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

This procedural document supersedes: PAT/PA 19 v.7 – Mental Capacity Act 2005 Policy and Guidance, including Deprivation of Liberty Safeguards

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Date written/revised:	February 2022
Approved by:	Strategic Safeguarding People Board (SSPB)
Date of approval:	24 February 2022
Date issued:	April 2022
Next review date:	February 2025
Target audience:	All Trust Staff

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 8	April 2022	• Updated Template. • Updated format, Page numbers etc. • Updated structure/job roles. • Updated contact details. • Section to introduce transition from DoLS to LPS. • Minor amendment to process for DoLS. • Updated policy reference.	Pat Johnson, Lead Professional, Safeguarding Adults
Version 7 (1 year only)	27 Jan 2021	• Section 4.3.5. Role of Next of Kin/family • Sections 4.5.7, 4.5.8 and 4.5.9 Additions to LPA process • Section 4.6 Addition re: Court Appointed Deputies • Section 4.7 Addition re: The Court of Protection • Updated sub-section numbering from 4.8-4.11 • Inclusion of Court Appointed Deputies and Court of Protection in to the Definitions section • Updated sub-section numbering from 8.7-8.20 • Updated page numbering	Pat Johnson
Version 6	6 Sept 2018	• 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
Version 5	13 August 2015	• 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
Version 4	9 October 2013	• 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

Version 3	October 2009	• 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	• There are significant changes made. The policy needs to be read in full as this is the application of the Act into practice	Safeguarding Adults Steering Group – MCA Subgroup

Contents **Page No.**

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 Hive, Safeguarding Adults page.

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 duty 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.

The Executive Team 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, and the imminent Liberty Protection 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 Adult Safeguarding Team, offer advice and support to those staff caring for patients who lack capacity, and those that 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. The team ensure that MCA is embedded in all areas of practice in line with the code of practice. They also develop training and deliver it to staff at all levels across the Trust.

Directorate/Division Managers 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, and the pending Liberty Protection Safeguards

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 also available on the Hive.

MCA code of practice.pdf

The relevant chapter in the code is indicated by Chapter xx

4.1 5 Principles of the MCA

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.

- 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

- 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).
- It does not matter whether the impairment or disturbance is permanent or temporary.
- No one can be labeled 'incapable' or lacking in capacity because of a particular medical condition or diagnosis.
- 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

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.

4.3.1 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, whilst 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.

- A person should not be treated as unable to make a decision because he makes an unwise decision or one which may appear irrational.

4.3.2 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 intervention is required, the doctor/clinician ***proposing the care or 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, capacity assessments regarding the ability to make an informed decision can be made by the social Worker proposing the plan of care.

4.3.3 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.

4.3.4 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 person's 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 or Court Appointed Deputy. (See Sections 4.5 and 4.6).

However, Next of Kin and family members ***must*** be given opportunity to be involved in any decision making on behalf of an individual. Their opinions and views must be taken into account – they are often the people that know the individual well, and can offer an opinion as to what the individual would likely have wanted when they had capacity. ***They must be involved in any discussion, and their views considered prior to the decision being made.***

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

4.3.5 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. 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.

4.3.6 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.

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

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.

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.

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.

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.

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.

If the Donee is unable, or unwilling 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 up to 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.

What decisions can a Donee make on behalf of another?
A personal welfare donor may make decisions about:

- Where the person should live, and who with, and who to have contact with
- The persons day to day care, including diet/dress etc
- Consenting to ***or*** reusing medical exam nation and/or treatment
- Assessment for services, participating in Social activities
- Access to personal information
- Complaints about care or treatment

A property and affairs Donor can make decisions about:

- Buying/selling property
- operating bank accounts
- Managing benefits and pensions
- Paying bills etc

The Donor can refuse permission for the Donee to make any of the decisions outlined above, provided it is written into the document at the time it is made, or amended whilst the donor still has the capacity to do so.

There are strict guidelines that a done must follow, and they must always act in the person's best interest. The duties and responsibilities of the Donee are fully discussed in the Code of Practice: Please see Chapter 7 for further, more detailed information.

4.6 Court appointed deputies

Chapter 8

The principle and management of a Court Appointed Deputy is very similar to that of the Lasting Power of Attorney, as are the decisions that may be made on behalf of the individual. However, in the case of a Court Appointed Deputies the authority given to the Deputy is determined by the court in situations where an individual has lost capacity without making a Lasting Power of Attorney. Instead an interested party may apply to the Court to take on the role on behalf of the individual. As with the LPA, a Deputy may deal with finance and property, Health and Wellbeing or both, as determined by the Court.

As with an LPA the deputy must adhere to the strict guidelines, and act in the individual's best interest. The duties and responsibilities of the Deputy are fully discussed in the Code of Practice. (Please see Chapter 8 for further, more detailed information).

4.7 Court of Protection

The MCA set up the Court of Protection, to deal with decision-making for adults (and children in a few cases) who may lack capacity to make specific decisions for themselves. As well as property and affairs, the new court also deals with serious decisions affecting healthcare and personal welfare matters.

The Court of Protection has powers to:

- decide whether a person has capacity to make a particular decision for themselves
- appoint deputies to make decisions for people lacking capacity to make those decisions
- decide whether an LPA or EPA is valid, and
- remove deputies or attorneys who fail to carry out their duties.

In addition the Courts may make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions. An application to the Court may be relevant if:

- a person wants to challenge a decision that they lack capacity
- professionals disagree about a person's capacity to make a specific (usually serious) decision
- There is a dispute over whether the person has capacity (for example, between family members).

4.8 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. It has previously been referred to as a 'living will', or 'advanced directive'

- 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
- It does not allow an individual to choose what treatment he ***would want to undergo*** in the event of his losing capacity. This would be determined via a Best Interest decision

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

4.9 Young persons aged 16 or 17

Chapter 12

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.

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).

4.10 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.

4.11 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 "De-escalation: Principles and Guidance including restraint." This policy emphasises that any restraint should be proportionate ie. the least restrictive which means the shortest time possible and only used when reasonable to do so.

Please note: It is not essential for an individual to have a DoLS authorisation in place in order to implement restraint. This can lawfully be carried out if it is the persons Best Interest, provided it is necessary and proportionate.

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:

Deprivation of Liberty Safeguards[1

The relevant chapter in the code is indicated by; **Chapter xx**

Please see Appendix 4 – Recognising Deprivation of Liberty.

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 Deprivation of Liberty 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 at the time, to be in his best interest. His carers challenged this decision and the European Court of Human Rights ruled that the Deprivation of his 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 patient's 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.

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. It 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." (ie. 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 Safeguards

- 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 .
- The referral form ***must*** be sent to the safeguarding Team as an attachment to an e-mail, and not as a scanned document, or PDF file
- **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
- 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
	E-Mail;	dols@nottscc.gov.uk

Due to the volume of referrals received by both Local Authorities, it is likely that a patient may not be reviewed by the DoLS team within the 7 days, as stated in the guidance.

Both local authorities have agreed that on the basis of this, there will be no necessity to request an extension to an urgent authorisation already granted, and provided the original request was made, the authorisation will stand.

5.5 Arrangements for Those Patients Likely to Regain Capacity/Be Discharged in 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, from 6 weeks, up to a year dependent on circumstances of the deprivation.

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. (See 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.
- 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.

5.6 Death of a patient whilst subject to Deprivation of Liberty authorisations

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 April 2017, 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 LIBERTY PROTECTION SAFEGUARDS

The Law Commission published a report in March 2017, recommending a new scheme for the authorisation of Deprivation of Liberty. It was taken to the House of Lords in July 2018.

The recommendation established the need for a new process for authorising arrangements enabling the care and treatment for those individuals who lack the capacity to consent. The safeguards will be known as Liberty Protection Safeguards, and will take the place of the current Deprivation of Liberty Safeguards.

LPS was anticipated to be implemented in April 2020. However due to the impact felt by the COVID19 Pandemic and the restrictions it imposed, the implementation has been delayed on a number of occasions.

The latest update from the Department of Health and Social Care, (December 2021) states:

We had hoped to launch the consultation in the summer. However, we were not able to do so due to a number of factors outside of our control. It is paramount that the implementation of the LPS is successful so that the new system provides the safeguards that are needed. We recognise that without adequate time to prepare, implementation will not be a success.

We think it would be premature to set a new implementation date or confirm any funding to support implementation before we have been able to consider responses to the consultation.

Until there is any further update from the Department of Health and social care, the existing process (Deprivation of Liberty Safeguards) will continue.

7 TRAINING/ SUPPORT

Please note: The training requirements of staff will be identified through a learning needs analysis (LNA). Role specific education will be co-ordinated/ delivered by the topic lead. Alternatively, training may be accessed via an approved e-learning platform where available.

8 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	Ongoing	

9 DEFINITIONS

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.

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. (See Section 10).

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)

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.

Court Appointed deputies. A legal document whereby a person may apply to the Court to gain authorization to act on an individual's behalf, in the event that individual doesn't have the capacity to make his own decisions, but he has not previously made a Lasting Power of Attorney. (Section 12)

Court of Protection: The legal body set up, to deal with decision-making for adults (and children in a few cases) who may lack capacity to make specific decisions for themselves and for whom there is no Lasting Power of Attorney, and there may be dispute or disagreement over the individual's affairs

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.

Deprivation of Liberty. Deprivation of Liberty applies only to those people who have been assessed as lacking capacity under the Mental Capacity Act (2005) to consent to remaining in hospital in order to receive e care and treatment. In order to determine if an adult is being deprived of his liberty, the acid test is used (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.

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.

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)

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)

Liberty Protection Safeguards. A new process for authorising arrangements enabling the care and treatment for those individuals who lack the capacity to consent, which will supersede DoLS. Date of implementation not yet confirmed.

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.

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'.

Relevant Person. A person who is, or may be deprived of his liberty is known within the Codes of Practice as 'the relevant person'.

Relevant Persons Representative (RPR) The supervisory body will appoint a Person's representative to support the person Deprived of his Liberty.

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.

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.

Supervisory Body: The Local Authority with responsibility for the locality in which the relevant person normally resides (Not necessarily where he is an inpatient)

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. The urgent authorisation will be granted by the Safeguarding 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 De-escalation: Principles and Guidance including restraint

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/PA 2 Consent to Examination or Treatment Policy

11 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

12 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

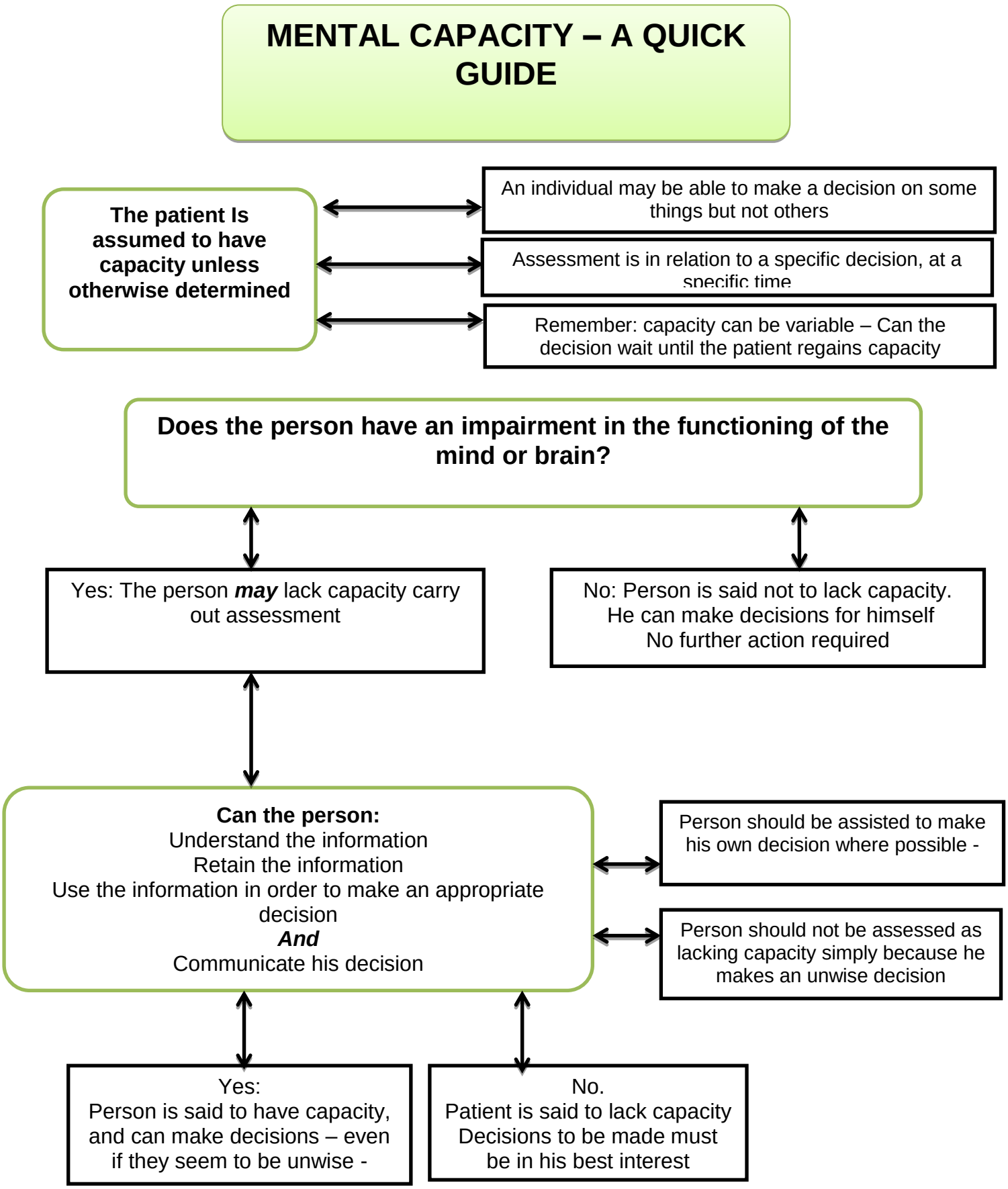
Department of Health
Deprivation of Liberty code of practice 2008

Office of Public Sector Information
Human Rights Act 1998 www.opsi.gov.uk

Doncaster Joint Agency Agreement 2013
Mental Capacity Act

Department of Health and Social Care
Mental Capacity (Amendment Act 2019) Liberty Protection Safeguards

APPENDIX 1 – MENTAL CAPACITY AND BEST INTEREST FLOW CHART



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 642434/642435

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***	***If Yes record symptoms, behaviours and any relevant information***
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			
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?			
	Response		***You must provide evidence of the steps you have taken as to how you came to your opinion***
	Yes	***No***	
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?			
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			
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.			
Q5. Is the person able to **communicate** their decision? All steps must be taken to aid communication.			
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**.			
Sign/date this form and record the outcome within the person's case records. **DO NOT PROCEED TO MAKE A BEST INTERESTS DECISION**			
If you have answered **NO** to any of the questions, proceed to **Q6.**			
	Please provide details of the outcome of your assessment		
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?			

Signature		**Date assessment completed**	

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?
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.
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.

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		**Comments**	
	Yes	***No***	**Date**	**Name of Assessor**
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?	

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	
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	
Q5. Are they any **additional factors** such as family relationships that need to taken into account?	

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.

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 persons best interest and record any information they have about the person wishes and feelings beliefs and values

Name	Role/Relationship	Views of people consulted /reasons why person not consulted

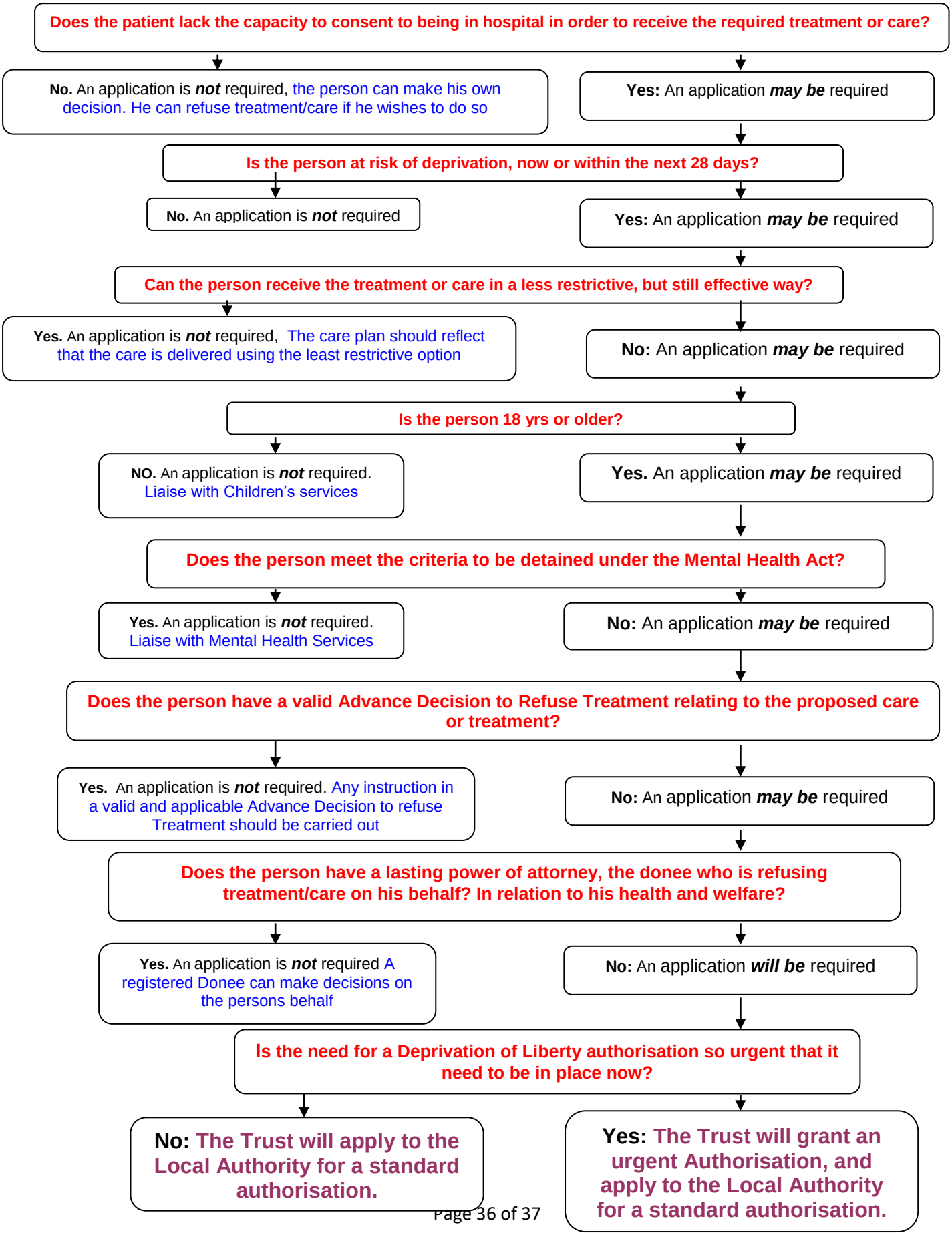
Consideration of the person wishes and feeling, beliefs and values is an important part of the best interest process	
Q7.Have you been able to ascertain what the person`s **wishes and feelings** are or would be if they were able to make the decision themselves?	
The nearer the person is to having capacity the more weight you need to give to their wishes and feelings	
Q8. Does the person have any specific **beliefs and values** that need to be considered?	
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?	

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	03.02.22

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

- **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

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**

Date for next review: February 2025

Checked by Gill Wood **Date** April 2022