Humber Teaching
NHS Foundation Trust

MENTAL CAPACITY ACT 2005
DEPRIVATION OF LIBERTY SAFEGUARDS POLICY
(M-002)

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Policies should be accessed via the Trust intranet to ensure the current version is used

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1. INTRODUCTION

The aim of the Humber Teaching NHS Foundation Trust Mental Capacity Act 2005 Deprivation of Liberty Safeguards Policy is to clearly state an agreed approach to the appropriate and effective use of the Deprivation of Liberty Safeguards.

The Deprivation of Liberty Safeguards provides a legal protection to those vulnerable individuals who are, or may become, deprived of their liberty within the meaning of Article 5 of the European Convention of Human Rights (ECHR).

On 19 March 2014 the Supreme Court delivered its judgment in the cases of P&Q and Cheshire West which has had a significant impact in relation to deciding which legal framework is used to admit and provide care and/or treatment for individuals who may lack the capacity to consent to their admission, care and treatment in hospitals and care homes.

The Supreme Court judgement stated that the following three criteria must exist together for the situation of the patient to be a deprivation of liberty:

- does the person lack capacity to make a decision about where they are living and what their care and treatment needs are?
- are they subject to continuous supervision and control?
- are they not free to leave?

Continuous supervision and control refers to oversight even when the patient is not in the line of sight, it must amount to supervision and have a clear element of control.

Free to leave – the person may not be asking to go or showing this in their actions but the important factor is how staff would react if that person did try to leave or if a relative or friend asked to remove them.

Deprivation of Liberty will only apply to those persons who are resident or temporarily accommodated in a hospital, care home or registered care facility. The authority to deprive an incapacitated person of their liberty in any other setting can only be given by the Court of Protection.

This policy should be read in conjunction with the Mental Capacity Act 2005, Mental Capacity Act Codes of Practice (2007) and the Deprivation of Liberty Safeguards Code of Practice (2008), which serves as an addendum to the Mental Capacity Act Code of Practice.

This policy assumes a knowledge and understanding of the Mental Capacity Act Policy and should be read in conjunction with other policies which include:

- Safeguarding Adults Policy
- Safeguarding Childrens Policy
- Mental Health Act 1983 Policy
- Use of Seclusion or Segregation Policy
- Managing Work-Related Violence and Aggression Policy
- Consent Policy

This policy is not a replacement for the Mental Capacity Act Code of Practice Code of Practice (2007) or the Deprivation of Liberty Safeguards Code of Practice (2008).

The new Mental Capacity (Amendment) Act 2019, was given Royal Accent on 16 May 2019, this will amend the current Deprivation of Liberty Safeguards that are in place. The implementation date has been postponed until after the next general election.

2. PURPOSE AND DEFINITIONS

The purpose of this policy is to provide staff working in or with Humber Teaching NHS Foundation Trust Foundation Trust with guidance about the Mental Capacity Act 2005, Deprivation of Liberty Safeguards. It sets out the main provisions of the Act, identifies the duties placed on health and social care staff and provides a procedure to determine the circumstances in which the various processes described within the Deprivation of Liberty Safeguards should be followed.

This policy supplements, and should be used in conjunction with the Mental Capacity Act and the Deprivation of Liberty Safeguards guidance. The Trust is committed to ensuring that all people who are using our services are treated with dignity and respect and those individuals and their families/carers receive appropriate care and support.

2.1. Definitions/Explanation of Terms Used

Deprivation of Liberty Safeguards (DoLS): when assessing individuals for admission to hospital, staff need to be aware that a Deprivation of Liberty is not to be confused with the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards is the legal framework set out within the Mental Capacity Act (MCA 2005) which authorises the deprivation of liberty of a person in a hospital or care home when the **person lacks** the capacity to consent to stay and is subject to **continuous supervision** and **control**, and is not **free to leave**.

Consent: consent is the voluntary and continuing permission of a patient to be admitted to hospital and/or given a particular treatment, based on sufficient knowledge of the purpose, likely effect and risk of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent. Patients who lack capacity to consent **cannot** consent. Compliant acceptance of any intervention, including admission to hospital is **not** consent.

Restraint: the Mental Capacity Act 2005 affords protection to health and social care staff who are obliged to use restraint to provide care or treatment to adults who lack capacity and who would be at risk of harm if they did not receive the necessary care or treatment. Under the Mental Capacity Act 2005, health and social care staff will be protected from liability when applying restraint in these circumstances, as long as the restraint is necessary to prevent the incapacitated person from coming to harm, is proportionate to the likelihood and seriousness of that harm, and the degree of restraint applied does not amount to a deprivation of the person's liberty.

Capacity: mental capacity is always referred to as time- and situation-specific. Where the term 'lack of capacity' is used throughout this document it refers specifically to the capacity to decide whether or not they wish to be accommodated by the Trust (whether temporarily or permanently) and whether they consent to the proposed care and/or treatment that involves circumstances that amount to deprivation of liberty when that decision needs to be made.

Managing Authority: under the Deprivation of Liberty Safeguards the term Managing Authority refers to any hospitals or care homes that are registered with the Care Quality Commission. Throughout this policy the term Managing Authority refers to Humber Teaching NHS Foundation Trust.

Supervisory Body: Supervisory Bodies are those organisations that commission and authorise the Deprivation of Liberty Safeguards. For the purpose of this policy the Supervisory Bodies are Hull City Council, East Riding of Yorkshire Council and North Yorkshire Council.

Mental Health Legislation Team: the administration of Deprivation of Liberty Safeguards within the Trust is the responsibility of the Mental Health Legislation Team.

Clinician in Charge: the clinician in charge will be responsible for the completion and submission of all Deprivation of Liberty Safeguards documentation and informing the Mental Health Legislation

Team when Applications are made to the Supervisory Body and when Authorisations are granted by the Supervisory Body. The Appropriate Manager must also ensure that staff discuss/report any potential deprivation to them.

Standard Authorisation: an Authorisation given by the Supervisory Body after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in the relevant hospital or care home.

Urgent Authorisation: an Authorisation given by a Managing Authority for a maximum of seven days, which may be extended by a maximum of a further seven days by a Supervisory Body. The Urgent Authorisation gives the Managing Authority lawful authority to deprive a person of their liberty whilst the Standard Authorisation process is undertaken.

Code of Practice: This refers to the Deprivation of Liberty Safeguards Code of Practice which supplements the main Mental Capacity Act 2005 Code of Practice.

Best Interest Assessor (BIA): the Best Interest Assessor is a specially-trained professional who is responsible for conducting a range of assessments to ascertain whether an Authorisation for deprivation of liberty should be granted. The Best Interest Assessor is appointed by the Supervisory Body.

Mental Health Assessor: the Mental Health Assessor is a Section 12 Approved Doctor or a Registered Medical Practitioner (with at least 3 years post-registration experience in the diagnosis or treatment of mental disorder) who has completed the necessary Mental Health Assessor training. The purpose of the mental health assessment is to ensure that the person suffers from a mental disorder as defined by the Mental Health Act 1983 (any disorder or disability of the mind) in order to ensure that the deprivation is in accordance with Article 5 of the European Convention on Human Rights which required the individual in these circumstances to be of 'unsound mind'.

Independent Mental Capacity Advocate (IMCA): this is someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. An IMCA is not the same as an ordinary advocate. The IMCA service was established by the Mental Capacity Act 2005.

Relevant Person: is the person who is made subject to an Urgent and/or Standard Authorisation under the Deprivation of Liberty process.

Relevant Person's Representative: the role of the Representative is to maintain contact with the Relevant Person, support that person and represent that person in matters relating to the Deprivation of Liberty Safeguards. The Relevant Person's Representative may be a family member or appropriate carer. If no such person is available or forthcoming then the Supervisory Body may appoint a paid representative.

3. SCOPE

This document gives guidance to practitioners on the identification of a potential deprivation of liberty and the process to be followed if it is identified that an unavoidable deprivation of liberty is occurring or is going to occur. It also outlines the processes and subsequent requirements where an Authorisation, either Standard or Urgent, is given.

This policy represents the agreed Policies and Procedures of Humber NHS Foundation Trust and applies to all staff employed by the Trust.

3.1. Responsibilities and Accountabilities

Trust Board
The Trust Board is responsible for implementing a robust system of corporate governance within the organisation. This includes having a systematic process for the development, management and authorisation of policies.

Chief Executive
The chief executive has overall responsibility to ensure that policies and processes are in place for the Mental Capacity Act Deprivation of Liberty Safeguards.

Director of Nursing and Allied Health and Social Care Professionals with support of the Medical Director
Both directors are responsible for ensuring that this policy is understood and carried out by all staff and that processes are in place to ensure the policy is implemented.

Divisional Leads
The divisional leads have the responsibility to ensure that divisions are suitably equipped to meet the Deprivation of Liberty Safeguards and to ensure that all staff understand and comply with the policy and procedure.

MCA DoLS Lead
The MCA DoLS lead is responsible for ensuring that MCA DoLS processes are adhering to policy and that there are quality procedures in place. They are also responsible for making sure staff have access to up to date information and training.

All Staff
All staff within the scope of the policy are responsible for its implementation within their area of accountability. It is each individual's responsibility to ensure they make themselves aware of this guidance and receive sufficient training and information about the Deprivation of Liberty Safeguards to undertake their role. Staff must keep all patients in their care under review for potential deprivation of liberty situations, if a deprivation of liberty is identified, this must be escalated immediately to an appropriate Manager.

3.2. Duties

Managing Authority
Humber Teaching NHS Foundation Trust to:

- Ensure the Deprivation of Liberty Safeguards are implemented effectively within the Trust by providing systems which support the safeguards and monitoring compliance.
- Ensure Authorisations for deprivation of liberty are sought from the appropriate Supervisory Body in all instances where a person is considered to be deprived of their liberty.
- Ensure appropriate records are kept.
- Inform all relevant parties, including the patient, regarding the application details and outcomes of the deprivation of liberty safeguards process.

Manager
It is the responsibility of individual managers to ensure their staff are informed of the Deprivation of Liberty Safeguards and receive sufficient training and support to undertake their role. The manager in charge will also be responsible for ensuring that when a patient is identified as being deprived of their liberty the appropriate documentation is completed and submitted for application to the Supervisory Body. They must also:

- Take all steps to minimise the restrictions imposed on a person.
- Ensure that an application for the Authorisation of a deprivation of liberty for any person who may come within the scope of the Deprivation of Liberty Safeguards and comes under their area of responsibility is made.
- Ensure that an Urgent Authorisation is granted where a deprivation of liberty is apparent.

- Ensure the supervisory body are contacted on at least a weekly basis to chase up any unauthorised applications for a standard authorisation.
- Ensure the deprivation of liberty Authorisation is reviewed, remains current where necessary, and is ended when appropriate.
- Ensure appropriate advocacy and representation, to include family as well as formal advocacy services, is provided wherever necessary.

4. PROCEDURE/IMPLEMENTATION

The question of whether the steps taken by staff amount to a deprivation of a person's liberty are ultimately a legal question and only the courts can determine the law. Further legal developments (changes in case law) may occur, and healthcare and social care staff need to keep themselves informed of legal developments that may have a bearing on their practice.

When a person is about to be admitted or has been admitted to one of the Trust's inpatient wards or registered homes, and it is identified that the person lacks capacity to not only consent to their admission but also lack capacity to make an informed decision about their proposed care and treatment whilst being under the care of the Trust, then they are at risk of being deprived of their liberty.

Where the MHA is available i.e., on our mental health and learning disability inpatient wards, this legal framework should **always** be used above DoLS, if the criteria is met. If a patient is detained under the MHA then a DOLs application is not required.

4.1. What is a Deprivation of Liberty?

The requirement for the Deprivation of Liberty Safeguards remains unchanged. There are still six requirements which need to be met is the patient:

- 18 and over
- Suffering from a mental disorder
- Lacking capacity for the decision to be accommodated in the hospital or care home
- No decision previously made to refuse treatment or care, or conflict relating to this such as Lasting Power of Attorney (LPA)
- Not ineligible for DoLS, (this will be of significance and require consideration of the Mental Health Act, for those receiving treatment for a mental disorder within HFT)
- The person needs to be deprived of liberty, in their best interests

The Supreme Court has now confirmed that to determine whether a person is objectively deprived of their liberty there are three key questions which staff need to ask themselves:

1. Is the person subject to continuous supervision?
2. **and** control?
3. **and** Is the person free to leave? (The person may not be saying this or acting on it but the issue is about how staff would react if the person did try to leave.) All three of these requirements must be met.

Note – continuous supervision and control refers to oversight even when the patient is not in the line of sight, it must amount to supervision and have a clear element of control. **Not free to leave** – the person may not be asking to go or showing this in their actions but the important factor is how staff would react if that person did try to leave or if a relative or friend asked to remove them.

Article 5 of the Human Rights Act 1998 states that 'everyone has the right to liberty and security of person. No-one shall be deprived of his or her liberty (unless) in accordance with a procedure prescribed in law'. The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

A Supreme Court judgement in March 2014 made reference to the 'acid test' to see whether a person is being deprived of their liberty, whether a patient is compliant or does not object to their car, treatment and accommodation is no longer relevant, neither is the reason or purpose behind these arrangements, which consisted of two questions:

- Is the person subject to continuous supervision and control? and
- Is the person free to leave?

Each case must be considered on its own merits, but in addition to the two 'acid test' questions, if the following features are present, it would make sense to consider a deprivation of liberty application:

- frequent use of sedation/medication to control behaviour
- regular use of physical restraint to control behaviour
- requirement that person is supervised when outside of the hospital or care home
- the person concerned objects verbally or physically to the restriction and/or restraint
- objections from family and/or friends to the restriction or restraint
- the person is confined to a particular part of the establishment in which they are being cared for
- staff exercising complete and effective control over the care and movement of a person for a significant period
- physical restrictions preventing the person leaving such as locked door, bed rails, wheelchair straps
- the placement is potentially unstable
- possible challenge to the restriction and restraint being proposed to the Court of Protection or the Ombudsman, or a letter of complaint or a solicitor's letter
- the person is already subject to a deprivation of liberty authorisation which is about to expire

4.2. Identifying Possible Deprivation of Liberty

Initially, staff must review any previous decision made for individuals under their care where a patient's decision-making capacity has been, or continues to be, in question, i.e. where a patient has not given fully informed consent to admission and any treatment or care that is being provided and where any care and/or treatment is currently being provided in the patients best interest. In these cases Staff **must** formally assess the person's capacity.

Where it is established that the patient lacks capacity the assessing clinician/professional **must** then establish whether the person is under continuous supervision and control and not free to leave. This assessment must be fully documented on the Trust's Assessment of capacity paperwork and the clinical team will have to decide under which legal framework the care and treatment they are providing is being delivered:

- under the Deprivation of Liberty Safeguards 2005; or
- under the Mental Health Act 1983.

4.3. Procedure for Urgent Authorisation

An Urgent Authorisation cannot be made unless a Standard Authorisation is made at the same time. Therefore, the clinical team must reasonably believe that the person will meet the requirement of a Standard Authorisation. Once the decision is made to apply for a standard Authorisation and the person is considered to be deprived of their liberty with immediate effect then the Trust will need to grant itself an Urgent Authorisation. In this case the appropriate manager should complete the appropriate form (ADASS Form 1).

Form 1 should be sent to the appropriate Local Authority with a copy of the Assessment of Capacity form to support the application via email and copy in Mental Health Legislation at hnr-tr.mentalhealthlegislation@nhs.net. The Mental Health Legislation Team will then check the

paperwork and ensure it has been sent to the correct Local Authority .

The maximum period the Trust can give itself an Urgent Authorisation is seven days, during which time the assessments carried out by the Mental Health Assessor and the Best Interest Assessor should be completed.

4.4. Requesting an Extension of an Urgent Authorisation

In exceptional circumstances where the assessment has not been completed within the seven day period, the Urgent Authorisation can be extended by the Supervisory Body for a further seven days. Exceptional circumstances would not normally be because the supervisory body hasn't sent a BIA to complete the assessment although this does happen in practice. The extension is requested by completing a further section on Form 1 and resubmitting to the local authority. This only comes into force if the local authority confirms the seven-day extension is granted by returning the Form 1 with their signed confirmation. Within Humber Teaching NHS Foundation Trust the extension to the urgent authorisation should be requested after 3 days of the urgent authorisation being initiated due to the delays in assessments being carried out.

If no response to the request for extension of the urgent authorisation within the 7 day period a datix should be completed to flag up the unlawful detention.

The supervisory body should be contacted on a weekly basis to chase the status of the assessment being carried out – CC mental health legislation into any emails.

4.5. The Assessment under Deprivation of Liberty Safeguards

Once the Standard Authorisation has been submitted to the Local Authority DoLS team it will arrange for the patient to be visited and assessed by a Mental Health Assessor, a Best Interest Assessor and an Independent Mental Capacity Advocate where appropriate. These individuals will determine whether the person meets the requirement of the Deprivation of Liberty Safeguards. During the assessment the assessors and the Independent Mental Capacity Advocate will visit the patient and may ask to examine and take copies of:

- any health or social care records which relate to the person, and
- the person's Care Plan.

The assessor(s) will also need to consult with a senior member of staff and other staff on duty who know the patient. They will also consult with the patient's family/significant others and therefore it is important that where an application under the Deprivation of Liberty Safeguards is submitted, that the appropriate manager ensures that the patient and the patient's family/significant others are fully aware that the Standard Authorisation has been submitted.

4.6. Assessment Outcome

Where the assessment concludes that the patient is eligible, lacks capacity and that they are deprived of their liberty in their best interest, the Supervisory Body will then issue a written Authorisation (ADASS Form 5). This Authorisation will give details of the duration and purpose of the Authorisation and any conditions which may relate to it.

Conditions: where there are conditions attached to the authorisation it is the Managing Authorities responsibility to ensure that these conditions are met and that the Supervisory Body is informed upon their completion.

The managing authority must then notify the Care Quality Commission (CQC) via the CQC portal. This is done by the Mental Health Legislation Team for all areas apart from Granville Court.

Where an Authorisation is refused (ADASS Form 6) by the Supervisory Body the person's care will need to be reviewed **immediately** and, if appropriate, a request for an assessment under the Mental Health Act should be sought.

It is the responsibility of the Trust as the Managing Authority to ensure that all practicable steps are

taken to ensure that the patient and the patient's relevant person's representative understand the effects of the Authorisation and their rights.

4.7. Discharge

When a patient who is subject to an Authorisation under the Deprivation of Liberty Safeguards either:

- no longer meets the requirement; or
- is due to be discharged from the care of the Trust

then the clinician in charge **must** complete a Form 10 and send this to the Supervisory Body who will arrange for the Authorisation to be reviewed and ended.

4.8. Continuation of Deprivation of Liberty Safeguards

Where it is expected that the patient will remain under the care of the Trust when the Standard Authorisation is due to expire, it is the responsibility of the Trust (Clinician in Charge and Manager) to ensure that a Form 2 and further assessment of capacity form is submitted to the Supervisory Body 28 days before the original Authorisation expires. If there is less than 28 days before the authorisation expires it must be done as soon as a review is needed.

4.9. The Relevant Person's Representative

Every person who is made subject to an Authorisation under the Deprivation of Liberty Safeguards will have a relevant person's representative appointed. As soon as possible after the Standard Authorisation is granted the Trust must ensure that the person who is deprived of their liberty and their representative are made aware of:

- the effects of the Authorisation
- the right to request a review
- the formal and informal complaints procedures
- their right to apply to the Court of Protection to seek a variation or termination of the Authorisation
- the right of the person who does not have a 'paid' relevant person's representative to request the support of an Independent Mental Capacity Advocate

5. WHEN SHOULD AN IMCA BE INSTRUCTED?

The **supervisory body** (local authority) is responsible for instructing an IMCA if there is nobody appropriate to consult with about proposed care and treatment, other than people engaged in providing care or treatment for the Relevant Person in a professional capacity or for remuneration. The Managing Authority must make the Supervisory Body aware when submitting an application. This must be done quickly if an Urgent Authorisation has been given.

An IMCA must also be instructed during gaps in the appointment of a relevant person's representative and also in the following circumstances:

- The Relevant Person does not have a paid 'professional representative';
- The Relevant Person or their representative requests that an IMCA is instructed to help them; or
- A Supervisory Body believes that instructing an IMCA will help ensure that the person's rights are protected.

6. TRAINING IMPLICATIONS

All staff need to be aware of the key points that the policy covers, and have a responsibility to familiarise themselves with the policy and other resources which are available on the Trust intranet .

Staff must also ensure they are compliant with Mental Capacity Act 2005 training in accordance with their assigned competency, this is updated every three years. Training can be accessed by the staff member via ESR.

Any changes in legislation or processes will be circulated to Trust staff when available.

7. MONITORING ARRANGEMENTS

Monitoring of appropriate use of the MCA/DoLS will be done by the Mental Health Steering Group as part of exception reporting and relevant findings shared with the Mental Health Legislation Committee.

8. EQUALITY IMPACT ASSESSMENT SCREENING

See Appendix 8.

9. LINKS TO ANY ASSOCIATED DOCUMENTS

Mental Health Act 1983 (as amended by the Mental Health Act 2007) Mental Health Act Code of Practice 2015
Mental Capacity Act Code of Practice 2005
Deprivation of Liberty Safeguards 2008 Code of Practice
ADASS Mental Capacity Act Deprivation of Liberty Safeguards – guidance to forms Law Commission review report

10. REFERENCES

The Mental Capacity Act 2005 applies in conjunction with other legislation in addition to that described above under which health and social care staff have obligations relating to people who lack capacity.

- Human Rights Act 1998
- Data Protection Act 1998
- P&Q and Cheshire West (Supreme Court Judgment, laid down on 19 March 2014)
- Coroners and Justice Act 2009

APPENDIX 1 – FORM 1: STANDARD REQUEST, URGENT AUTHORISATION AND EXTENSION TO URGENT

www.adass.org.uk/uploadedFiles/adass_content/policy_networks/mental_health_Drugs_and_Alcohol/public_content/Form-1-Standard-and-Urgent-Request-Final.docx

APPENDIX 2 – FORM 2: REQUEST FOR FURTHER STANDARD AUTHORISATION

www.adass.org.uk/uploadedFiles/adass_content/policy_networks/mental_health_Drugs_and_Alcohol/public_content/Form-2-Further-Authorisation-Request-Final.docx

APPENDIX 3 – FORM 7: SUSPENSION OF AUTHORISATION

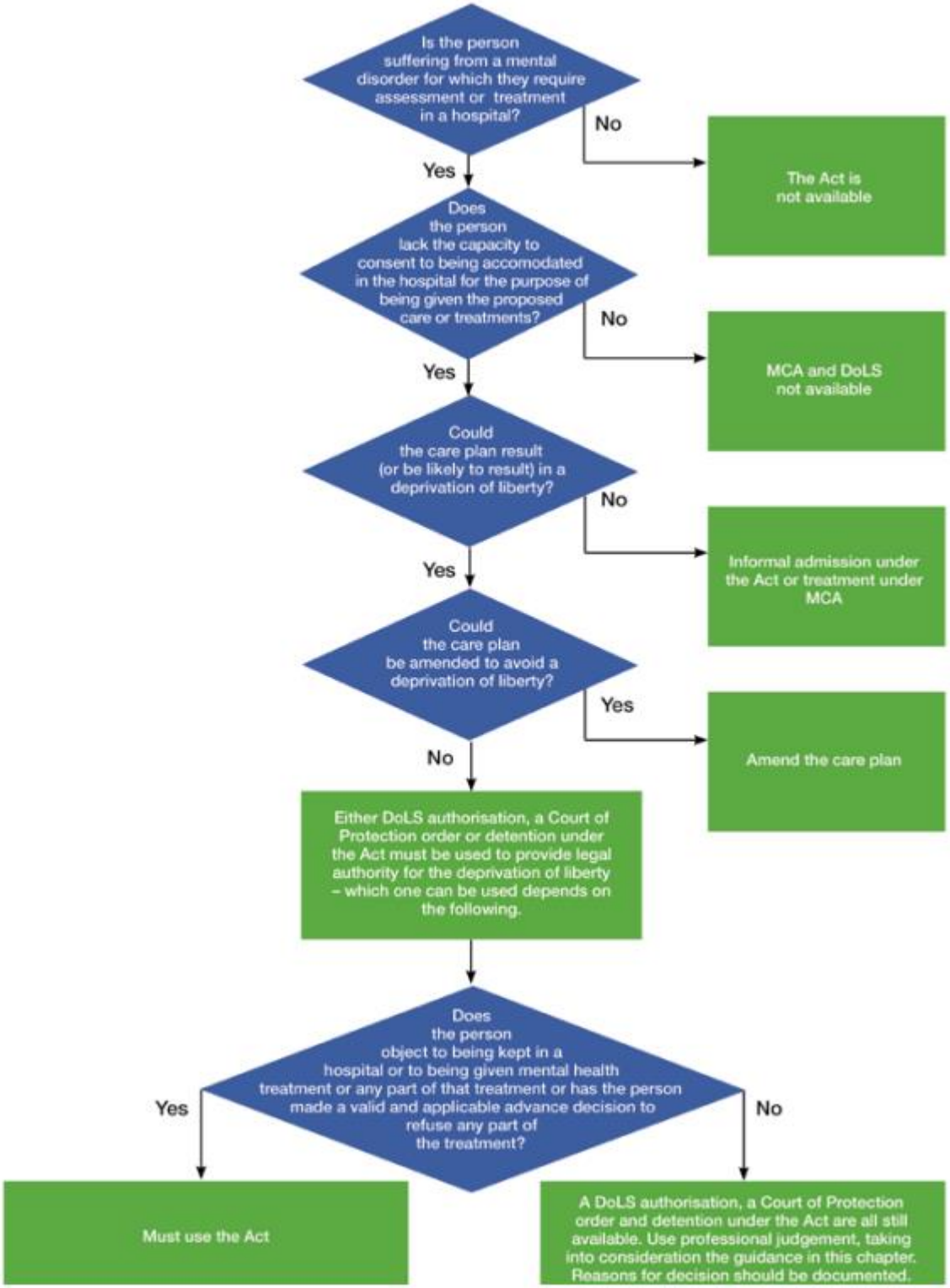
www.adass.org.uk/uploadedFiles/adass_content/policy_networks/mental_health_Drugs_and_Alcohol/public_content/Form-7-Suspension-of-Standard-Authorisation-Final.docx

APPENDIX 4 – FORM 10: REVIEW OF CURRENT AUTHORISATION

www.adass.org.uk/uploadedFiles/adass_content/policy_networks/mental_health_Drugs_and_Alcohol/public_content/Form-10-Review-Request-Final.docx

APPENDIX 5 – DECIDING WHETHER THE ACT AND/OR MCA WILL BE AVAILABLE TO BE USED

The MHA Code of Practice provides a useful flow chart below on deciding whether the Act or MCA will be available to be used.



APPENDIX 6 – LEVEL ONE LEAFLET FOR STAFF IN RELATION TO MCA AND DOLS

The Mental Capacity Act (2005) provides the legal framework for acting and making decisions on behalf of individuals who lack the capacity to make particular decisions. The Act is supportive, not restrictive or controlling and protects the person who lacks the capacity and you (Code of Practice (2007) p15).

Consent needs to be gained for each decision or action to be taken, e.g. for admission, or assessment or for any treatments or interventions (this does not apply to any admissions under the Mental Health Act).

Whilst a person must be assumed to have capacity for every decision and or action, only if this is doubted should an assessment of capacity be undertaken.

An Assessment of Capacity can be undertaken by any professional working with the person, e.g. admitting nurse at point of admission. This must be documented on the in- patient documentation, only if a formal assessment of capacity needs to be undertaken should staff use the Trust approved Assessment of Capacity and Best Interests paperwork.

Everyone should follow the five statutory principles at all times.

1. What are the 5 Key Principles of the Mental Capacity Act? – Code of Practice, Chapter 2, p19

- A person must be assumed to have capacity unless it is established that they lack capacity
- A person should not be treated as unable to make a decision unless all practicable steps have been taken to help the person understand
- A person should not be treated as unable to make a decision because they make an unwise decision
- An act done or decision made should always be made in a person's best interests
- Before the act is done or decision made, consideration should be given that this is the least restrictive of the person's basic rights and freedoms

If it is likely that the person will regain capacity, the decision should be delayed until that time.

2. What does 'lacks capacity' mean? – Code of Practice, Chapter 4

When a person is unable make a particular decision (or action for themselves) at the time the decision or action needs to be taken.

3. How do I test capacity? – See Trust approved paperwork for assessing capacity – Code of Practice, Chapter 4

It is important that if capacity is doubted, it needs to be tested using the two-stage test for Capacity.

- Stage 1: does the person have an impairment or a disturbance in the functioning of their mind or brain? This could cover a range of problems, such as psychiatric illness, learning disability, dementia, brain damage or temporary states of confusion due to alcohol or drug use
- Stage 2: does the impairment or disturbance means that the person is unable to make a specific decision when they need to?

This can only apply if all practicable and appropriate support to help the person has failed.

A person is unable to make a decision if they cannot:

- **Understand** information about the decision;
- **Retain** the information;
- **Use or weigh** that information as part of the decision making process; or
- **Communicate** their decision, by talking, use sign language or other means.

If the decision maker finds the person lacks the capacity to consent, they cannot make the decision in isolation and must always work in the best interests of the person.

4. What is a 'Best Interest' Decision? – Code of Practice, Chapter 5

Any act done or decision made for or on behalf of a person who lacks capacity must be done or made in the person's best interests. The Code of Practice (2007) provides a summary of the areas which should be considered when deciding what is in a person's best interests (see **Trust approved paperwork for making Best Interest Decisions**).

5. Who can make a Best Interest decision? – Code of Practice, Chapter 5

The Mental Capacity Act identifies these people as a 'Decision Maker – 'a person who makes a decision on behalf of a person who lacks the capacity to consent'. They are people who are legally responsible to work out what would be in the best interests of the person. It is the responsibility of the decision maker to follow the five key principles of the Act at all times. This can be undertaken via a best interests meeting, unless the person has a Lasting Power of Attorney (see point 12) or has made an Advance Decision (see point 13).

6. Who can be a decision maker? – Code of Practice, Chapter 5

Different people can be decision makers at different times dependent upon the decision to be made. If the decision to be made is to carry out surgery, the decision maker will be person responsible for carrying out the surgery, which would be the surgeon.

7. What is a best interests meeting? – Code of Practice, Chapter 5

This is a forum initiated at the request of the decision maker when a decision or action needs to be taken and person lacks the capacity to consent.

The decision maker will invite a group of people (relevant to the decision to be made) to consider what is in the person's best interests. This must include family or friends. If the person does not have any family or friends, then an IMCA (Independent Mental Capacity Advocate) must be instructed. Any best interest decision should be clearly documented, including detailed information about who made the decision and why the decision was considered to be in the person's best interests.

8. What do I need to consider when carrying out a best interest meeting? – Code of Practice, Chapter 5

Encourage participation by the person in the decision-making process: make any reasonable adjustments to enable the person to take part in making the decision.

Identify all the relevant circumstances: this would be the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.

Find out the person's views: this would mean trying to find out the person's past and present wishes and feelings; these could have been expressed verbally or in writing, which would be known as an advance decision, or through behaviour or habits.

Any beliefs and values: religious, cultural and moral that would influence the decision in question.

Avoid discrimination: do not make assumptions based upon a person's age, appearance, condition or behaviour.

Consider if the person is likely to regain capacity: if so, can the decision wait?

If the decision concerns life-sustaining treatment: the decision should not be motivated in any way by a desire to bring about the person's death. They should not make assumptions about the person's quality of life.

Consult others relevant to the decision to be made for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values.

Avoid restricting the person's rights: review other care or treatment options that maybe less restrictive.

Take all of the above into account when making a best interest decision both in relation to care and or consideration of treatment required.

9. Does everything we do for a person who lacks capacity need to be discussed in a best interest meeting? – Code of Practice, Chapter 6

No, the Act recognises that there are a number of acts and decisions taken daily that do not need to be discussed within a best interests meeting. These can include personal care and healthcare and treatment. Areas that might be covered include:

Personal Care: help with washing and dressing or personal hygiene, helping with eating and drinking, helping with mobility – see Chapter 6, p95 Code of Practice for more details.

Healthcare and Treatment: carrying out diagnostic examinations and tests to identify an illness, condition or other problem, providing professional medical or nursing care, giving medication, carrying out other medical procedures, for example, taking a blood test or therapy, e.g. physiotherapy or chiropody, or providing care in an emergency.

These actions only receive protection from liability if the person is reasonably believed to lack capacity to give permission for the action and that the action is in the best interests of the person.

Making these decisions via an multi-disciplinary team, which is then written into a person's care plan will provide protection to all, ensuring that at all times an assessment of the person's capacity to consent to the actions covered by the care plan is undertaken, with the confirmation that the actions to be taken are in the person's best interests.

Staff may then be able to assume that any actions they take under the care plan are in the person's best interests and therefore receive protection from liability (see section 5).

10. Am I allowed to use restraint? – Code of Practice, Chapter 6

Restraint should only be used when the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity and the restraint used will be proportionate to the likelihood and seriousness of the harm. A 'proportionate response' means using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of the person who lacks capacity, for example, holding a person to undertake tests such as taking blood rather than administration medication.

On occasions when the use of force may be necessary, staff should use the minimum amount of force for the shortest possible time. Although section 6 of the Act permits the use of restraint where

it is necessary under the above conditions, section 6(5) confirms that there is no protection under the Act for actions that result in someone being deprived of their liberty.

These actions only receive protection from liability if the person is reasonably believed to lack capacity to give permission for the action and that the action is in the best interests of the person.

Making these decisions via an multi-disciplinary team, which is then written into a person's care plan will provide protection to all, ensuring that at all times an assessment of the person's capacity to consent to the actions covered by the care plan is undertaken, with the confirmation that the actions to be taken are in the person's best interests.

Staff may then be able to assume that any actions they take under the care plan are in the person's best interests and therefore receive protection from liability (see section 5).

Care Planning should include risk assessments and set out appropriate actions which may include the use of restraint to try to prevent possible risks and to work in the best interests of the patient.

11. What is an IMCA – Independent Mental Capacity Advocate? – Code of Practice, Chapter 10

This is a person who is independent, someone who is there to review what is in the best interests of the person when the person has no family or friends. **They must be instructed (if they do not have family or friends) and be part of any best interest meeting if the decision involves serious medical treatment or the NHS arranges a hospital stay for 28 days or more**.

Some examples that might be considered serious include:

- Chemotherapy and surgery for cancer
- Electroconvulsive therapy
- Therapeutic sterilisation
- Major surgery such as open heart surgery
- Major amputations
- Treatments which will result in permanent loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration
- DNACPR (Do not attempt cardio–pulmonary resuscitation)

12. Lasting power of attorney (LPA) – Code of Practice, Chapter 7

This is a person who is legally accountable to make decisions upon behalf of someone who lacks the capacity to consent. An LPA can make decisions relating to health or finances or both. If a person has an LPA, the decision maker should identify the powers of their decisions to be made and if the decisions relate to health, they should always be consulted and decisions made accepted as if they were made by the person who lacks the capacity. All decisions made should be in a person's best interests.

13. Advance Decision Making – Code of Practice, Chapter 9

This is where a person has made an advance decision in relation to the issue in question while they had the capacity to do so Their advance decision should be respected at the time they lack capacity. All professionals must ask if the person referred has an Advance Decision, this must occur at the point of entry into services. If they have one, this should already be flagged on the Trust's patient administration system. If the patient requests one to be completed, please refer to the Advance Decision Policy.

There may be occasions when professionals feel that the decision to refuse treatment is not in their best interests, however, the advance decision should be adhered to.

Healthcare professionals will be protected from liability if they:

- Stop or withhold treatment because they reasonably believe that an advance decision exists and that it is valid and applicable
- Treat a person because, having taken all practicable and appropriate steps to find out if the person has made an advance decision to refuse treatment, they do not know or are not satisfied that a valid or applicable advance decision exists.

14. New criminal offence, what does this mean? – Code of Practice, Chapter 14

The Act introduces a new criminal offence of ill treatment or wilful neglect of a person who lacks capacity.

This is termed as abuse, which can be anything that goes against a person's human and civil rights (sexual, physical, psychological, financial abuse and neglect and acts of omission). This could be:

- A single act
- A series of repeated acts
- A failure to provide necessary care or
- Neglect

Examples include:

Physical – slapping, pushing or other forms of violence, misuse of medication, increasing dosage to make someone drowsy, inappropriate punishments, not giving someone a meal because they have been bad.

Psychological – threats of harm, threats to restrict a person's liberty.

Neglect and actions of omission – ignoring a person's medical or physical care needs, failure to get health care or social care, withholding medication, food or heating.

Financial – theft, fraud, undue pressure, misuse of, or dishonest gain of property, possessions or benefits.

Sexual – rape, sexual assault and sexual acts without consent.

15. Deprivation of Liberty Safeguards – See Deprivation of Liberty Safeguards Code of Practice

Deprivation is a matter of type, duration, effect and manner of implementation rather than of nature or substance. Confining a person in their room, locking a door, sedating them or placing them under close supervision for a very short period may not be a deprivation, but doing so for an extended period could be.

The Cheshire West ruling by the Supreme Court informs the approach to be taken.

The judgement is important for deciding whether arrangements made for the care and/or treatment of an individual who might lack capacity to consent to those arrangements amount to a deprivation of liberty. It has widened and clarified the definition of deprivation of liberty.

A deprivation of liberty in such a situation must be authorised in accordance with one of the following legal regimes:

- a deprivation of liberty authorisation or Court of Protection order under the Mental Capacity Act Deprivation of Liberty Safeguards; or
- (if applicable) under the Mental Health Act 1983; or
- in some rare situations, under the inherent jurisdiction of the High Court.

The Supreme Court has now confirmed that there are two key questions to ask:

I**s the person subject to continuous supervision and control?** It is still not clear what exactly this means: but the three cases in the Annex to this guidance show how wide the definition appears to be.

and

Is the person free to leave? The person may seem happy to stay, but the issue is about how staff would react if the person did try to leave or if relatives/friends asked to remove them permanently.

It is now clear that if a person lacking capacity to consent to the arrangements is subject both to **continuous supervision and control and not free to leave**, they are deprived of their liberty.

If a provider suspects, from the initial care plan or prior knowledge of the person, that someone coming in to their care may be deprived of liberty, the authorisation should be in place before the person arrives. It protects the person's rights; it does not mean they have to restrict the person's freedoms unless they have to do so in the person's best interests.

Care plans for people lacking mental capacity to agree to arrangements for their care or treatment should show evidence of best interests decision-making in accordance with the Mental Capacity Act, based on decision-specific capacity assessments.

In a psychiatric inpatient setting, clinical staff may want to review the situation of all informal patients who lack mental capacity to consent to admission and consider if they are deprived of their liberty. If they are at risk of being deprived of their liberty, the first step is to scrutinise the care plan to see if this could be safely altered to reduce the restrictions so there is no longer a deprivation of liberty. If this is not possible then the provider must decide between using the Mental Health Act and the MCA deprivation of liberty safeguards to protect the person's rights. The criteria for deciding between these have not been changed by this judgement.
Professionals should not assume one regime is "less restrictive" than the other. It is the care plan which imposes the restrictions, not the procedural safeguards that are required if these restrictions amount to a deprivation of liberty.

For further details with regards to application for the Mental Capacity Act or Deprivation of Liberty Safeguards consult:

- The Codes of Practice
- Mental Health Legislation Department
- Humber Safeguarding Team
- CQC Briefing – April 2014

APPENDIX 7 – DOCUMENT CONTROL SHEET

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	Mental Capacity Act 2005 Deprivation of Liberty Safeguards policy (M-002)		
Document Purpose	This policy is to provide staff working in or with Humber NHS Foundation Trust Foundation Trust with guidance about the Mental Capacity Act 2005, Deprivation of Liberty Safeguards. It sets out the main provisions of the Act, identifies the duties placed on health and social care staff and provides a procedure to determine the circumstances in which the various processes described within the Deprivation of Liberty Safeguards should be followed		
Consultation/ Peer Review:	Date:	Group / Individual	
list in right hand columns consultation groups and dates ->	August 2020		
Approving Committee:	MHLC	Date of Approval:	6 August 2020
Ratified at:	Trust Board	Date of Ratification:	Sept-2020
Training Needs Analysis: (please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)	Any changes in legislation or processes will be circulated to Trust staff when available.	Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Clinical Policy Team [✓]	HealthAssure [✓]	Author [ ]
Implementation:	Describe implementation plans below - to be delivered by the Author:		
	• Ratified policy will be uploaded onto Trust intranet • Staff will be informed via Trust Midweek Global email • Individual teams are responsible for implementation		
Monitoring and Compliance:	Monitoring of appropriate use of the MCA/DoLS will be done by the Mental Health Steering Group on a six-monthly basis and findings shared with the Mental Health Legislation Committee		

Document Change History:			
Version Number / Name of procedural document this supersedes	Type of Change i.e. Review / Legislation	Date	Details of Change and approving group or Executive Lead (if done outside of the formal revision process)
1.0	*New policy*	*Feb 16*	*New policy for legislation*
1.1	*Review*	*Nov 17*	*Approved QPaS 1 Nov 17*
1.2	*Review*	*Jul 20*	*Approved MHQC 6 Aug 20*
1.3	*Review*	*Aug-23*	*Policy reviewed and minor amendments to section 4 and 6* *Approved at QPaS 7-Sept-23 (Director sign off)*

APPENDIX 8 – EQUALITY IMPACT ASSESSMENT (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Name of document: **Mental Capacity Act and Deprivation of Liberty Safeguards Policy**
2. EIA Reviewer: **Rosie O'Connell,**
3. Type of document: **Policy**

Main Aims of the Document, Process or Service The purpose of this policy is to provide staff working in or with Humber NHS Foundation Trust with guidance about the Mental Capacity Act 2005. It sets out the main provisions of the Act, identifies the duties placed on health and social care staff and provides a procedure to determine the circumstances in which the various processed described within the Mental Capacity Act should be followed.		
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro		
Equality Target Group 1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	MCA can affect all age groups but would not apply to those under 16 years old. The highest proportions of those affected by the MCA process are those in older person's services but anyone can have a need for capacity to be assessed in different circumstances. There is currently a clear process and guidance for assessment for staff and a full training programme which is above compliance levels.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	Low	Staff have full training is assessing capacity and supporting those who lack capacity with advocacy and IMCA where required. Training levels are compliant throughout the trust. Learning disability services have a high proportion of service users who may lack capacity at times and there is evidence of a thorough awareness of the process and the need to provide good support and access to advocacy in this area.
Sex	Men/Male Women/Female	Low	MCA is gender neutral and all measure are taken to ensure the all genders are supported through the MCA process and their specific needs considered.
Marriage/Civil Partnership		Low	There is no evidence that this area is impacted by the MCA process.
Pregnancy/ Maternity		Low	All specialist support is provided to any individual who is experiencing problems regarding capacity and there are links with children's safeguarding and maternity services

			for specialist advice
Race	Colour Nationality Ethnic/national origins	Low	The MCA process always recognises specific needs of any ethnic or national groups and staff provides whatever specialist support is required. This could include family support, access to interpreters, advocacy and specialist support
Religion or Belief	All Religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	During the MCA process there should always be consideration of religious s beliefs or lack of belief and staff will identify what support is required in these areas.
Sexual Orientation	Lesbian Gay Men Bisexual	Low	Any sexual orientation issues will be identified and appropriate support given during the MCA process. Specialist support will be identified where required.
Gender reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	When gender re assignment or transgender issues are identified staff will offer a safeguarding review as part of the MCA Process. The Trust have a supporting Transgender Patient policy in place.

Summary

The Trust has above compliance ratings for MCA training and has recently updated the MCA Assessment process to clarify the process for staff. Advocacy and the IMCA process are available when required and staff evidence their awareness of this process trust wide. All staff are trained to either level one or level two training throughout the trust and have access to on line leaflets for MCA awareness
EIA Reviewer: **Rosie O'Connell**
Date completed: **21 August 2023** Signature **Rosie O'Connell**