

## Mental Capacity Act and Deprivation of Liberty Safeguards Procedure

<b>PROCEDURE NUMBER:</b>	MCPG2
<b>VERSION NUMBER:</b>	1.2
<b>KEY CHANGES FROM PREVIOUS VERSION:</b>	Covid-19 6 month extension applied
<b>AUTHOR:</b>	Head of Safeguarding
<b>CONSULTATION:</b>	Safeguarding Group Mental Health & Safeguarding Committee
<b>IMPLEMENTATION DATE:</b>	June 1 <sup>st</sup> 2017
<b>AMENDMENT DATE(S):</b>	Feb 2020 (review date amended); June 2020 (Covid-19 6 month extension)
<b>LAST REVIEW DATE:</b>	June 2017
<b>NEXT REVIEW DATE:</b>	June December 2020
<b>APPROVAL BY CLINICAL GOVERNANCE &amp; QUALITY SUB-COMMITTEE</b>	26 May 2017
<b>RATIFICATION BY QUALITY COMMITTEE</b>	15 <sup>th</sup> June 2017

PROCEDURE SUMMARY		
<p>These procedural guidelines provide detailed operational guidance for staff about the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards in EPUT. It will enable staff to recognise and take appropriate action when there is a concern regarding a person's mental capacity and if there is a need to lawfully deprive someone of their liberty. These procedures are not static documents but subject to amendments and version control as services develop.</p> <p>The procedures comply with the Mental Health Act 2005, the Local Authority Safeguarding Adults Boards guidance.</p>		
The Trust monitors the implementation of and compliance with this procedure in the following ways;		
Safeguarding Group Action Log, Internal and External Audit Compliance Reports to CCG and Local Safeguarding Boards		
Services	Applicable	Comments
Trust wide	✓	

**The Director responsible for monitoring and reviewing this procedure is the Executive Nurse**

**ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST**

**MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY SAFEGUARDS  
PROCEDURAL GUIDANCE**

**CONTENTS**

THIS IS AN INTERACTIVE CONTENTS PAGE, BY CLICKING ON THE TITLES BELOW YOU WILL BE  
TAKEN TO THE SECTION THAT YOU WANT.

- 1.0 MENTAL CAPACITY**
- 1.1 INTRODUCTION**
- 2.0 ASSESSING MENTAL CAPACITY**
- 2.1 ASSESSING CAPACITY – STAGE 1**
- 2.2 STAGE 2**
- 2.3 DAY TO DAY DECISIONS**
- 2.4 COMPLEX DECISIONS**
- 2.5 DETERMINING CAPACITY TO CONSENT WHERE AN INDIVIDUAL REFUSES TO ENGAGE IN THE ASSESSMENT**
- 2.6 REVIEWING CAPACITY ASSESSMENTS**
- 2.7 BEST INTEREST DECISIONS**
- 2.8 WHO CAN ASSESS CAPACITY**
- 2.9 HOW MANY ASSESSORS ARE NEEDED**
- 2.10 INDEPENDENT MENTAL CAPACITY ADVOCATES (IMCA)**
- 2.11 WHEN CAN A FAMILY MEMBER OR FRIEND BE PRESENT**
- 2.12 DISPUTES REGARDING THE OUTCOME OF ASSESSMENTS**
- 2.13 RESTRAINT**
- 2.14 COVERT MEDICATION**
- 2.15 ASSESSMENTS OF CAPACITY FOR INDIVIDUALS WHO HAVE A DONEE OF LASTING POWER OF ATTORNEY (LPA) OR A COURT APPOINTED DEPUTY**
- 2.16 ADVANCE STATEMENT**
- 2.17 ADVANCE DECISIONS TO REFUSE TREATMENT**
- 2.18 CONTINUING HEALTH CARE (CHC) FUNDING**
- 2.19 YOUNG PEOPLE AND THE MENTAL CAPACITY ACT**
- 3.0 DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)**
- 3.1 INTRODUCTION**
- 3.2 THE ACID TEST – WHAT A DEPRIVATION OF LIBERTY LOOKS LIKE**
- 3.3 KEY RESPONSIBILITIES OF EPUT, CARE HOMES AND HOSPITALS IN THEIR ROLE AS MANAGING AUTHORITIES**
- 3.4 MAKING AN APPLICATION FOR A DOLS AUTHORISATION**
- 3.4.4 APPEALS TO THE COURT OF PROTECTION**
- 3.5 DOLS IN A SETTING OTHER THAN HOSPITAL/REGISTERED CARE HOME**
- 3.6 DEATH OF SERVICE USER UNDER DOLS**

**ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST**

**MENTAL CAPACITY ACT AND DEPRIVATION OF LIBERTY SAFEGUARDS  
GUIDANCE**

**1.0 MENTAL CAPACITY**

**1.1 Introduction**

1.2 The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make specific decisions for them. Everyone working with or caring for an adult who may lack capacity must comply with the Mental Capacity Act 2005 and the Code of Practice (2007).

1.3 The Trust Safeguarding Team are responsible for managing the Mental Capacity and Deprivation of Liberty Safeguards (MCA & DOLs) service in the Trust and can be contacted for advice and support

1.4 Clinical staff will be required to receive training in MCA & DOLs at a level appropriate to their role. For further information please consult the Safeguarding Adult Procedure CPG39 Appendix 1 Training Framework.

**2.0 ASSESSING MENTAL CAPACITY**

**2.1 Assessing capacity - Stage 1 (the diagnostic test)**

2.1.1 This requires that the individual has an impairment or disturbance of the mind or brain, whether temporary or permanent. This does not require that there is a formal diagnosis, rather that the decision maker believes, on the balance of probabilities and based on information available at the time, from records, information from others or the actual interview with the person, that the individual has an impairment or disturbance of the mind or brain.

2.1.2 If the person does NOT have an impairment or disturbance of the mind or brain whether temporary or permanent, the person does **not** lack mental capacity within the meaning of MCA. The assessors should not proceed to assess mental capacity via the functional/ second stage.

2.1.3 However, individuals may struggle to make certain decisions at certain times because of a number of factors unrelated to any impairment or disturbance that they may or may not suffer. These factors will be:

- Pressure, coercion, duress

- Lack of sufficient information
- Information in an inaccessible format.

In this situation assessors should ensure adjustments and support are offered to ensure that person is enabled to make their own decision.

2.1.4 The diagnostic test is broad and by itself cannot lead to the conclusion that someone lacks capacity to make a decision. It is the 'effects' of some of the conditions that can cause impairment/disturbance, i.e. confusion, disorientation, drowsiness. Examples may include:

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning disabilities
- Long-term effects of brain damage
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury, and
- Symptoms of alcohol or drug use.

## 2.2 Stage 2 (the functional test)

2.2.1 Can the individual:

1. **understand** the information relevant to the specific decision,
2. **retain** the information,
3. **weigh up the pros and cons** and finally
4. **communicate** their decision (Communication is a functional skill and via any means; speech, use of sign language, interpreters, writing).

2.2.2 The burden of proof is on the assessor to provide evidence that any of the 4 functional tests is not met by the person and to prove that the person lacks mental capacity. This is because all persons 16 and over are presumed to have mental capacity.

2.2.3 For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make the specific decision when they need to. Fundamentally, the person must first be given all practical and appropriate support to help them make the decision for themselves. Stage 2 can only apply if all practical and appropriate support to help the person make the decision has failed.

- 2.2.4 There is no requirement to assess capacity unless there are doubts about the individual's capacity to make a specific decision.

*Example: Jack (82) has complex physical needs and vascular dementia. He is living in a residential care home and the District Nurse visits to provide the residents with a flu immunisation jab. The District Nurse meets with Jack to discuss this but Jack explains he understands perfectly, but he does not want a flu jab, he feels 82 is a good age and he does not want to live much longer, if he gets the flu and dies that is fine, it would be better than living with dementia and just becoming less able.*

*The District Nurse concludes that Jack does understand the information relevant to the decision (about having a flu jab) and that there is no requirement to undertake an assessment of his capacity to evidence this and that he is refusing his flu jab. The District Nurse then records the conversation and her decisions in the clinical notes and advises the care home manager and GP of Jack's decision.*

### 2.3 Day-to-day decisions

- 2.3.1 Where EPUT staff are undertaking the day-to-day care of an individual, they are required to obtain consent to that care. Where an adult has **not** consented to that care, then carers could potentially face a charge of criminal assault.
- 2.3.2 Many individuals (such as those living with dementia or a severe learning disability) may lack the capacity to make a decision about their day-to-day care – e.g. assistance with showering or with eating and drinking. In such circumstances, it would get in the way of the provision of care and support if the carer were to have to seek to gain consent (and assess capacity) on every single occasion that assistance was required.
- 2.3.3 Assessments of capacity regarding day-to-day decisions should be carefully recorded in the individuals care plan/case notes. It must include the actual mental capacity assessment and separately a best interest's assessment and be relevant to the specific care/support/treatment or decision in question.

The MCA Assessment form can be used as a guide to support you through the process and ensure that the assessment complies with legislation and best practice.

### 2.4 Complex decisions

- 2.4.1 A complex decision may be one where there are serious or long term consequences for the adult, such as:
- a change of accommodation,
  - limitations on who they can associate with,

- medical treatment which will have long term consequences or may endanger life,
- major financial decisions that may involve for example mortgages
- entering into or terminating tenancy agreements.

2.4.2 This list is not exclusive, but in all these circumstances, assessments MUST be undertaken by an appropriately qualified professional. The Safeguarding Team are available for support and advice and the accompanying appendices provide flowcharts and appropriate forms, all of which are on the Trust InPut.

## 2.5 Determining capacity to consent where an individual refuses to engage in the assessment

2.5.1 There are occasions when adults may refuse to engage in assessment of their capacity to make a specific decision. All efforts should be made to establish a rapport with the person and seek their engagement, and to explain the consequences of not making the relevant decision.

2.5.2 Where this occurs, professionals should advise the individual that, if they decline to engage, the professional will need to make a determination of the individual's ability to make this specific decision on the balance of probabilities, taking into account the knowledge they already have about the individual – their cognitive abilities, diagnosis and presentation.

2.5.3 Where an individual refuses to engage because they do not understand (due to their impairment or disturbance of the mind or brain whether temporary or permanent) then the decision maker can conclude, on the balance of probabilities, that the individual lacks capacity to agree or refuse the assessment and the assessment can normally go ahead, although no one can be forced to undergo an assessment of capacity.

**Example:** *Mavis has severe learning disabilities and physical disabilities and is in an inpatient unit. The Doctor has called to examine her as staff are concerned that she is physically unwell. The Doctor wishes to take her blood to check if she is anaemic, he seeks Mavis's consent to take her bloods but Mavis is non-verbal. The Doctor together with a member of staff with whom Mavis has a positive relationship, attempt to explain to Mavis through signing and use of a talking mat (communication aids that Mavis is familiar with) however Mavis is becoming agitated and distressed. The Doctor (who is the decision-maker) concludes, on the balance of probabilities, that:*

- *as Mavis appears unable to comprehend the information being provided to her,*
- *she has a known diagnosis of severe learning disabilities,*
- *she appears to be physically unwell and*

- *staff advise that it is unlikely she would have capacity to consent to this decision, on the balance of probabilities she lacks capacity to consent to the blood test.*

*Taking bloods is necessary to ensure Mavis does not have a serious underlying physical condition - consequently the Doctor prescribes some diazepam and uses a topical anaesthetic cream (such as EMLA) to ensure that the blood test can proceed. The diazepam is essentially the lawful use of restraint (under s5 MCA) and is in Mavis's best interests to enable the blood tests to be completed in the least distressing manner.*

## 2.6 Reviewing capacity assessments

2.6.1 It is important to review capacity as people can improve their decision-making capabilities. In particular, someone with an ongoing condition may become able to make some, if not all, decisions. Some people will learn new skills throughout their life, improving their capacity to make certain decisions. So assessments should be reviewed from time to time. Capacity should always be reviewed:

- whenever a care plan is being developed or reviewed
- at other relevant stages of the care planning process, and
- as particular decisions need to be made.

2.6.2 This will ensure that there is a lawful basis for ongoing provision of care/support and /or treatment. Staff must recognise that an individual may have capacity in respect of some day-to-day decisions (such as choice of clothing) but not others and that capacity can fluctuate over time.

2.6.3 If the person's condition does not change and the original capacity assessment recorded on the form remains valid and applicable to the same decision. The care plan should reflect this.

## 2.7 Best Interest Decisions

2.7.1 Best interests include a checklist of factors which must be considered in determining an individual's best interests. These include taking into account the views of 'anyone named by the person as someone to be consulted on the matter in question' (e.g. family or friends) or 'anyone engaged in caring for the person or interested in his welfare'.

2.7.2 Staff should make every effort not to act in a discriminatory way, by making assumptions about what a person's best interests might be, simply on the basis of their:

- age
- appearance
- condition
- behaviour

2.7.3 Staff must consider the medical, social, psychological and emotional benefits of a decision and that they fully explore with the individual the pros and cons of any proposed decision, providing full information of all potential risks and any reasonable alternatives, before determining decisions in best interests and record their professional reasoning.

## 2.8 Who can assess capacity?

2.8.1 The Mental Capacity Act is very clear that the staff member who is going to take action or make a decision on behalf of an adult should be the person who assesses their capacity.

2.8.2 The staff member does not need to be 'qualified' but should have the necessary knowledge and skills of the Mental Capacity Act and Code of Practice. The decision maker or assessor has to 'satisfy themselves' that the service user lacks capacity in the matter to be decided.

2.8.3 There are however limited instances where it is permissible for the assessor and decision maker to be two different professionals involved in the patients care. For example, the assessor may be the Community Psychiatric Nurse, as the decision maker with the registered LPA or deputy in the matter. Examples include:

Decision to be made	Assessor (Best Practice)
Adult needs to have dental treatment	Dentist
Adult needs to be admitted to a hospital bed	Ward manager, charge nurse, staff nurse or Medic on the ward, community staff to evidence lack of capacity and make best interests decision if applicable to send to hospital. Where the adult may be resisting being sent to hospital, community staff should evidence lack of capacity and best interest decision to send to hospital
Adult needs to have a blood test at the GP practice	The doctor who has requested the blood test will need to provide the information to the patient as to why the blood test is being conducted and (where necessary) assess capacity to consent to the blood test being conducted



MCPG2 - MENTAL CAPACITY & DEPRIVATION OF LIBERTY SAFEGUARDS  
PROCEDURE

Adult needs to have a care review	Person carrying out the review
Adult needs to have her incontinence pads changed	Person who is going to change her pads
Adult needs assistance eating	Person who is providing that assistance
Adult needs washing or dressing	Person who is providing that assistance
Adult needs to have a change of accommodation funded by social care	Social Work Professional
Adult living independently wishes to have social contact with friends and family who are subject of a safeguarding alert	Professional leading the safeguarding investigation
Adult needs urgent medical treatment and is unconscious	Medical professional provides treatment without attempting to assess capacity, in best interests (para 6.35 MCA Code of Practice)
Adult wishes to enter into a sexual relationship	If there are doubts about person's ability to validly consent to sexual contact, mental capacity assessment should be undertaken by the most appropriate professional. However, if person lacks mental capacity, a best interest's decision cannot be made on their behalf. Safeguarding procedures will apply and legal advice needs to be sought as required.

**2.9 How many assessors are needed?**

2.9.1 It is **not** a requirement that assessments are undertaken by more than one professional and in most cases this will not be required or appropriate.

2.9.2 However under some circumstances, consideration should be given as to whether there should be a second assessor present at the assessment. For example:

- Significant restraint
- Where there is a known conflict about the care and support of the individual
- Where it is likely that the adult's family may dispute or complain about the outcome of the capacity assessment
- Where capacity is fluctuating or is difficult to assess
- Where a known co-dependent relationship is involved which has been a source of conflict or risk.

## 2.10 Independent Mental Capacity Advocates (IMCA)

2.10.1 An Independent Mental Capacity Advocate **MUST** be appointed where it is determined that an adult lacks capacity and has **nobody** to support them (other than paid staff) and a specific decision is being made about:

- A change of accommodation – a move to a care home for more than 8 weeks or an admission to a hospital bed for 28 days or more
- Serious medical treatment

2.10.2 When the decision maker concludes the individual lacks capacity and the threshold for requesting an IMCA has been reached, then there is a statutory duty to provide an IMCA (Mental Capacity Act 2005). Please see IMCA Flow Chart Appendix 2

2.10.3 An IMCA **MAY** also be instructed to support someone who lacks capacity to make decisions concerning:

- Care Reviews – where no-one else is available to be consulted
- Adult Safeguarding cases – whether or not family, friends or others are involved.

2.10.4 An IMCA is **not** a decision maker, they have the right to be consulted but they do not make the decision.

## 2.11 When can a family member or friend be present at the assessment of capacity?

2.11.1 All practical steps must be taken to support an individual to make a decision. This may include facilitating and supporting family members to share their views with the individual before the formal assessment of capacity commences but only if the person agrees.

2.11.2 Family members or friends have no automatic right to be present when an assessment of capacity is being undertaken. Family members can be present in assessments only where there will be no negative impact on the process of assessment, and if the presence of a family member will appropriately support the individual to make his/ her own decision.

2.11.3 Decision makers must be aware that the presence of a family member during the assessment could result in a challenge that the outcome of the assessment is invalid as the individual whose capacity was assessed has been coerced, or has made a decision under duress, coercive control or undue influence.

2.11.4 Where a family member is present they should be advised that they must not prompt the individual whose capacity is being assessed or lead their family member during the assessment and the decision maker/assessor has clearly documented that the presence of the family member is a practical step which will support the individual to make a decision.

2.11.5 Where it is determined that an individual lacks capacity and the decision maker is consulting with others, then 'remember that the person who lacks capacity to make a decision or act for themselves still has the right to keep their affairs private so it would not be right to share every piece of information with everyone'

## **2.12 Disputes regarding the outcome of assessments of capacity**

2.12.1 Where there is a dispute or disagreement about the outcome of an assessment of capacity – for example where a professional has concluded an individual does have capacity to decide where they wish to live and a family member feels the person lack capacity to make this decision then it is the decision-maker who has the final determination regarding the outcome of the assessment.

2.12.2 Professionals should take into account the concerns of family or friends if they dispute the outcome of an assessment and where necessary they can request a second opinion or (where a dispute is anticipated prior to the assessment occurring) consider the use of two professionals to jointly assess an individual's capacity to make a specific decision.

2.12.3 Where, having involved a second professional there is disagreement between them about the outcome (i.e. one concludes on the balance of probabilities that the individual has capacity whilst the other concludes on the balance of probabilities that they do not have capacity), then it must be presumed that the individual does have capacity. Specialist assessments of mental capacity can be commissioned from independent assessors in exceptional circumstances. Also, the ultimate arbiter in resolving disputes in relation to assessments of mental capacity or best interests is the Court of Protection. Legal advice or advice from the Safeguarding Team should be sought in these situations.

## **2.13 Restraint**

2.13.1 If restraint is necessary in the best interests of the individual, then any restraint used must be a proportionate response to the degree of harm that might otherwise occur. The nature of the restraint used, length of time it lasted

and reasons why it was used must be clearly documented. For full policy and procedure regarding restraint, staff should consult the Trust Restrictive Practice Policy, RM05

2.13.2 The Mental Capacity Act allows restrictions and restraint to be used in a person's support, but only if this is in the best interests of the person who lacks capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the staff member is seeking to prevent, and can include:

- using locks or key pads which stop a person going out or into different areas of a building
- the use of some medication, for example, to calm a person
- close supervision in the home, or the use of isolation
- requiring a person to be supervised when out
- restricting contact with friends, family and acquaintances, including if they could cause the person harm
- physically stopping a person from doing something which could cause them and/or others harm
- removing items from a person which could cause them and/or others harm
- holding a person so that they can be given care, support or treatment
- bedrails, wheelchair straps, restraints in a vehicle, and splints
- the person having to stay somewhere against their wishes or the wishes of a family member
- saying to a person they will be restrained if they persist in certain behaviour.

2.13.3 Section 6(4) of the Mental Capacity 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.

2.13.4 In an emergency: if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

## 2.14 Covert Medication

2.14.1 Covert medication involves administering medicines in disguised form, for example in food and drink, where a person is refusing treatment necessary for their physical or mental health. For full guidance Staff should consult the Trust Policy on Safe and Secure Handling of Medicines CLP13.

2.14.2 Medication must not be disguised for the convenience of the healthcare team and must never be given to someone who is capable of consenting to medical treatment. If a service user's decision is thought to be unwise or eccentric it does not necessarily mean they lack capacity to consent.

2.14.3 Adults who have been assessed as lacking capacity are only administered medicine covertly if a management plan is agreed after a best interest's assessment. The management plan must include the how the medicine can be covertly administered, whether it is safe to do so and to ensure that need for continued covert administration is regularly reviewed (as capacity can fluctuate over time).

2.14.4 Crushing tablets or opening capsules should be regarded as a last resort, as this renders the product unlicensed and is likely to alter the bioavailability of the medication. Where a best interest's decision has been made to administer medicine covertly, advice should be sought from a pharmacist.

2.14.5 Consider the following guidance;

- if a person lacks capacity and is unable to understand the risks to their health if they do not take their prescribed medication and the person is refusing to take the medication then it should only be administered covertly in exceptional circumstances;
- before the medication is administered covertly there must be a best interest decision which includes the relevant health professionals and the person's family members;
- if it is agreed that the administration of covert medication is in their best interests then this must be recorded and placed in the person's medical records/care home records and there must be an agreed management plan including details of how it is to be reviewed; and
- all of the above documentation must be easily accessible on any viewing of the person's records within the care/nursing home.

## **2.15 Assessments of capacity for individuals who have a donee of Lasting Power of Attorney (LPA) or a Court Appointed Deputy**

2.15.1 If a friend or relative states that they are a donee of LPA or deputy (Personal Welfare and/or property and affairs), then the decision maker must assure themselves of the validity of such statements by requesting to see a copy of the relevant registrations. A Deputy for Property and Affairs cannot make a decision relating to Health and Welfare; there has to be the two LPAs.

2.15.2 Where it is concluded that an individual lacks capacity to make a decision *and* they have a donee of LPA or deputy then unless there are safeguarding concerns about the LPA or deputy, the decision maker is the donee of LPA or the Deputy.

2.15.3 If staff are concerned that donee of the LPA or the Deputy is not acting in the best interests of the individual then staff **MUST** raise an urgent safeguarding alert and discuss the matter with the line manager urgently as legal action may be required. The Office of the Public Guardian will also need to be notified.

2.15.4 Staff have a duty to consult the person appointed as a donee or deputy. However the decision maker remains the staff member as they have the legal liability.

2.15.5 Members of staff should not engage in requests to sign a certificate for the purposes of an LPA. In such circumstances staff should inform their manager or a member of the Trust Safeguarding team.

## **2.16 Advance statement**

2.16.1 Staff must consider discussing with service users, their preferences regarding the type of care they would wish to receive and where they wish to be cared for in case they lose capacity or are unable to express a preference in the future.

2.16.2 These discussions clearly need to be handled with skill and sensitivity. The outcomes of such discussions may then need to be documented, regularly reviewed and communicated to other relevant people, subject to the individual's agreement. This is the process of Advance Care Planning (ACP) and known as an advance statement.

2.16.3 For individuals with no concern about lack of capacity, it is their current wishes about their care which need to be considered. Under the MCA 2005, individuals can continue to anticipate future decision making about their care or treatment should they lack capacity. In this context, the outcome of ACP

may be the completion of a statement of wishes and preferences or if referring to refusal of specific treatment may lead onto an advance decision to refuse treatment.

2.16.4 This is not mandatory or automatic and will depend on the person's wishes. Alternatively, an individual may decide to appoint a person to represent them by choosing a person (an 'attorney') to take decisions on their behalf if they subsequently lose capacity.

2.16.5 A statement of wishes and preferences is not legally binding. However, it does have legal standing and must be taken into account when making a judgement in a person's best interests. Careful account needs to be taken of the relevance of statements of wishes and preferences when making best interests decisions.

## **2.17 Advance decisions to refuse treatment**

2.17.1 If an advance decision to refuse treatment has been made it is a legally binding document if that advance decision can be shown to be valid and applicable to the current circumstances. In all cases, an individual's contemporaneous capacity must be assessed on a decision-by-decision basis if there are doubts about mental capacity. An individual may retain the ability to make a simple decision but not more complex decisions

2.17.2 It is essential that where an advance decision is made, a copy of this is held in the individual's clinical records and that the individual is encouraged to share copies with family and those health and social care professionals coordinating their care.

2.17.3 An advance decision must be followed where it is concluded that an individual lacks capacity to make a specific decision about their medical treatment and it is known that they have previously made a valid and applicable advance decision (relating to the proposed specific medical treatment).

2.17.4 If it is a refusal of life sustaining treatment then it must contain a statement that the advance decision applies even if your life is at risk. Decision makers are advised to consult senior clinicians as required.

2.17.5 An advance decision can only be overruled if it relates to treatment of a mental disorder and the individual has been detained under the Mental Health Act (1983). If the individual has made a specific decision to refuse ECT, the guidance in s59-62 of the Mental Health Act, (1983) must be followed.

There is no legal template for recording advance decisions to refuse treatment and advance directives, however Planning for your Future (Advanced care Planning) Guidance document provide a useful templates for recording both advance statements and advance decisions.

## **2.18 Continuing Health Care (CHC) funding**

2.18.1 Everyone (aged 16 and over) is presumed to have capacity regardless of their presentation, disability or behaviour. Consequently it is not a requirement that all those referred for consideration of Continuing Health Care funding require an assessment of their mental capacity to consent to the referral to the panel.

2.18.2 Mental Capacity is presumed and assessments of capacity to consent to specific decisions should only occur where doubts are raised about an individual's capacity to validly consent to the referral or engage in the assessment process.

2.18.3 The National Framework for Continuing Healthcare (DoH, 2012) states that Assessments of eligibility for NHS continuing healthcare and NHS-funded nursing care should be organised so that the individual being assessed and their representative understand the process, and receive advice and information that will maximise their ability to participate in informed decision-making about their future care. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike.

2.18.4 As with any examination or treatment, the individual's consent should be obtained before the start of the process to determine eligibility for NHS continuing healthcare. It should be made explicit to the individual whether their consent is being sought for a specific aspect of the eligibility consideration process (e.g. completion of the checklist) or for the full process, and for personal information to be shared between different organisations involved in their care. It should also be noted that individuals may withdraw their consent at any time in the process.

2.18.5 If an individual does not consent to assessment of eligibility for NHS continuing healthcare, the potential effect this will have on the ability of the NHS and the LA to provide appropriate services should be carefully explained to them.

2.18.6 The fact that an individual declines to be considered for NHS continuing healthcare does not, in itself, mean that an LA has an additional responsibility to meet their needs, over and above the responsibility it would have had if consent had been given.



- 2.18.7 Where there are concerns that an individual may have significant ongoing needs, and that the level of appropriate support could be affected by their decision not to give consent, the appropriate way forward should be considered jointly by the CCG and the LA, taking account of each organisation's legal powers and duties. It may be appropriate for the organisations involved to seek legal advice.
- 2.18.8 It is important to be aware that just because an individual may have difficulty in expressing their views or understanding some information, this does not in itself mean that they lack capacity. Appropriate support and adjustments should be made available to the person, in compliance with the Mental Capacity Act 2005 and with disability discrimination legislation (Equality Act 2010).
- 2.18.9 If the person lacks the mental capacity to either give or refuse consent to the use of the Checklist, a 'best interests' decision, taking the individual's previously expressed views into account, should be taken (and recorded) as to whether or not to proceed with assessment of eligibility for NHS continuing healthcare.
- 2.18.10 The person leading the assessment is responsible for making this decision and should bear in mind the expectation that everyone who is potentially eligible for NHS continuing healthcare should have the opportunity to be considered for eligibility. A third party cannot give or refuse consent for an assessment of eligibility for NHS continuing healthcare on behalf of a person who lacks capacity, unless they have a valid and applicable Lasting Power of Attorney (Welfare) or they have been appointed a Welfare Deputy by the Court of Protection.
- 2.18.11 Where a 'best interests' decision needs to be made; the 'decision-maker' must consult with any relevant third party who has a genuine interest in the person's welfare. This will normally include family and friends. However, third parties should not receive information where the patient has previously made it clear that they do not consent to information being shared with them.

## **2.19 Young people and the Mental Capacity Act**

- 2.19.1 The Mental Capacity Act 2005 states that everyone aged 16 and over is presumed to have capacity. The Children Act 1989 notes that a young person does not legally become an adult until their 18<sup>th</sup> birthday and Section 8 of the Family Law Reform Act 1969 provides that young people age 16 and 17 have the right to consent to treatment and that such treatment can be given without the need to obtain the consent of a person with parental responsibility.

2.19.2 Where a young person aged 16 and over has capacity and does not consent to a decision, their wishes and views must be upheld. Professionals are advised against relying on the consent of a person with parental responsibility and are advised to seek legal advice if required.

2.19.3 Where a young person aged 16 and over lacks capacity to make a specific decision, the decision should be taken within the framework of the Mental Capacity Act 2005.

*Example: Sarah is 16 and suffers from a psychotic illness. The illness is preventing her from making decisions about her care and treatment. She is assessed to lack capacity within the meaning of the MCA 2005. Accordingly decisions are made for her on her behalf within the legal framework of the MCA 2005. Whilst her parents are consulted and their views are taken into account regarding decisions about her care and treatment, final responsibility lies with the decision maker – the Responsible Clinician who has determined that Sarah should be prescribed and given medication.*

2.19.4 Young people under the age of 16 may still have capacity or be Gillick-competent to make a decision. Gillick competence refers to the fact that some children under the age of 16 are able to give consent. The key to whether the child can give consent is their emotional and intellectual maturity and their ability to understand the proposed treatment. Those children who are deemed by the health-care professional to be Gillick competent are the ones who can provide consent for the proposed treatment.

For a young person under the age of 16, the professional has a duty to evidence that the young person has capacity or is Gillick-competent.

### 3.0 DEPRIVATION OF LIBERTY SAFEGUARDS (DOLs)

#### 3.1 Introduction

3.1.1 A person's liberty can only be taken away in very specific circumstances. It is only used if it is the least restrictive way of keeping a person safe or making sure the person receives the right medical treatment.

- Being deprived of liberty means keeping a service user in a ward or room and not being free to go anywhere without permission or close supervision. This is against the law unless it is done in accordance with the DOLs process
- The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.

3.1.2 The Human Rights Act states that *"Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law"*

3.1.3 In England and Wales, a person can only be lawfully deprived of their liberty for more than 72 hours if they are;

- detained under the Mental Health Act 1983
- detained under a DOLs authorisation (Mental Capacity Act and Deprivation of Liberty Safeguards).
- are sent to prison by a court

#### 3.2 The Acid Test – What a deprivation of liberty looks like

3.2.1 The Deprivation of Liberty Safeguards apply to an individual aged 18 and over who is being cared for in a registered care home or hospital bed (regardless of how this is funded – i.e. whether state or private).

3.2.2 The Acid Test is a list of conditions which, when satisfied, will identify whether or not a person is being deprived of liberty.

3.2.3 A person will be deprived of their liberty when **ALL three** of the below are evident.

Where the person:

1. Is being deprived of their liberty for more than a few days. Use your professional judgement and ensure all actions are recorded with the clinical reasoning to support them being in evidence.

**If it is anticipated the deprivation will last 7 days or more an application MUST be made.**

2. Is subject to continuous supervision and control (i.e. in practice there is a care plan which requires that carers know their whereabouts at all times) **AND** is not free to leave (i.e. in practice the individual is unable to leave without the support of a carer or family member and would not be permitted to live elsewhere unless the provider and commissioner of the care agreed to a change of accommodation

3. Is under the responsibility of the state for any aspect of the supervision of their care, however that care is funded or provided. For example every care provider registered with the CQC, support living arrangements brokered by the local authority.

4. Is a young person under the age of 18 they can also require authorisation of a Deprivation of Liberty from the appropriate Court.

### 3.3 Key responsibilities of EPUT, care homes and hospitals in their role as Managing Authorities

#### 3.3.1

- To adapt care-planning processes to ensure consideration is given to whether a person lacks mental capacity to consent (in accordance with the Mental Capacity Act 2005) to the services which are to be provided and whether their actions are likely to result in a Deprivation of Liberty.
- To consider before admitting a person to a hospital or care home if their circumstances may amount to Deprivation of Liberty. In such cases staff should consider if the person's needs could be met in a less restrictive way. and ensure that any restrictions are the minimum necessary and in place for the shortest possible period.
- To take steps to help the relevant person retain contact with family, friends & carers.
- Where local advocacy services are available, their involvement should be encouraged to support the person & their family, friends & carers.

## MCPG2 - MENTAL CAPACITY & DEPRIVATION OF LIBERTY SAFEGUARDS PROCEDURE

- To issue Urgent Authorisation while applying for Standard Authorisation when required.
- To obtain authorisation from the Supervisory Body (Local Authority) in advance of the Deprivation of Liberty, except in urgent circumstances, in which case authorisation must be obtained from the Supervisory Body within seven calendar days of the start of the Deprivation of Liberty.
- To comply with any conditions attached to the authorisation as requested by the Best Interests Assessor (BIA) and recorded in the authorisation form signed by the DOLs Authoriser in the Local Authority.
- To maintain effective communication and co-operation with the Best Interests Assessor (BIA), Mental Health Assessor (MHA) IMCA/Paid Rep, & Supervisory Body both during the assessment process.
- To monitor whether the relevant person's representative (RPR) maintains regular contact with the person as the RPR is empowered to raise any concerns with the supervisory body, or the Court of Protection. If the RPR is not maintaining contact the supervisory body must be informed.
- To review and update the care plan on an ongoing basis giving consideration to the involvement of an advocacy service in the review. It should be noted that Deprivation of Liberty can be ended before a formal review.
- Ensure ALL updates relating to DOLs are documented clearly within the patient notes
- No more than 28 days before the end of an authorisation make a request for this to be reassessed as appropriate ADASS form 2.
- EPUT (as a Managing Authority) must note that a failure to identify a potential Deprivation of Liberty might be construed as a breach of rights and a safeguarding matter. In such circumstances the Trust Safeguarding Team should be notified.
- To notify CQC of authorised Deprivations of Liberty.
- Notify the Supervisory Body of changes in circumstances, and -
- To raise a safeguarding concern for an adult deprived of liberty who does not lack mental capacity.
- The Patient's relevant person and their representative should be made aware of the types of questions/issues they can take to the Court as stated in the Code of Practice.
- EPUT (Managing Authority) and the Local Authority (Supervisory Body) should endeavour to resolve any concerns through mediation, or their own complaints procedures before the relevant person or their representative refer the matter to the Court. The Managing Authority and Supervisory Body are required to comply with any conditions imposed by the Court following a hearing.

## MCPG2 - MENTAL CAPACITY & DEPRIVATION OF LIBERTY SAFEGUARDS PROCEDURE

- It is the responsibility of the Managing Authority to ensure that the relevant person and their representative is aware of their rights to apply to the court both before the authorisation is granted and afterwards and that they have the information required in order to make a referral to the Court.

### 3.3.2 Key responsibilities of the Supervisory Body (Local Authority)

- To co-ordinate a dedicated Deprivation of Liberty Safeguards Service to undertake the work related to Deprivation of Liberty.
- To ensure there is a clear referral pathway for all Managing Authorities for all issues relating to DOLs.
- To have overall responsibility for granting or refusing authorisations for Deprivation of Liberty and to be responsible for signing authorisations.
- When giving authorisation for Deprivation of Liberty, to specify the duration of the Deprivation of Liberty, which cannot exceed 12 months.
- To attach appropriate conditions to the authorisation and make recommendations based on the best interests of the relevant person.
- Where appropriate to commission an Independent Mental Capacity Advocate (IMCA) and other relevant advocacy support as required.
- Where an authorisation for a Deprivation of Liberty has been granted by the Supervisory Body, to appoint a Relevant Person's Representative (RPR) to represent the interests of the relevant person.

### 3.4 Making an application for a DOLs authorisation

3.4.1 Where staff believe a patient may be deprived of their liberty an application for a DOLs authorisation to the Local Authority must be made using ADASS Form 1

3.4.2 The DOLs application may include an urgent authorisation for up to 7 days (a further extension of 7 days may also be requested).

3.4.3 Staff must ensure that ALL completed applications for DOLs are signed and sent to the Trust DOLs service at

██

#### 3.4.4 Appeals to the Court of Protection about an authorised standard Deprivation of Liberty Safeguards application (s21A MCA)

3.4.5 The Court of Protection, established by the Mental Capacity Act 2005, exists to allow anybody deprived of their liberty the right to speedy access to a court that can review the lawfulness of their Deprivation of Liberty.

3.4.6 The following have an automatic right of access to the Court of Protection and can make an application:

- The Person who lacks or is alleged to lack mental capacity
- The donor of a Lasting Power of Attorney or their donee
- A Deputy appointed by the court
- Anyone named in an existing court order
- The person's appointed Representative under DOLs.

### **3.5 Deprivation of Liberty in a setting other than a hospital or registered care home**

3.5.1 Individuals that we are providing support for may be deprived of their liberty in settings other than registered care homes or hospital and nursing homes. This may include supported living settings, private homes or shared accommodation.

3.5.2 It is unlawful for any individual to be deprived of their liberty except where this occurs through a procedure prescribed by law and the individual has speedy access to the court for a review of the deprivation.

3.5.3 Staff will need to consult with safeguarding team when there are concerns regarding such cases. Determination of which agency is most appropriate to make the application to the Court may need to be determined on a case-by-case basis – the state authority with greatest responsibility for their care typically being responsible for the application. It is vital where both Local Authority and CCG are responsible for a care-package that there are no delays in appropriate applications to the Court.

### **3.6 Death of Service User under DOLs**

When a patient dies and was subject to an authorised DOLs the Coroner need only be notified if:

- The cause of death is unknown
- Where there is concern regarding the death e.g. concern regarding the care and treatment before death
- Unnatural or violent cause of death

3.6.1 In such cases the Trust Safeguarding MCA DOLs Team would contact the coroner to notify them of the death. The coroner would discuss with the doctor who is certifying the death and advise on any further requirements.

## MCPG2 - MENTAL CAPACITY & DEPRIVATION OF LIBERTY SAFEGUARDS PROCEDURE

3.6.2 The ADASS Form 12 must be completed for all patients who have died under DOLs (granted) by a qualified staff member and forwarded to the Safeguarding MCA DOLs team inbox so that it can be forwarded to the relevant Supervisory body in order to withdraw or cease the DOLs.

3.6.3 Additional information can be accessed via the Safeguarding page on InPut or via the Local Authority websites and the Law Society Guidance as below.

- Southend: <http://www.safeguardingsouthend.co.uk/adults/index.html>
- Essex: <http://www.essexsab.org.uk>
- Thurrock: <https://www.thurrock.gov.uk/keeping-safe-from-abuse/making-important-decisions>
- Bedfordshire: [www.bedford.gov.uk](http://www.bedford.gov.uk) › Health and Social Care › Mental Capacity Act (MCA)
- Suffolk: [www.suffolk.gov.uk](http://www.suffolk.gov.uk)
- The Law Society Guidance can be found at:  
<http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/>.

**END**