Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009

Policy Template for Care Homes

This policy has been developed jointly by Barnet, Enfield and Haringey CCGs

DOCUMENT CONTROL

Date	Version	Action	Author
	V1	Policy Approval by MCA in London NHS Commissioning Steering Board	Joanna Georgiades

1. Introduction

1.1 The Mental Capacity Act 2005 (MCA 2005) provides a statutory framework for people who lack capacity to make decisions, or who have capacity and want to make preparations for a time when they may lack capacity in the future.

1.2 It sets out who can take decisions, in which situations, and how they should go about it. It applies to all those involved in providing health and social care in England and Wales. The Act is supported by a Code of Practice 2007 (CoP) which gives guidance on its implementation.

1.3 The Act sets out how capacity should be assessed and procedures for making decisions on behalf of people who lack mental capacity. "The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests."[1]

1.4 The Act covers day to day decisions such as what to eat and wear, and also more complex or life changing decisions such as whether to undertake major surgery.[2]

1.5 The MCA 2005 defines lack of capacity in the following way:

"A person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain".[3]

The Act assumes that a person has capacity until it is proven otherwise, there is a two stage diagnostic test which should be used when determining if a person may lack capacity under the definition provided by the Act.

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works?
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?[4]

1.6 If yes, a four stage functional test is undertaken to assess a person's ability to make a decision for themselves. It is more likely than not that a person will be unable to make a decision if they cannot:

- **Understand** the information about the decision to be made.
- **Retain** that information in their mind.
- **Use or weigh** that information as part of the decision-making process, or
- **Communicate** their decision (by talking, using sign language or any other means).

Capacity **is decision and time specific**, in other words assessing capacity refers to assessing a person's ability to make a particular decision at a particular moment in time, rather than being an overarching judgement about an individual's ability to make decisions in general.

[1] Page 15 paragraph 1.3 Mental Capacity Act Code of Practice 2007 TSO

[2] Some decisions are NOT covered by the Act these can be found on pages 16 and 17 of the Code of Practice and relate to family relationships, the Mental Health Act (section 28), voting rights and unlawful killing or suicide (section 62).

[3] c9 Part 1 Persons who lack capacity Mental Capacity Act 2005

[4] Page 41 Mental Capacity Act Code of Practice 2007 TSO

2. The Five Statutory Principles

2.1 ***Principle 1*** *a person must be assumed to have capacity unless it is established that they lack capacity*.

> Every person has the right to make their own decisions unless it can be established that they cannot make that particular decision at that particular time.

2.2 ***Principle 2*** *a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.* Individuals should be given support to make their own decisions and all practicable steps should be taken to make that possible. Support might include:

- ❖ Different forms of communication e.g. non-verbal such as sign language.
- ❖ Information in different formats, e.g. photographs or flash cards.
- ❖ Treating a medical condition that may be affecting an individual's capacity.
- ❖ A structured programme to improve capacity to make particular decisions, especially relevant for individuals with learning disabilities

2.3 ***Principle 3*** *a person is not to be treated as unable to make a decision merely because he makes an unwise decision.* People have a right to make a decision that others do not agree with. If there is concern a person is acting in a way that isn't consistent with previous behaviour, or they are making decisions that may put them at risk of harm, then a mental capacity test should be undertaken

2.4 ***Principle 4*** *an act done or decision made, under the Act for or on behalf of a person who lack capacity must be done, or made in, the person* ***best interests****.*

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

3. Purpose

3.1 The purpose of this policy is to support compliance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009.

3.2 The Care Quality Commission (CQC) provides guidance on residential adult care services and how they inspect against the MCA 2005. The CQC recognises the MCA 2005 as a crucial safeguard for people who lack capacity to make decisions, including decisions relating to consent to care or treatment. Staff are expected to understand how the MCA 2005 works for those people with cognitive difficulties such as Dementia but also how to proceed when lack of mental capacity is temporary. Those working in health and care services must have regard to the Act and the principles within it.

3.3 Inspections will look at how the MCA 2005 is being implemented and used to promote rights to freedom and family life in line with the European Convention on Human Rights. Other areas of focus will be on when and how capacity is assessed, how capacity to make decisions is maximised and how best interest decisions are made and recorded.

4. Scope

4.1 This policy has been developed by Barnet, Enfield and Haringey Clinical Commissioning groups as a template for nursing and residential care homes. It aims to support managers and staff in understanding responsibilities to residents and patients under the MCA 2005 and Deprivation of Liberty Safeguards 2009.

4.2 This policy should be locally reviewed and updated annually to reflect current case law and legislative change. The policy may be adapted to reflect local policy and procedure, but it is advised that changes should be legally reviewed before the policy is implemented. Barnet, Enfield and Haringey Clinical Commissioning groups will not be responsible for changes made to this document.

5. Assessing Capacity and Best Interest Decision Making

5.1 **Capacity** Mental Capacity Act 2005 (c.9)

A person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

5.1.1 The definition makes clear that capacity is **time and decision specific.** The legislation is flexible and recognises that some people may be able to make some decisions while lack capacity to make others and that this state may change over time.

5.1.2 The Act challenges a blanket assumption that because a person may not have the mental capacity to for example, to organise their finances, that they don't have mental capacity to decide what treatment or care they receive. A person may be able to make day to day decisions but lack capacity to make decisions that are more complex.

5.2 **Consent and Capacity**

5.2.1 Capacity should be **assessed** when a person's mental capacity to consent to their treatment or care is in doubt. Capacity may be called into question for a number of reasons including:

- An individual's behaviour or circumstances.
- Where concern about capacity has been raised by someone.
- Where a person has been previously diagnosed with an impairment or disturbance that affects the way their mind or brain works.
- A previous mental capacity assessment has shown lack of capacity to make a decision.

5.2.2 You must have **reasonable belief** that the individual lacks mental capacity to have legal protection under the MCA 2005 for making decisions on a person's behalf.

5.2.3 To have reasonable belief you must take certain steps to establish that the person lacks mental capacity to make a decision or consent to an act at the time the decision or consent to act is needed.

5.2.4 You must establish and be able to show that the decision or act is in the person's best interests. A mental capacity assessment must be completed using the two and four stage tests outlined in the introduction and demonstrated in Appendix B.

5.2.5 A mental capacity assessment helps demonstrate that on a **balance of probabilities it is more likely than not that the person lacks capacity**.

5.2.6 Not all decisions will need a formal mental capacity assessment. Consent for the person's care plan will cover many day to day decisions, but there will be times when a formal mental capacity assessment should be undertaken.

Examples include but not exclusive to:

- ❖ Use of bed rails
- ❖ Use of restraint
- ❖ Any invasive procedures
- ❖ Covert medication
- ❖ Any procedures where the resident is touched
- ❖ Medical photography
- ❖ Research

5.2.7 There may be times when you need to involve other professionals and colleagues in carrying out a mental capacity assessment and/or best interest's decision. If the decision to be made is complex or may have serious consequences, if there is disagreement about a person's capacity, or if there are safeguarding issues.

5.2.8 Occasionally you may have a resident or patient who objects to having a mental capacity assessment. Where this happens it is good practice to explain what the mental capacity assessment is and how it will help to protect their rights. There should be no undue pressure for the person to have the assessment, as a person has the right to refuse.

5.2.9 If it's clear that the person lacks the mental capacity to consent to the assessment then the assessment can usually go ahead as long the assessment is in the person's best interests.

5.3 **Consent and Care Planning** Where it has been shown that a person lacks mental capacity to consent to a care plan through the capacity test, then **consent to the care plan** should be achieved through a best interest's decision. The care plan should show how lack of mental capacity was established and a best interest's decision made, with evidences.

5.3.1 Care plans should be regularly reviewed to ensure that decisions agreed within it as part of the best interest's decision making and less restrictive option are still appropriate. If the person is being protected by Deprivation of Liberty Safeguards then the records should also reflect this.

5.3.2 Consent to care is critical to delivering lawful care**.** For a patient to be able to give informed consent they need to have:

- ❖ Been given all the relevant information about their care, treatment or support
- ❖ Understand the different options and possible consequences of each
- ❖ Be free from duress and understand they have the right to refuse
- ❖ Be able to weigh up the options and use this information to make a decision and communicate this

5.3.3 Consent for everyday care can be verbal or implied, for example opening the mouth for food, raising arms ready to be dressed.

5.3.4 It is very important to remember that although friends and family will be consulted in best interests decision making, decisions about serious treatment or changes of accommodation **cannot** be made by the next of kin or relative unless they have been given legal authority to do so. Families should be consulted about the care plan and views taken into consideration, but this is not the same as consent.

5.4 **Best interest decisions** Mental Capacity Act 2005 (c.9)
Once a capacity assessment has been completed and lack of capacity has been demonstrated, the care or treatment decision in question should be made following the best interest principle. The MCA 2005 states that a decision cannot be made merely on the basis of:

(a) The person's age or appearance, or,
(b) A condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests

5.4.1 The Code of Practice 2007 provides a checklist of things to be weighed up when making a decision in a person's best interests. Following this checklist and acting in line with the statutory principles will afford legal protection for decision makers.

This includes:

- Encouraging participation in the decision making.
- Trying to understand what the person would have wanted if they had capacity.
- Trying to find out the views of the person who lacks capacity by talking to the person's family, friends and other health professionals.
- Not making assumptions about what is in a person's best interests based on age, appearance, condition or behaviour.
- Considering whether a person might regain capacity and if so whether the decision can wait until such time.
- Consulting others about their views including an Independent Mental Capacity Advocate (IMCA) where appropriate.
- Avoiding decisions that are restrictive of a person's rights.

5.4.2 It is not uncommon for friends and family to have different views about the treatment or care of a loved one. It is very important to keep good records, including a completed best interest's decision form, notes of any best interest's decision meetings, and involvement of family, friends and advocates. Disputes may be resolved through getting a second opinion, mediation or referring to the Court of Protection for a ruling.

5.4.3 The **best interest decision maker** is the person who will establish what is in the best interests of the individual lacking mental capacity. Usually this is the person who assesses the person's capacity to make a decision and is the person who is directly concerned with the individuals care at the time the decision needs to be made.

- Day to day decisions are usually made by the person most directly involved in the individuals care.
- Decisions for medical treatment would usually be the clinician responsible for the treatment.
- Decisions about nursing or care planning would usually be the nurse or carer.
- Where there is a health and welfare or property and financial affairs lasting power of attorney (LPA) or deputy appointed by the Court of Protection, the

decision maker will be the appointed attorney for decisions within the scope of their authority. Attorneys may be asked to produce evidence that the LPA covers the decision in question. The Office of the Public Guardian may be contacted directly if there are concerns**.**

6. Advance Decisions

6.1 Some patients may wish to plan ahead for their health and social care knowing that there may be a time in the future when they are unable to consent. There are different ways a person can do this:

6.2 **Verbally** – Conversations with family, friends, and healthcare professionals about their wishes and preferences.

6.3 **An advance statement** or preferred priorities for care form. This is a non-legally binding document that those involved in treatment and care should take into consideration when making a best interests decision. It is a statement of the views and wishes of the individual, and might reflect treatment preferences.

6.4 An **Advance Decision** (to refuse treatment life and non-life threatening) is a legally binding document that allows an individual over the age of 18 to refuse a specific treatment in the future when they lack the capacity to consent, or refuse, that treatment, even if this results in death, as long as they have capacity to make the decision at the time it is being made.

6.5 Under the Mental Capacity Act 2005, a valid and applicable advance decision has the same effect as a decision that is made at the time by a person who has capacity.

6.6 For an advance decision to refuse treatment to be valid, health professionals must try to establish if:

- The patient has done anything since making the advance decision that would clearly suggest that they no longer agree with the advance decision.
- The patient has withdrawn the advance decision.
- Power has been given to an attorney to make the same treatment decision as covered in the advance decision.
- The patient would have changed their mind if they had known more about the current circumstances.

6.7 For an advance decision to refuse life sustaining treatment to apply, the patient must no longer have capacity to make the decision for themselves. The advance decision must also:

- State exactly what treatment is to be refused.
- Set out the circumstances when the refusal should apply.
- State that the refusal is to apply even if there is a risk to life.
- Be in writing.
- Be signed by the patient refusing the treatment or by another person in the patient's presence and by their direction.
- The signature must be witnessed and signed in the presence of the patient.

6.8 An advance decision which is not in relation to life sustaining treatment does not need to be in writing to be legally binding. The Court of Protection may be asked to decide whether the advance decision exists, is valid or applicable to the current situation, if the advance decision is called into question. While a decision is being made by the court, life sustaining treatment or treatment necessary to prevent a

patient's deterioration may still be provided. Advance decisions can only be made to refuse treatment; not to demand a treatment choice.

6.9 **A Lasting Power of Attorney** the MCA 2005 allows a person to give statutory authority to another (known as an attorney or donee) to make decision(s) on their behalf through a lasting power of attorney.

There are <u>two</u> types of lasting power of attorney:

- ❖ Health and welfare and
- ❖ Property and finance.

6.10 A health and welfare LPA can be created while a person still has capacity to give authority to an attorney to make decisions when they are no longer able to consent to treatment or care. The attorney may be given power to make decisions about day to day care, consenting or refusing medical treatments, moving accommodation, refusing life sustaining treatment and more.

6.11 All lasting power of attorneys should be checked either with the Office of the Public Guardian, or the attorney can be asked to provide a copy, this is to ensure that it has been registered and valid, and to clarify what decisions the attorney is allowed to make under the terms of the LPA. For example, they may have been given authority to make choices about accommodation but not to refuse treatments.

6.12 A lasting power of attorney <u>must be registered with the Office of the Public Guardian before it is valid</u> and can only be used once the person who made it no longer has capacity. Records must reflect whether an LPA has been registered, and what decisions are given to the attorney.

6.13 Advance care planning is voluntary but can be used to help people retain control of their treatment and care. Advance care planning can only be undertaken by a person who has capacity. Discussions relating to advance care planning should be formally recorded.

7. Independent Mental Capacity Advocate IMCA

7.1 The IMCA is an independent safeguarding service was created under the Act to give support to very vulnerable patients who lack mental capacity to make decisions about serious medical treatments and changes of accommodation, and who also have no friends or family that can be appropriately consulted during the best interest's decision making process.

7.2 An IMCA **must** be instructed if it has been established that a person lacks mental capacity and has no network of friends and family that can be consulted in making the best interests decision relating to:

- ❖ An NHS body proposing to provide serious medical treatment
- ❖ An NHS body or local authority proposing to arrange accommodation (or change of accommodation) in hospital or care home, and
- ❖ The person will stay in hospital longer than 28 days, or
- ❖ They will stay in the care home for more than eight weeks

IMCAs **may** be instructed to support someone who lacks capacity concerning:

- ❖ Care reviews, where no one else is available to be consulted
- ❖ Adult protection cases, in such cases and IMCA may be appointed

The information provided by the IMCA must be taken into account by the decision maker.

8. Restraint

8.1 The Act defines use of restraint in Section 6(4) as:
Use of force-or threaten to use force-to make someone do something they are resisting, or
Restrict a person's freedom of movement, whether they are resisting or not.

8.2 The Act only provides protection from liability in using restraint only under certain conditions:

8.3 The person taking action must **reasonably believe** that restraint it necessary to prevent harm to the person who lacks capacity, and

8.4 The amount or type of restraint used and the amount of time it lasts must be **proportionate** response to the likelihood of serious harm.

8.5 Less restrictive options should always be considered before restraint. The Act describes a proportionate response as one that means using the least intrusive type and minimum amount of restraint to achieve a specific outcome.

> The Act only gives limited liability for use of restraint. Actions may not be lawful where there is an inappropriate use of restraint or where a person who lacks mental capacity is deprived of their liberty without appropriate authorisation.

9. Record Keeping

9.1 Assessments of capacity for day to day decision making or consent to care do not need to be formally recorded, but it is good practice for these everyday decisions to be part of the persons care plan.

9.2 Formal mental capacity assessments to assess the mental capacity for an individual to make a particular decision at a particular time should be kept in the relevant patient records.

What should be in the care plan?

- Informed consent to the care plan, or why a person was assessed as lacking capacity to consent.
- Are they any special communication needs?
- What capacity assessments have been made relating to serious treatments or accommodation?
- Where lack of capacity has been established: best interests checklist and evidences
- Were friends and family consulted in the best interest's decision? What were their views?
- Was there a need to refer to the IMCA service?
- What is being done to help support the person to be involved in decision making, and understanding the options and consequences?
- What kinds of views and beliefs has the person expressed? What is their background?
- How is the person's liberty being championed?
- Where there has been a capacity assessment what were the options under consideration, was it risk assessed? Were less restrictive options considered?
- How is the care going to be delivered? Has the person seen their care plan?
- Is there a lasting power of attorney or advance decision or statement?

10. Interface with the Mental Health Act 1983 MHA

10.1 The Mental Capacity Act provides a framework for decision making on behalf of people who lack capacity to decide for themselves. The issue of capacity (or more accurately lack of capacity) is central to the operation of this Act. Statutory provisions only come into play if a person lacks capacity for the specific decision in question.

10.2 The Mental Health Act provides a framework for treating mental disorder in the absence of consent, whether due to lack of capacity or valid refusal of treatment, if the criteria for detention are fulfilled. Unlike the Mental Capacity Act capacity is not central to the operation of the Mental Health Act.

10.3 The Mental Capacity Act does not allow decisions to be made on behalf of people who have capacity to make them themselves. People subject to the Mental Health Act may have capacity to make decisions about their mental health treatment, but the Mental Health Act allows this to be overridden in certain circumstances.

10.4 This is a complex area and if there is doubt whether the Mental Health Act applies then further advice should be sought from the GP.

11. Deprivation of Liberty Safeguards (DoLS) 2009

11.1 The DoLS were created to help protect vulnerable people who lack capacity to consent to treatment that might deprive them of their liberty, where this care or treatment is in their best interests or will protect them from harm.

11.2 The DoLS are an extra protection for vulnerable people to ensure that deprivation is only used when necessary, and that any deprivations are lawful.

11.3 The Act recognises that in some cases there is no other way to provide treatment and care other than by depriving a person of their liberty. The Act provides a legal process for this deprivation which makes sure that it is unavoidable and in the persons' best interests.

11.4 The DoLS only relate to people aged 18 or over and those adults that are not detained under the Mental Health Act 1983.

11.5 A person may only be deprived of their liberty if:

- It is in their own best interests to protect them from harm.
- It is an appropriate and proportionate to the threat of harm.
- There isn't an option that is less restrictive.

11.6 The legality of deprivations of liberty may change in light of legal developments arising from case law. There have been a number of Supreme Court Rulings that have affected the implementation of the Act. This policy reflects legal developments up to the date of publication.

11.7 The DoLS Code of Practice 2009 defines the difference between a deprivation of, and restriction upon, liberty, as one of degree or intensity.

11.8 A person's treatment and care may move along the scale of restriction of liberty and deprivation over time and circumstances. It is therefore, important for DoLS to be reviewed.

11.9 Case law has helped determine factors that might indicate a person is subject to deprivation rather than restriction or restraint.

11.10 The Law Society has provided a comprehensive set of liberty restricting measures that can be used to help front line staff understand if a deprivation is occurring.

http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Some common indicators that a person is being deprived of their liberty

- Has a decision been made by the Care Home that the person will not be released into the care of others, or permitted to live elsewhere unless the Care Home considers it appropriate?
- Has the Care Home refused a request by carers to discharge a person into their care?
- Does the person have access to friends and family, to social contacts?
- Is the person under continuous supervision and control?
- Is the person being restrained?
- Is the person free to leave at any time?
- Has sedation been used to admit a person to care that has been resisting?

11.11 The Supreme Court Judgement P v Cheshire West 2014

11.12 **'Acid Test'** The Supreme Court Ruling introduced an acid test for determining whether an individual was being deprived of their liberty.

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

Under the ruling it is NOT relevant if:

- The individual doesn't object or complies to the deprivation.
- The relative normality of the placement.
- The reason or purpose behind the placement.

11.13 Significantly the judgement determined that a deprivation of liberty could occur in a domestic or supported living arrangement.

11.14 Incapacitated 16/17 years olds in accommodation under Section 20 of the Children Act may be deprived of their liberty according to the acid test. In such cases authorisation for deprivation should be sought from the Court of Protection.

11.15 The emphasis of the DoLS is to avoid depriving a person of their liberty if possible by choosing a less restrictive delivery of care or treatment. Implementing the MCA should reduce the numbers of DoLS applications that need to be made.

11.16 The Deprivation Checklist (Appendix A) can be used to help determine whether it is necessary make a DoLS application. The **managing authority** has the responsibility to make the application for authorisation from the **supervisory body.**

11.17 The managing authority is the person registered under part 2 of the Care Standards Act 2000 where the provider is a care home or private hospital.

11.18 A supervisory body is responsible for receiving the requests for authorisation, commissioning the assessments and where agreed authorising the request for deprivation. For care homes the supervisory body is the local authority where ordinary residence is established or where a person is of no fixed abode, the borough of the care home.

11.19 There are two types of authorisation, **standard** and **urgent.** A standard authorisation is used where it is anticipated that a deprivation is going to occur within 28 days, and so should be done in advance of any deprivation. It is important to remember that an authorisation only **permits** a deprivation; **it does not mean that a person MUST be deprived** of their liberty.

11.20 **An urgent authorisation** should be made when a person needs to be deprived of their liberty in their own best interests before a standard authorisation can be processed. A standard authorisation should then be requested within 7 days of the urgent authorisation.

11.21 A deprivation of liberty must be in a person's best interests, which means that as part of the process those with an interest in the person's health and welfare should be consulted and given an opportunity to give their views. Where the person has no interested party outside of those providing care or treatment then the supervisory body will instruct an IMCA.

11.22 Under the terms of the Act an assessment must be made by the supervisory body within **21 days** of an application for a standard authorisation. Where there is already an urgent authorisation in place then the assessment needs to take place before the urgent authorisation expires.

11.23 Urgent authorisations can only be given for 7 days; this may be extended by the supervisory body for a further 7 days in exceptional circumstances.

11.24 Once all the assessments have been completed by the supervisory body a decision will be made to authorise the deprivation or not. Where a deprivation is authorised it will be time limited in line with the recommendations of the assessor.

11.25 **If the person under the DoLS moves to another hospital or care home then a new application for DoLS will need to be made. This should happen in advance of the move.**

11.26 All authorisations should be kept in the person's care records, it is important that friends, family and carers are kept up to date and that an

effort is made to help the person subject to the DoLS understand the effect of the authorisation and their right to challenge.

11.27 **The relevant person's representative RPR** is appointed by the supervisory body for each person who has a standard DoLS authorisation. The role of this person is to maintain contact with the person subject to DoLS and represent and support them in any matters relating to the deprivation. It is important that the RPR is informed of:

- the effect of the authorisation,
- their right to request a review,
- their right to make a complaint and the procedure for doing so,
- Their right to apply to the Court of Protection and their right to request an IMCA.

11.28 DoLS should be kept under review. Where capacity fluctuates it is important to recognise where capacity has returned in the longer term. Where capacity returns for short periods of time the authorisation should remain in place.

11.29 There is a new DoLS form guide on the ADDAS website.

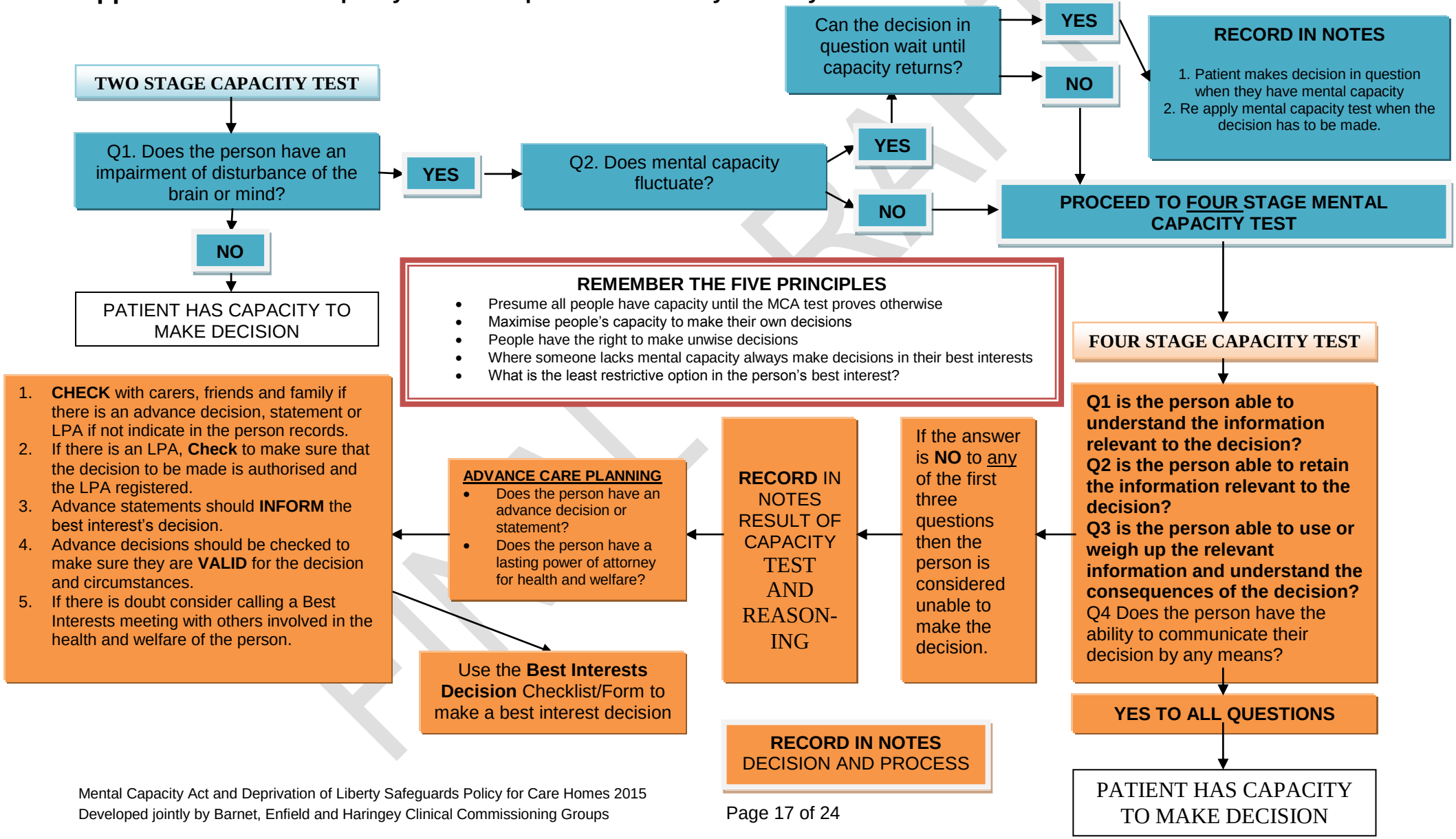
http://www.adass.org.uk/mental-health-Drugs-and-Alcohol/key-documents/New-DoLS-Forms/

11.30 Please remember that the CQC must be informed of any DoLS applications and that the managing authority (care home or hospital) must inform the coroner where a person is subject to DoLS and dies as this is deemed to be death in custody at present.

12. References

- Social Care Institute for Excellence Report 70 The Mental Capacity Act (MCA) and care planning
- The Mental Capacity Act 2005 c.9
  - Mental Capacity Act 2005 Code of Practice 2007 Department for
  - Constitutional Affairs and Deprivation of Liberty Safeguards Code of Practice 2009
- Capacity, care planning and advance care planning in life limiting illness: A Guide for Health and Social Care Staff National End of Life Care Programme
- The Law Society Deprivation of Liberty: A practical Guide April 2015

Appendix A: Mental Capacity Act and Deprivation of Liberty Pathway



DEPRIVATION CHECKLIST

To be used when a person does not have capacity to consent to admission and/or care plan, and when there is a change of circumstances

- Was restraint or sedatives used because the person resisted being admitted?
- Was the person misled to ensure they cooperated?
- Did anyone involved in the persons care and welfare object to the person being admitted?
- Is restraint being used when the person is expressing refusal or resistance to treatment other than in an emergency?
- Have relatives/carers requested the persons discharge into their care, and has this been refused?
- Has the person been refused or restricted access to friends and family?
- Does the care plan use the least restrictive options available in the person's best interests?
- Has the person's access to the community been restricted due to safety concerns?

Yes to any of the above would indicate that the person may be being deprived of their liberty.

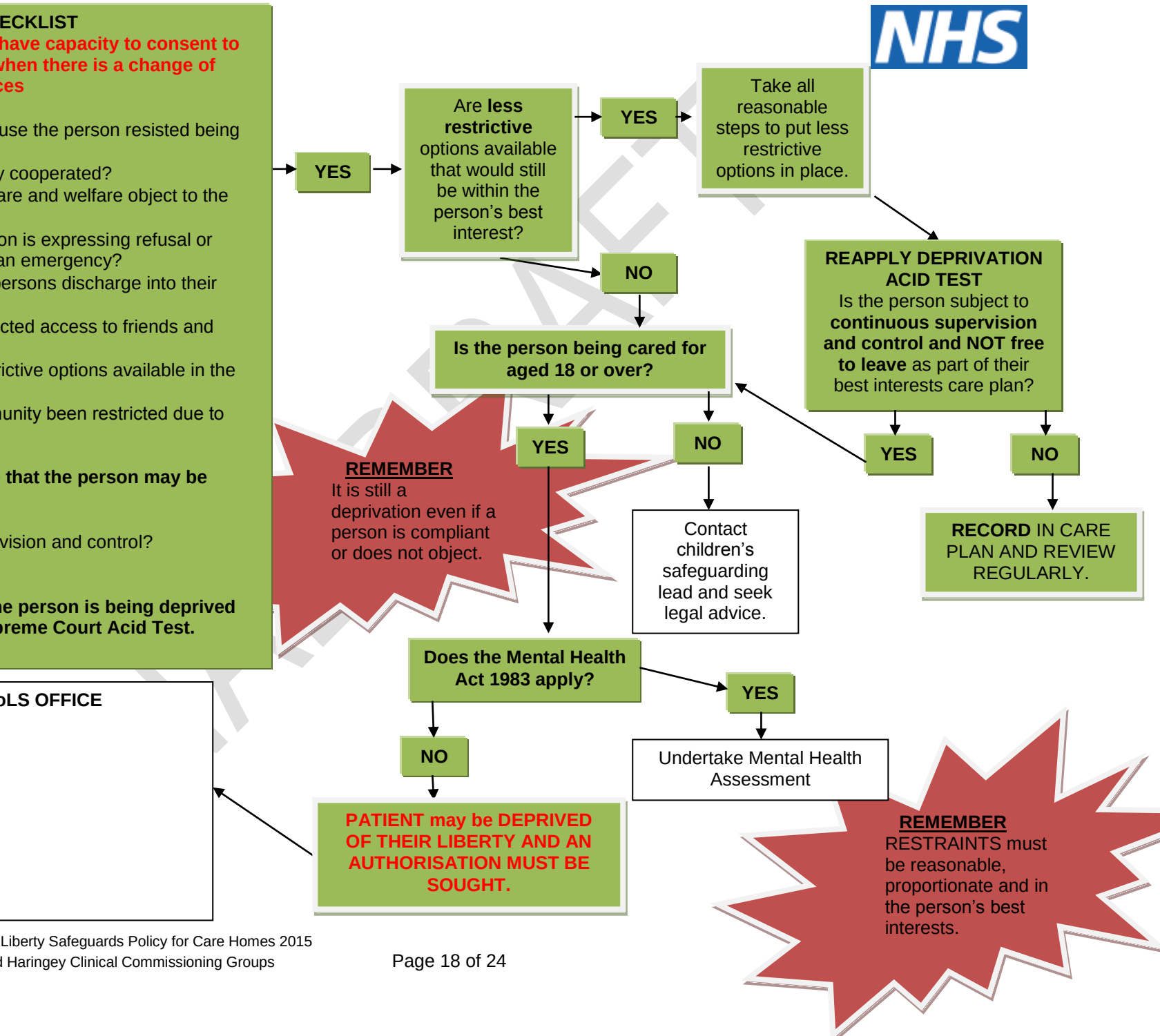
- Is the person under continuous supervision and control?
- Is the person free to leave?

Yes to the above would indicate that the person is being deprived of their liberty in line with the 2014 Supreme Court Acid Test.

CONTACT YOUR LOCAL DoLS OFFICE

ADDRESS

TEL:
FAX:
EMAIL:



Appendix B: MCA DoLS Decision Making Tool

Organisation:	Date completed:	Patient name:	
Name of person completing assessment:	Patient name:	NHS no Rio no:	
Signature of person completing assessment:	Date of birth:		
What triggered the capacity assessment?			
Stage 1: Diagnostic Test			
Q1 Does the person have an impairment of, or disturbance in the functioning of, the mind or brain?		YES	NO
If the answer is “no” then the person cannot lack capacity within the meaning of the MCA. Please make a note in the patient record. If the answer is “yes” please answer all following questions			
Clinical diagnosis: Where the impairment or disturbance arises out of a specific diagnosis, please set out the diagnosis or diagnoses here.			
What is the decision that needs to be made?			
Is this impairment or disturbance:		Fluctuating	Permanent
Q2 If the person has fluctuating capacity does the decision need to be made immediately?		YES	NO
Please explain why:			
Stage 2: Functional test			
Q1 Does the person have a general understanding of the decision they need to make, why they need to make it and the likely consequences of making the decision (including the consequences of making no decision at all)?		YES	NO

Please give details:		
Q2 Is the person able to retain information relevant to the decision long enough to take it?	YES	NO
Please give details		
Q3 Is the person able to use or weigh information relevant to the decision, as part of the process of making the decision?	YES	NO
Please give details		
Q4 Can the person able to communicate their decision (by talking, using sign language, or any means at all)?	YES	NO
Please give details		
If the answer to any of these questions is NO, and this is caused by the impairment or disturbance you have identified, and your decision is on a balance of probabilities, the person lacks capacity to make this decision.		

Advance Decisions		
Has the person made a **health and welfare lasting power of attorney** which has been registered and gives the attorney(s) the authority to make the decision in question?	YES	NO
Has the person made a valid, applicable **advance decision to refuse the same treatment** that this decision is about?	YES	NO
Has a **deputy been appointed by the Court** with the power to make the decision in question?	YES	NO
If you have answered “no” to all of the above, you may proceed with a best interest’s decision.		

Best interests decision		
Is an IMCA referral required? If there is no one to consult (other than paid staff) to support or represent the person, or to be consulted as part of the best interest decision process.	Name of IMCA:	Tel:
What are the options available as they relate to the decision in question? Please consider the positive and negative aspects of each option, and note which is less restrictive in terms of the person's rights and freedom of action.		
Option 1		
Option 2		
Option 3		
Have you identified and taken into account the person's past and present wishes and preferences, beliefs and values (including their treatment preferences): whether written or verbal?	YES	NO
What were these views?		

Have you consulted and taken into account the views of other interested parties (family, carers, friends, advocate, deputy or attorney)?	YES	NO
If yes, who was consulted and what was their view. *(please use additional space if necessary)*		
Have the views of other professionals involved in the person's care been consulted.	YES	NO
Please give details:		
Which option have you decided is in the person's best interests, and why (please record the decision clearly here)?		
Please describe how your decision reflects the less restrictive principle?		

Was there disagreement in reaching this decision? If yes, please give details and describe what actions are being taken to seek resolution.			
Has every option been explored in communicating this decision to the person?		YES	NO
Date of decision	Date of review	Date of amendment	
Have the patient records been updated?		YES	NO

Deprivation of Liberty Checklist

WILLTHE BEST INTEREST DECISION RESULT IN ANY OF THE FOLLOWING

- Use of restraint or sedatives on admission because the person is resisting or objecting to admission to the care home?
- Misinformation to the person to admit them?
- Did anyone object to admitting the person as part of the Best Interest Decision process?
- Is restraint likely to be used, has been used, because of refusal or resistance to treatment other than in an emergency?
- Have relatives/carers requested the persons discharge into their care, and has this been refused?
- Has, or will, the person have restricted access to family or friends?
- Does the care plan use the least restrictive options available in the person's best interests?
- Has, or will, the person's access to the community been restricted due to safety concerns?
- Has, or will, the person under continuous supervision and control?
- Is the person free to leave?

YES TO ANY OF THESE QUESTIONS SHOULD PROMPT AN URGENT AUTHORISATION WHERE DEPRIVATION IS ALREADY OCCURING AND A STANDARD AUTHORISAITON WHERE DEPRIVATION OF LIBERTY IS LIKELY TO OCCUR AS A RESULT OF THE BEST INTEREST DECISION.