

TRUST CORPORATE POLICY
SAFEGUARDING ADULTS AT RISK OF HARM
INCLUDES MENTAL CAPACITY ACT; DEPRIVATION OF LIBERTY AND PREVENT

APPROVING COMMITTEE(S)	Trust Policies Committee	Date approved:	19/03/2015
EFFECTIVE FROM	Date of approval		
DISTRIBUTION			
RELATED DOCUMENTS	<p>Adverse Incident Policy COR/POL/041/2012-001</p> <p>Safeguarding Children Policy COR/POL/044/2012-001</p> <p>Therapeutic Restraint and Containment Policy COR/POL/084/2013-001</p> <p>Disciplinary Policy COR/POL/009/2012-001</p> <p>Whistleblowing Policy COR-POL/005/2013-002</p> <p>Consent to examination and treatment COR/POL/046/2012-001</p> <p>Pre and post-employment checks policy COR/POL/088/2013-001</p> <p>Disclosure and Barring Service Policy COR/POL/061/2014-001</p> <p>Legacy Trust Advocacy policies</p> <p>Legacy Learning Disabilities Policy</p> <p>VIP policy</p> <p>Policy for managing allegations of abuse made against staff</p> <p>Complaints and PALS polices</p> <p>Information Governance Policy</p> <p>Domestic Violence</p> <p>Pressure Ulcer Management Policy</p>		
STANDARDS	<p>Mental Capacity Act 2005</p> <p>Equality Act 2010</p> <p>Safeguarding Vulnerable Groups Act 2006</p> <p>Mental Health Act 2003</p> <p>Nice Guidance</p> <p>The London multi-agency policy and procedures to safeguard adults from abuse.</p> <p>Amendments to the Care Act 2015</p>		
OWNER	Chief Nurse		
AUTHOR/FURTHER INFORMATION	Head of Safeguarding Adults		
SUPERCEDED DOCUMENTS	<p>Barts Health Protection of Adults at Risk of Harm (Safeguarding) 2012</p> <p>COR/POL/045/2012-001</p>		
REVIEW DUE	September 2017		
KEYWORDS	Safeguarding, Abuse , Mental Capacity, Liberty, Human Rights <i>PREVENT</i>		

INTRANET LOCATION(S)	http://bartshealthintranet/Policies/Policies.aspx
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CONSULTATION	<i>Barts Health</i>	Tissue Viability Lead Directors of Nursing Heads of Therapies Staff side HR
	<i>External Partner(s)</i>	<i>London Boroughs of Waltham Forest; Tower Hamlets; Newham and City and Hackney CCGs</i>

SCOPE OF APPLICATION AND EXEMPTIONS	<p>Included in policy: <i>For the groups listed below, failure to follow the policy may result in investigation and management action which may include formal action in line with the Trust's disciplinary or capability procedures for Trust employees, and other action in relation to organisations contracted to the Trust, which may result in the termination of a contract, assignment, placement, secondment or honorary arrangement.</i></p>
	<p>All Trust staff, working in whatever capacity</p>
	<p><i>All individuals working in the Trust, in whatever capacity, including those employed by the Trust's private sector partners providing Facilities Management services and including those who have been seconded to work for its private sector partners under Retention of Employment (RoE) arrangements. CHL and its Service Providers are therefore expected to comply with this policy.</i></p>
	<p>Exempted from policy: No staff groups are exempt from this policy</p>

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1 INTRODUCTION

- 1.1 Barts Health NHS Trust is committed to providing high quality care to patients, and ensuring that their rights are protected at all times. Barts Health is a statutory partner working with other agencies to protect adults at risk of abuse.
- 1.2 The purpose of this policy is to provide guidance and support for staff to protect adults at risk of abuse who are receiving care in our hospitals and departments. This includes guidance on what to do when a patient lacks mental capacity (Mental Capacity Act), is being deprived of liberty in hospital (Deprivation of Liberty Safeguards), or is at risk of radicalisation (*Prevent Strategy*).
- 1.3 People have fundamental rights contained within the Human Rights Act, 1998. Health care providers as public bodies have statutory obligations to uphold these rights and protect patients who are unable to do this for themselves. Other legislation particularly relevant to safeguarding adults includes:
- The Equality Act, 2010
 - The Mental Capacity Act, 2005
 - Safeguarding Vulnerable Groups Act, 2006
 - Mental Health Act, 1983, as amended, including MHA 2007
 - NHS Act 2006
 - The Care Act 2015
- 1.4 This policy enshrines six principles of safeguarding
- Empowerment
 - Prevention
 - Proportionality
 - Protection
 - Partnerships
 - Accountability
- 1.5 The aims of this policy are
- To provide staff with the information and support they need to raise concerns they have about the welfare or wellbeing of an individual.
 - To provide a process to report abuse of an adult at risk and support for continued management and referral.
 - To promote a culture of care that protects the rights of adults who may be at risk of abuse or neglect; ensure the views of these people are known and that they receive the same high quality of care that the Trust seeks to provide to all patients.
- 1.6 Staff may have safeguarding concerns because

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- A patient now in their care has suffered abuse or neglect at home, in the community or in another institution. The concern may arise as a result of disclosure by a patient or third party or by the patient’s symptoms or presentation, (see definitions of abuse below).
- Patients, relatives or staff members raise concerns that a patient or patients have experienced harm within Bart’s Health as a result of acts of abuse or omissions of care from our own staff or practices.

1.7 Escalating concerns raised about neglect or abuse which has happened elsewhere is easier than acknowledging neglect or harm caused by our own staff. Nevertheless it is important that all staff take responsibility for protecting patients who may be harmed as a result of the standards of care provided in our hospitals.

1.8 The safeguarding agenda covers a range of issues some of which are detailed in other policies. This policy refers to

- Safeguarding Adults at Risk
- Human Trafficking and Modern slavery
- Mental Capacity Act (2005) implementation and caring for patients who lack capacity within its legal framework
- Deprivation of Liberty Safeguards
- Promoting appropriate care of patients with Learning Disabilities
- The *Prevent* Strategy, for addressing risks associated with radicalisation and recruitment to terrorist organisation

2 DEFINITIONS AND TERMINOLOGY

<p>Adult at Risk</p>	<p>A person aged 18 years or over who may be in need of care or services, whether or not they are in receipt of them, by reason of mental or other disability, age or illness and who is or may not be able to take care of himself or herself or may be unable to protect him or herself against significant harm or exploitation.</p> <p>In this policy ‘adult’ means a person aged 18 years or over.</p> <p>A safeguarding concern will be considered if the person</p> <ul style="list-style-type: none"> • has needs for care and support (whether or not the local authority is meeting any of those needs) • is experiencing, or at risk of, abuse or neglect • as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect. <p>Adults at risk may be:</p> <ul style="list-style-type: none"> • Elderly people who have become frail • People with learning disabilities • People with physical disabilities • People who lack mental capacity
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	<ul style="list-style-type: none"> • People with long term conditions • People with a sensory impairment • People with mental health needs • People with a life limiting illness • People who misuse substances or alcohol • People unable or reluctant to advocate for themselves due to personal factors, including immigration or asylum status, communication difficulties or history of previous or on-going abuse or exploitation. • People who self-Neglect
<p>Abuse</p>	<p>A violation of individual human and civil rights by any other person or persons (<i>No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect adults at risk from abuse. DH, 2000</i>)</p> <p>Abuse may be ill treatment, neglect or an omission of care which causes significant harm and can result in the deterioration of a person's physical, emotional social or behavioural development, (e.g. failure to ensure a person who is in hospital and is depending on staff for their meals, has adequate food and drink or the assistance they need to eat and drink. This includes those who may lack mental capacity and are refusing food and drink).</p> <p>Abuse reflects a lack of respect and is an infringement of legal and civil rights. It may be an abuse of power and may constitute a criminal act.</p> <p>It may be a single incident, a repeated incident or part of a systematic pattern and may take place in a person's own home, a friend's home, a day centre, hospital or residential/nursing home.</p> <p>It may take place within personal and professional relationships; relationships with other service users or with any third party who deliberately forms a relationship with an adult at risk in order to exploit them.</p> <p>Abuse may be wilful or malicious but could also be the result of ignorance or mistakes.</p> <p>Abuse is defined by the impact on the adult not the intentions of the perpetrator.</p>
<p>Forms of Abuse</p>	<ul style="list-style-type: none"> • Physical • Verbal • Psychological / emotional • Radicalisation • Sexual • Financial or material • Neglect and acts of omission

	<ul style="list-style-type: none"> • Discriminatory • Institutional • Domestic violence • Harmful practices against women
Abuser/Perpetrator	A person who is committing the abuse and / or causing harm
Indicators of Abuse	<ul style="list-style-type: none"> • Seeking shelter • Unexplained reactions towards particular individuals or settings • Frequent or regular visits to ED or hospital admissions • Frequent or irrational refusal to accept investigations or treatments • Carer, care worker or third party always wishing to be present at interviews • People wandering or trying to leave an environment • Dislike of being touched or flinching on being touched • Obsessive or challenging behaviours • Self-harm; panic attacks; withdrawal of verbal communication • History of domestic violence • Bruising, burns or scald injuries • Unkempt or dishevelled appearance • Pressure Ulcers – see appendix 4 • Evidence of person being targeted or befriended by a radical group • Unexpected development of radical ideas or preoccupation with radical issues. <p>(This is not an exhaustive or definitive list)</p>
<i>PREVENT</i>	A government initiative that aims to work with individuals, including patients or staff, who may be at risk of being exploited by radical groups and subsequently drawn into terrorist related activity. Healthcare organisation are key partners in the strategy
Mental Capacity	<p>The ability to make a particular decision, based on an understanding of relevant factors, an ability to retain that understanding long enough to make the decision, to weigh those factors, and communicate the decision.</p> <p>There is a presumption in law that adults are capable of making their own decisions about all aspects of their life including hospital admission, medical treatment and care, personal relationships, financial decisions and housing unless they have been properly assessed as</p>

	<p>lacking this ability.</p> <p>Mental Capacity is specific to a particular decision at a particular time. A person may have capacity to take some decisions but not others, or may be able to take decisions at some times but not others. Some people may require support (e.g. simplified explanations, advocacy, additional time etc.) in order to make a decision and they are entitled in law to receive this support.</p>
Best Interests	<p>Any act done, or decision made on behalf of a mentally incapacitated person must, by law, be done in their “best interests”. As far as possible, any decision taken in the best interests of a person without capacity should be the decision which that person would take themselves if they had capacity. It must therefore take account of information gained from the patient and from others who know the patient. Where there is more than one decision that could reasonably be taken, the one least restrictive of the persons’ rights and freedom should be chosen. If it is possible, without harm to the patient, to defer a decision to allow the patient to make the decision themselves when their capacity improves, this will usually be the least restrictive option.</p>
Independent Mental Capacity Advocates (IMCAs)	<p>Some people who lack capacity have the right to receive support from an IMCA in relation to specific decisions, as set out in the Mental Capacity Act. An IMCA will represent the person in relation to their best interests in relation to these decisions. The service is independent from the NHS and local authorities.</p>
Deprivation of Liberty Safeguards (DoLS)	<p>Statutory requirements that came into effect as a result of the Mental Capacity Act (2005). The safeguards ensure that people are only deprived of their liberty if all the relevant criteria are fulfilled. Most importantly, the person must be confirmed as lacking capacity to take their own accommodation decisions, it must be in their best interests for them to be deprived of liberty in the way proposed, and this must be the least restrictive arrangement that could give them the care they need.</p>

2.9 Preventing abuse is as important as good practice in response to allegations of abuse, (*No Secrets, 2009*). Preventing abuse and harm caused by abuse is a key priority for the Trust and integral to the Trust values. Measures in place to promote prevention include

- Commitment to the principle of wellbeing for all those in our care
- Development of a training strategy to ensure staff have the right level of knowledge and skill
- Partnership working and to sharing information to protect an adult at risk.
- Zero tolerance of abuse, neglect or any form of inappropriate care, unacceptable practice or unacceptable attitudes
- Clear and concise policies that support good practice
- Reporting, recording and responding to complaints and incidents
- Development of workplace cultures that are sensitive and support staff to raise concerns
- Effective whistle-blowing policies and systems
- Robust and effective safe recruitment practices

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- Availability of advice and guidance from specialist teams and advisors, e.g. Safeguarding Adults Team, Legal Services Team, Tissue Viability Team etc

3 PROCESS FOR MANAGING SUSPECTED ABUSE OR ALLEGED ABUSE

3.10 Flow chart for reporting alleged or suspected abuse is included in **appendix 1**.

3.11 Any member of Trust staff who suspects that any patient is at risk of being or has been abused has a responsibility to ensure that

- The person at risk is safe
- The person at risk is included in the process at all stages wherever possible and their views and wishes influence the actions taken.
- They report their concerns to their line manager or out of hours the site manager
- An incident form is completed on Datix – categorised as safeguarding with as much additional information as possible.
- A Serious Incident pro forma is completed when indicated
- A referral is made to the Safeguarding Adults team for advice and support, using the [Barts Health Safeguarding Adults Alert form](#).
- If a crime is suspected, it is reported to the police
- If a person attends ED or is admitted to hospital and abuse is suspected in their residence or care home, they must **not** be discharged back to that place until a protection plan is in place; if relevant, immediate steps must be taken to ensure the protection of that person during their period in hospital

3.12 If the perpetrator or the person who is alleged to cause the harm is a member of staff please refer to the *Managing Allegations of Abuse against Children or Adults at Risk made against Staff Policy*. However the principles are

- Protect the rights of the adult at risk
- Protect the rights of the member of staff
- Support the manager to take the right action

3.13 There may be occasions where more than one investigation process is applicable. In these cases the following principles apply.

- A police investigation of a possible criminal offence takes primacy over a safeguarding or serious incident investigation. Clarification should be sought from the police regarding their investigation to avoid compromising a criminal investigation.
- Serious Incident investigations may be undertaken in response to safeguarding incidents. When this is the case, the safeguarding investigation is often deferred pending the outcome. However, the investigating officer should confer with the allocated safeguarding case manager in the local authority to ensure that the safeguarding elements are investigated and completed in a timely way.
- Investigations in line with the Trust's disciplinary policy may be undertaken in response to a safeguarding incident. The outcome of a disciplinary investigation may be needed to inform the outcome of the safeguarding investigation.

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- Acquired grade 3 and 4 pressure ulcers will be reported as serious incidents and investigated using root cause analysis (RCA). All acquired grade 3 and 4 pressure ulcers must be reviewed using the agreed guidance tool and referred to the safeguarding adults team where indicated, (see *appendix 3*). If not referred to the safeguarding adults team on detection, further assessment is undertaken following completion of the RCA and a referral made where indicated.
- Serious case reviews and domestic homicide reviews may be commissioned following the investigation of a safeguarding incident (see *appendix 4*).

4 PREVENT – SUPPORTING ADULTS AT RISK OF RADICALISATION

- 4.14 The *Prevent* Strategy is the governmental initiative that aims to work with vulnerable individuals – including staff - who may be at risk of being exploited by radical groups and subsequently drawn into terrorist-related activity. Healthcare organisations are key partners in this strategy.
- 4.15 Trust staff may become concerned, as a result of changes in behaviour or other signs, that a particular patient or colleague may be at risk of radicalisation or of exploitation by a radical group. Any change in an individual's behaviour should be viewed as part of a wider picture and not in isolation, and staff should consider, or discuss with the safeguarding adults team, how reliable or significant these changes are. Changes that may arouse concern may include
- reports of unusual changes in behaviour, friendships or actions and requests for assistance
 - indication of vulnerable person being insistently befriended by individuals or groups with radical views
 - evidence of patients / staff accessing extremist material online
 - Use of extremist or hate terms to exclude others or incite violence; writing or artwork promoting violent extremist messages or images.
- 4.16 Any staff member who is concerned that a colleague or patient is at risk of radicalisation or may have become radicalised must contact the safeguarding adults team to raise this concern. Team members are available to discuss any concerns and can either take them up on behalf of the staff member raising the concern or put the staff member in touch with local and regional advisers with relevant experience and expertise. [Information about the Prevent Strategy](#) is available on the Trust intranet under Adult Safeguarding.

5 MENTAL CAPACITY ACT

- 5.17 Detailed guidance on the Mental Capacity Act (MCA) and the related Deprivation of Liberty Safeguards (DoLS) is [available on the Trust Intranet](#). (Navigate to this via "I want to" - find out about safeguarding - Safeguarding Adults - Mental Capacity Act).
- 5.18 Not all patients who lack capacity are at risk of harm and not all persons at risk of harm lack capacity. This part of the policy covers all patients without capacity, regardless of any risks that may be posed.
- 5.19 This policy covers routine decision making where a patient lacks capacity and has neither made advance arrangements to refuse treatment nor granted another person Lasting Power of Attorney to take health and welfare decisions on their behalf.

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5.20 Details of actions to be taken if the patient has made an advance directive or granted power of attorney over health and welfare are included in the Consent to Examination and Treatment Policy. (Note: Appointment of an Attorney is only valid if all the documentation has been properly registered with the Court of Protection. In any situation where these powers apply, the documentation must be checked for validity by the Legal Services Team.

Capacity and Consent

- 5.21 There is a presumption in law that all adults are capable of making their own decisions, and that all decisions about treatment and care require the person's consent. Consent is covered in the Trust's [Consent to Examination and Treatment](#) Policy.
- 5.22 Some people, however, because of illness or injury, are unable to make decisions for themselves, or may be able to make some decisions but not others. In these cases there is a requirement for care-givers to take decisions on behalf of the patient and in their best interests.
- 5.23 The Mental Capacity Act 2005 (MCA) provides a framework to empower and protect people under these circumstances. It makes clear who can take decisions in which situations and how they should go about it. Where a patient lacks capacity, the Mental Capacity Act requires care-givers to act in the best interests of the incapable person, and provides legal protection to those who are doing so.
- 5.24 Anyone who works with or cares for an adult who lacks capacity must comply with the MCA when making decisions or acting for that person. The MCA is supported by a Code of Practice which explains in more detail the key features of the Act.
- 5.25 Information about all aspects of the MCA are available on the Trust intranet under Adult Safeguarding. The five key principles in the Act are:
- Every adult has the right to make his or her own decisions and must be assumed to have capacity to make them unless it is proved otherwise.
 - A person must be given all practicable help before anyone treats them as not being able to make their own decisions.
 - Just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
 - Anything done or any decision made on behalf of a person who lacks capacity must be done in their best interests.
 - Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.
- 5.26 In some cases a competent person may wish to refuse, in advance, certain treatment that might be proposed at a later date, when they no longer have capacity. There are arrangements for this in the Mental Capacity Act, as well as residual arrangements which remain in force in cases where these decisions have been made under older legislation. These arrangements (now referred to as Advance Decisions, but previously referred to as Advance Directives or Living Wills) are covered in the Consent to Examination and Treatment Policy.
- 5.27 In some cases a competent person may appoint, in advance, an attorney who is empowered to make certain decisions on their behalf, if they lose capacity in the future. These arrangements are covered in the Consent to Examination and Treatment Policy. It is not uncommon for people to believe they have been granted a Power of Attorney when in fact this power has not been ratified by the Court of Protection as required, or for misunderstandings to arise as to the scope

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of decisions which a particular Attorney can make. In any situation involving a Power of Attorney, the documentation must be checked by the Legal Services Team who will be able to advise on the validity and scope of the arrangements in place.

Assessing Capacity

5.28 Healthcare professionals are particularly concerned about capacity to take decisions relating to hospital admission, medical treatment and care. However, capacity is relevant to all decisions e.g. financial, housing, personal care and relationships

5.29 In assessing capacity, the healthcare professional must bear all of the following points in mind:

- A person must be presumed to have capacity unless the matter has been assessed and determined otherwise.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- Capacity is specific to the particular decision that is being made. A person may have capacity to decide simple things but not have capacity to decide complex things. People should always be supported to make their own decision in any matter where they have the capacity to do so.
- Loss of capacity may be temporary. If a person is likely to regain capacity, decisions which can reasonably be deferred should be deferred.

5.30 A [form for documenting the assessment of capacity](#) is available on the Trust Intranet

5.31 In assessing capacity, the clinician is required to establish, by talking to the patient and observing their behaviour, that the answer is YES to ALL of the following in relation to the decision being made. If the answer is “no” to any of these questions, then the patient does not have capacity to take that decision.

Dimension of capacity	Note
Can the person understand enough of the relevant information to make the decision?	The person may not need to understand the information as fully as a professional in order to be able to take the decision. Staff must make every reasonable effort to help them to gain an adequate understanding of the information within the limits of their ability, e.g. through simple words or pictures
Can the person retain information related to the decision for long enough to make the decision?	They do not have to be able to retain the information for a long time, but they do need to be able to retain it for long enough to weigh up and make the decision
Can the person weigh up the information whilst considering the decision?	Factors such as mental illness, anxiety, or cognitive deficits may make this impossible, but will not do so in all cases
Can the person communicate their decision by any means?	Every attempt must be made to allow the patient to communicate their decision in whatever language or modality they can use. It does not have to be verbal in all cases

Best interests

- 5.32 Any act done, or decision made, on behalf of a mentally incapacitated person must by law be done in their best interests. 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.
- 5.33 The law gives a checklist of key factors which decision makers must consider when working out what is in the best interests of a person who lacks capacity.
- It is important not to make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour.
 - The decision-maker must consider all the relevant circumstances relating to the decision in question.
 - The decision-maker must consider whether the person is likely to regain capacity (for example, after receiving medical treatment). If so, can the decision or act wait until then?
 - The decision-maker must involve the person as fully as possible in the decision that is being made on their behalf.
 - If the decision concerns the provision or withdrawal of life-sustaining treatment the decision-maker must not be motivated by a desire to bring about the person's death.
 - The decision maker must in particular consider the person's past and present wishes and feelings (in particular if these have been written down); and any beliefs and values (for example, religious, cultural or moral) that would be likely to influence the decision in question and any other relevant factors.
 - As far as possible the decision-maker must consult other people if it is appropriate to do so and take into account their views as to what would be in the best interests of the person lacking capacity, especially:
 - Anyone previously named by the person lacking capacity as someone to be consulted; carers, close relatives or close friends or anyone else interested in the person's welfare
 - Any Attorney appointed under a Lasting Power of Attorney;
 - Any Deputy appointed by the Court of Protection to make decisions for the person.
 - An Independent Mental Capacity Assessor, where there is a legal requirement to do so (see below).
 - Some decisions MAY by law not be made on behalf of an incapacitated person This includes decisions about family relationships, sexual matters; decisions covered by the Mental Health Act; voting decisions; assisted suicide.

Independent Mental Capacity Advocates (IMCAs)

- 5.34 An IMCA is a type of advocate introduced by the Mental Capacity Act 2005, (the Act). The Act gives some people who lack capacity a right to receive support from an IMCA in relation to important decisions about their care. IMCA services are provided by organisations that are independent from the NHS and local authorities.
- 5.35 A flowchart covering the situations when an IMCA may need to be contacted is given in appendix 4.
- 5.36 There is a duty to consult an IMCA where the following criteria apply:

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- the patient lacks capacity
- AND the patient has nobody else (no friend / relative / informal carer) who is available to be consulted by the clinical team about the patient's best interests in relation
- AND a decision is being made on behalf of the patient about serious medical treatment or long term care (a hospital stay of more than 4 weeks or placement in a different residential setting for more than 8 weeks)

5.37 The only exception to the requirement to consult an IMCA before taking such a decision is in situations where an urgent decision is needed.

5.38 Serious medical treatment is defined as treatment that involves giving new treatment, stopping treatment that has already started, or withholding treatment that could be offered, in circumstances where:

- a single treatment is proposed and there is a fine balance between the likely benefits, the burden to the patient, and the risks involved or
- a decision between a choice of significant treatments clinical care approaches is finely balanced or
- what is proposed is likely to have serious consequences for the patient (this will normally include an surgical treatment or any treatment carrying significant risks or side effects)

5.39 An IMCA may also be consulted in cases where there are Adult Protection Procedures or a formal Care Review and the team caring for the patient believes that it would be beneficial for the patient to have this support.

5.40 IMCAs do not make decisions on behalf of the person they are representing. This remains the responsibility of the 'best interests decision maker' who is normally the healthcare professional responsible for the procedure or treatment in question. An IMCA's role is to:

- Represent and support the person in relation to their best interests.
- Find out the views / feelings / beliefs of the person.
- Make sure that the person can participate in the decision-making process.
- Obtain and evaluate information
- Look at other courses of action
- Consider seeking a further medical opinion if necessary.
- Check that the Mental Capacity Act principles and best interests process are being followed
- Prepare a report, which the decision maker has a legal duty to consider
- Challenge the decision (including about capacity) if necessary, informally first and through Court of Protection as a last resort

Undertaking and Documenting the capacity and best interests assessment

5.41 All nurses, medical staff and other healthcare professionals receive training related to mental capacity and are competent to identify patients who do not have capacity to consent to the care and treatment that they provide.

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- 5.42 It is only necessary to involve a psychiatrist if the patient's mental state is very complex or they appear to be mentally ill.
- 5.43 A formal assessment tool is provided ([available on the Trust Intranet](#) and shortly to be made available as a form on CRS) to guide and document this assessment. This tool may be completed by a doctor, nurse or other healthcare professional and should be used to document the patient's capacity to consent to their admission and treatment whenever for any patient who is diagnosed on admission or subsequently with
- Dementia
 - Current mental illness
 - Learning disabilities
 - Brain injury
 - Impairment of consciousness (for example a low Glasgow Coma Score)
- 5.44 Because the form documents capacity in relation to a particular decision at a particular time, it will be necessary for the form to be completed again or updated on any occasion where there is a significant change in the patient's mental condition or whenever a new and significant decision (not covered by the general decision about admission for hospital treatment) needs to be made.
- 5.45 Throughout the patient's treatment, different decisions will need to be made. Wherever possible, these decisions will be taken by the patient. In any case where the patient is not able to take the decision, and care is provided in their best interests, this fact should be routinely included in the documentation of the care given.
- 5.46 The Trust's expectations in relation to the documentation of capacity and best interests decisions are summarised in the table below.

Task	Responsibility for assessment and best interest decision	Documentation of capacity and best interest decision
Admission of patient with no evident mental disorder / brain injury / learning disability or other mental issues of concern	Healthcare professional admitting patient	Note in admission-discharge booklet, confirming capacity
Patient admitted with or subsequently diagnosed with <ul style="list-style-type: none"> • Dementia • Current mental illness • Learning disabilities • Brain injury • Impairment of consciousness (e.g. a low Glasgow Coma Score) • Confusional state or other mental impairment 	Member of medical team	Formal capacity and best interests form, in relation to the decision to be admitted and treated in hospital or to continue such treatment

Task	Responsibility for assessment and best interest decision	Documentation of capacity and best interest decision
Routine nursing, medical or other care – compliant patient without capacity to consent to this care	Healthcare professional prescribing or planning care	Note in healthcare record that patient lacks capacity and is being treated in best interests
Routine nursing and medical or other care – non-compliant patient without capacity to consent to this treatment	Nursing care: nurse in charge of area, who may delegate to an appropriately trained and experienced colleague. Medical or other care: doctor or other professional responsible for care	Formal capacity and best interests form, in relation to the current plan of care
Treatment which would normally require written consent, patient unable to consent to this treatment	Doctor responsible for prescribing treatment	Formal capacity and best interests form, in relation to the current plan of care, plus Consent Form 4
Decision over long term (more than 4 weeks in hospital or 8 weeks in nursing home) change of residence	Clinical team proposing placement	Formal capacity and best interests form, (Trust or Local authority form) in relation to the current plan of care

6 DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

6.47 A flowchart covering the situations when DoLS may need to be applied is given in appendix 3.

About the Safeguards

6.48 The Safeguards are statutory requirements that came into effect as a result of the Mental Capacity Act 2005, as amended by the Mental Health Act 2007. They aim to ensure that people are only deprived of their liberty if it is in their best interests and if there is no other form of treatment that could give them the care they need. The scope of the Safeguards in relation to patients in hospital has been significantly extended as a result of a decision by the Supreme Court in March 2014 (Cheshire West judgment). (See Appendix 7 for the Trust’s interim plan pending full implementation of these requirements).

6.49 As now determined by the Supreme Court in March 2014, a patient is deprived of liberty in any case where they are

- kept under continuous supervision and control (even if they do not object to this) *and*
- would not be allowed to leave if they so wished (even if they have given no indication of wishing to leave)

6.50 The above covers the large majority of patients without capacity to make decisions about their treatment who are receiving care and treatment as inpatients in any Trust hospital.

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6.51 With few exceptions, if the Trust (“Managing Authority”) plans to deprive, or is depriving, an incapacitated person of their liberty, it must apply to the patient's local authority for authorisation to do so under the Deprivation of Liberty Safeguards. (See the flowchart at Appendix 5)

Process for DoLS Applications

- 6.52 It is the responsibility of the clinical team treating or proposing to treat the patient to identify those patients who meet the requirements above, and to complete the relevant application form.
- 6.53 DoLS forms should be completed after MDT discussion, following completion of a formal capacity and best interests assessment (involving the patient's informal carers or friends / family wherever possible). The DoLS forms may then be completed by a member of the clinical team (doctor, nurse, therapist) or a member of the Safeguarding Team.
- 6.54 If the team knows more than three weeks in advance that such a patient is to be admitted, a [“Standard Application”](#) form should be completed in advance of the admission.
- 6.55 If the patient is already deprived of liberty (eg already admitted) the Trust may itself authorise the deprivation of liberty this for the first seven days, pending completion of the assessment by the Local Authority. In this case the combined [“Urgent Authorisation and Standard Application”](#). Should be completed at the earliest opportunity.
- 6.56 Completed forms must be completed electronically forwarded to the Safeguarding Adults team as an email attachment.
- 6.57 Applications under DoLS are administered by the Safeguarding Adults Team. The Safeguarding Adults Team will in each case check the application, submit it to the local authority, ensure that all necessary notifications and other information (to the local authority, the patient, carers/family, attorneys, IMCAs and the CQC) and track the course of the patient's deprivation of liberty to ensure that relevant deadlines are met.
- 6.58 DoLS-related documents intended for the patient are sent by the Safeguarding Adults team to the relevant ward manager, who must ensure that the patient receives a copy and is given all reasonable assistance in understanding it. Documents intended for carers are also sent to the Ward Manager, to pass on to the patient's carers if they visit; where the Trust has a postal address for the carers, these documents are also sent to the carers by post.
- 6.59 All documentation relating to DoLS that is forwarded to clinical teams by the Safeguarding Adults team should be filed in the patient's notes. A copy is also retained by the Safeguarding Adults Team.
- 6.60 The clinical team is responsible for informing the Safeguarding Adults team immediately if a patient subject to a DoLS application
- regains capacity
 - is discharged
 - is transferred to a different ward or hospital
 - dies

Outcome of DoLS Applications

6.61 The Safeguarding Adults team will receive from the Local Authority and pass on to the clinical team the outcome of the Application.

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- 6.62 If the application is approved, it will last for a specified period and may include conditions that the Trust must meet. Responsibility for meeting these conditions normally rests with the clinical team responsible for the patient. The Safeguarding Adults team will follow up with the clinical team when the period of authorisation is approaching its end, to determine whether a fresh application will be required.
- 6.63 If the application is rejected, then the patient may continue to be treated in hospital, but it will not be lawful to deprive them of liberty; they must be free to leave and not subject to any restriction (unless restrictions authorised in some other way, eg under the Mental Health Act). In any situation where a rejection of a DoLS application results in concern about a patient's safety, the matter must be discussed with the Safeguarding Adults team or the Legal Services Team.

Deaths of patients subject to DoLS

- 6.64 If a patient dies whilst subject to a current DoLS Authorisation, the death must be referred to the Coroner, who will arrange for an inquest to be conducted and will issue the Death Certificate. In most cases only a paper inquest will be required and should not result in a long delay for the patient's family.
- 6.65 The Trust Bereavement Teams have access to the DoLS database and will be able to advise on whether a deceased patient was subject to DoLS.

Advice and training in relation to DoLS and Mental Capacity Act

- 6.66 Information about DoLS and the Mental Capacity Act is included [on the intranet](#).
- 6.67 Advice on all aspects of the Deprivation of Liberty Standards and the Mental Capacity Act can be obtained from the Adult Safeguarding Team or the Legal Services Managers.
- 6.68 Training in these areas is mandatory for all clinical staff and included in the Trust clinical Statutory and Mandatory Training booklet. Face to face training sessions can be arranged for individuals or groups by contacting the Safeguarding Adults team. All in-patient teams are encouraged to include DoLS training sessions in their regular programme of staff training and updates.

7 DUTIES AND RESPONSIBILITIES (ALL ISSUES COVERED BY THIS POLICY)

All staff working in the Trust	<p>To recognise, respond and report any concerns irrespective of whether or not they have proof of abuse</p> <p>To comply with statutory/mandatory training requirements and maintain knowledge and skills in protecting and responding to concerns of harm caused to adults at risk, including matters covered by the Mental Capacity Act.</p> <p>To act to protect patients through demonstrating no tolerance for any circumstance or behaviour that they witness that may lead to or result in harm to an adult at risk</p> <p>To comply with information requests to inform safeguarding investigations</p>
Healthcare Professionals	To identify those in their care who may be adults at risk and ensure adjustments are made to ensure an equal standard of

	<p>care is provided to them and their rights are protected</p> <p>To assess and document capacity and where the patient has capacity to seek informed consent from for the provision of care or treatment</p> <p>To be aware of the principles underlying the MCA and to treat patients in line with these principles.</p> <p>To identify through thorough assessment, patients who may lack capacity to consent and take decisions in their best interests unless other provisions for decision-making are established in law</p> <p>To consult with relevant others such as carers and IMCAs when seeking to make best interest decision</p> <p>To make DoLS authorisations and applications when a person being treated in the Trust and meets the criteria for this</p> <p>To pass on information to the patient in relation to DoLS authorisations, as advised by the Safeguarding Adults Team</p>
<p>Governance teams/complaints and PALS</p>	<p>To ensure that when they receive a complaint or concern about a ward of service suggesting neglect or an omission of care about an adult at risk, it is passed to the safeguarding adults' team for review.</p>
<p>Medical Staff</p>	<p>To have overall responsibility for ensuring that appropriate action is taken under the Deprivation of Liberty Safeguards or the Mental Health Act in circumstances where any incapacitated patient under their care is deprived of liberty</p>
<p>Managers</p>	<p>To ensure that staff are aware of the Trust and multi-agency policies and agreements</p> <p>To make explicit the expectation to raise concerns and report incidents of about abuse of adults at risk</p> <p>To support staff to respond to concerns raised about the abuse or harm of an adult at risk</p> <p>Ensure compliance with safeguarding training commensurate with role</p> <p>To pre-empt and escalate concerns about any issue that may increase risks to vulnerable adults in Barts Health care</p> <p>Ensure a timely response to requests for information about safeguarding incidents</p> <p>Ensure appropriate representation at safeguarding strategy and conference meetings</p>
<p>CAG Directors of Nursing and Therapies/Associate Directors</p>	<p>Ensure a nominated staff member attends the safeguarding operational committee to represent the CAG</p> <p>To identify any specific training needs in their services and facilitate meeting these needs</p> <p>To support staff to investigate safeguarding incidents and report within agreed timeframes</p>

	<p>To facilitate learning from safeguarding incidents for their teams and support implementation of recommended change</p> <p>To incorporate safeguarding incidents into the CAG governance reports</p> <p>To monitor, with support from the Safeguarding Adults Team, the application of DoLS, MCA and MHA in their area, and to take action in cases where these provisions are not being appropriately applied.</p>
<p>Head of Safeguarding adults</p>	<p>To ensure that Barts Health has policies and procedures in place to protect adults at risk and patients who lack capacity</p> <p>To identify and escalate any issues that may prevent the Trust from executing its responsibilities to safeguard adults at risk or patients who lack capacity</p> <p>To ensure that serious or potentially serious safeguarding incidents are escalated to the responsible executive</p> <p>To provide assurance to the executive and the Local Authority safeguarding adults' boards that safeguarding concerns are being reported, investigated and responded to and that learning from these incidents is shared.</p> <p>To build and maintain positive working relationships characterised by trust and respect for the different roles and responsibilities, with partner agencies and Local Authority Safeguarding Adults Boards</p> <p>To ensure co-operative and critical partnership working within Barts Health and external partner agencies</p>
<p>Safeguarding Adults team</p>	<p>To provide expert advice to clinical staff and other partners about safeguarding in health care settings</p> <p>To facilitate the safeguarding processes</p> <p>To record and report on safeguarding governance including incidents, investigations, training compliance and risks.</p> <p>Ensure staff are aware of the requirements of the Mental Capacity Act and Deprivation of Liberty Standards and support clinicians in complying with this Legislation</p> <p>To co-ordinate the application of DoLS within the Trust including:</p> <ul style="list-style-type: none"> - Recording all authorisations and applications under DoLS provisions - Submitting applications to the relevant local authorities - Preparing all statutory notifications and providing required information to patients, carers and other involved persons - Notifying clinical teams of relevant deadlines relating to the DoLS authorisations - Providing data on the application of DoLS to relevant Trust or

	external bodies.
Bereavement Teams	Check the DoLS database before any death certificate is issued, and ensure that where required the death is reported to the Coroner.
Chief Nurse/Deputy Chief Nurse	Executive responsible officer for safeguarding adults at risk throughout Barts Health and for the application of the Mental Capacity Act and Deprivation of Liberty Safeguards.
The Safeguarding Operational Committee	To progress the objectives and action plan designed to continuously improve safeguarding at Barts Health
Integrated Safeguarding Assurance Committee	To provide assurance to the executive officer that safeguarding processes and procedures are implemented To highlight risks to achievement of safeguarding adults objectives To brief about relevant national reports and inquires To highlight changes in national policy/strategy that will impact on the safeguarding agenda
Trust Board	To receive, support and challenge monthly performance reports for safeguarding adults To receive an annual report into the work of the Safeguarding Adults Team To support the objectives and work plan to of the safeguarding team.

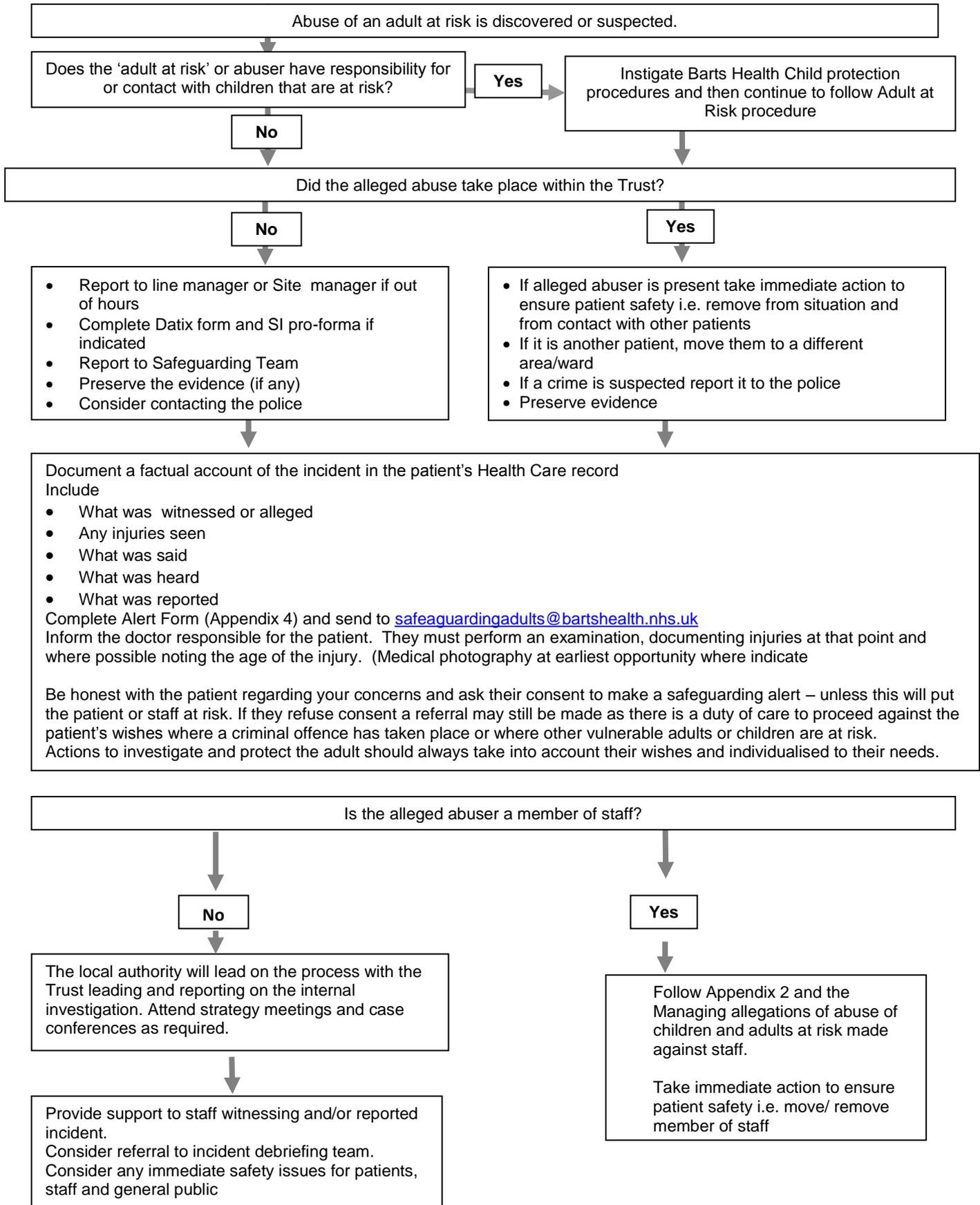
8 MONITORING THE EFFECTIVENESS OF THIS POLICY

Issue being monitored	Monitoring method	Responsibility	Frequency	Reviewed by and actions arising followed up by
Practical application through the annual safeguarding adults audit	Audit	Head of Safeguarding Adults		Integrated Safeguarding Assurance Committee
Staff awareness of and compliance with Safeguarding	Rolling CQC compliance audit	Compliance Team		CAG Directors of Nursing and Governance

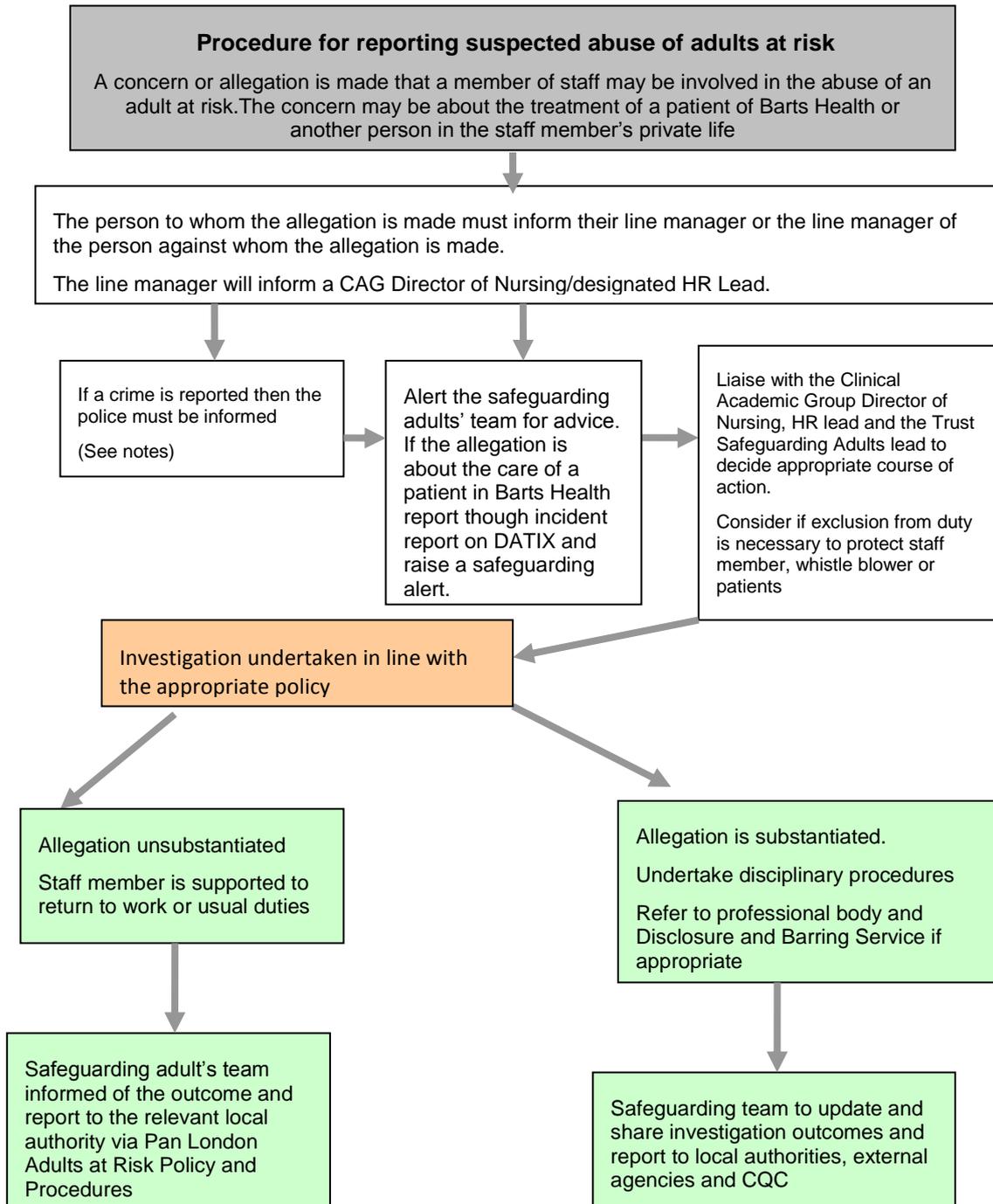
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provisions				
Compliance with DoLS and MCA	On-going review of use of DoLS	Safeguarding Lead for DoLS / MCA		Integrated Safeguarding Assurance Committee

APPENDIX 1 - PROCEDURE FOR MANAGING SUSPECTED OR ALLEGED ABUSE OR NEGLECT OF AN ADULT AT RISK



APPENDIX 2 – PROCEDURE FOR MANAGING ALLEGATIONS AGAINST STAFF



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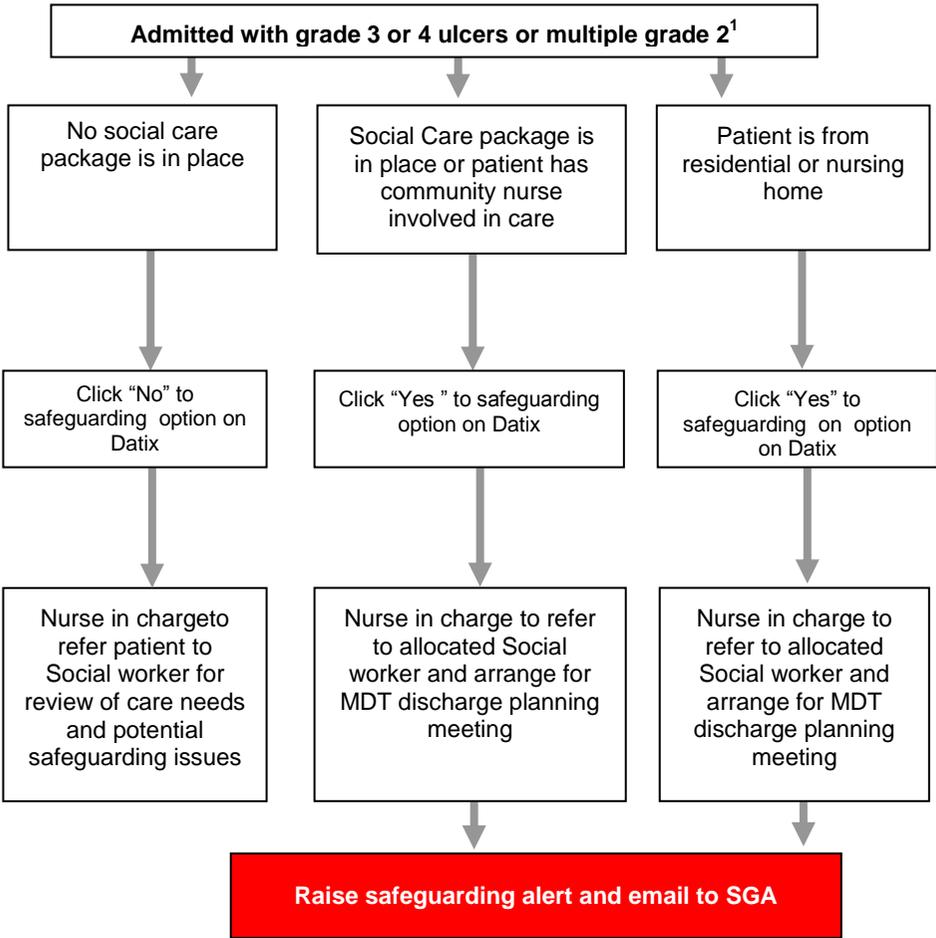
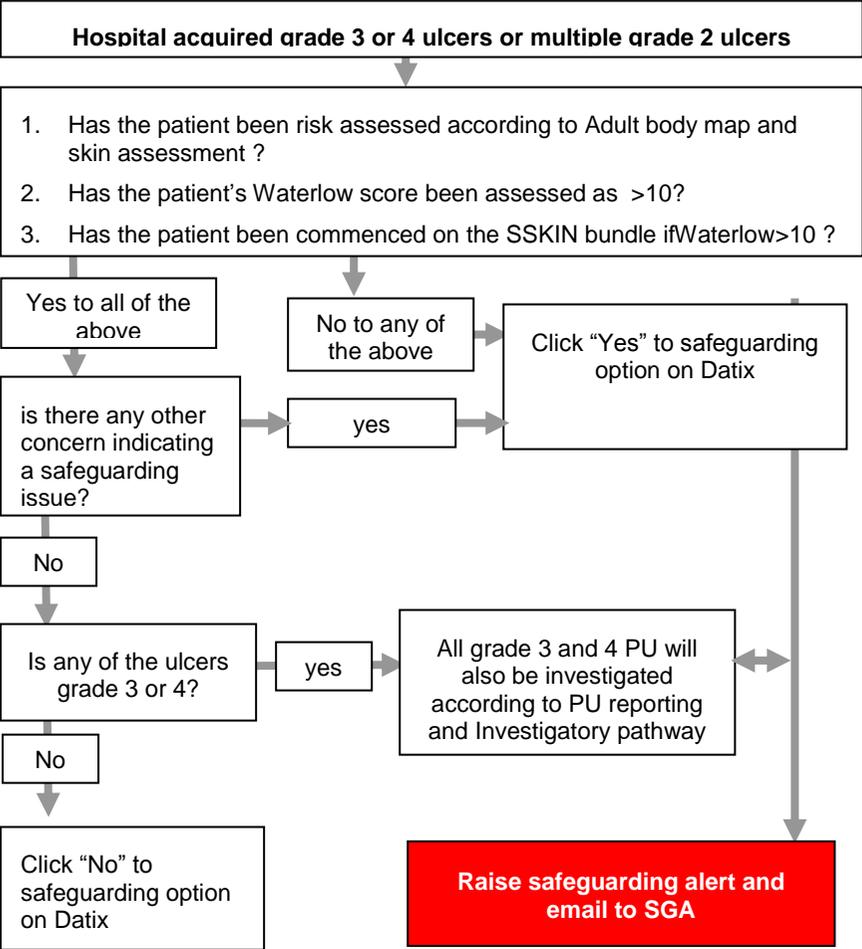
Notes to appendix 1 and 2

- 8.70 Allegations may be made by staff patients careres or members of the public.
- 8.71 The priority of all staff at all times must be the safety of patients in the care of Barts Health. Any allegation of abuse made against a member of staff must be reported.
- 8.72 If the allegation being made is about a crime committed outside Trust premises, by a staff member, then the person making the allegation should be asked if they have reported it to the police. If they have the crime reference number can be requested.
- 8.73 If the police have not been informedask them to do so.
- 8.74 If the allegation made is about a crime committed on Trust premises and the person who made the allegation has not informed the police, this may be done by the line manager or another staff member as a third party, after discussion and advice from the Deputy Chief Nurse or the Safeguarding Adults Team.
- 8.75 Whoever receives the allegation must esclate to their line manager or the line manager of the person against whom the allegation is made.
- 8.76 The line manager must seek to interview the person at the earliest possible time. This should be the same day if they are at work.
- 8.77 If the staff member is not at work, they should be contacted andasked to attend for interview as soon as possible and before they return to work.
- 8.78 The line manager must inform the Deputy Chief Nurse and the Safeguarding Adults Team whowill advise on the next steps.
- 8.79 The Deputy Chief Nurse or the Lead for Safeguarding Adults will inform the Chief Nurse
- 8.80 If the alleged abuse was committed against patient(s) of Barts Health Services, the line manager will complete an incident form, categorise if for safeguarding adults and complete safeguarding adult alert form. The alert form should be forwarded to the safeguarding adults team who will report it to the appropriate authority in line with the Pan London Adults at Risk Policy and Procedures.
- 8.81 If the alleged abuse was committed against a person outside of the Trust, thesafeguarding adults team in the Borough where the victim is resident should be informed if not already contacted by the police or the person reporting the abuse

APPENDIX 3 – PRESSURE ULCERS

Screening Tool for Safeguarding Adults with grade 3 or 4 Pressure Ulcers or multiple Grade 2 ulcers

To be followed by Nurse in Charge or Ward Manager within 24 hours of TVN verification

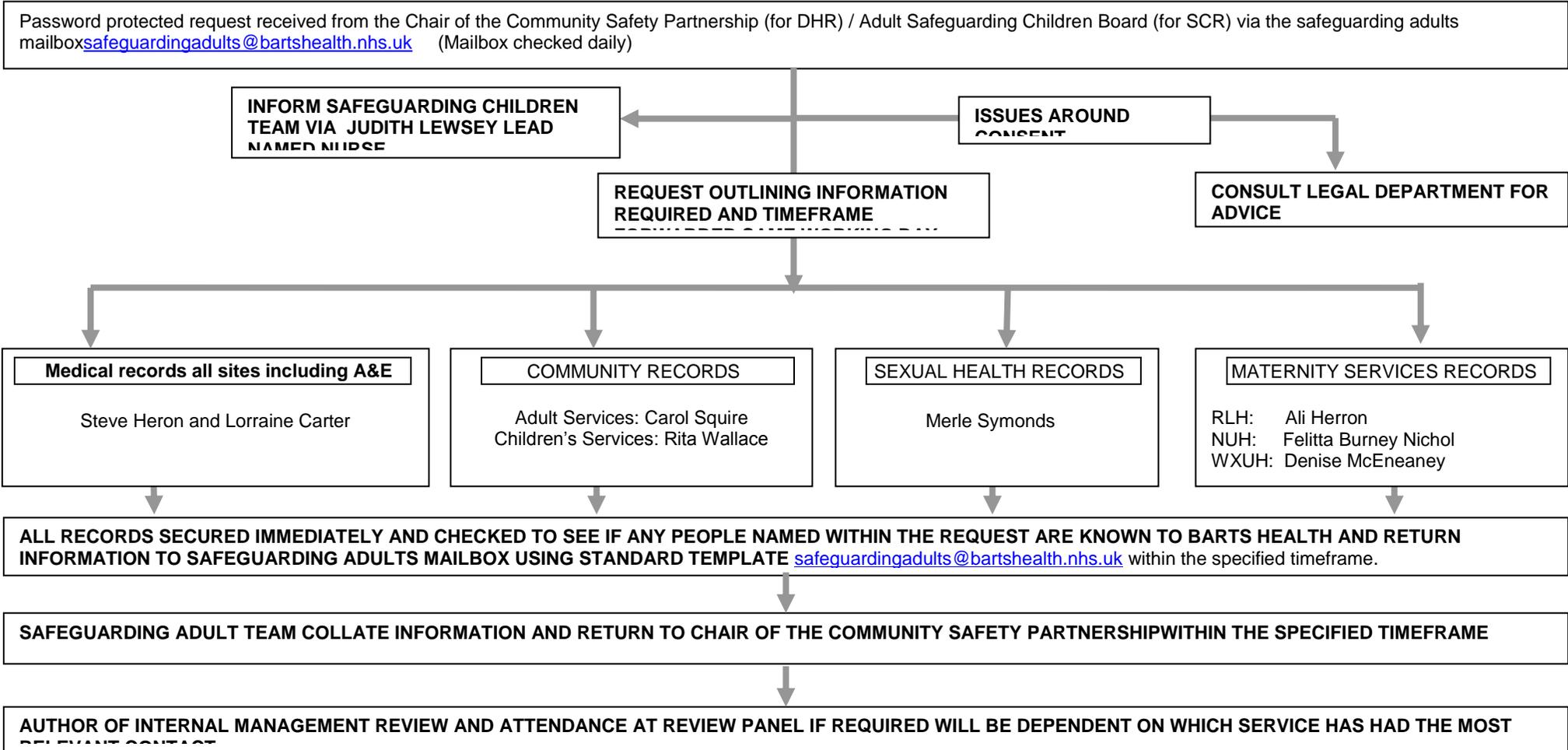


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¹>3 PUs overlying different body sites

APPENDIX 4 - DOMESTIC HOMICIDE

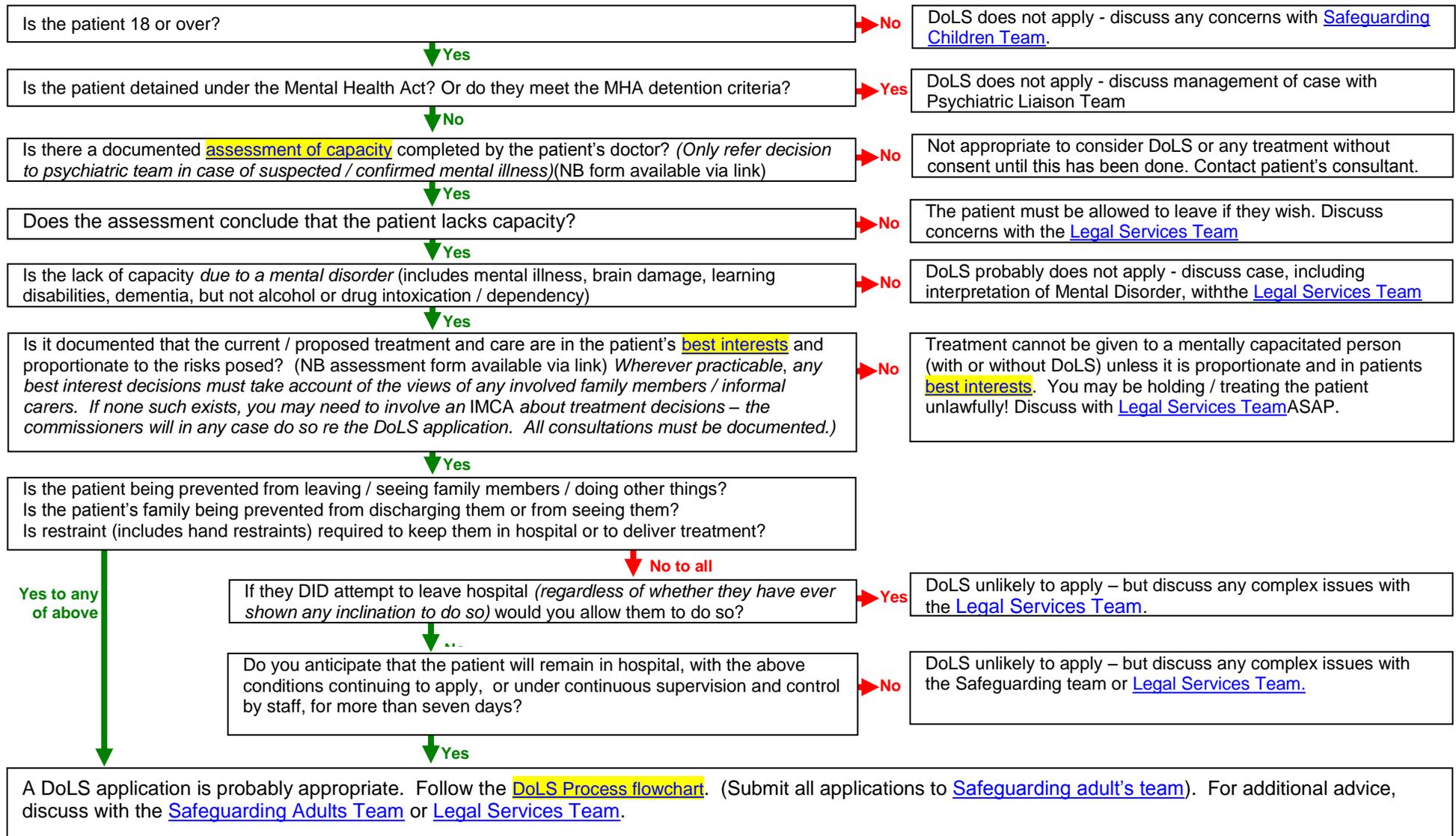
Barts Health Domestic Homicide (DHR) / Adult Serious Case Review (SCR) Process



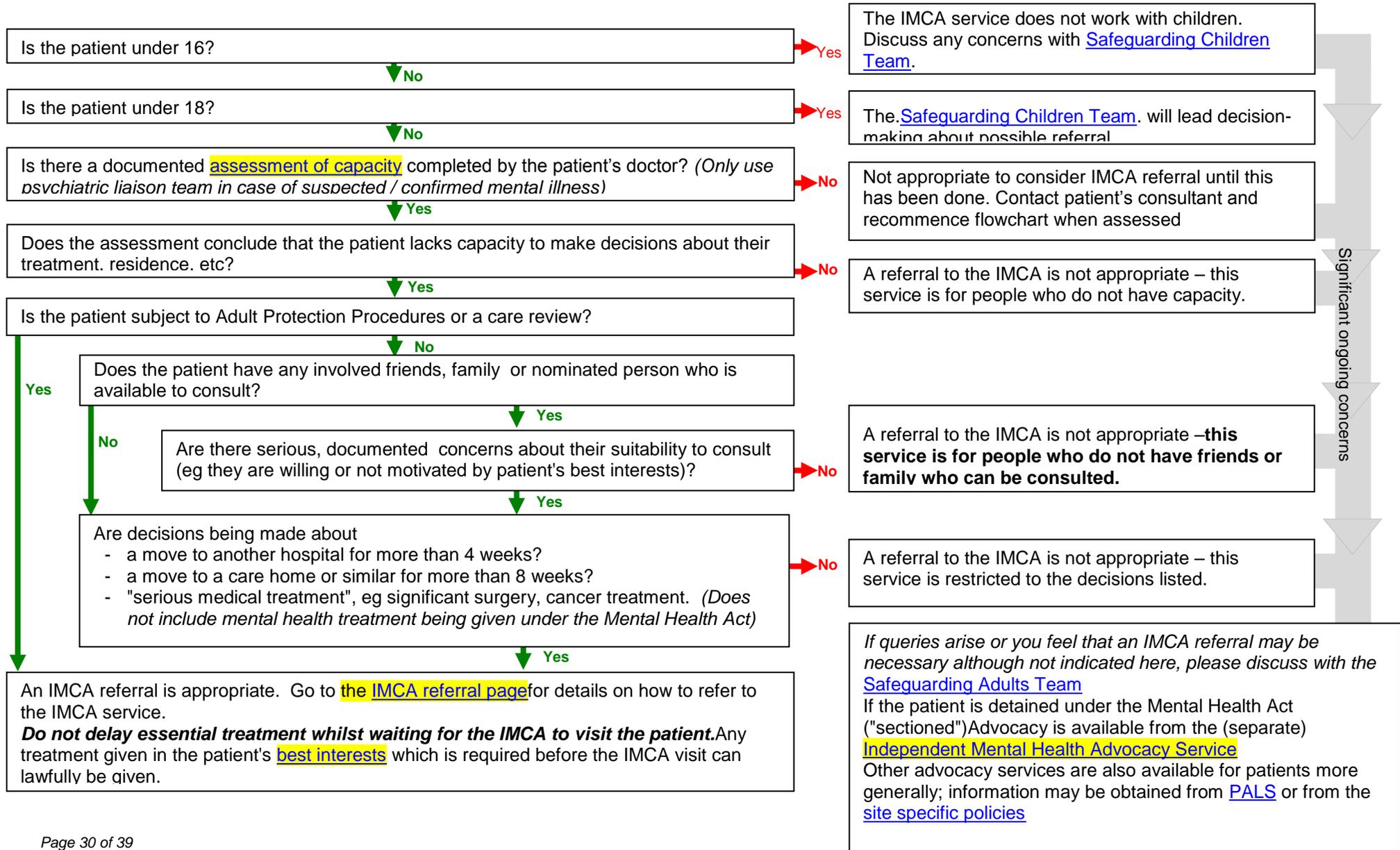
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APPENDIX 5 - DOLS DECISION MAKING

This flowchart will help you to determine whether a Deprivation of Liberty (DoLS) application ought to be made.



APPENDIX 6 - IMCA DECISION MAKING



APPENDIX 7 - INTERIM DOLS PROTOCOL

Management of Deprivation of Liberty Safeguards following the Cheshire-West Supreme Court ruling

Background

1. The massive extension in the applicability of DoLS following the Cheshire West ruling in March 2014 imposes major, unfunded, administrative demands on the Trust and partner agencies. Implementation of the new requirements is underway but incomplete both in Trusts and in Local Authorities. Furthermore there are currently some areas where the legal requirements are not clear, and where clarity will only be achieved over time, as case law develops.
2. This protocol sets out the approach adopted by the Trust during the transitional period pending full implementation by all parties and clarification of the requirements.

General principles applied in all areas

General obligation to make and process applications

3. All clinical teams have a duty to identify patients without capacity and complete DoLS applications in respect of these. A streamlined application form is available at <http://bartshealthintranet/About-Us/Corporate-Directorates/Nursing-and-Governance/Safeguarding/Safeguarding-Adults/Mental-Capacity/DoLS-resources.aspx>. On completion, this form must be submitted to the Safeguarding Adults team.
4. Where there are a large number of applications to be made from a particular area, the Safeguarding Adults team may be able to assist with completion of forms ([contact safeguardingadults@bartshealth.nhs.uk](mailto:safeguardingadults@bartshealth.nhs.uk)).
5. All applications received from any service are immediately processed by the Safeguarding Adults team and submitted to the relevant local authority in the order in which they are received.

Prioritisation within clinical teams in making applications

6. Priority in the completion of DoLS applications must be given in the following order:
 - a) Any patient without capacity who is subject to any form of restraint, including hand restraint gloves
 - b) Any patient without capacity who is expressing a wish to leave hospital or objection to any aspect of their treatment (including patients in A&E)
 - c) Any patient without capacity whose treatment in hospital is contentious in any way (eg concerns expressed by relatives, uncertainty as to patient's best interests)
 - d) Any patient without capacity who is unbefriended.
 - e) Any other patient without capacity who is likely to remain in hospital for a week or more
 - f) Any other patient without capacity.
7. Whether or not an application has been made, all patients without capacity must be treated in line with the general requirements of the Mental Capacity Act (See Adult Safeguarding protocol).
8. The workload associated with making applications must not be allowed to compromise the delivery of patient care. If a team is experiencing difficulties in making relevant applications as a result of capacity issues, the matter should be escalated through management lines and the

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Safeguarding Adults team should be advised. Where a large number of applications are due to be made, the Safeguarding Adults team may be able to assist in completion of paperwork.

Prioritisation by Safeguarding Adults Team

9. In implementing the requirements across all services and working with teams to ensure that all relevant applications are made, the Safeguarding Adults team is prioritising in the following order:
- a) Patients subject to possible active restriction of liberty, as above
 - b) Services with the largest number of conscious patients likely to lack capacity, ie elderly care services, brain injury services, stroke services
 - c) Patients with known learning disability in any service
 - d) Relevant patients (see below) in ITU
 - e) Relevant patients (see below) in palliative care
 - f) All other in-patients without capacity
 - g) Outpatients without capacity being assessed for elective admission

Patients for whom Applications will not be made

10. Pending any contrary legal precedents being reported, applications will not be made in respect of the following groups, on the basis that it does not currently appear that these patients meet the criteria for an application under DoLS.
- a) Patients who are expected to be discharged or transferred, or to die or regain capacity, in under seven days (DoLS Code of Practice, para 6.3ff applies) unless they are subject to active restraint
 - b) Patients who would have capacity were it not for the effects of medication or other medical treatment (mental disorder criterion not met)
 - c) Patients under police guard (Deprivation of Liberty is not by the Trust)
 - d) Patients who have, whilst capable, given valid consent to a course of treatment during which they recognise they might lose capacity (applies to some patients having serious elective surgery, and some going into terminal care situations). It is defensible and in line with DoH guidance to argue that these patients are not deprived of liberty as they have given advance consent to the restrictions imposed.
 - e) Patients already subject to DoLS who have subsequently moved from one ward to another without a change in hospital (some local authorities have demanded fresh applications in this situation. The Trust can find no legal authority for this demand.)

Additional considerations in specific areas

End of life care

11. The Trust will not make applications in respect of dying patients who are actively supported by family or friends who endorse the care being provided **and** do not regard it as a deprivation of the patients liberty **and** might suffer unnecessary distress as a result of the DoLS process **and** there are no indicators to suggest that the patient is being actively restricted in any way (*Department of Health Letter, 14 January 2015: "We must remember that the reality on the ground is, that in the great*

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majority of palliative care cases, the family and loved ones of the individual concerned do not recognise any "deprivation of liberty" in a conventional sense. Rather they see a normal care situation. Practitioners will be only too aware that an unnecessary DoLS assessment could cause considerable distress to the family with no benefit to the individual".)

Emergency Departments

12. Some patients who lack capacity are brought to A&E by family, friends or the police, without their consent and without any other clear legal authority (this includes patients brought into the department by the police, without S136).
13. Pending clarification of the legal position, DoLS applications will NOT be made in respect of incapacitous patients in the Emergency Department unless:
 - a) There is a prospect that they may be admitted and require a DoLS authorisation (otherwise Paragraph 6.4 of the Code of Practice applies) **and**
 - b) They are objecting to treatment or being actively prevented from leaving the department

Pre-admission clinics / patients booked for elective procedures

14. Where it is known in advance that a patient without capacity is to be admitted to hospital for a planned procedure and may be in hospital for a week or more, a DoLS application should be made.
15. When resources allow, a procedure will be introduced whereby those managing such admissions will inform the Safeguarding Adults team of such future elective treatments. Currently no such procedure is in place.
16. However, managers of outpatient areas must inform the the Safeguarding Team if admission plans are being made for any patient where it is anticipated that any restraint may be required (this applies particularly to some patients with learning disabilities) so that the safeguarding team can determine whether an advance application should be made.
17. If no advance application has been made, an application should be completed for elective admissions when a patient without capacity arrives in hospital.

Management of delays

18. Capacity issues relating to the Trust and its partner organisation have resulted in a situation where it is not feasible within existing resources for all the legal requirements associated with DoLS to be met within the legal time limits, and in some cases it is not possible for them to be met at all.
19. Whether or not there are delays in the application of DoLS or breaches in the associated legal or regulatory requirements, the Trust will at all times seek to protect the rights of patients without capacity and to work within the key principles set out in the Mental Capacity Act.

Delays resulting from Trust capacity issues

20. Processing and follow up of DoLS applications places major demand on the Safeguarding Adults service and there would not be capacity to process all applications if all relevant applications were to be made.
21. In the event that the Safeguarding team receives more applications than it has capacity to process or follow up, or if processing of DoLS applications impacts significantly on other duties of the team, the matter will be immediately escalated via management lines and a decision will be taken

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as to how to proceed. The outcome of this decision will be notified to the relevant Deputy Chief Nurse.

22. In processing existing applications, the Safeguarding Adults team will prioritise
 - a) Submission of completed applications (once submitted, the Trust has authority to continue treating the patient, whether or not all other aspects of the requirements have been met).
 - b) Informing patients and their families of the Safeguards and the implications for care

Delays resulting from local authority capacity issues

23. The Trust application authorises the deprivation of the patient's liberty for 7 days, which can be extended by the relevant local authority for a further 7 days. Within this period, the local authority is required to assess the patient and the circumstances of the deprivation of liberty and either approve or reject the application. At the end of 7 days, or 14 days if extension is authorised by the local authority, the right to deprive the patient of liberty lapses. There is no provision for further extension beyond the 14 day period.
24. Because of capacity issues following the Supreme Court ruling, local authorities are frequently failing to complete assessments within the required timescales. With some local authorities, the delays continue for weeks or months. During this period, the Trust has no legal authority to keep the patient unless it obtains this separately through a specific application to the Court of Protection. The Court of Protection is itself under unprecedented pressure because of the Supreme Court ruling, so is in any case not able to process all such applications in a timely fashion.
25. An Deprivation of Liberty application will be made to the Court of Protection only where the Trust is also making an application to the Court in respect of treatment decisions. Such applications typically relate to administration of serious medical treatment to which an incapacitous patient is objecting, and such applications are rare.
26. In all other cases where a DoLS application or authorisation has been made by the Trust but lapsed due to local authority delays, the Trust will continue to treat the patient, including depriving them of liberty in their best interests, on the same basis as if a DoLS authorisation were still in force. However, in the event of the death of such a patient, the requirement to report to the Coroner will not apply.
27. Periodic reminders are sent to local authorities by the Safeguarding Adults team, at least monthly, in respect of any application which is still awaiting a response.

Delays resulting from IMCA capacity issues

28. Where a DoLS application is made in respect of an unbefriended person, the DoLS process requires that an IMCA (independent mental capacity advocate) be consulted as part of the best interests assessment. The IMCA services contracted by local CCGs are also affected by the current capacity issues, and some delays are introduced due to difficulties in securing the services of an IMCA.
29. The IMCA service responsible for referrals to one of the Trust hospitals has recently announced that its pressures have become unmanageable and it is not accepting further referrals at the present time. In the hospital concerned, this means that DoLS applications cannot be processed for unbefriended patients.

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30. In these cases where a DoLS application lapses because of IMCA unavailability, the Trust will continue to treat the patient, including depriving them of liberty in their best interests, on the same basis as if a DoLS authorisation were in force.
31. Teams must be particularly vigilant in protecting the rights of unbefriended patients under these circumstances and any concerns about decision making relating to these patients should be referred to the Safeguarding Adults team.

Management of cases where DoLS application has been rejected by the local authority

32. The current situation imposes a steep learning curve for all parties and there are a number of cases where applications by the Trust have been rejected by the local authority in circumstances where the Trust believes that it is necessary to deprive the patient of their liberty. To date, this issue has arisen
- Where the local authority has ruled that the patient should be subject to the Mental Health Act rather than DoLS, but the patient has been assessed as not sectionable.
 - Where the local authority disagrees with the Trust's assessment of capacity, and concluded that the patient does have capacity
 - Where the Local Authority has determined that it is not in the patient's best interests for them to be in hospital, but no other accommodation is available.
33. In either such case, the Trust is without clear legal authority to continue to hold and treat the patient. Under these circumstances, local authority staff have been assertive in telling staff that they have no authority to keep the patient and that if the patient seeks to leave they must not prevent them – and indeed must facilitate them in so doing. This is a matter of concern to staff who may continue to believe that the patient lacks capacity, may come to harm if allowed to leave and that they have a duty of care to protect them.

DoLS refused on grounds that the local authority find the patient has capacity

34. If DoLS is refused on grounds that the Local Authority finds the patient to have capacity, the Trust will accept the LA finding and treat the patient as having consented to their admission. The patient's capacity to consent to medical or other treatment (as opposed to admission) will continue to be assessed by the clinical team (under the MCA, assessments of capacity are time specific and decision specific). If not deemed to have capacity, the patient will be treated in their best interests as long as they do not object to any such treatment.
35. If DoLS is refused on grounds that the patient should be treated under the MHA, an immediate MHA assessment will be arranged, unless there has already been a recent assessment and the patient's condition has not subsequently changed..
36. If DoLS is refused on grounds that it is not in the patient's best interests to be in hospital, urgent efforts will be made to find another suitable location for the patient. Pending such arrangements being made, the patient will continue to be treated under the MCA in their best interests.
37. In all of the above cases, there will be a low threshold for making a fresh DoLS application in the event that the patient's conditions changes or deteriorates, particularly if a patient who has previously been compliant with hospitalisation tries to leave,
38. If the LA continues to refuse authorisation under DoLS, and the clinical team believes that deprivation of liberty is essential in the patient's best interests, consideration will be given to an application to the court of protection.

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39. If such a patient seeks to leave hospital, and the clinical team believes that they will be at risk if they do so, the clinical team will hold the patient for a brief period to allow the risks to be assessed, advice to be taken from the legal services team (or Trust legal advisors out of hours) and liaison to be undertaken with appropriate agencies or individuals (Social Services, relatives, police, Court of Protection). If need be, the patient may be briefly restrained to prevent them from leaving. In the view of the Trust, this brief deprivation of liberty, outside of the DoLS requirements is deemed a proportionate response in the light of the Trust's duty of care.

APPENDIX 8 - REFERENCES

Note: additional references relating to the Mental Capacity Act are included in the Trust intranet pages under Safeguarding Adults.

- HO. Human Rights Act (1998), London.
<http://www.legislation.gov.uk/ukpga/1998/42/data.pdf>
- DoH (2000), No Secrets. London.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4074540.pdf
- Domestic Violence, Crime and Victims Act (2004). London.
http://www.legislation.gov.uk/ukpga/2004/28/pdfs/ukpga_20040028_en.pdf
- Mental Capacity Act (2005). London.
http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf
- DoH (2009), Report on the Review of No Secrets. London.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102981.pdf
- SCIE. Pan London Adult Safeguarding Policy (2011). Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse.
<http://www.scie.org.uk/publications/reports/report39.pdf>
- DoH. Safeguarding Adults - The role of health service managers and their boards. (2011).
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125035.pdf
- DoH. Safeguarding Adults - The role of health service Practitioners. (2011).
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_125233.pdf
- DoH. Safeguarding Adults - The role of health service managers and their boards. (2011).
- Transforming care: A national response to Winterbourne View Hospital. Department of Health Review :Final Report (2012)
<http://www.scie.org.uk/publications/reports/report39.pdf>
- Giving Victims a Voice, Joint report into sexual allegations made about Jimmy Savile (2013). <http://content.met.police.uk/>
- Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary (2013).<http://cdn.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>
- Home Office Prevent Strategy (2011)<http://www.homeoffice.gov.uk/publications/counter-terrorism/prevent/prevent-strategy/>
- DoLS Code of Practice

APPENDIX 9 - CHANGE LOG AND IMPACT ASSESSMENTS

ChangeLog – Safeguarding Adults at Risk		
Substantive changes since previous version	Reason for Change	Author & Group(s) approving change(s)
Inclusion of DoLS processes, application of the mental capacity act and the prevent strategy	Change in the law	ISAC
Inclusion of recent developments in the safeguarding agenda	National developments	ISAC
Clarification of interface between PALS, Complaints and SI processes	Learning from audit and inspection	
Clarification of what constitutes neglect in hospitals including provision of adequate food and drink.	Learning from SI report	
Expanding scope of safeguarding Incorporating the safeguarding principles Focus on wellbeing rather than thresholds and process.	Changes to the Care Act	
Inclusion of screening tool for pressure ulcers	Adapted from NHS England tool	
Inclusion of process for responding to SCR and DHR.	Learning from practice	

Impact assessments

Equalities impact checklist - must be completed for all new policies

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equalities

Organisational impact checklist - must be completed for all new policies



Organisational
impact assessment