

Brighton and Sussex University Hospitals

Mental Capacity Act Policy (Incorporating Deprivation of Liberty Safeguards)

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1 Introduction

- 1.1 The Mental Capacity Act 2005 (MCA) provides the legal framework for acting and making decisions on behalf of individuals aged 16 and older who lack the mental capacity to make particular decisions for themselves. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. This applies whether the decisions are about life-changing events or for everyday matters.
- 1.2 Many of the provisions in the Act are based upon existing common law principles (i.e. principles that have been established through decisions made by courts in individual cases). The Act clarifies, improves and builds on good practice based on those principles.
- 1.3 The Act covers a wide range of decisions to be made, or actions to be taken, on behalf of people who may lack capacity to make specific decisions for themselves. These can be decisions about day-to-day matters – like what to wear, or what to buy when doing the weekly shopping – or decisions about major life-changing events, such as whether the person should move into a care home or undergo a major surgical operation.
- 1.4 The Act is intended to assist and support people who may lack capacity, and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. However, the Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm, if they lack capacity to make decisions to protect themselves.
- 1.5 The Act sets out a legal framework of how to act or make decisions on behalf of people who lack capacity to make those specific decisions for themselves. It sets out some core principles and methods for making decisions and carrying out actions in relation to personal welfare, healthcare and financial matters affecting people who may lack capacity to make specific decisions about these issues for themselves.
- 1.6 There are certain decisions which can never be made on behalf of a person who lacks capacity to make those specific decisions themselves. This is because they are either so personal to the individual concerned, or governed by other legislation. (See 5.6.1 for examples).
- 1.7 Following applications to the European Court of Human Rights, the Mental Health Act (2007) amended the Mental Capacity Act (2005) by introducing Deprivation of Liberty Safeguards (DoLS). There is a DoLS Code of Practice (2008) which supplements the main MCA Code of Practice. Both are available on the BSUH infonet:
 - MCA Code of Practice: [BSUH info-net - Mental Capacity Act](#)

- DoLS Code of Practice: [BSUH info-net - Deprivation of Liberty Safeguards \(DoLS\)](#)

1.8 The MCA introduced several new roles, bodies and powers, all of which support the Act's provisions. These include - Attorneys appointed under Lasting Powers of Attorney (see section 5.8) The Court of Protection, the Public Guardian and court-appointed deputies (see section 5.10) and Independent Mental Capacity Advocates (see section 5.9).

2. Purpose

2.1 This policy sets out the standards and procedures required to ensure that staff in Brighton and Sussex University Hospitals NHS Trust (BSUH) comply with the legal requirements of the MCA.

2.2 All health and social care professionals working with people who may lack capacity have a legal duty to respect the MCA and its Code of Practice.

3. Definitions

3.1 What is mental capacity?

3.1.1 Mental capacity is the ability to make a specific decision at the time it needs to be made.

3.1.2 This includes the ability to make a decision that affects daily life – such as when to get up, what to wear or whether to go to the doctor when feeling ill – as well as more serious or significant decisions.

3.1.3 It also refers to a person's ability to make a decision that may have legal consequences – for them or others. Examples include agreeing to have medical treatment, buying goods or making a will.

3.1.4 The starting point must always be to assume that a person has the capacity to make a specific decision. Some people may need help to be able to make or communicate a decision. However, this does not necessarily mean that they lack the capacity to do so. What matters is their ability to carry out the processes involved in making the decision – not the outcome.

3.2 What the Act means by 'lack of capacity'(Code of Practice, 2007)

3.2.1 Section 2(1) of the Act states:

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

3.2.2 This means that a person lacks capacity if:

- they have an impairment or disturbance (for example, a disability, condition or trauma) that affects the way their mind or brain works, and
- the impairment or disturbance means that they are unable to make a specific decision at the time it needs to be made.

3.2.3 An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general.

3.2.4 Section 2(2) of MCA states that the impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

- the loss of capacity is partial
- the loss of capacity is temporary
- their capacity changes over time.

3.2.4 A person may also lack capacity to make a decision about one issue but not about others.

3.3 What is 'best interest'?

'Best interest' is a method for making decisions which aims to be more objective than that of substituted judgement. It requires the decision maker to think what the 'best course of action' is for the person lacking capacity. It should not be the personal views of the decision-maker. Instead it considers both the current and future interests of the person who lacks capacity, weighs them up and decides which course of action is, on balance, the best course of action for them (British Psychological Society, 2007).

4. Responsibilities, Accountabilities and Duties

4.1 Chief Executive and Trust Management Board

The Chief Executive and Trust Management Board have overall responsibility for ensuring that the Trust has the necessary arrangements in place to enable the effective implementation of this policy.

4.2 The Medical Director

The Medical Director is responsible for ensuring medical staff comply with the principles and requirements of the MCA when obtaining consent including clear documentation of capacity assessments and best interest decisions. For ensuring the implementation of audit recommendations as appropriate. For ensuring HM Coroner is notified of the death of a patient in hospital with a current deprivation of liberty safeguard in place.

4.3 Responsibility of the Executive Safety and Quality Meeting

The Executive Safety and Quality Meeting is responsible for reviewing the findings of audit undertaken by BSUH and also in partnership with Adult Social Care Safeguarding Adults Board MCA and DoLS Sub Group. For identifying learning from

audit and making recommendations for further action as appropriate. For providing feedback to the Trust Board.

4.4 Responsibility of the Deputy Chief Nurse, Patient Experience.

The Deputy Chief Nurse Patient Experience is responsible for facilitating the development of training in accordance with the Trust Training Needs Analysis. For undertaking audit of MCA and DoLS in partnership with Adult Social Care Safeguarding Adults Board MCA and DoLS Sub Group and providing feedback to the Executive Safety and Quality Meeting. For supporting the implementation of any recommendations from audit as appropriate. For liaising directly with the CCG providing up to date information regarding DoLS authorisations for patients within BSUH. To act as a resource providing advice to senior nursing staff when a deprivation of liberty safeguard is being considered. For the three yearly review and update of this policy in consultation with the Medico Legal Services Manager

4.5 Responsibility of the Mental Capacity and Mental Health Education Lead

To design and implement training regarding MCA and DoLS as agreed with the Deputy Chief Nurse Patient Experience. To support the Deputy Chief Nurse Patient Experience undertaking audit and implementing any recommendations as appropriate. To act as a resource providing advice to staff undertaking capacity assessments. To act as a resource providing advice to senior nursing staff when a deprivation of liberty safeguard is being considered. To work closely with the Lead Nurse Safeguarding Adults; Learning Disability Liaison Nurses and the Dementia Nurse Specialist to support staff to implement the principles and requirements of the MCA. To feedback any concerns to the Deputy Chief Nurse Patient Experience and the Medico Legal Services Manager as appropriate.

4.6 Responsibility of the Lead Nurse, Safeguarding Adults

To work closely with the Mental Capacity and Mental Health Education Lead supporting the implementation of training regarding MCA and DoLS as appropriate. To provide support to the Deputy Chief Nurse Patient Experience undertaking audit and implementing any recommendations as appropriate. To act as a resource providing advice to staff undertaking capacity assessments. To act as a resource providing advice to senior nursing staff when a deprivation of liberty safeguard is being considered. To work closely with the Learning Disability Liaison Nurses and the Dementia Nurse Specialist to support staff to implement the principles and requirements of the MCA. To feedback any concerns to the Deputy Chief Nurse Patient Experience and the Medico Legal Services Manager as appropriate

4.7 Responsibility of Learning Disability Liaison Nurses.

To work directly with clinical staff providing support, advice and education regarding working with patients with a Learning Disability. To act as a resource providing advice to staff undertaking capacity assessments and supporting staff and patients when undertaking best interest decisions. To work closely with the Mental Capacity and Mental Health Education Lead and the Lead Nurse, Safeguarding Adults. To feedback any concerns to the Deputy Chief Nurse Patient Experience and the Medico Legal Services Manager as appropriate.

4.8 Responsibility of the Dementia Nurse Specialist

To work directly with clinical staff providing support, advice and education regarding working with patients with dementia. To act as a resource providing advice to staff undertaking capacity assessments and supporting staff and patients when undertaking best interest decisions. To work closely with the Mental Capacity and Mental Health Education Lead and the Lead Nurse, Safeguarding Adults. To feedback any concerns to the Deputy Chief Nurse Patient Experience and the Medico Legal Services Manager as appropriate.

4.9 Responsibility of the Medico Legal Services Manager.

To inform the Deputy Chief Nurse Patient Safety of any updates or developments regarding legislation which may need to be reflected in practice. For liaising with the Deputy Chief Nurse Patient Safety in the three yearly review and updating of this policy. Advising the Deputy Chief Nurse Patient Safety of any legislative amendments needing to be made to this policy outside of the review period

4.10 Responsibility of all Managers

All Departmental Managers should ensure their staff are aware of, and have access to, all current BSUH policies and associated documentation. Managers must ensure that their staff have undertaken mandatory training about the Mental Capacity Act and DoLS. They must ensure that staff training records are maintained and updated.

4.11 All Staff

This policy applies to all BSUH staff who, in the course of their work, may make decisions on behalf of any adult who lacks capacity. All staff must adhere to the principles of the MCA.

Staff must have regard to the Mental Capacity Act Code of Practice, to include the supplementary DoLS Code of Practice and the accompanying guidance.

All staff must ensure that they undergo mandatory training about the MCA and DoLS. This is a one off requirement on entry to the Trust unless there are changes to the law that require explanation. Further legal developments may occur after the publication of this policy. Healthcare staff have a duty to keep themselves informed of legal developments that may have a bearing on their practice.

5 Policy

5.1 Section 1 of the Act sets out the **five 'statutory principles'** – the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, and not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to enable them to participate in decision-making, as far as they are able to do so.

The five statutory principles are:

1. A person must be assumed to have capacity unless it is established that they lack capacity. Any determination of lack of capacity **must not be based on** a person's age, appearance (for example, features linked to Down's Syndrome or muscle spasms caused by cerebral palsy), assumptions about their medical condition (for example, drunkenness or unconsciousness) or any aspect of their behaviour (for example, shouting and gesticulating, talking to themselves or avoiding eye contact).
2. 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.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise or eccentric decision.
4. Any act or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is completed, or the decision is made, regard must be given as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

5.2 What might prompt a decision to question whether someone has capacity to make a specific decision? There are a number of reasons which might include:

- 5.2.1 the person's behaviour or circumstances causing doubt as to whether they have capacity to make a decision
- 5.2.2 someone else says they are concerned about a person's capacity
- 5.2.3 the person has previously been diagnosed with an impairment or disturbance that affects the way their brain or mind works and it has already been shown that they lack capacity to make other decisions in their life.

5.3 The starting assumption must be that the person has capacity to make a specific decision. Before this can be challenged, it must be clear that the following questions have been considered:

- 5.3.1 Does the person have all the relevant information they need to make the decision?
- 5.3.2 If they are making a decision that involves choosing between alternatives, do they have information on all the different options?
- 5.3.3 Would the person have a better understanding if the information were explained or presented in another way?

5.3.4 Are there times of day when the person's understanding is better?

5.3.5 Are there locations where they may feel more at ease?

5.3.6 Can the decision be put off until the circumstances are different and the person may be able to make the decision? For example, until the delirium caused by infection, which is affecting the cognitive process and the capacity to make decisions, is resolved by treatment with antibiotics.

5.3.7 Can anyone else help the person to make choices or express a view (for example, a family member or carer, an advocate or someone to help with communication)?

5.4 Once it is identified that a person may lack capacity to make a particular decision, who may then perform the assessment of capacity?

5.4.1 The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing someone's capacity to make different decisions at different times.

5.4.2 If a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity to consent. In settings such as a hospital, this can involve the multi-disciplinary team (a team of people from different professional backgrounds who share responsibility for a patient). But ultimately, it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed.

5.4.3 For a legal transaction (for example, making a will), a solicitor or legal practitioner must assess the client's capacity to instruct them. They must assess whether the client has the capacity to satisfy any relevant legal test. In cases of doubt, they should get an opinion from a doctor or other professional expert.

5.4.4 More complex decisions are likely to need more formal assessments. A professional opinion on the person's capacity might be necessary. This could be, for example, from a psychiatrist, psychologist, a speech and language therapist, occupational therapist or social worker. But the final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity – not the professional, who is there to advise.

5.5 An assessment of capacity is made in 2 parts.

5.5.1 **Part 1** - Does the person have an identified disturbance of the brain that affects the way their brain or mind works, for example, dementia, learning disability, the effects of stroke, delirium, head injury, confusion, drowsiness, unconsciousness or the effects of alcohol or drugs?

5.5.2 If the answer is yes, then a further four questions need to be asked. Are they able to:

1. Understand the information that is relevant to the decision they are being asked to make
2. Retain that information long enough to be able to make a choice about it – depending on what is necessary for the decision in question. (this can be for as little as 5 minutes, for example, as long as the same decision is reached when the information is given again). Consideration must be given to the complexity of the decision and reasonable time allowed to reflect on the information given, as would be allowed for a person whose capacity was not in doubt.
3. Weigh up the pros and cons – balancing the arguments about risks and benefits in order to make an informed decision
4. Communicate their decision (even if it is only by blinking or squeezing a hand)

5.5.3 If the person being assessed fails one of the four questions above, then they may be said to lack capacity to make the specific decision being asked of them at this time.

5.6 Having failed an assessment of capacity, a decision may then be made on that person's behalf and in their 'best interest'.

5.6.1 Some decisions can never be made by one individual on behalf of another person. These include: those concerning family or personal relationships – including consent to marriage, sexual relationships, divorce, placing a child for adoption, taking over parental responsibility for a child or consent to fertility treatment - and decisions on voting or casting a vote at an election or a referendum.

5.6.2 Section 4 of the Act explains how to determine the best interests of a person who lacks capacity to make a decision at the time it needs to be made. This section sets out a checklist of common factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. The checklist must be completed by the clinician responsible for the treatment proposed and, on completion, should be placed in the healthcare record. (see BSUH Incapacity Form - Assessment of capacity of adult patient: determination of best interests), [BSUH info-net - Mental Capacity Act](#)

5.6.3 This checklist is only the starting point: in many cases, extra factors will need to be considered. Factors for consideration include:

- Will capacity be regained in due course and can the decision therefore wait until this happens?
- Has the person been involved as far as possible?

- Have all practicable steps been taken to enable the person to communicate their choice?
- Has regard been paid to the person's past and present wishes, beliefs and values and is there an Advance Decision? (See Section 5.7)
- Have the views of significant others been taken account of or has an Independent Mental Capacity Advocate (IMCA) been consulted?
- Can the procedure under discussion be carried out in a less restrictive way?
- Have all the decisions regarding consent and capacity been documented in the person's notes?

5.7 Advance Decision

5.7.1 An advance decision enables someone, while still capable, to refuse specified medical treatment for a time in the future when they may lack the capacity to consent to or refuse that treatment.

5.7.2 People can only make an advance decision under the Act if they are 18 or over and have the capacity at the time to make the decision. They may only say what treatment they want **to refuse**, and they can cancel their decision – or part of it – at any time.

5.7.3 It is up to individuals to decide whether they want to refuse treatment in advance. Some people choose to make advance decisions while they are still healthy, even if there is no prospect of illness. This might be because they want to keep some control over what might happen to them in the future. Others may think of an advance decision as part of their preparations for growing older (similar to making a will). Or they might make an advance decision after they have been told they have a specific disease or condition.

5.7.4 An advance decision may only refuse offered treatments. A person may not demand specific treatments to be given if it is the clinical opinion of the clinician responsible that it is not in their best interest to receive that treatment. For example, a person may not demand to be resuscitated no matter what the clinical circumstances.

5.7.5 If the advance decision refuses life-sustaining treatment, it must:

- be in writing. It can be written by someone else or recorded in advance in the health care notes – (see the Trust's document Advance Decision for adult patients [BSUH info-net - Mental Capacity Act](#))
- be signed by the person whose decision it is, and witnessed (with each of these two people seeing the other one signing, and
- state clearly that the decision applies even if life is at risk.

5.7.6 An advance decision to refuse treatment must be valid and applicable to current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity. Healthcare professionals must respect and comply with this decision.

5.7.7 To establish whether an advance decision is valid and applicable, healthcare professionals must try to find out if the person (now lacking capacity):

- has done anything since that clearly goes against their advance decision
- has withdrawn their decision
- has subsequently conferred the power to make that decision on an attorney, or
- would have changed their decision if they had known more about the current circumstances.

5.7.8 Many people prefer not to make an advance decision, and instead leave healthcare professionals to make decisions in their best interests at the time a decision needs to be made. Another option is to make a Lasting Power of Attorney for Health and Personal Welfare decisions. This allows a designated other person or people to make personal welfare decisions, such as those around treatment, on someone's behalf, and in their best interests if they ever lose capacity to make those decisions themselves.

5.8 Lasting Power of Attorney – the MCA created a new power, known as Lasting Power of Attorney (LPA). These replaced the Enduring Power of Attorney previously required for decision making on behalf of an individual who now lacks capacity.

5.8.1 A Lasting Power of Attorney is a legal document in which someone, known as the donor, gives another person (formally known as the “donee”) the authority to make a decision on their behalf at a time when they do not have capacity to do so themselves. The donor must have capacity at the time of completing the document in order to ensure the LPA is legally valid. It does not come into effect until it has been registered and then the donor is assessed as lacking capacity.

5.8.2 The LPA must be registered with the Office of the Public Guardian to make it legal. The donee (the person or people identified in the Lasting Power of Attorney document) can then make decisions that are as valid as decisions which would have been made by the donor when that person had capacity.

5.8.3 Separate Lasting Powers of Attorney can be drawn up for a) property and financial affairs, and/or b) health and personal welfare. The latter can include healthcare decisions such as giving or refusing consent to treatment..

5.8.4 Guidance booklets are available from the Office of the Public Guardian for people wishing to make an LPA. Contact details and guidance is also available on the Trust infonet on the Mental Capacity Act homepage at: [BSUH info-net - Mental Capacity Act](#)

5.8.5 The donee must ensure a copy of the legal document, sealed by the Office of the Public Guardian, is made available to Trust employees in order to have their role in the LPA respected.

5.8.6 Trust staff must not agree to act as a donee for a patient's LPA.

5.9 The Independent Mental Capacity Advocate (IMCA) Service was created under the Act.

5.9.1 The IMCA service provides independent safeguards for people who lack the capacity to make certain important decisions and who have no one else, other than paid staff, to consult, support or represent them with regard to their best interests.

5.9.2 Information about how to contact and make referrals to the IMCA Service is available on the Trust infonet on:

[BSUH info-net - Independent Mental Capacity Advocate](#)

It is the responsibility of the clinician responsible for making health and personal welfare 'best interest' decisions (decision maker) to make a referral to the IMCA service.

5.9.3 Trust Staff have a statutory obligation to instruct an IMCA for any patient who lacks capacity and has no family, friend, carer (who is not paid), Lasting Power of Attorney, or court appointed deputy, to support them when:

- it is proposed to provide, withhold, or stop serious medical treatment (unless it is emergency treatment, however an IMCA must be instructed for all serious medical treatment following the emergency treatment), or
- it is proposed that the patient will move to a new/different hospital for more than 28 days or to a care home for more than 8 weeks. (In some circumstances, such a referral may be made by a social worker, but the clinician has an obligation to ensure that such a referral is made if they believe the patient lacks capacity to reach such a decision.)

5.9.4 The decision maker ultimately makes the decision in question, as an IMCA may not become a decision maker. However, an IMCA's report must be taken into account as part of the process of working out whether a proposed decision is in the best interests of the patient.

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

- if a single treatment is proposed there is a fine balance between the likely benefits and the burdens to the patient and the risks involved
- a decision between a choice of treatments is finely balanced, or
- what is proposed is likely to have serious consequences for the patient.

5.9.6 'Serious consequences' are those which could have a serious impact on the patient, either from the effects of the treatment itself or its wider implications. This may include treatments which:

- cause serious and prolonged pain, distress or side effects
- have potentially major consequences for the patient (for example, stopping life-sustaining treatment or having major surgery such as heart surgery), or
- have a serious impact on the patient's future life choices (for example, interventions for ovarian cancer).

5.9.7 It is impossible to set out all types of procedures that may amount to 'serious medical treatment', although some examples of medical treatments that might be considered serious include:

- chemotherapy and surgery for cancer
- therapeutic sterilisation
- major surgery (such as open-heart surgery or neuro-surgery)
- major amputations (for example, loss of an arm or leg)
- treatments which will result in permanent loss of hearing or sight
- withholding or stopping artificial nutrition and hydration
- termination of pregnancy.

5.10 Court of Protection and the Office of the Public Guardian. The MCA established a specialised court, with its own judges and procedures, known as the Court of Protection.

5.10.1 The Court of Protection (CP) has jurisdiction relating to the MCA in relation to the management of property and affairs of a person lacking capacity.

5.10.2 CP is the final arbiter for decision making in relation to capacity matters and addresses all serious decisions affecting healthcare and personal welfare matters that were previously dealt with by the High Court.

5.10.3 The MCA provides for a system of CP appointed deputies. Deputies will be appointed to take decisions on welfare, healthcare and financial matters, in the best interests of the person, as authorised by the Court, if it is not appropriate for the Court to make a one-off decision to resolve the issues.

5.10.4 The Office of the Public Guardian supervises and supports court appointed deputies. It also keeps a register of, and investigates concerns about, LPAs and deputies.

5.11 Use of Restraint – Section 6(4) of the Act states that someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting
- restrict a person's freedom of movement, whether they are resisting
- or not.

5.11.1 However, the MCA Code of Practice states that staff acting to restrain a person who lacks capacity will not be liable for prosecution under the Act provided that the following two conditions are met:

- the person taking action must reasonably believe that restraint is *necessary* to prevent *harm* to the person who lacks capacity, 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 (p106)

5.11.2 Examples of appropriate/proportionate restraint might include:

- the use of distraction, for example, utilising items available in the Dementia Resource Box
- employing a 1:1 nurse special to observe and care for that individual alone
- locking a ward door to prevent a patient from wandering out onto the road
- using Posey Closed End mittens where patients have made repeated attempts to pull out essential and potentially lifesaving equipment, for example, naso-gastric feeding tubes, tracheostomy tubes, endotracheal tubes, central venous catheters. The use of mittens on both hands, for example, prevents the fine motor movements required to grasp and pull on tubes and lines. **NB attaching the ties that come with the mittens' packaging to either bedrails or bed frames, however, is always an unacceptable form of restraint. The hands must be left free, albeit they are in the mittens.**
(See the BSUH Policy for the Use of Hand Control Mittens in Adult Patients) [BSUH info-net - Policies](#)

5.12 Deprivation of Liberty Safeguards (DoLS)

5.12.1 The Deprivation of Liberty Safeguards (DoLS) were introduced in 2007 as a supplement to the MCA following successful applications to the European Convention on Human Rights where persons who lacked capacity were said to have been deprived of their liberty unjustly by the institutions caring for them. These applications were made principally on behalf of persons being cared for in care homes or institutions for persons who had learning disabilities. Nonetheless, it is true that restraint (as identified for example in 5.11.2) used in secondary care institutions like BSUH might be construed in law as depriving individuals of their liberty.

5.12.2 DoLS do not apply to people detained under the Mental Health Act. DoLS makes it clear that a person in England and Wales may only be subject to deprivation of liberty authorisation:

- if they are 18 or older
- have a well documented disorder or disability of the mind (apart from dependence on drugs or alcohol)
- have been identified as lacking capacity to consent to current arrangements made for their care or treatment
- and if there is no less restrictive alternative.

5.12.3 The DoLS Code of Practice (p11) says that in order to come within the scope of a deprivation of liberty authorisation, a person must be detained in a hospital, for the purpose of being given care or treatment in circumstances that amount to a deprivation of liberty (for example, see section 5.11.2). The authorisation must relate to the individual concerned and to the hospital in which they are detained.

5.12.4 The “Cheshire West” Supreme Court Judgement March 2014 clarified the “acid test” for what constitutes a Deprivation of Liberty. The acid test states that an individual is deprived of their liberty for the purposes of Article 5 of the European Court of Human Rights if they

- Lack capacity to consent to their care or treatment arrangements
- Are under continuous supervision and control
- Are not free to leave

5.12.5 The Supreme Court Judgement made clear the factors NOT relevant when determining whether there is a deprivation of liberty are:

- A person’s compliance or lack of objection
- The relative normality of the placement
- Reason or purpose behind a particular placement

Therefore there will be occasions when people who lack capacity to consent to admission are taken to hospital for treatment of physical illnesses or injuries, and then need to be cared for in circumstances that amount to a deprivation of liberty.

If so, then the hospital must apply for authorisation under DoLS .

5.12.6 **DoLS in Intensive Care and Emergency Settings**

The state of unconsciousness in itself is not considered as being a mental disorder for the purposes of Schedule 1A to the MCA. When considering if it is necessary to apply for a DoLS authorisation consideration must be given to whether the deprivation will last for a “**non-negligible period of time**”. There is no set definition of what constitutes a non-negligible period of time and managing authorities may wish to agree local arrangements with the supervisory body to ensure an appropriate response.

In an emergency situation where the person lacks capacity to consent, care and treatment should not be delayed. Professionals should proceed in the best interests of the individual and in accordance with the principles of the Mental Capacity Act

The Cheshire West Supreme Court judgement did not specifically address the intensive care setting; however the concept of the acid test is applicable to this setting. There may be exclusions where patients are not considered to be deprived of their liberty:

- If they have capacity to consent to be admitted to intensive care
- If they have capacity to consent to restrictions being applied
- If they give consent for admission to intensive care prior to losing capacity such as pre-op consent for surgery where a post-operative period in intensive care is anticipated

5.12.7 Recent Case Law relating to DoLS in ITU

R (Ferreira) v HM Senior Coroner for Inner South London (January 2017) : the Court of Appeal has held that in general there will be no deprivation of liberty when giving life-saving treatment where that treatment is for physical illness and would be the same for someone with or without capacity. As such, the majority of patients in ICU will not require a DoLS authorisation.

Cases must be considered on an individual basis

5.12.8 Hospitals (and care homes) are known, under DoLS, as 'managing authorities' and have a legal duty to seek formal authorisation to deprive someone of their liberty, from a 'supervisory body' (the Care Commissioning Group where the person is normally resident).

5.12.9 There are two kinds of authorisations: standard and urgent. The required authorisation forms are available on the Trust intranet at:
[BSUH info-net - Deprivation of Liberty Safeguards \(DoLS\)](#)

5.12.10 **Standard authorisation.** The managing authority (ie BSUH) must normally apply for a standard authorisation before depriving anyone of their liberty. It is vital to be proactive for planned admissions to hospital: if planning to admit or treat a patient who is likely to require deprivation of their liberty and fulfil the criteria detailed in this policy, the Matron of the area must be informed well in advance. Whenever possible, authorisation should be applied for and obtained in advance. Where this is not possible, and the managing authority believes it is necessary to deprive someone of their liberty in their best interests **before** the standard authorisation process can be completed, the managing authority must itself give an urgent authorisation and then obtain standard authorisation within seven calendar days.

5.12.11 **Urgent authorisation** must be made by the managing authority (ie BSUH) if the need to deprive a person of their liberty could not have been foreseen and is urgent. For emergency admissions or newly arising circumstances in which immediate Deprivation of Liberty is required, the Matron or Clinical Site Manager must be notified urgently of any resisting patient, especially if family or friends have any objection to what is proposed. Keep restrictions to a minimum, and for the shortest possible time. Take steps to assist the patient to retain contact with family/friends/carers. Urgent authorisations must be made with a simultaneous application for a standard authorisation to the supervisory body. On receipt of the application form, the supervisory body will commission six assessments which are used to decide whether to authorise a deprivation of liberty. Urgent authorisations last for a maximum of seven calendar days. In exceptional circumstances, an urgent authorisation can be extended by a supervisory body for an additional seven calendar days. The managing authority must inform the supervisory body if an extension is needed but only one such extension can be granted.

(See the process for submission of DoLS paperwork Appendix 1)

5.12.12 If the patient also has no one other than paid staff to represent them, ensure the supervisory body is aware of this when requesting the authorisation, as the patient will also be eligible for an IMCA.

5.12.13A copy of both standard and urgent authorisations must be sent to the safeguarding team via the BSUH DoLS in-box: DoLS@bsuh.nhs.uk

5.12.14 Guidance on completing DoLS authorisation forms can be found on the BSUH info-net [BSUH info-net - Deprivation of Liberty Safeguards \(DoLS\)](#)

5.12.15 The supervisory body authorising the deprivation of liberty must be notified of any change to the person's circumstances that could result in a change to the DoLS e.g. If the person regains capacity or if they are discharged / transferred to another hospital where BSUH is not the managing authority.

5.12.16 Following an amendment included in the Policing and Crime Act 2017, from 3rd April 2017 people subject to DoLS will no longer be considered to be 'otherwise in state detention' for the purposes of Section 1 of the Coroners and Justice Act 2009. For any death where the deceased was subject to DoLS, the Coroner will no longer have a duty to conduct an inquest in all cases. Their death need only be reported to the Coroner where the cause of death is unknown or where there are concerns that the cause of death was unnatural or violent, including where there is any concern about the care given having contributed to the person's death.

5.12.17 For patients living in Brighton and Hove:

Tel: 01273 295555 and Fax: 01273 296372.

E-mail: dols@brighton-hove.gov.uk

5.12.18 For patients living in West Sussex:

Tel: 033 022 23691 and Fax: 01903 839786

E-mail: dols@westsussex.gov.uk

5.12.19 For patients living in East Sussex:

Tel: 01273 336022 and Fax: 01323 464504

E-mail: dols@eastsussex.gov.uk

6 Training Implications

6.1 All clinical staff are required to undergo mandatory training with regard to the MCA Policy and DoLS. Clinical staff are defined as Allied Health professionals and their helpers, Nurses, Midwives and Health Care Assistants and all Doctors employed directly by the Trust. The training is required once only.

6.2 Training is provided by the Mental Capacity and Mental Health Education Lead. Contact ext. 62950 for details

- 6.3 Managers must ensure that their staff have undertaken mandatory training. Training will be recorded on IRIS the Trust electronic system and reported in line with Trust mandatory training requirements.

7. Monitoring Arrangements

Measurable Policy Objective <i>What are you going to monitor?</i>	Monitoring / Audit Method <i>How are you going to monitor?</i>	Frequency <i>When will monitoring be performed?*</i>	Responsibility for performing monitoring <i>Who will perform the monitoring?</i>	Where is monitoring reported and which groups / committees will be responsible for progressing and reviewing action plans
Review of documentation to ensure adherence to principles and requirements for assessment of capacity and best interest decisions	Trust wide Clinical Audit	Annual – dependent on findings as may lead to more frequent audit	Head of Clinical Effectiveness and Audit; Chiefs of Divisions	Executive Safety and Quality Meeting
Ensure all staff undertake mandatory training	Quarterly RAGE reports produced by Learning and Development Department	Quarterly RAGE reports produced by Learning and Development Department	Deputy Chief Nurse Patient Experience	Executive Safety and Quality Meeting Safeguarding Committee
MCA and DoLS Quality Assurance Audit in partnership with Adult Social Care	Trust Wide audit	Annual	Deputy Chief Nurse Patient Experience	Executive Safety and Quality Meeting Quarterly Safeguarding Committee External Adult Safeguarding Board – MCA and DoLS Subgroup

8 Due Regard Assessment Screening

As an NHS organisation, BSUH is under a statutory duty to set out arrangements to assess and consult on whether this policy and function impacts on equality. This policy does not discriminate against any groups on the basis of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age, disability, gender identity, marriage/civil partnership status, pregnancy and maternity.

9 Links to Trust Policies

[Supporting Staff and Patient's Language and Communication Needs Policy](#)
[Equality, Diversity and Human Rights Policy \(Version 2.0\)](#)

Safeguarding Adults Policy

Physical Intervention Policy

Managing Delirium in Older People

Caring for Adult Patients with a Learning Disability in the Acute Hospital

Policy for Consent to Examination or Treatment

Policy for Use of Hand Control Mittens in Adult Patients

10 References

Code of Practice: Mental Capacity Act (2005) available electronically on [BSUH info-net – Mental Capacity Act](#)

DoLS Code of Practice (2008) Available electronically on [BSUH info-net – Deprivation of Liberty Safeguards \(DoLS\)](#)

British Psychological Society (2007) Best Interests: Guidance on determining the best interests of adults who lack the capacity to make a decision (or decisions) for themselves (England and Wales) *A report published by the Professional Practice Board of the British Psychological Society (2007) available electronically at:* [http://www.mentalhealthcare.org.uk/media/downloads/Best Interests Guidance.pdf](http://www.mentalhealthcare.org.uk/media/downloads/Best_Interests_Guidance.pdf)

Further information booklets on Making Decisions - Guides for patients, relatives and health and social care staff can be found on [BSUH info-net - Mental Capacity Act](#)

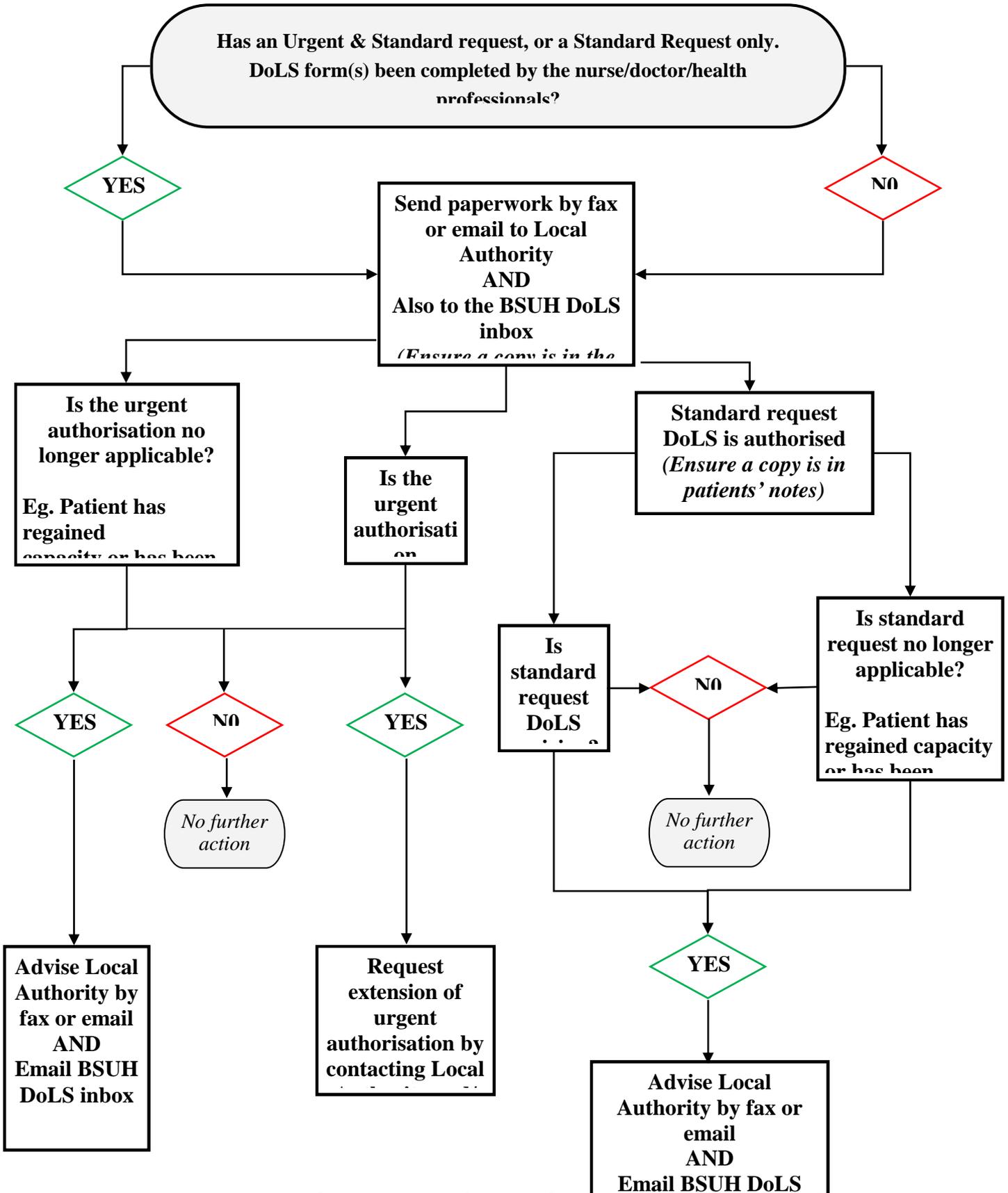
Chief Coroner's Guidance No. 16 Deprivation of Liberty Safeguards (DoLS)
Chief Coroner December 2014

The Intensive Care Society (2014) Crews et al *Deprivation of Liberty in Intensive Care* Ethics and Law Vol 15 Number 4, October 2014

The Law Society (2015) Identifying a deprivation of liberty: a practical guide
www.lawsociety.org.uk

Appendix 1 - process for submitting DoLS paperwork

PROCESS FOR SUBMITTING DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) PAPERWORK



Appendix 2 – Due Regard Assessment Tool

To be completed and attached to any policy when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Does the document/guidance affect one group less or more favourably than another on the basis of:		
	• Age	No	
	• Disability	Potential	There is the potential for patients with a learning disability to be adversely affected. However measures are in place to protect against this as indicated in section 5 – see 5.1 (Statutory principle 1) and also 4.7 and 4.8
	• Gender	No	
	• Gender identity	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	No	
	• Race		
	• Religion or belief	No	
	• Sexual orientation, including lesbian, gay and bisexual people	No	
2.	Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?	Potential	See above under ‘Disability’
3.	If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the document/guidance likely to be negative?	No	
5.	If so, can the impact be avoided?	N/A	
6.	What alternative is there to achieving the document/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the policy should continue in its current form?	N/A	
8.	Has the policy/guidance been assessed in terms of Human Rights to ensure service users, carers and staff are treated in line with the FREDA principles (fairness, respect, equality, dignity and autonomy)	N/A	

Mental Capacity Act Policy (incorporating Deprivation of Liberty Safeguards)

If you have identified a potential discriminatory impact of this policy, please refer it to the Deputy Chief Nurse Patient Experience, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Deputy Chief Nurse Patient Experience