



Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)

This procedural document supersedes: PAT/PA 19 v.5 – Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards



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Date written/revised:	June 2018
Approved by:	Strategic Safeguarding People Board (SSPB)
Date of approval:	13 August 2018
Date issued:	6 September 2018
Next review date:	June 2021
Target audience:	All Trust Staff

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 6	6 Sept 2018	<ul style="list-style-type: none"> • Changes to formatting in line with CORP/COMM 1 • Changes to section 5 Deprivation of Liberty to reflect interim arrangements • Changes to 5.6 – Death of a patient whilst subject to DoLS, to reflect Coroners change of ruling. 	Pat Johnson, Lead Professional, Safeguarding Adults
Version 5	13 August 2015	<ul style="list-style-type: none"> • Changes to reflect the supreme court ruling around DoLS -(Cheshire West) • Updated MCA forms 1, 2, 3 • Changes to reflect restructure and new job roles 	Pat Johnson, Lead Professional, Safeguarding Adults
Version 4	9 October 2013	<ul style="list-style-type: none"> • Title changed to 'Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)' • Policy changed to reflect the Trust APD format – sections renumbered accordingly • Section 5 – New section in relation to Deprivation of Liberty Safeguards • Links added for Codes of Practice. 	Pat Johnson, Lead Professional, Safeguarding Adults
Version 3	October 2009	<ul style="list-style-type: none"> • Section 11.3 - Addition of IMCA Contact Details • Section 13 - (Advance Decision to Refuse Treatment) removed, referenced to new policy • Section 17.3 - (Deprivation of Liberty) amended to reflect code of practice. • Addition of Deprivation of Liberty Code of Practice to references. • Addition of Appendix 1 - MCA Assessment form. • Addition of Appendix 2 - Best Interest Assessment form 	Safeguarding Adults Steering Group – MCA Subgroup
Version 2	Sept 2007	<ul style="list-style-type: none"> • There are significant changes made. The policy needs to be read in full as this is the application of the Ac into practice 	Safeguarding Adults Steering Group – MCA Subgroup

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1 INTRODUCTION

The Mental Capacity Act 2005 (The Act or MCA) received Royal Assent in April 2005, and became law in April 2007. It provides a statutory framework to empower and protect vulnerable people aged 16 years and over, who are not able to make their own decisions. It makes clear who can take decisions, in which situations and how they should go about this. It enables people to plan for a time when they may lose capacity.

Deprivation of Liberty Safeguards (DoLS) became a statutory obligation in April 2009. The introduction of these Safeguards was to protect the most vulnerable people in our society. The Safeguards apply to those adults who lack the capacity to make a decision about their care and/or treatment, where it has been determined that the proposed care or treatment is in that person's best interest, and the person is in a hospital or Care Home.

The deprivation of a person's liberty is a serious matter, and should only happen if absolutely necessary; however if the process is used appropriately, such a deprivation will be lawful.

The Trust policy reflects the principles enshrined in the Act and the guidance contained within the Codes of Practice to the Act. The Act and Codes of Practice can be accessed via this link:



MCA code of
practice.pdf

It can also be found on the intranet, on section 3 of the Policies/APD page, and on the Safeguarding page of the intranet.

Although applying equally to patients of either sex, for ease of reading, throughout the policy, the patient will be referred to as male.

2 PURPOSE

The purpose of this policy is:

- To provide staff with a general understanding of the principles of MCA /DoLS.
- To assist staff, clinical and non-clinical, working with patients with impaired mental capacity.
- To ensure that Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH or The Trust) meets the standard required as a Managing Authority within the context of the Mental Capacity Act, including the Deprivation of Liberty Safeguards.
- To guide staff through the process to be followed if it is believed that a person lacks capacity, or is being – or may need to be- deprived of his liberty.

- To describe management arrangements for the Trust, for implementing the Deprivation of Liberty Safeguards, for those patients who are, or may be deprived of their liberty.
- To set out routes of support and guidance in relation to MCA/DoLS.

3 DUTIES AND RESPONSIBILITIES

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (The Trust or DBTH) has a responsibility within the context of the Mental Capacity Act (2005), including the Deprivation of Liberty Safeguards, to lawfully protect the interest of those people within the Organisation who lack capacity, and those who are, or may be deprived of their liberty (See section 6 for further information.)

The Chief Executive has overall responsibility for ensuring that the Trust is compliant with the Act. This responsibility will be delegated to the Director of Nursing, Midwifery and Quality.

The Director of Nursing, Midwifery and Allied Health Professionals has the delegated responsibility to ensure Trust compliance with the Act and is the professional lead for Safeguarding across the Trust. This role involves supporting the implementation of the Mental Capacity Act (2005), and the Deprivation of Liberty Safeguards throughout the Trust, and providing assurance to the Board of Directors and external bodies, that systems and processes are in place to ensure compliance.

The Lead Professional Safeguarding Adults, and the **Nurse Specialist, Safeguarding Adults** offer advice and support to those staff caring for patients who lack capacity, and are, or may be deprived of their Liberty. They participate in multi-agency work across both Doncaster and North Nottinghamshire, in order to ensure, and maintain up to date practice across all areas of the Trust. They also develop training and deliver it to staff at all levels across the Trust.

Matrons and Heads of Nursing/Heads of Services have a responsibility to ensure that staff act within the context of the Mental Capacity Act to protect the interest of those people lacking capacity, and those who are, or may be deprived of their liberty.

Ward and Department Managers are responsible for ensuring that staff have access to training and maintain competencies in applying the Mental Capacity Act principles in practice as appropriate to their role. They also have a responsibility to ensure their staff are aware of and comply with the Mental Capacity Act (2005) Code of Practice, and The Deprivation of Liberty Safeguards Code of Practice.

All staff have a responsibility to act within the provisions of the Mental Capacity Act (2005), including the Deprivation of Liberty Safeguards as laid down within the Codes of Practice. It is the responsibility of all staff to ensure that privacy and dignity is maintained for those patients lacking capacity, in accordance with the Trust Privacy and Dignity Policy (PAT/PA 28).

4 PROCEDURE

Comprehensive information relating to this section can be found in the Mental Capacity Code of Practice, which can be accessed via this link and is posted on the intranet:



The relevant chapter in the code is indicated by

Chapter xx

4.1 There are five statutory principles as set out in the Act. These principles underpin the legal requirements of the act, and are the basis for all Mental Capacity assessments and decisions.

Key Principles of the Mental Capacity Act 2005

Chapter 2

- A person must be **assumed to have capacity** unless it is established that he lacks capacity.
- 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 because he makes an **unwise decision**.
- An act done, or decision made under the Mental Capacity Act for, or on behalf of, a person who lacks capacity must be done, or made, in his **best interests**.
- Least restrictive intervention – anything done for, or on behalf of a person who lacks capacity, should be the **least restrictive or intrusive**.

4.2 Determination of who lacks capacity

Chapter 4

4.2.1 The Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a two stage "decision-specific" test, which must be applied: (see section 5.3)

4.2.2 It does not matter whether the impairment or disturbance is permanent or temporary.

4.2.3 No one can be labeled 'incapable' or lacking in capacity because of a particular medical condition or diagnosis.

4.2.4 A lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour, which might lead others to make unjustified assumptions about capacity.

4.3 Testing for capacity

4.3.1 The Act states that everyone must be assumed to have capacity unless it is established that they lack capacity, and that all practical steps must be taken to help the person to make a decision. (See section 5.1). Where capacity is questioned, the 2- stage test must be applied as follows.

Part 1: Is there an impairment of or disturbance in, the functioning of the person's mind or brain?

NB: Impairment or disturbance in the functioning of the mind or brain may include: Mental Health issues, dementia type illnesses, Brain injuries, Learning disability, acute confusion or delirium, alcohol/substance misuse, post anaesthesia.

It must be noted that this list is not exhaustive, and the presence of one or more of these conditions does not automatically indicate that the person lacks capacity

- If there is no such impairment, the person cannot be said to lack capacity *under the MCA*.
- If there *is* an impairment or disturbance in the functioning of the brain the second part of the test must be applied.

Part 2: Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

The Act goes on to set out the following four criteria for deciding if a person lacks capacity:

Is he able to;

- understand the information relevant to the decision, **and**
- retain that information, **and**
- use or weigh that information as part of the decision making process, **and**
- communicate the decision (whether by talking, using sign language, visual aids or any other means)

If the person is unable to meet **one or more** of the above criteria, he can be determined to lack capacity.

4.3.2 When carrying out a Mental Capacity Assessment it is important to remember;

- For some people with impaired cognitive functions, their ability to meet some or all of these criteria will fluctuate over time.
- The ability to retain information for a short period only should not automatically disqualify the person from making the decision – it will depend on what is necessary for the decision in question. Aids, such as notebooks, photographs, videos and voice recorders, if available, may also be used to assist retention and recording of information.
- An individual may have capacity to make certain decisions, but at the same time may lack the capacity make other, more complex decisions.

- When assessing capacity to make a particular decision, the assessment should be made at the time the decision needs to be made. Where it involves more than one decision, each decision must be considered in turn, as a person may have capacity to make one decision but lack capacity to make another.
- A person should not be treated as unable to make a decision because he makes an unwise decision or one which appears irrational.

4.3.3 Who should assess for capacity

Chapter 4

- Every professional working in health and social care will almost certainly at some time in their working life need to assess capacity.
- The best person to assess capacity is dependent on the decision which needs to be made. For most day-to-day decisions, such as when to get up or what clothes to wear, the carer most directly involved with the patient needing the care will be best placed to assess the patient's capacity to make the decision at the time it needs to be made.
- When consent for medical treatment or examination is required, the doctor/clinician *proposing the treatment* should assess whether the patient has the capacity to consent or refuse the treatment.
- In circumstances such as legal matters, (for example, making a Lasting Power of Attorney), the patient's solicitor, if involved will need to decide whether the patient has sufficient capacity to make the decision. They may ask for an assessment from a Health Care Professional.
- For care planning issues, such as decisions whether or not to move into residential care, assessments regarding the ability to make an informed decision can be made by a doctor, or the social Worker proposing the plan of care.

4.3.4 Helping people to make their own decisions

Chapter 3

- The Act requires that all practicable steps be taken to help someone make their own decisions, before they can be regarded as unable to do so.
- All information relevant to the decision must be explained to the person, but a balance must be struck between giving insufficient information to make a decision, and giving too much information or in too much detail, which could be confusing.
- Simple language should be used, avoiding jargon. Use of pictures or objects could be helpful.
- Family, carers and others who know the patient well, can advise on the most effective methods of communication with the person.

- The presence of relatives, friends or other people who know the patient, can assist communication.
- Communication aids may be necessary.
- Most people find it easier to make decisions when they are in an environment where they feel more at ease. Consider the most appropriate location for the patient. A familiar place is often the most suitable, if practicable.
- Consider the timing of the decision, as some people's functioning may vary between different times of the day, or may be affected by particular medication.
- Where the patient can be helped or supported to make choices or express a view by someone else, such as a relative or an independent advocate, arrangements must be made to provide that support.

4.3.5 Actions to be taken when someone lacks capacity to make decisions

Chapter 5

Once it has been determined that a person lacks the capacity to make a specific decision, it must be remembered that any decision made for or on behalf of that person must be done so in his **best interests**. This incorporates the requirement to always act to maximise the patient's dignity and self-respect.

In determining what is in a patient's best interests, the Act sets out a statutory checklist of factors, which must **always** be taken into account when a decision is made for a patient lacking capacity. The key issues for the decision-maker are:

- Consider whether the person may regain capacity, and if this is likely, can the decision wait?
- The person must be encouraged and supported to participate in the Best Interest meeting.
- Determination of Best Interest must not be solely made on the basis of a person's appearance, age behavior or condition – this may lead to unjustified assumptions about what may be in the person's best interest. – do not discriminate.
- Consider the beliefs and values that would be likely to influence the persons decision if he had capacity.
- Consider all circumstances relevant to the decision to be made.
- Consider clinical judgement in respect of the benefits or limitations of any proposed treatment.
- Take into account the views and wishes of any interested parties.

Please remember that a relative **cannot solely** make a decision on behalf of another, unless they have legal authorization to do so, EG Power of Attorney. (See section 4.5). However, they can, and should be involved in any discussion, and their views considered.

Please see; **Appendix 1 Quick guide flow chart for Mental Capacity and Best Interest**
Appendix 2 MCA1- Capacity Assessment form
Appendix 3 MCA 2 - Best Interest form

4.3.6 Documentation

- Initial nursing assessment documentation should include a prompt for staff to record whether or not the patient has the capacity to consent to admission and treatment.
- Daily plan of care should have a prompt to remind staff that they should have regard to the Mental Capacity Act when caring for those patients having been assessed as lacking capacity - It will not then be necessary to document the assessment of a patient's mental capacity for all routine and low-risk interventions (such as providing personal care or taking a blood sample) on each intervention. However. ***Remember, capacity can fluctuate in some patients.***
- When assessments of capacity to make decisions regarding significant matters are required, it is essential for health and social care professionals to clearly document the process of the assessment, using the MCA 1 form, and filing within the clinical records. This may include decisions around discharge planning, and accommodation, (Patients going into a care home for the first time) or decisions about serious medical/surgical treatment or intervention, or decisions around Do Not Attempt Resuscitation. An example of the form can be found in Appendix 1. It is important that the nature of the decision to be made is clearly defined within the form.
- For those individuals lacking capacity to make significant decisions (see above) a Best Interest Decision should be made.
- Not all best interest decisions will require a formal meeting; this will be determined by the significance of the decision to be made. For less significant decisions, a simple phone call, or an informal/virtual meeting would be appropriate. However, where the decision is unusually complex, or complicated, or if it is likely to be controversial, a formal Best Interest meeting should be held. This should involve any person relevant to the patient, including family members and be in accordance with the Best Interest checklist (section 4.3.5) it may be part of a Multi-Disciplinary meeting, or a stand-alone meeting. In either case, the nature of the specific decision to be made should be clear. The outcome of the Best Interest meeting should be documented on form MCA2.

4.3.7 Capacity and consent

- When a patient requires a treatment or significant intervention which *does* not require written consent, and there is doubt about his capacity to consent to this treatment, a Mental Capacity Assessment should be carried out and documented using the MCA1 and MCA2'.
- If the patient requires treatment or significant intervention which requires written consent, a consent form 4 should be completed as described in the Consent to Examination or Treatment Policy – (PAT/PA 2.)

This form documents the assessment process and the rationale for the Best Interest Decision taken in relation to the proposed intervention, so would negate undue duplication.

4.4 The Independent Mental Capacity Advocate (IMCA) Service

Chapter 10

The need for additional safeguards has been identified in the following situations, for particularly vulnerable people **i.e. people who lack capacity and who have no one else to support them, (and are therefore referred to as ‘unbefriended’)**.

The Code of Practice will provide clear guidance on the invocation of IMCA’s and the roles and responsibilities within the application of this service. There is a statutory duty under the Act for the key decision maker to refer an individual to the IMCA service in the following circumstances:

- An NHS body is proposing to provide serious medical treatment.
- An NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in a hospital, (or care home), and the person will stay in hospital longer than 28 days, (or in the care home longer than 8 weeks).
- In addition to the situations described above, an IMCA can also be appointed to support and represent a person who lacks capacity, **‘even if they have friends and/or family, and are therefore not ‘unbefriended’**, where it is alleged that the person is, or has been abused or neglected by another person or persons, or it is alleged - or suspected that a friend or family member is not acting in the person’s best interest.
- The IMCA will also have legal authority to take copies of or examine any records which the record holder considers may be relevant to the advocate’s role and to obtain a further medical opinion if considered necessary for treatment decisions.
- The IMCA service is not a 24hour service, so regard must be given to emergency situations, where contacting an IMCA would not be timely. In these instances the patient’s Best interest and preservation of life should always be the first consideration.

The organisations providing IMCA services for the Trust are;

- Doncaster; **‘Voiceabilty’**
Tel: 0300 330 5499
Fax: 0208 330 6622
- Bassetlaw; **‘Your choice, Your voice’**
Tel: 0300 0200093

4.5 Lasting Power of Attorney (LPA)

Chapter 7

4.5.1 Section 9 – 14 of the Act provides another means for people to plan for a time when they may lack capacity. An individual (*the donor*) makes the power when they have capacity and it gives another person or persons (*the donee/s*) the authority to make decisions on the donor’s behalf, when they are unable to do so for themselves.

To make a lasting power of attorney the person must be at least 18 years of age and have capacity. The donee must also be 18 years or over.

More than one person may act as an attorney for someone by acting either jointly or severally. If acting jointly both attorneys must agree each decision that is made. If acting severally, any of the attorneys appointed can make decisions unilaterally without the involvement of the others.

Before the LPA can be used, it must be registered with the Office of the Public Guardian. Without registration, an LPA cannot be used at all.

There are two categories of Lasting Power of Attorney.

- **Personal welfare**, including healthcare and medical treatment. These LPA's can cover such decisions as where the adult should live, consenting to, or refusing medical examination and treatment, including life-sustaining treatment.
- **Property and affairs** can cover managing bank accounts, dealing with tax affairs, dealing with day to day spending.

4.5.2 Where the donor authorizes the donee to make property and affairs decisions, the donee can make those decisions as soon as the LPA is registered, **even if the donor retains capacity** if the donor directs them to do so.

4.5.3 Where the donor authorises the attorney to make personal welfare decisions the donee can only makes decisions on behalf of the donor **once he lacks the capacity** to make his own decisions.

4.5.4 Some patients may present with an 'ENDURING Power of attorney (EPA). This was the official authority to act on someone's behalf prior to the Mental Capacity Act (2005) replacing them with the Lasting Power of Attorney. They relate only to the management of property and affairs, and *not* personal welfare.

4.5.5 If a person has a Lasting/Enduring Power of attorney, staff must see the document related to it, in order to verify its contents. The donee should be able to produce the original document. This has an embossed emblem within the document, to ensure its authenticity.

4.5.6 If the donee is unable, or reluctant to produce documentation, the patient should be treated as though no such document exists, until verification is received.

To verify a LPA/EPA, contact the Safeguarding Team who are able to apply to the Office of the Public Guardian for information about donors and donees. It typically takes 5 working days for a response to be received, so until it has been received, the patient should be cared for as though it doesn't exist.

Since the Act came into force, only LPA's can be created, but existing EPA's will continue to be valid if they can be verified as above.

4.6 Advance Decision to Refuse Treatment

Chapter 9

In October 2007, as part of the Act, Advance Decision to Refuse Treatment (ADRT) became subject to statutory law, rather than case law, as had been the case prior to this date.

- An ADRT enables someone of 18 years or older to **refuse** specific medical treatment at a time in the future when they may have lost capacity.
- It is made by the person when he has capacity and becomes effective if he should lose capacity

Information relating to the management of an ADRT can be found in the Advance Decisions to Refuse Treatment (ADRT) Policy - PAT/PA 27.

4.7 Young Persons aged 16 or 17 years

Chapter 12

4.7.1 Most of the Mental Capacity Act (2005) applies to young persons aged 16 years and over.

- In respect of young persons, the provisions made under the Children Act 1989 are not displaced by the Mental Capacity Act, but an overlap exists between the provisions.
- In order for the decision-making arrangements set out in the Mental Capacity Act to apply to young persons, they must lack capacity within the meaning of the Act.

4.7.2 Provisions of the Act not available to 16 or 17 year olds

- LPA's may only be made by a person who has reached the age of 18.
- Whilst persons of 16 and 17 years old who have capacity, may give consent to medical treatment at the time it is offered, they have no power, under the Act to make an Advance decision, until they reach the age of 18. 16 and 17 year olds should be treated in accordance with the Children's Act 1989.
- The Court of Protection can only make a will for those people over the age of 18 who lack the capacity to do so for themselves.
- The Deprivation of Liberty Safeguards can only be applied to those people having attained the age of 18yrs. (See section 5 for further information about Deprivation of Liberty.)

4.8 Acts in connection with care or treatment

Chapter 6

Section 5 of the Act provides 'Protection from liability' where a person is providing care or treatment for someone who lacks capacity. Actions covered by this section of the Act include;

- Assistance to maintain the activities of daily living, eg nutrition, hygiene, mobility etc.
- Healthcare and treatment, e.g. carrying out diagnostic tests, giving medication, giving medical treatment etc.

Actions are only protected from liability if they can be shown to be taken in the Persons best interest

4.9 The use of restraint under the MCA

Restraint, under the Mental Capacity Act is defined as:

- To use – or threaten to use force- to make someone do something that they are resisting, or
 - To restrict a person’s freedom of movement, whether they are resisting or not.
- In circumstances where restraint needs to be used, staff restraining a person who lacks capacity will be protected from liability (for example, criminal charges) if certain conditions are met.
 - The person taking the action must reasonably believe that restraint is necessary to prevent harm to the individual *and*
 - The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.
 - The use of restraint must be carried out with reference to the Trust policy PAT/PS 15 - Restrictive Practice Policy: Clinical holding, restraint and restriction. This policy emphasises that any restraint should be proportionate i.e. the least restrictive which means the shortest time possible and only used when reasonable to do so.

5 DEPRIVATION OF LIBERTY

In some instances, the care necessary to protect a person from harm may amount to that individual being deprived of their liberty. The Deprivation of Liberty Safeguards came into force on 1st April 2009. The safeguards have been put in place to protect the most vulnerable people in society, and ensure that deprivation of liberty, where it does need to occur, is lawful.

This policy should be used in conjunction with the Deprivation of Liberty Code of Practice, where comprehensive information relating to this section can be accessed via this link:



The relevant chapter in the code is indicated by;

Please see appendix 4 – Recognising Deprivation of Liberty.

Chapter xx

5.1 What are the Deprivation of Liberty Safeguards?

Chapter 1

In addition to the main Act, the Government added a new provision to the Act, the Deprivation of Liberty Safeguards (DoLS) which became a statutory obligation in April 2009.

These Safeguards were introduced to protect the most vulnerable people in our society. This section of the Act applies to those adults of 18yrs or over.

Young people of 16 and 17yrs can be deprived of their liberty; however, they are not able to be detained under the Deprivation of Liberty Safeguards. Detention of young people can only be authorised by:

- The Court of protection/inherent jurisdiction
- Under the Mental Health Act 1983

Please refer to the Safeguarding children policy, and the Children Act

The Safeguards were introduced to prevent breaches of the European Convention on Human Rights (ECHR), following a case concerning an adult man with Autism, who lacked the capacity to decide whether to be admitted to a hospital for treatment. He was admitted under common law, in what was considered to be in his best interest. His carers challenged this decision and the European Court of Human Rights ruled that the Deprivation of Liberty had not been in accordance with a procedure prescribed by the law and was therefore unlawful.

The Safeguards apply to those adults who lack the capacity to make a decision about their care and/or treatment, where it has been determined that the proposed care or treatment is in that person's best interest and the person is in a hospital or Care Home. The deprivation of a person's liberty is a serious matter, and should only happen if absolutely necessary; however if the process is used appropriately, such a deprivation will be lawful.

The Mental Capacity Act (2005), and the Deprivation of Liberty Code of Practice make it clear that to deprive a person of his Liberty is a serious matter and the decision to do so should not be taken lightly, The Code of Practice states that a person should only be deprived of his liberty if;

- He lacks the capacity to consent to care and treatment
- It has been determined that it is in his best interest to protect him from harm.
- It is a proportionate response to the likelihood and seriousness of the risk of harm
- It is the least restrictive option.

If the above criteria are met, and the process used appropriately, then the Deprivation of Liberty will be lawful.

NB. The Deprivation of Liberty Safeguards **do not** apply to those people who are detained under the Mental Health Act.

5.2 Prevention of Deprivation of Liberty - The best approach to dealing with a Deprivation of Liberty situation is to prevent it happening in the first place. This may be achieved by robust care planning. The Managing Authority (the organisation providing the care) should seek to ensure that all interventions are the least restrictive for the patient. Care plans should readily identify the manner in which care is to be given and care plans should be regularly updated. Restrictions of Liberty should be reduced as the patients condition allows.

The involvement of family, carers and friends is important and they should be kept informed of the situation at all times.

5.3 Recognise and Identify

Chapter 2

On the introduction of the Deprivation of Liberty Safeguards, several factors were taken into account when identifying that a person may be deprived of their liberty.

There was no single definition of Deprivation of Liberty. The circumstances and facts are likely to be different in each situation and for each individual

- Is the person making meaningful attempts to leave the ward?
- Is he having 1 to 1 care or supervision?
- Does he need regular sedation/mood changing medications?
- Is restraint being used?

The most difficult task for the Organisation was to be able to recognise when someone was being deprived of his liberty.

5.3.1 The Acid Test

On March 19th 2014, the Supreme Court handed down its judgement in 2 unrelated cases. The first involved two sisters aged 17 and 18, both of whom had learning difficulties. The second case involved a man with Cerebral Palsy. In both cases the judgement determined that the individuals ***were being deprived of their liberty***, even though they had previously assessed as ***not being deprived of their liberty***.

Following this judgment, the Supreme Court confirmed that to determine whether a person is being deprived of his liberty, there are *two key questions* which must be asked. This is described as ***“the acid test”***.

- Is the person subject to **continuous supervision** and **control**?

(The oversight must be continuous, though does not have to be ‘in line of sight’ - it must amount to supervision, and have an element of control.) **and**

- Is he **free to leave**?

The person ***need not*** be asking to leave, or making a meaningful attempt to leave and does not simply apply to him leaving the ward to go outside for a cigarette, or to visit the coffee shop etc.

Free to leave is defined as “removing himself permanently from the ward or department.” (i.e. Being discharged).

The individual’s compliance or lack of objection, is no longer relevant to the decision when determining if he is being deprived of his liberty, nor is the fact that a patient may not be physically able to remove himself from the ward.

For a person to be deprived of his liberty both elements must be present – i.e. he must be subject to **supervision and control** and **not free to leave, (be discharged.)**

If, on completing the Acid Test, it is believed that a patient is, or may be deprived of his liberty, a request for Deprivation of Liberty Safeguards must be made.

- If it is anticipated that a patient will, or may be, deprived of his liberty within the next 28 days a **standard authorisation** should be applied for (**For example**; if a patient is having a planned admission, and it is likely that the circumstances of that admission will amount to him being deprived of his liberty).

5.4 Process for requesting Deprivation of Liberty Safeguard.

- Once it has been determined that a patient may be deprived of his Liberty, the Trust, as Managing Authority has a duty to apply to the Supervisory Body, for Deprivation of Liberty Safeguards as above.
- It is the responsibility of the Care group to complete the request form, - form 1 (Urgent and Standard Authorisation) and forward it to the Safeguarding Team, at safeguardingadultsreferral@nhs.net for those patients residing in Doncaster, or referdols@nottscg.gov.uk for those residing in Bassetlaw.
- **Please note**, an **urgent authorisation** must be granted if the patient meets the Criteria, and at **the same time**, a request for **standard authorisation** must be made to the Supervisory Body. (Form 1 covers both aspects of the referral) **essentially, we are not able to grant an urgent authorisation in isolation.** - Form 1 (Urgent and Standard Authorisation) can be accessed via the intranet, on the policies page or the Safeguarding page using the following link. http://intranet/Corporate-Directorates/Nursing-Quality/Safeguarding_Adults.aspx
- The Safeguarding Adults Team will process the form, and grant an Urgent authorisation, where the criteria are met. The safeguarding Team will then forward the Request to the appropriate DoLS team, to request assessment for Standard Authorisation.
- The supervisory Body will arrange for the assessments to take place, and communicate details of the assessments with the ward caring for the patient. It is the responsibility of the Managing Authority to accommodate these assessments and allow access to the assessors to the patients Health Care records.
- If the assessments determine that the person is being deprived of his liberty, the Trust will work together with the Supervisory Body to review the authorisation as required, and remove the authorisation if no longer required.
- The Supervisory Body will appoint a 'Persons Representative' (See definitions) who will maintain contact with the person, and support the person in matters relating to the Deprivation of Liberty. The Managing Authority will work with this individual, to ensure that the person's best interests are met.
- The assessors may attach conditions to the authorisation, for example, they may make recommendations about contact with family/friends, or about the way that certain aspects of care are being delivered. It is the responsibility of the managing authority to ensure that these conditions are adhered to.

- The Trust will work with the Supervisory body to ensure that the Deprivation of Liberty Safeguards Authorisation process is followed.
- Further advice can be sought from the Safeguarding Team within the Trust on extension 642437, or the Local Authority Leads for DoLS;

Doncaster - MCA/DOLS Team
 Tel; 01302 736944
 E-Mail; dols@doncaster.gov.uk

Bassetlaw – Nottinghamshire DoLS team;
 Tel; 01158 040128
 Fax; 01623 434063
 E-Mail; referdols@nottsc.gov.uk

5.5 Interim arrangements

The Law Commission held a review of the DoLS process nationally, and changes to the process are expected. However, there is no timescale as yet disclosed for these changes to be implemented. In the interim period the Trust and the Local Authorities have agreed that the following arrangements will stand

5.5.1 Arrangements for those patients who are likely to regain capacity, or be discharged within a few days.

Section 5.4 of the Code of Practice states that:

- The Trust is able to grant an urgent authorisation ***only at the same time as they request a standard authorisation.***
- An urgent authorisation lasts for a period of 7 days, to enable the Supervisory Body to carry out assessments, and issue a Standard Authorisation for a specified length of time

Many patients will temporarily lack capacity to consent to admission and treatment due to an acute illness, for example infection, sepsis alcohol/substance misuse, collapse, brain injury, reduced consciousness or any other acute event. It is possible that this group of people will regain capacity on treatment of the illness causing the lack of capacity. The Trust believes that 3-4 days is an appropriate timescale to determine if the person is responding to treatment, and if capacity is expected to return.

For this group of people, during the initial phase of their admission they can be cared for under section 5 of the Mental Capacity Act – that is acting in their Best Interest. The Act requires the decision maker to consider if there is likelihood that the individual will regain capacity. (Section 5.25)

- If the patient does regain capacity, then he no longer meets the criteria for the Deprivation of Liberty Safeguards, and can himself consent to being in hospital, or indeed is at liberty to take his own discharge if he wishes to do so.

- The patient may be discharged, even though he lacks capacity if he is medically fit, and appropriate discharge planning has taken place. A DoLS request will not then be required.
- If the patient doesn't appear to be regaining capacity a request for Deprivation of Liberty Safeguards may need to be considered.
- The Code of Practice states that the urgent authorisation can only be applied at the same time as a standard authorisation is requested, therefore, if it is likely that the patient will be discharged before the seven day urgent authorisation runs out, a DoLS request is not applicable, and the patient will continue to be cared for in their best interest.
- It is important that the ward caring for the patient informs the safeguarding team if the patient regains capacity, is discharged or passes away, as the request for assessment will need to be cancelled.

5.5.2

Due to the increase in the number of requests being made to the Local Authority, many patients are not being assessed in a timely manner, and indeed are being discharged, or sadly passing away before the assessments can be completed. As an interim measure, an extension to the urgent authorisation is automatically applied for at the same time as the initial request is made. This then enables the patient to be lawfully detained for 14 days prior to assessment. We do not need to complete any further paperwork in respect of extending the urgent authorisation

5.6 Death of a patient whilst subject to Deprivation of liberty authorisation

- The Coroners (Inquests) Rules 2013 came into effect on 25th July 2013. These rules stated that care homes and hospitals have a duty to notify the coroner of any death occurring whilst the deceased was subject to detention under the Deprivation of Liberty safeguards. The coroner then had a duty to hold an inquest. The rules formalised this as a legal duty.
- From Monday 3rd 2017 April the Coroners and Justice Act was amended so that Coroners will no longer be under a duty to investigate a death simply because the deceased is subject to DoLS.
- However, a deceased person should still be referred to the Coroner if he would have been if the DoLS authorisations had not been in place – i.e. if there is another reason for the referral to take place.

6 TRAINING/ SUPPORT

The training requirements of staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead.

7 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Knowledge of staff within the Trust around the Mental Capacity act 2005.	Safeguarding Adults Team	Quarterly	Audit results are shared with the relevant Head of Nursing/Midwifery/Therapy. The results will be reported to the Trusts Strategic Safeguarding People Board and via the annual/ quarterly safeguarding report
Compliance with the Act, by auditing Care records	Safeguarding Adults Team	Quarterly	
Quality of DoLS requests submitted	Safeguarding Adults Team	Quarterly	

8 DEFINITIONS

- 8.1 Advance Decisions to Refuse Treatment,** (Previously known as Advance Directive or a living will). A decision made by any person aged 18 or over, whilst having mental capacity, to refuse specified treatment or intervention at a later time, should he lose capacity to make such decisions. (Section 13) This may include life sustaining if the document is valid. (See Advance Decisions to Refuse Treatment (ADRT) Policy PAT/PA 27.)
- 8.2 Best Interests:** When a patient has been assessed as lacking capacity, any action taken, or decisions made on his behalf, should be done in his best interest. The Act provides a checklist of factors that a decision maker must consider. (Section 10)
- 8.3 Cognitive functions:** The mental process involved in thinking, perceiving, reasoning, comprehending and remembering. Impairment of cognitive function is assessed by measuring orientation, attention, recall and language. (Section 6.3)
- 8.4 Consent:** is a patient's agreement for a health professional to provide care. Patients may indicate consent verbally, non-verbally, or in writing. For consent to be valid, the patient must be competent to take the particular decision, have received sufficient information to take it and not be acting under duress.
- 8.5 Decision Maker:** The person who is required to assess a patient's capacity. This will change with the situation. In most instances, the carer most involved with the patient will be the best person to make a decision, at the time it needs to be made. See Section 4.3.3 – Who should assess for capacity.
- 8.6 Deprivation of Liberty.** There is no single definition of Deprivation of Liberty. It only applies to those people who have been assessed as lacking capacity under the Mental Capacity Act (2005) to decide upon, or consent to the care and treatment he is

receiving, In order to determine if an adult is being deprived of his liberty, the acid test is used carried out (See section 5.3) The MCA makes it clear that a person may only be deprived of his liberty if it is in his best interest, if it is a proportionate response to the likelihood that he would come to harm if the Safeguards were not in place, and if it is the least restrictive alternative. See section 5 for further guidance.

- 8.7 Enduring Power of Attorney (EPA)** The authority in force prior to the MCA, which enabled someone to act on another's behalf in the event of his losing capacity. The Lasting Powers of Attorney replaced these when the Act came into force. The EPA *only* related to finances and property. There may still be some EPA's in existence, and these remain lawful. Please speak to the Safeguarding Adults Team if you have any queries.
- 8.8 Independent Mental Capacity Advocate (IMCA) Service:** A service set up to further support particularly vulnerable patients, who have no one to act on their behalf. (see section 4.4)
- 8.9 Lasting Power of Attorney.** A legal document whereby an individual (The donor) authorises another person (The donee) to act on his behalf, in the event that the donor should lose the capacity to make his own decisions. This authority can be in respect of property and financial affairs, and/or personal welfare and decisions to consent to medical treatment. (Section 12)
- 8.10 Managing Authority:** The managing Authority is the organisation with responsibility for the care of the patient who is, or may be deprived of his liberty. This can be either a hospital, or a Care Home. For patients within the Trust, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust will be the Managing Authority.
- 8.11 Mental capacity:** the ability of an individual to make specific decisions regarding specific elements of his life, at the appropriate time. It was previously also sometimes referred to as 'competence'.
- 8.12 Mental incapacity:** 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. This lack of capacity may be permanent, or temporary.
- 8.13 Relevant Person.** A person who is, or may be deprived of his liberty is known within the Codes of Practice as 'the relevant person'.
- 8.14 Relevant Persons Representative (RPR)** The supervisory body will appoint a Person's representative to support the person Deprived of his Liberty. This person may be a friend or relative. If there are no suitable friends/relatives, the Supervisory body will appoint a 'paid representative' to fulfil the role. The RPR will provide independent support, and ensure that the best interest of the patient is met. He/she must keep in contact with the relevant person throughout the duration of the authorisation.
- 8.15 Restraint:** The use, or the threat of force to make a person do something they do not want to do, or are resisting. *Or* restriction of a persons freedom of movement whether they are resisting or not.

8.16 Standard Authorisation. An authorisation which is given by the Supervisory Body, after completion of the statutory assessments, giving lawful authority to deprive the relevant person of his liberty, in his best interest.

8.17 Supervisory Body: The Local Authority responsible for the locality in which the relevant person is or is likely to be deprived of his Liberty, and to whom an application for a Deprivation of Liberty Safeguard is made. The Supervisory Body for patients within the Trust, who are or may be deprived of their Liberty, will be Doncaster Metropolitan Borough Council, or Nottinghamshire County Council, dependant on the person's usual place of residence.

8.18 Urgent Authorisation. An authorisation given by the Managing Authority (Hospital, or Care Home) which gives legal authority for the relevant person to be deprived of his liberty, in his best interest, whilst the standard authorisation process is undertaken. It will last for 7 days, and a standard authorisation must be applied for at the time the urgent authorisation is issued. An urgent authorisation will be granted by the Safeguarding Adults Team.

9 EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (see Appendix 5).

10 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

[PAT/PA 28 - Privacy and Dignity Policy](#)

[PAT/PS 8 - Safeguarding Adults Policy](#)

[PAT/PS 15 - Restrictive Practice Policy](#)

[PAT/EC 2 - Do Not Attempt Cardiopulmonary Resuscitation \(DNACPR\) Policy](#)

[PAT/PS 10 - Safeguarding Children Policy](#)

[PAT/PA 27 Advance decision to refuse treatment \(ADRT\) Policy](#)

[PAT/PA2 - Consent to Examination or Treatment Policy](#)

11 REFERENCES

Department of Constitutional Affairs

Mental Capacity Act (2005): Code of Practice, 2007

www.dca.gov.uk

Department of Constitutional Affairs

Mental Capacity Act (2005): Summary,

www.dca.gov.uk

Department of Health

Mental Health Act 1983

www.dh.gov.uk

Department of Health

Mental Health Bill 2006-07

www.dh.gov.uk

Department of Health

Deprivation of Liberty code of practice 2008

Office of Public Sector Information

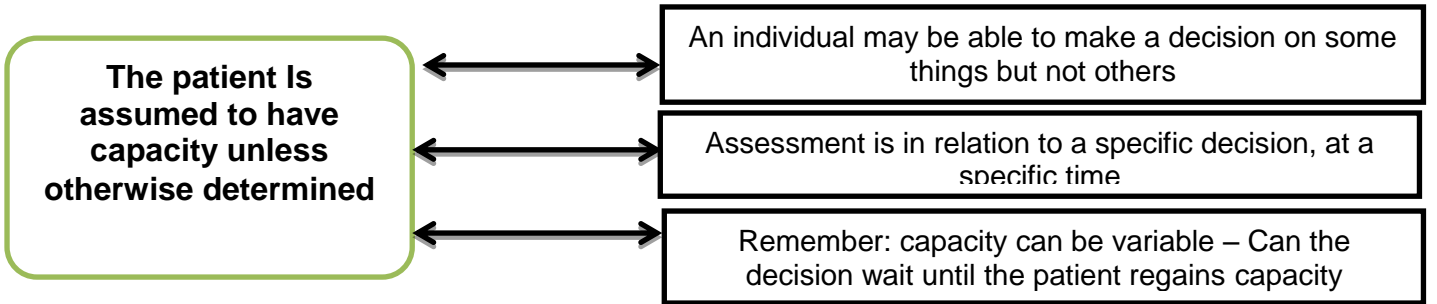
Human Rights Act 1998 www.opsi.gov.uk

Doncaster Joint Agency Agreement 2013

Mental Capacity Act

APPENDIX 1 – MENTAL CAPACITY AND BEST INTEREST FLOW CHART

MENTAL CAPACITY – A QUICK GUIDE



Does the person have an impairment in the functioning of the mind or brain?

Yes: The person *may* lack capacity carry out assessment

No: Person is said not to lack capacity. He can make decisions for himself. No further action required

Can the person:
 Understand the information
 Retain the information
 Use the information in order to make an appropriate decision
And
 Communicate his decision

Person should be assisted to make his own decision where possible -

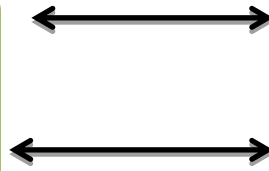
Person should not be assessed as lacking capacity simply because he makes an unwise decision

Yes:
 Person is said to have capacity, and can make decisions – even if they seem to be unwise -

No.
 Patient is said to lack capacity. Decisions to be made must be in his best interest

BEST INTEREST – A QUICK GUIDE

The patient has been assessed as lacking capacity



Decision on behalf of someone who lacks capacity should be taken in their Best Interest

Care or treatment carried out on behalf of someone lacking capacity should be the least restrictive option

Is the decision to be made significant?



Yes. When significant decisions are required eg. consent to treatment, transfer into Residential Care etc, A **Best Interest Meeting** should take place and a record of the decision must be made using form **MCA1** and **MCA2**



No:
Best interest decision to be made by the person proposing care or treatment : It is not necessary to document each low risk intervention
eg providing personal care, taking a blood

A Best Interest Meeting should:

- Involve the individual as much as is possible
- Consider if the individual is likely to regain capacity
- Take into account the persons past wishes, feelings and beliefs
- Consider all relevant circumstances related to the decision to be made
- Involve 'significant others' e.g. family, friends etc.
- Include anyone involved in the persons care.
- Not include decisions taken solely on age, appearance or condition of the individual
- Involve an IMCA if the individual has no-one else to consult, or if it is alleged, or suspected that a friend or family member is not acting against their best interest

REMEMBER.

For further information or guidance, contact the safeguarding team on ext 6468/4683

APPENDIX 2 – MCA 1 RECORD OF MENTAL CAPACITY ACT

A person must be assumed to have capacity unless it is established that they lack capacity to make a particular decision at the point in time the decision needs to be made.

A person’s capacity must not be judged simply on the basis of their age, appearance, condition or an aspect of their behaviour. It is important to take all possible steps to try to help the person to make the decision themselves. **An assessment should only be triggered if you have ‘reasonable belief ‘that the person may have difficulty making the decision. However where there is an impairment of or a disturbance in the functioning of the person’s mind or brain use of the Act should be considered.**

Name of Relevant Person		Reference number	
Name of Decision maker carrying out the Assessment		Role	
Date assessment started		Team	

As Decision maker you are assessing the person mental capacity to make this particular decision at this particular time. **If there is more than one decision to be made they must be assessed and recorded separately.**

Clearly state the decision to be made:

Do you need to involve anyone to help you to communicate with the person? Do you need anyone else to provide information or give their opinion? Please give the name and status of anyone who assisted with this assessment:

Name	Status	Contact Details

STAGE 1 - DETERMINING IMPAIRMENT OR DISTURBANCE OF MIND OR BRAIN

The Act requires assessors to have “reasonable belief” that a person lacks capacity in relation to a decision. If there is an established diagnosis of mental illness, learning disability, or some other condition then it is sufficient to confirm” impairment or disturbance of the mind”. You do not need to involve other professionals unless the assessment is complex, when they can be asked to assist or provide a diagnosis.

	Response		Evidence
	Yes	No	<i>If Yes record symptoms, behaviours and any relevant information</i>
Q1. Is there an impairment of, or disturbance in the functioning of the persons mind or brain? (e.g. symptoms of alcohol or drug use, delirium, concussion following head injury, conditions associated with some forms of mental illness, dementia, significant learning disability, long term effects of brain damage, confusion, drowsiness or loss of consciousness due to a physical or medical condition)	√		

If you have answered **YES** to Question 1, **PROCEED TO STAGE 2**

If you have answered **NO** to Question 1, there is no such impairment or disturbance and thus **THE PERSON DOES NOT LACK CAPACITY** within the meaning of the Mental Capacity Act 2005

Sign/date this form, record the outcome within the person’s case records. **DO NOT PROCEED ANY FURTHER.**

Record of a Mental Capacity Assessment – For adults age 16 and over

STAGE 2 - ASSESSMENT			
<p>Having determined impairment or disturbance (Stage 1) and given consideration to the ease, location and timing; relevance of information communicated; the communication method used; and others involvement, you now need to complete your assessment and form your opinion as to whether the impairment or disturbance is sufficient that the person lacks the capacity to make this particular decision at this moment in time. You must ensure that the information has been provided in a way that the person is able to understand?</p>			
	<p>Response</p> <p>Yes No</p>		<p><i>You must provide evidence of the steps you have taken as to how you came to your opinion</i></p>
<p>Q2. Is the person able to understand the information relevant to the decision to be made? Do they understand the nature and effect of the decision and the reason why it is needed? Are they able to understand the consequences of making or not making the decision?</p>			
<p>Q3. Is the person is able to retain the information for long enough to make an effective decision? People who can only retain the information for a short time must not be presumed to lack the capacity to decide - it depends on the importance of the decision to be made</p>			
<p>Q4. Is the person is able to use or weigh up the information to arrive at a decision? Sometimes people can understand information but impairment can and stop them using it.</p>			
<p>Q5. Is the person able to communicate their decision? All steps must be taken to aid communication.</p>			
<p>If you have answered YES consistently to Q2 to Q5, the person is considered on the balance of probability, to HAVE the mental capacity to make this particular decision at this point in time.</p>			
<p>Sign/date this form and record the outcome within the person’s case records. DO NOT PROCEED TO MAKE A BEST INTERESTS DECISION</p>			
<p>If you have answered NO to any of the questions, proceed to Q6.</p>			
		<p><i>Please provide details of the outcome of your assessment</i></p>	
<p>Q6. Overall, do you consider on the balance of probability, that there is sufficient evidence to indicate that the person lacks the capacity to make this particular decision at this point in time?</p>			
<p>Signature</p>		<p>Date assessment completed</p>	
<p>If the person is unable to make the decision themselves, is there someone with a Registered EPA, LPA or a Court appointed Deputy, with powers to make the decision which needs to be made?</p>			
<p>If Yes: - They make the decision. Record their details on Appendix 1. Authorised decision makers will only be able to make decisions on matters covered by their EPA, LPA or Court order, although they should still be consulted when a best interest decision on other matters needs to be made.</p>			
<p>If No: - You are able to proceed to make Best Interests decision on their behalf but should consider at this stage whether or not an Independent Mental Capacity Advocate (IMCA) needs to be appointed.</p>			

APPENDIX 3 – MCA 2 RECORD OF BEST INTEREST DECISION

FORM MCA2

Record of a decision made in a person who lacks capacity Best Interests

Name of person best interest decision needs to be made for		Organisation Ref No.	
Name of Best Interests Decision Maker		Role	
Date best interest decision making process started		Team	

Details of the decision to be made on behalf of person who lacks capacity as detailed on the relevant MCA1
Please be clear about the decision which needs to be made For complex decisions such as Change of accommodation, serious medical treatment, use of restriction, restraint and contact issues which may amount to a Deprivation of the person liberty or where there is objection to a proposed action you should hold a Best interest meeting. If so please use **MCA3** for recording the meeting and the outcome

PART 1 DETERMINING LACK OF CAPACITY

	Response		Date	Comments Name of Assessor
	Yes	No		
Has the person been determined as lacking capacity to make this particular decision at this moment in time?				

If you have answered **YES**, **PROCEED TO PART 2** of this document.

If you have answered **NO**, identify decision(s) to be made and complete capacity assessment.

PART 2 – DETERMINING BEST INTERESTS

All steps and decisions taken for someone who lacks capacity must be taken in their best interests.

Have you appointed an IMCA?	Response		If Yes: - Provide details of outcome of the IMCA report You MUST NOT make a decision until you have received and considered their report.
	Yes	No	
Q1. If the decision relates to serious medical treatment or changes to accommodation and there is no one appropriate to act on the persons behalf, you have a Statutory duty to instruct and consult an Independent Mental Capacity Advocate. An IMCA may also be involved in safeguarding adults cases and care reviews where appropriate.			
Date of IMCA referral		Date IMCA report received	Name of IMCA

You must provide details of your findings and reasons for you opinion

Q2. Regaining Capacity – Have you considered if the person is likely to regain capacity i.e. after receiving medical treatment. Can the decision be delayed until that time?	
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<p>Q3. Encourage Participation – What have you done to encourage the person's involvement in the process? Please indicate if you have not been able to get the person to participate</p>		
<p>Q4. Identify and Consider all the relevant circumstances – Do you have all the background information relating to why the decision needs to be made? Give details</p>		
<p>Q5. Are there any additional factors such as family relationships that need to be taken into account?</p>		
<p>Q6. Consult Others – You have a duty, where practicable and appropriate, to consult with and take into account the views of other interested parties? This should include anyone engaged in caring for the person, close relatives and friends, persons previously named by the person as someone to consult, Attorney under a Lasting or Enduring Power of Attorney or Deputy of the Court of Protection and other professionals.</p>		
<p>Please give the name and status of anyone who you consulted with as part of the best interest process. You should ask them what they consider to be in the person's best interest and record any information they have about the person's wishes and feelings, beliefs and values</p>		
Name	Role/Relationship	Views of people consulted /reasons why person not consulted

Consideration of the person wishes and feeling, beliefs and values is an important part of the best interest process

<p>Q7. Have you been able to ascertain what the person's wishes and feelings are or would be if they were able to make the decision themselves?</p>	
--	--

The nearer the person is to having capacity the more weight you need to give to their wishes and feelings

<p>Q8. Does the person have any specific beliefs and values that need to be considered?</p>	
--	--

<p>Q9. Advance Decisions - Written Statements - Does the person have any AD or written statements about their future care and treatment which you may need to consider?</p>	
--	--

Q10. Considering the Options: **Ensure you have carried out the necessary risk assessments and this is reflected in the best interest option chosen. Ensure wherever possible the least restrictive option is chosen, whilst retaining best interests.**

Option 1	Advantages/Benefits	Disadvantages/Risks
Option 2	Advantages/ Benefits	Disadvantages/Risks
Option 3	Advantages/ Benefits	Disadvantages/Risks

Part 3 - FINAL DECISION

Reaching a Decision: You must not make assumptions about someone’s best interests based on the **person’s age, appearance, condition or behaviour**. You must always avoid restricting the person’s rights and provide care and treatment in the least restrictive way.

Q11. What is your final decision?

Please provide the reasons for your decisions and why other options were ruled out.

--

Actions undertaken in relation to care and treatment which involve the use of restraint are only lawful if they are necessary to prevent harm, are a proportionate response to the level of harm the person is likely to incur and do not deprive the person of their liberty.

Special Considerations – Where the decision relates to life sustaining treatment, you must ensure that the decision has not been motivated in any way, by a desire to bring about their death

Signature of Decision Maker

Date decision made

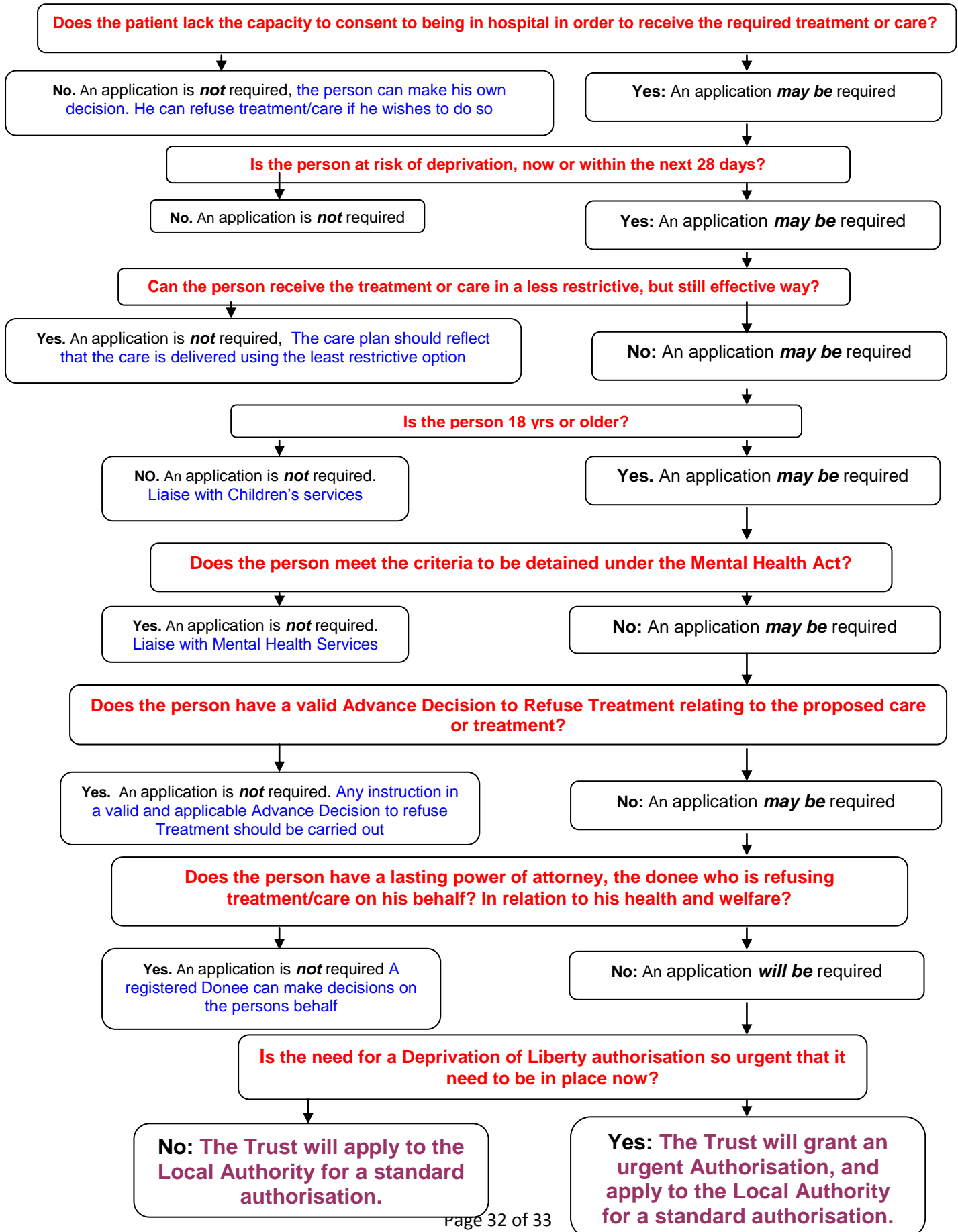
After the decision has been made

Q12. Has the relevant person been made aware of the decision?	Yes		No	
If no why please give your reasons why?				
Q13. How did they respond to the decision made?				
Q14. Have all interested parties be made aware of the decision?	Yes		No	
Q15. Do all interested parties agree with the decision?	Yes		No	
Q16. Do the Deprivation of Liberty Safeguards need to be considered?	Yes		No	

If the person or any interested party is unhappy with the decision that has been made you should consider, holding a formal best interest meeting to discuss the matter further This should be recorded on MCA3

APPENDIX 4 – RECOGNISING DEPRIVATION OF LIBERTY

Is the patient deprived of his Liberty?



APPENDIX 5 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

Service/Function/Policy/ Project/Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
PAT/PA19	Nursing and Quality	Pat Johnson	Existing Policy	04.05.18
1) Who is responsible for this policy		Nursing and Quality		
2) Describe the purpose of the service / function / policy / project/ strategy?			Inform all staff across the trust	
3) Are there any associated objectives? Legislation, targets national expectation, standards			MENTAL CAPACITY Act 2005	
4) What factors contribute or detract from achieving intended outcomes? –				
5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No				
<ul style="list-style-type: none"> • If yes, please describe current or planned activities to address the impact [e.g. Monitoring, consultation] – 				
6) Is there any scope for new measures which would promote equality?			No	
7) Are any of the following groups adversely affected by the policy?				
Protected Characteristics		Affected?	Impact	
a) Age		NO		
b) Disability		NO		
c) Gender		NO		
d) Gender Reassignment		NO		
e) Marriage/Civil Partnership		NO		
f) Maternity/Pregnancy		NO		
g) Race		NO		
h) Religion/Belief		NO		
i) Sexual Orientation		NO		
8) Provide the Equality Rating of the service / function /policy / project / strategy – tick outcome box				
Outcome 1 ✓		Outcome 2	Outcome 3	Outcome 4
<i>If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a Detailed Equality Analysis form in Appendix 4</i>				
Date for next review: June 2021				
Checked by Moira Hardy			Date August 2018	