
<td></td>
<td>Green sheet</td>
</tr>
<tr>
<td>Monitoring: (give brief details how this will be done)</td>
<td>This Policy &amp; Guidance will be distributed by the Deputy Chief Nurse to General Managers, Service managers, and all Ward/Department Managers and will be available on the Trust Internet and Intranet Sites.</td>
</tr>
<tr>
<td>Other relevant policies/documents and references:</td>
<td>Policy to Consent to Examination or Treatment. Multi-Agency Policy &amp; Procedure Deprivation of Liberty Safeguards. Policy for the Care and Support of Patients with a Learning Disability and/or Autism</td>
</tr>
<tr>
<td>Additional Information:</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 1
MENTAL CAPACITY ASSESSMENT RECORD FORM

The form to assess and document the mental capacity assessment is available on Evolve by clicking on the ‘Patient Icon’, then ‘Fill in a form’, then select ‘Mental Capacity’ from the drop-down box, then click on ‘Mental Capacity Assessment Record’.

When completed, print form and place in patient’s file with an entry confirming completion and review date in notes.
Mental Capacity Assessment Record

CAPACITY ASSESSMENT - STAGE 2:

If 'No' to one or more of the following - the patient lacks capacity

Do you consider the person is able to understand the information relevant to the decision?  
- Yes  
- No

Do you consider the person is able to retain the information for long enough to be able to make the decision?  
- Yes  
- No

Do you consider the person is able to use or weigh that information as part of the process of making the decision?  
- Yes  
- No

Do you consider the person is able to communicate their decision? (by any means)  
- Yes  
- No

Does the Patient have any of the following valid & applicable provisions in place to act on their behalf when lacking capacity?

- An Advance Decision to Refuse Treatment  
- Yes  
- No

- A Personal Welfare Lasting Power of Attorney  
- Yes  
- No

- A registered Enduring Power of Attorney  
- Yes  
- No

- An appointed Deputy  
- Yes  
- No

Do you have any information about the patient's wishes, values and beliefs? 
If no please state why?

What are the views of family/informal carers?  
If no family or informal carers what are the independent Mental Capacity Advocate (IMCA) recommendations?

Declaration of the Decision Maker
I confirm that I have considered all relevant factors. I have taken reasonable steps to establish whether the patient lacks capacity in this matter. In my clinical judgement, I reasonably believe that the patient does lack capacity in relation to this matter and that it will be in the patient’s best interest for the decision to be made/not to be done. I have considered all options and can confirm that this option is the least restrictive of the patient's rights and freedom of action.

This decision is to be reviewed on: ______

Completed by: ______  On: ______
APPENDIX 2

CHECKLIST FOR THE INVOLVEMENT OF AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)

Is the decision to be made about:
- Providing / withholding / stopping serious medical treatment or
- A change in accommodation in a hospital (for >28 days) or care home (for >8 weeks)

If yes follow the checklist below:

VoicAbility hosts the IMCA service for Suffolk. To make a referral a referral form needs to be completed. These are available on the internet at: [http://www.voicability.org/services/suffolk/independent-mental-capacity-advocacy-imca](http://www.voicability.org/services/suffolk/independent-mental-capacity-advocacy-imca) or telephone on 01473 857631 for further help/advice. Email: tvspartnership@voiceability.org
DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS) FLOWCHART
DECIDING IF A DoLS AUTHORISATION MAY BE NEEDED

Examples of DoLS Scenarios
- 48 year old male admitted with haematoma to frontal lobe
  Intoxicated by alcohol - Detox programme commenced
- Confused & delirious with increasing aggression to others
- Many attempts to leave ward
- ++ RPI calls

- 75 year old female admitted after ++ falls
  Advanced Dementia
  Requires 1:1 supervision
- Sedative medication to reduce agitation
- No attempts to leave ward

Does the patient meet the following criteria?
- Is 18 or over.
- Has been formally assessed and documented as lacking capacity to consent to remain in hospital for a period of care and treatment and to keep them from harm.
- Is under ‘continuous supervision & control’ (all in-patients are subject to this).
- Is not free to leave (the key point here is - if they were able to leave, would this be authorised?).
- Is not subject to any powers of the Mental Health Act that would conflict with a DoLS Authorisation application (i.e. under Section).

IN MAKING DECISION CONSIDER THE FOLLOWING

PATHWAY 1
RERAINT / RESTRICTION OF LIBERTY
[MCA BEST INTERESTS]
The patient is likely to regain capacity in the 72 hours because their condition affecting their ability to make the decision is temporary or fluctuating.

IMPORTANT: IF THE PATIENT’S LACK OF CAPACITY IS PERMANENT THEN A DOLS MUST BE APPLIED FOR (See PATHWAY 2) ON ADMISSION.

1. Inform Ward Manager & Matron.
2. Complete MCA Assessment Record & document in patient’s file (Form on EVOLVE in patient profile under ‘Fill in a form’).
3. Record in notes that ‘Restraint/Restriction is being used under MCA Best Interests’; include review date post review date.
4. If no change to capacity & provisions still in place at day 3 then application for DoLS Authorisation required (See PATHWAY 2).

PATHWAY 2
DEPRIVATION OF LIBERTY
AUTHORISATION APPLICATION
1. The patient’s lack of capacity is permanent.
2. The patient has been assessed under pathway 1 and is post day 3 of their admission.

1. Inform Ward Manager & Matron.
2. Complete MCA Assessment Record & document in patient’s file (Form on EVOLVE in patient profile under ‘Fill in a form’).
4. Email completed form to the relevant County’s Supervisory Body depending on where the patient normally resides.
5. Email to the WSFT DoLS Application mailbox in order for an internal record to be processed at: wsh-tr.DolsReferrals@nhs.net
6. Inform the patient as much as is possible & give them a copy of the DoLS Form 1.
7. Inform the patient’s family, friends and carers of the DoLS Authorisation – provide with ‘DoLS Leaflet’ and explain.
8. Place a copy of Form 1 in the patient’s file adding a record that this process has been completed, who has been informed and when Urgent Authorisation expires.

Supervisory Body’s Email Addresses:
- Suffolk: customer.first@suffolk.gcsx.gov.uk
- Norfolk: BIASecure@norfolk.gcsx.gov.uk
- Cambridgeshire: gcsx.mcadols@cambridgeshire.gcsx.gov.uk
- Essex: dolsreferrals@essex.gcsx.gov.uk

Source: Deputy Chief Nurse
Status: Approved
Issue date: January 2019
Review date: March 2020
Document reference: PP(19)223
**OVERVIEW OF THE DOLS PROCESS**

MCA and DoLS Screening on ward identifies patient at risk of Deprivation of Liberty

- Clinical staff consider conditions and apply appropriate Pathway.
- **Pathway 1** followed – MCA Best Interests: Restraint/Restriction of Liberty (document accordingly).
- **Pathway 2** followed – Form 1 Urgent & Standard DoLS Authorisation applied for (document accordingly).
- Form 1 DoLS Application emailed via EVOLVE to relevant Supervisory Body and WSFT DoLS Application Mailbox.
- Urgent DoLS in place for 7 days, with further 7 day Extension requested whilst waiting to obtain Standard Authorisation following Six Assessments by the Best Interest Assessor (BIA) and Mental Health Doctor.
- Patient and all relevant parties informed of DoLS Authorisation and process.
- Continue to monitor and review the need for DoLS – record in patient’s file.

- Six Assessments completed by BIA & Mental Health Doctor.
- IMCA appointed by BIA for patient if befriended.
- Facilitate the assessment process by providing assessors with prompt access to:
  - The patient, who will need to be interviewed in private.
  - Relevant clinical records.
  - Staff involved in caring for the patient.

**Any assessment says No**

- Request for authorisation declined
  - Reassess & re-apply for DoLS if required.

**All assessments support authorisation**

- Best Interest Assessor recommends period for which Deprivation of Liberty should be authorised
- Best Interest Assessor recommends person to be appointed as patient’s Representative

**Authorisation is given and Representative appointed**

- Authorisation implemented by hospital
  - Six Assessment documentation filed in patient’s file.
  - Ensure all staff are aware that the Standard Authorisation has been granted.
  - Comply with any conditions to the authorisation.
  - Support the patient’s Representative to understand & carry out their role.

**DoLS no longer required**

Hospital informs Supervisory Body of changes in patient’s circumstances:
- Capacity regained
- Patient discharged / transferred
- Patient has died – if patient under DoLS when died doctor to inform Coroner (Form 12).

**Patient or Representative requests review**

- Patient or their Representative applies to Court of Protection which has powers to terminate authorisation or vary conditions

*Source: Deputy Chief Nurse*

*Status: Approved*

*Issue date: January 2019*

*Review date: March 2020*

*Document reference: PP(19)223*
Follow the 5 Principles of the MCA

1. Assume Capacity
2. Do everything possible to help patient have capacity
3. People are entitled to make unwise/eccentric decisions
4. Decisions made on behalf of someone else should be in his/her Best Interests
5. Anything done for or on behalf of a patient without capacity should be as least restrictive as possible

IF CAPACITY TO MAKE A DECISION IS IN DOUBT – CAPACITY MUST BE ASSESSED

Is there an impairment or disturbance in the function of the mind or brain? (permanent or temporary) e.g. a mental health disorder, significant learning disability, dementia, delirium, confusion, intoxication, unconscious

Yes

Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? If the answer to any of the following questions is NO, then patient lacks capacity to make decision:

1. Can the patient understand the information given to them?
2. Can the patient retain the information?
3. Can the patient balance the information?
4. Can the patient communicate their decision (by any means)?

Does capacity fluctuate?

Is it temporary?

Yes

No

If the decision can wait, consider delay until patient regains capacity

Act accordingly

Seek Legal Advice

Discuss Best Interests

Involve patient as much as possible

Record in medical/nursing notes

Patient does not have capacity

Complete Mental Capacity Assessment Form (accessed on Staff Intranet)

Record in medical/nursing notes

Is there a Registered Lasting Power of Attorney (LPA) or an Advance Decision (AD) in place to help inform decision?

Yes

No

Does the patient have any relatives, next-of-kin, un-paid carers to consult / act as an advocate?

Yes

No

IMCA Referral:

Tel: 01473 857631

For MCA/DoLS advice contact:

Safeguarding Adults Lead : 2746
Safeguarding Adults Nurse : 2750
Alternatively – discuss with Matron or manager.
See MCA Resource Folder & info on Staff Intranet in ‘Safeguarding Adults’ section.

In an emergency, act in best interests – unless LPA/Advance Decision in place

Patient has capacity to make the decision

End Assessment

Yes

No

PATIENT REQUIRED TO MAKE A DECISION

Yes

No

APPENDIX 4

Does the patient have relatives, next-of-kin, unpaid carers to consult / act as an advocate?