Mental Capacity Act and Deprivation Liberty Safeguards (DoLS) Policy

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Policy Summary Overview
The Mental Capacity and Deprivation of Liberty Safeguards Guidance aims to provide a clear and consistent approach to supporting individuals with decision making. This guidance clearly outlines the legal requirements in relation to the Mental Capacity Act 2005 and Deprivation Liberty Safeguards and Restraint. The guidance provides clear processes for completing both a Mental Capacity Assessment and Deprivation of Liberty Safeguards Applications; a comprehensive list of Definitions is found in the Appendix.

2. INTRODUCTION

The Mental Capacity Act 2005 for England & Wales (The Act) received Royal Assent on 7 April 2005, and came into force in October 2007.

The Mental Capacity Act affects people aged 16 and over, and provides a statutory framework for the protection of people who may lack capacity to make some decisions themselves, based on current best practice and common law principles. It also makes it clear who can take decisions in which situations and enables people to plan ahead (Advance Decisions) for a time when they may lack capacity. The Mental Capacity Act can apply to all sorts of decisions such as: major decisions about personal finance, social care or medical treatment or, every day decisions such as what to eat or wear; there are some decisions that cannot be made on someone's else's behalf and these include:

- Sex
- Marriage

- Divorce
- Adoption/IVF
- Voting
- Sex

In addition there are some decisions that can be made by the Court of Protection

- Withholding or withdrawal of artificial nutrition and hydration from a patient in a permanent vegetative state
- Cases where it is proposed that a person who lacks capacity to consent should donate an organ or bone marrow to another person
- Non-therapeutic sterilization of a person who lacks capacity to consent
- Cases where there is a dispute about whether a particular treatment will be in a person's best interests.

For all other decisions CSH Surrey co-owners can support patients using the Mental Capacity Act 2005.

The Act replaces schemes for Enduring Powers of Attorney and provides Court of Protection receivers with reformed and updated schemes. The Act introduced a new criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

In April 2009, the Deprivation of Liberty Safeguards (DoLS) were added to The Act; they were introduced to provide a legal framework around the deprivation of liberty, and the Guidance is to be used in conjunction with the Mental Capacity Act Guidance 2005. DoLS were introduced to prevent breaches of the European Convention on Human Rights (ECHR) to provide safeguards for people who lack capacity specifically to consent to treatment or care in either a hospital or a care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty, and where detention under the Mental Health Act 1983 is not appropriate for the person at that time**.** The Deprivation of Liberty Safeguards apply to both publicly and privately arranged care or treatment

The Mental Capacity Act and the Mental Health Act 1983 (MHA) are independent of each other. The MHA relates to people who are diagnosed as having a mental health problem, which requires that they be detained or treated in the interests of their own safety or to protect other people. Prior to an application under the MHA any decision maker should consider whether the aims could be safely achieved by using the MCA instead.

DoLS do not apply to people detained under the Mental Health Act 1983. It will only be lawful to deprive somebody of their liberty elsewhere (for example, in their own home, in supported living arrangements other than in a care home, or in a day centre) when following an order of the Court of Protection on a personal welfare matter. In such a case, the Court of Protection order itself provides a legal basis for the deprivation of liberty.

2.1 Purpose

The aim of the CSH Surrey Guidance on Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) is to provide a clear and consistent approach to supporting individuals with decision making, and to ensure that all co-owners are aware of their legal responsibilities in relation to Mental Capacity and DoLS legislation.

2.2 Scope

This Guidance is applicable to all co-owners (permanent and temporary) employed by CSH working with those aged 16 or above.

2.3 Definitions

To ensure that co-owners are providing care and treatment in line with The Mental Capacity Act, they must have an understanding of the definitions outlined in the Act. A full list of relevant definitions and meanings can be found in Appendix 1. These include:

Advance decision to refuse treatment	Assessing lack of capacity	Best Interests (MCA)
Best Interest Assessment	Acts of care or treatment	Code of Practice (MCA)
Code of Practice (DOLS)	Court appointed Deputies	Court of Protection
Decision – maker	Excluded decisions	Independent Mental Capacity Advocate (IMCA)
Lasting Power of Attorney (LPA)	Managing Authority (DOLS)	Public Guardian
Research	Relevant person	Restraint
Supervisory Body (DOLS)		

3. RESPONSIBILITIES

Chief Executive Officer (CEO: has clear lines of accountability in order to safeguard and promote the welfare of indiviudals with an impairment of the mind or brain. The CEO has ultimate responsibility to ensure that all young people aged 16 or over, have access to well trained knowledgable co-owners who can work safely within the legal framework outlined by the Mental Capcity Act 2005 and Deprivation of Liberty Safegaurds.

The Director of Nursing and Quality: Takes responsibility for governance systems and organisational focus for those working with individiuals aged 16 or over with an impairment of the mind or brain. The Director has responsibility for ensuring that appropriately trained support is available for co-owners working with individuals who may have an impairment difficulty with decision making.

Service Leads and Team Leaders: Are responsible for ensuring co-owners have timely access to suppport, advice and training relating to mental capacity and DoLS issues issues and that co-owners embed the principles of the Mental Capcity Act 2005 in every day clinical practice.

Co-owners: Are **r**esponsible for ensuring they have the knowledge and skills to work within the principles outlined by the Mental Capcity Act 2005 and Deprivation of Liberty Safeguards. It is the respsonsibility of co-owners to seek advice and support with complex mental capacity issues and DoLS when required.

4. Five Principles of the Mental Capacity Act

The laws states that it should presumed that an adult (aged 16 or over) has full legal capacity to make decisions for they unless it can be shown they lack capacity to make the decision for themselves at the time the decision needs to be made.

The Act clearly outlines 5 principles which underpin the legislation and support people with their decision making as far as they are able.

It is the responsibility of those CSH Surrey co-owners working directly in clinical care to understand and apply these principles when supporting patients with decision making

Five key principles:

A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.

Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions.

Unwise decisions – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.

Best interests – all decisions made and actions carried out on behalf of a person who lacks capacity must be done in their best interests.

Least restrictive option – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms. Decisions must be clearly recorded in the relevant patient notes.

Co-owners must ensure they are demonstrating the principles of the Mental Capacity Act during their clinical intervention.

4.1 Consent

When providing care and treatment, co-owners should presume that the adult has the capacity to consent. Where there is concern surrounding an individual's ability to consent to care and treatment, co-owners should ensure that the individual:

- Has capacity in relation to the particular care or treatment decision
- Has been given any relevant information in a way that they understand
- Has given consent voluntarily and free from the influence of others

To ensure competence with consent and decision making, co-owners should complete consent on-line training in line with CSH Surrey Statutory and Mandatory requirements.
If there are concerns surrounding an individual's ability to consent to care and treatment an assessment of capacity should be considered.

Assessing Capacity (the ability to make an informed decision)
When supporting patients to make informed decisions, CSH Surrey co-owners have a responsibility to assess capacity in line with the Mental Capacity Act. When assessing capacity, co-owners should follow the two stage test outlined in the Act. There are two basic questions that clinicians must consider:

(Stage 1)

- Is there an impairment of or disturbance in the person's mind or brain?
- Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

If the answer to Stage 1 is yes, co-owners can move onto Stage 2 of the test

If the answer to Stage 1 is no, the person does not lack capacity and the co-owner must presume capacity.

(Stage 2)

In order for a person to have mental capacity they should have the ability to:

- Understand information given to them about the decision
- Retain that information long enough to help make that decision
- Use or weigh up that information as part of the decision making process, or
- Communicate their decision, by talking, using sign language or even simple muscle movements like blinking an eye or squeezing a hand

To act in line with the Mental Capacity Act it is essential that co-owners ensure a person is given all practicable help to make that decision before anyone treats them as not being able to make their own decisions. A person is deemed unable to make a decision if it is demonstrated the individual cannot do any one of the above criteria.

The outcome of any Mental Capacity Assessment should be clearly recorded within patient records and should include:

- The specific decision being made
- The reason to question capacity
- The outcome of the assessment e.g. could the person understand, retain, weigh up or communicate including evidence to support this.

If a person is deemed to not have capacity to make their own decision the Mental Capacity Act states that a decision must be made in their Best Interest. If an individual has a Last Power Of Attorney Health and Welfare in place, then the attorney can also make this decision on their behalf. If the co-owner does not feel that the attorney is acting in the individual's best interest in relation to their decision making, it is the responsibility of the co-owner to challenge this decision and seek support from the Adult Safeguarding Team if required.

Lasting Power of Attorney and Decision Making

Lasting Power of Attorney (LPA) - A personal welfare LPA allows the person/s chosen as the attorney to make decisions on behalf of an individual about personal welfare. It can include the power for the attorney to give or refuse consent to medical treatment if this power has been expressly given in the LPA. A personal welfare LPA can only be used once the form is registered at the Office of Public Guardian (OPG)

and the individual has become mentally incapable of making decisions about their own welfare; this could include decisions such as DNACPR.

It is the responsibility of CSH Surrey co-owners to understand the principles of Best Interest and apply it in all cases where an individual is deemed to lack capacity to make their own decision.

Making a decision in Best Interest:

Co-owners can only make a decision in someone's best interest if they lack capacity to make that decision themselves; this decision cannot be made in isolation.

It is the care giver who usually makes the decision in the person's best Interest, and a best interest meeting with all relevant parties and the individual themselves should be considered.

To ensure you are acting in Best Interest, the following process co-owners should ensure they:

- Encourage the person to participate in making the decision;
- Identify all the relevant circumstances
- Find out the person's views
- Avoid discrimination – don't make assumptions about someone's best interests on the basis of their age, appearance, condition or behaviour;
- Assess whether the person might regain capacity;
- Consult others for their views about the person's best interest
- Choose the least restrictive option
- Don't be motivated by a desire to bring about the persons death

Best interest decisions should be clearly documented in patient records; there is a Best Interest recording Tool at the back of the CSH Surrey Mental Capacity Assessment Tool which can be used if required (available on the MCA/DoLS page of the intranet).

4.2 Assessment of Capacity Procedures (Process flowchart appendix 2)

All co-owners providing face to face clinical care should complete Mental Capacity and DoLS training in line with CSH Surrey Statutory and Mandatory requirements.

See below for guidelines on how and when to complete a Mental Capacity Assessment:

1	The co-owner directly involved with the person should carry out the two stage assessment of capacity to make a particular decision	Triggers to do so might include: • If the person's behaviour or circumstances cause doubt as to whether they have capacity, or • they have already been shown to lack capacity in other areas of their life, or • somebody else expressed concern about the person's capacity
2	**Stage 1** The co-owner should decide if the person has an impairment of the mind or brain, or if there is some sort of disturbance affecting the way their mind or brain works. If it is decided there is an impairment it is necessary to move onto **stage 2.** If there is no identified impairment or disturbance in the functioning of the persons mind or brain the person does not lack capacity	If impairment is present support should be provided to the person to maximise their ability to make the decision, consider; • Does the person have all the relevant information they need? • Have different methods of communication been explored, including non-verbal communication? Is the person known to a Speech and Language Therapy team/require assessment? • Are there particular times of day when the person's understanding is better? • Can anyone else help or support the person to make choices or express a view? E.g. NOK/family members
3	**Stage 2** The co-owner should assess if the impairment or disturbance is sufficient to make the person unable to make the particular decision required. A person is unable to make a	CSH Surrey has tools to support assessment of capacity; these are accessible on the Mental Capacity and DoLS page on the intranet site.

	decision if he is unable to; • Understand the information relevant to the decision • Retain that information • Use or weigh that information as part of the process of making the decision; or • Communicate the decision	
4	If the person is assessed as having capacity this decision should be clearly recorded and treatment/care should continue as agreed.	Accurate records must be maintained in accordance with CSH Record Keeping Policy. The Standard Operating for Documentation of Patient Choice available on the intranet site can also be used with unwise decisions. There is a CSH Surrey Mental Capacity Assessment Tool available on the Mental Capacity/DoLS page on the intranet.
5	If the person is assessed as not having capacity to make a particular decision at that time the co-owner , with the support of relevant multi-disciplinary colleagues and family members will need to make a decision on the persons behalf which must be made in the persons best interests.	To decide best interests • Encourage the persons participation where ever possible • Identify all relevant circumstances • Try to find out the persons views Persons past and present wishes and feelings • Establish any beliefs and values • Avoid discrimination • Avoid restricting the persons rights • Assess whether the person may regain capacity if so can the particular decision wait • If appropriate consult close relatives, carers, friends, anyone caring on interested, Lasting Power of Attorney (LPA), Deputy

		appointed by Court of Protection.
6	Where there is no one to consult other than multidisciplinary team members an Independent Mental Capacity Advocate (IMCA) must be consulted for major decisions about serious medical treatment or changes in accommodation	IMCAs may also be instructed to support a person in decision regarding care reviews or adult protection cases (Information on how to access an IMCA is found on the MCA/DOLS Intranet page. A referral form is sent to an advisory group who will visit the patient and act as an advocate on their behalf. It is the responsibility of co-owners to identify patients who require an IMCA and to make a referral.
	The CSH Adult Safeguarding Team will monitor the number of patients referred to an IMCA, and report to the Safeguarding group at each meeting.	To ensure appropriate use of IMCA service It is the responsibility of the Ward Managers to inform the CSH Surrey Adult Safeguarding Team of any IMCA referrals made.
7	Accurate Healthcare records must be maintained at all times	
8	Further guides and information for clinicians, clients and carers relating to the Mental Capacity Act are accessible via the MCA/DoLS page on the intranet. The CSH Surrey Safeguarding Team can be contacted for advice and guidance.	To ensure all involved are aware of processes and can access further advice if needed CSH.AdultSafeguardingTeam@nhs.net

4.3 Restraint

Section 6(4) of the MCA 2005 states that restraint is where a person - uses, or threatens to use, force to secure the doing of an act which the person in question resists, or where the person's liberty of movement is restricted, whether or not he/she resists.

If the patient is assessed as having mental capacity to consent and refuses restraint then its use would be unlawful and could constitute an assault, unless it is used under common law to protect others from harm.

To ensure that co-owners are acting in line with the Mental Capacity Act, co-owners should have a good understanding of the types of restraint that may occur in practice and recognise when restraint has occurred.

Types of Restraint

Physical restraint

Stopping an individual's movement by the use of equipment that is not specifically designed for that purpose e.g. bed rails, belts, tables or chairs.

Physical intervention

Refers to the direct action by one or more persons restricting or blocking the persons movement or mobility to stop them going where they wish during a time when the person initiates dangerous or harmful contact to themselves or others. The aim of physical intervention is to redirect, limit or deny free bodily movements as a last resort and should not be confused with interventions such as guiding and prompting that are intended to support the person.

Mechanical restraint

This is restraint that is applied by the use of a specific piece of equipment to control activity for the safety of the person or others. This includes the use of mittens, belts, arm cuffs, splints or helmets to limit movement to prevent self-injurious behaviour or harm to others. It is generally accepted that mechanical restraint will only be used as a planned response by multi-disciplinary team when no other alternative can be found.

Environmental restraint

Environmental restraint is where a patient regardless of legal status is kept confined within an area and maybe segregated from others and prevented from leaving at will.

Designing the environment to limit people's ability to move as they might wish, for example, locking doors, poor lighting or heating, preventing the patient from leaving the hospital and the use of bed rails and low riser beds. Positioning of table in front of chair to prevent person from getting up is not appropriate restraint.

Environmental restraint can be used in an acute situation to PREVENT or MINIMISE:

- Emotional/physical injury to other persons
- The person being a danger to themselves

Chemical restraint

In certain situations, the use of drugs and prescriptions may be indicated as a method of chemical restraint to change or moderate peoples' behaviour. Medication must only be administered under medical advice and must not be used as a routine method of managing difficult behaviour.

When can restraint be used?

Restraint can only be used where a patient lacks mental capacity to consent to it if -

The staff member using it reasonably believes that it is necessary to prevent harm to the patient **and**

Its use is *proportionate* both to the likelihood and seriousness of harm **and**

The restraint must be in the patient's *best interests* **and**

The restraint is the *least restrictive* means by which to keep the patient safe from harm.

If these conditions are met, then Section 5 of MCA 2005 offers protection to CSH co-owners against civil or criminal liability for certain acts done in the care or treatment of the patient which would normally require the patient's consent.

Restraint can therefore only be used after a detailed risk assessment is undertaken and the risk of using restraint is considered less than the risk it aims to reduce. The

effects of restraint will need to be closely evaluated and its application reviewed on an on-going basis.

If restraint is used which cannot be justified, then the protection from prosecution or being sued afforded by the Mental Capacity Act will fall away. If a co-owner restrains a patient without a sound professional and legal basis, the client may bring a civil claim against the staff member in negligence and make a claim for compensation for any harm suffered as a result of the restraint. Both the length of time the restraint lasted and the amount of force used would be factors for the courts to assess to determine whether the restraint was reasonable and professionally accepted and thereby justifiable.

Staff must never use restraint for other purposes – e.g. to compensate for inadequate staffing levels or just so they can do something more easily.

The meaning of "proportionate"

If restraint is assessed as being required then the response should be proportionate. The restraint should be the minimal necessary to achieve effective risk reduction and used for the minimal possible time.

The meaning of "best interests"

The decision to use restraint in the patient's best interests must be based on reasonable grounds and objective reasons, following consideration of:

The patient's feelings and wishes: His/her past and present wishes and feelings, as far as they are reasonably ascertainable; the beliefs and values that would be likely to influence their decision if they had capacity, and the other factors that he/she would be likely to consider if he/she were able to. In determining best interests, staff must take in to account the detailed guidance contained within the MCA Code of Practice. An incapacitated person's best interests, including the consultations that occurred with others in order to arrive at best interests, must be recorded in the patient's notes.

The views of other people: The person making the decision must take into account, if it is practicable and appropriate to consult with them, the views of anyone named by the person as someone to be consulted with; anyone engaged in caring for the person or interested in his welfare; any donee of a Lasting Power of Attorney, and any Deputy appointed for the person by the Court.

The meaning of "least restrictive"

Co-owners need to respond to the requirement to act in a way that would interfere least with the patient's rights and freedom in order to be assured of the legal protection accorded by the MCA in relation to an act of restraint.

Staff must consider whether there is a need to use restraint at all, or if the patient's safety could be assured by other means.

If restraint is used which cannot be justified then the protection from prosecution or being sued afforded by the MCA will fall away.

Advance decisions, Lasting Power of Attorney and Court Appointed Deputies

Advance decisions – if the patient has made a valid and applicable advance decision refusing the proposed restraint, then it cannot be used.

Lasting Power of Attorney – if decisions concerning the proposed restraint have been handed over to another person (donee) under a Lasting Power of Attorney, then it is the donee who must either consent to or decline the restraint.

Court Appointed Deputy – if the patient has a Court Appointed Deputy who has been given authority to take decisions about proposed restraint, then it is the Deputy who must consent to or decline the restraint.

Staff must consider whether there is a need to use restraint at all, or if the patient's safety could be assured by other means. If you need to restrain someone in their 'best interests' please ensure that the appropriate mental capacity assessment, risk assessment and documentation has been completed.

4.4 Deprivation of Liberty Safeguards (DoLS) Applications (Process flowchart appendix 3)

In July 2018 The Mental Capacity (Amendment) Bill was introduced to the House of Lords and seeks to replace the current system known as 'Deprivation of Liberty Safeguards' (DoLS). The government has now developed a new system, known as 'Liberty Protection Safeguards', which will become law through the bill; this is expected to be introduced in 2020. Until this date CSH Surrey will continue to follow the DoLS process outlined below. This Policy will be amended as soon as the new "Liberty Protection Safeguards" become legislation.

The Mental Capacity Act permits the use of restraint where necessary, however confirms there is no protection under the Act for actions that result in someone being deprived of their liberty.

DOLS apply to people in hospital and care homes who meet all of the following criteria

- Aged 18 or over
- Have a mental disorder such as dementia or learning disability
- The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements.
- Need to have their liberty taken away in their own best interests to protect them from harm

Examples within CSH services might include:

- Restraint used to admit a person to a hospital or care home when the person is resisting admission
- Hospital or care home staff taking all decisions on a person's behalf, including choices relating to assessments, treatments, visitors and where they can live
- Hospital or care home staff taking responsibility for deciding if a person can be released into the care of others or allowed to live else where

In cases where the registered Clinician feels that a person is being deprived of their Liberties the clinician should consider the revised test for the deprivation of liberty – The Acid Test (Supreme Court Ruling 2014). If the person meets the acid test a DoLS application should be completed.

The acid test:
"The person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements."

1	Assess whether the care or treatment takes away freedom to do what they want – apply the acid test
2	Consider whether the treatment or care can be provided in a less restrictive way
3	If alternative options are available then treatment or care can progress
4	If no alternative options are available the Ward Manager/Ward Sister/Nurse in Charge must apply to the Local Authority (Supervisory body) for authorisation to continue with the care programme and deprive the person of their liberty. To make an application the Ward Manager/Nursing staff must complete the DoLS application forms. The forms are available on the MCA/DoLS page of the CSH Surrey intranet site or on the Surrey County Council web site themselves. There are two kinds of authorisation – standard and urgent. **Urgent DoLS:** *An urgent application is made if the patient is unable to consent to being in the hospital/ care setting and is making obvious attempts to leave.* *A Standard DoLS should applied for at the same time as an urgent DoLS* *An urgent DoLS covers the patient for 7 days and one further extension can be made after this* **Standard DoLS** *An application should be made for patients that are not making active attempts to leave but cannot consent to being in the hospital/ care setting.* . A quick link to this information is available on the Safeguarding Intranet page. The Adult Safeguarding Team must be informed of any DoLS applications.
6	The registered clinician must sign the application and submit it to the SURREY DoLS Team – please also include: csh.adultsafeguardingteam@nhs.net Surrey County Council, Quadrant Court, 3rd Floor 35 Guildford Road, Woking GU22 7QQ. dolsteam@surreycc.gov.uk Telephone: 01483-517644

	Fax: 01483-517830 If an urgent application has been made it is the responsibility of the Ward Manager/Nurse in charge to apply for a further 7 day extension on the appropriate day if required; this is completed on the original application form.
8	The Supervisory Body (Local Authority) will then decide on whether to authorise the deprivation of liberty.
9	The Ward Manager and MCA/DoLS Lead (or Clinical Manager) will be informed of the outcome of the decision which must be clearly recorded in the person's healthcare records.
10	The MCA/DoLS Lead/Safeguarding Team is responsible for providing CQC with the required information regarding any DoLS applications and reporting to the Adult Safeguarding Group at each meeting.

5. ASSOCIATED DOCUMENTS AND REFERENCES

- Department of Health (2005). Mental Capacity Act. London, HMSO.
- Department for Constructional Affairs (2007). Mental Capacity Act 2005: Code of Practice. London, TSO.
- Ministry of Justice (2008). Mental Capacity Act 2005, Deprivation of Liberty Safeguards. London, TSO
- Social Care Institute for Excellence (2009). Mental Capacity at a Glance.
- Ministry of Justice, 2007. Making Decisions, The Independent Mental Capacity Advocate (IMCA) Service. DOH.
- Department of Health and Office of the Public Guardian. (2009). Deprivation on Liberty Safeguards: A Guide for hospitals and care homes. DOH. London
- CQC Essential Standards for Quality and Safety 2010
- Deprivation of Liberty Safeguards, Judgement of the Supreme Court Ruling, PV Cheshire West and Chester Council and another P and Q Surrey County Council, DOH, 2014.
- Mental Capacity (Amendment) Bill [HL] 2017-19

5.1 Related CSH Documents

Other related polices include:

CSH Surrey Safeguarding Adults Policy
CSH Surrey Consent Policy

6 Training

To ensure that co-owners are competent in the application of the Mental Capacity and DoLS guidance, all co-owners who provide face to face direct clinical care should undertake Mental Capacity and Deprivation of Liberty Safeguards training face to face every two years; these same co-owners should also complete Consent on-line training every two years.

7. MONITORING COMPLIANCE AUDIT & REVIEW

CSH Surrey regards Mental Capacity and Deprivation of Liberty Safeguards as integral to clinical governance and audit arrangements. Annually CSH complete a Mental Capacity Deprivation of Liberty Safeguards audit which is shared with both Mid Surrey and NWS CCG and also with the Surrey Safeguarding Adults Board.

This Policy will ordinarily be reviewed on a three year cycle. However if there is significant legislative changes or changes in CSH Operations or Service Delivery, then this policy will be reviewed and updated accordingly; this policy will be updated when the new Liberty Protection Safeguards are introduced following parliamentary review in 2019; the Safeguarding Adults and Children's Committee will be responsible for overseeing this policy review.

7. CONSULTATION, APPROVAL, RATIFICATION & REVIEW

This Policy was ratified by the Adults and Children Committee members who have confirmed that the appropriate process had been followed in the development of the document. Without this policy in place CSH Surrey are at risk of breaching the Human Rights Act 1998, and the Mental Capacity Act 2005.

8. DISSEMINATION AND IMPLEMENTATION

This policy will be made to available to CSH Surrey co-owners. All new CSH Surrey co-owners will be informed during induction that all its policies are available on the intranet. Reference to Policies will be made in both Safeguarding Adults Training and Mental Capacity and Deprivation of Liberty Safeguards training and will also be available on the Safeguarding Adults and Mental Capacity pages of the intranet.

This policy will be reviewed in the light of changing legislation and will be monitored via the CSH Surrey Safeguarding Adult and Children Group to ensure the effectiveness of these guidelines.

9. VERSION CONTROL

Record of Changes			
Date	Version	Changes / Comments	Approving Forum
01/07/11	1	New Policy	
01/10/14	2	Policy updated to include new Deprivation Of Liberty Safeguards Judgement. Policy in new template format	
01/04/15	3	Policy updated to include new Restraint Section	
01/11/19	3.1	Policy review – minor wording changes made	
25/01/19	4	Policy review – minor wording changes and section added re: Best Interest and future changes to DoLS. Policy in new template format	Safeguarding Committee

Appendix 1 - Definition of Terms

Advance decisions to refuse treatment – The Act creates statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future. The Act sets out two important safeguards of validity and applicability in relation to advance decisions. Where an advance decision concerns treatment that is necessary to sustain life, strict formalities must be complied with in order for the advance decision to be applicable. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands "even if life is at risk" which must also be in writing, signed and witnessed.

Assessing lack of 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 "decision-specific" and time specific test. No one can be labelled 'incapable' simply as a result of a particular medical condition or diagnosis. Section 2 of the Act makes it clear that 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. People may, however, have difficulties in making some decisions all or some of the time if they have a learning disability; dementia; a mental health problem; a brain injury or stroke; confusion, drowsiness or unconsciousness by illness or the treatment of that illness. It may even be due to the effects of substance misuse.

Best Interests (MCA) –An act done or decision made for or on behalf of a person who lacks capacity must be in that person's best interests. The Act provides a non-exhaustive checklist of factors that decision-makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person making the determination must consider. Also, people involved in caring for the person lacking capacity gain a right to be consulted concerning a person's best interests.

Best Interest Assessment (DOLS) - An assessment, for the purpose of the deprivation of liberty safeguards, of whether deprivation of liberty is in a detained person's best interests, is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm.

Acts of care or treatment - Section 5 offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity**.** This could cover actions that might otherwise attract criminal prosecution or civil liability if someone has to interfere with the person's body or property in the course of providing care or treatment.

Code of Practice (MCA) -The Code will provide guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do these things themselves. Those who will have a duty of care to a person lacking capacity, such as attorneys, deputies, IMCAs, professionals and paid carers must have regard to the Code. The Code of Practice is available on the CSH Intranet (Policy SG 4)

Code of Practice (DOLS) - This Code of Practice provides guidance to anyone working with and/or caring for adults who lack capacity, but it particularly focuses on those who have a 'duty of care' to a person who lacks the capacity to consent to the care or treatment that is being provided, where that care or treatment may include the need to deprive the person of their liberty. This Code of Practice is also intended to provide information for people who are, or could become, subject to the deprivation of liberty safeguards, and for their families, friends and carers, as well as for anyone who believes that someone is being deprived of their liberty unlawfully. This Code of Practice is available on the CSH Intranet; The DOLS Guide for Hospitals and Care Home is available on the CSH Intranet (Policy SG 5).

Court appointed Deputies -The Act provides for a system of court appointed deputies to replace the current system of receivership in the existing Court of Protection. Deputies will be able to be appointed to take decisions on welfare, healthcare and financial matters as authorised by the new Court of Protection (see below) but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues. People appointed as receivers before October 2007 will retain their powers concerning property and affairs after the implementation date in October 2007 and will be treated as deputies after this time.

Court of Protection - It will have its own procedures and nominated judges. It will be able to make declarations, decisions and orders affecting people who lack capacity and make decisions for or appoint deputies to make decisions on behalf of people lacking capacity. It will deal with decisions concerning property and affairs, as well as health and welfare decisions. It will be particularly important in resolving complex or disputed cases involving, for example, about whether someone lacks capacity or what is in their best interests. The Court will be based in venues in a small number of locations across England and Wales and will be supported by a central administration in London.

Decision – maker - Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to as the 'decision-maker', and it is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity. For PCT staff this would be the lead clinician i.e. Consultant (who may be medical, non-medical, dental etc.) or a GP. In the ASIST referral form and documentation, this person is often referred to as the "Authorised Officer".

Excluded decisions- A person (on behalf of another person who lacks capacity) can never make some types of decisions and the Act does not change this. This is because these decisions or actions are either so personal to the individual or because other laws govern

them. These include decisions such as marriage or civil partnership, divorce, sexual relationships and voting. They also include decisions about treatment for mental disorder where someone is being detained and treated under Part 4 (Consent to Treatment) of the Mental Health Act which allows the person to be treated without their consent.

IMCA -An IMCA will be someone appointed to support a person who lacks capacity but has no one to speak for them, such as family or friends. They will only be involved where decisions are being made about serious medical treatment or a change in the person's accommodation where it is provided by the National Health Service or a local authority. The IMCA makes representations about the person's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary. Timely identification of the need to refer to an IMCA is crucial as any delay in doing so will cause delays in medical treatment, discharge from hospital or a placement in a care home. The IMCA referral form is available on the Safeguarding Hub on the intranet.

Lasting Power of Attorney (LPA) -The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This is like the current Enduring Power of Attorney (EPA) in relation to property and affairs, but the Act also allows people to empower an attorney make health and welfare decisions. Before it can be used an LPA must be registered with the Office of the Public Guardian (see below). EPAs created before October 2007 can be registered after the implementation date but it will not be possible to create EPAs after this time.

Managing Authority (DOLS) - The person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty. A managing authority must not, except in an urgent situation, deprive a person of liberty unless a standard authorisation has been given by the supervisory body for that specific situation, and remains in force. It is up to the managing authority to request such authorisation and implement the outcomes.

Public Guardian - The Public Guardian has several duties under the Act and will be supported in carrying these out by an Office of the Public Guardian (OPG). The Public Guardian and his staff will be the registering authority for LPAs and deputies. They will supervise deputies appointed by the Court and provide information to help the Court make decisions.

Research - Research involving, or in relation to, a person lacking capacity may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees that the research is safe, relates to the person's condition and cannot be done as effectively using people who have mental capacity. The research must produce a benefit to the person that outweighs any risk or burden.

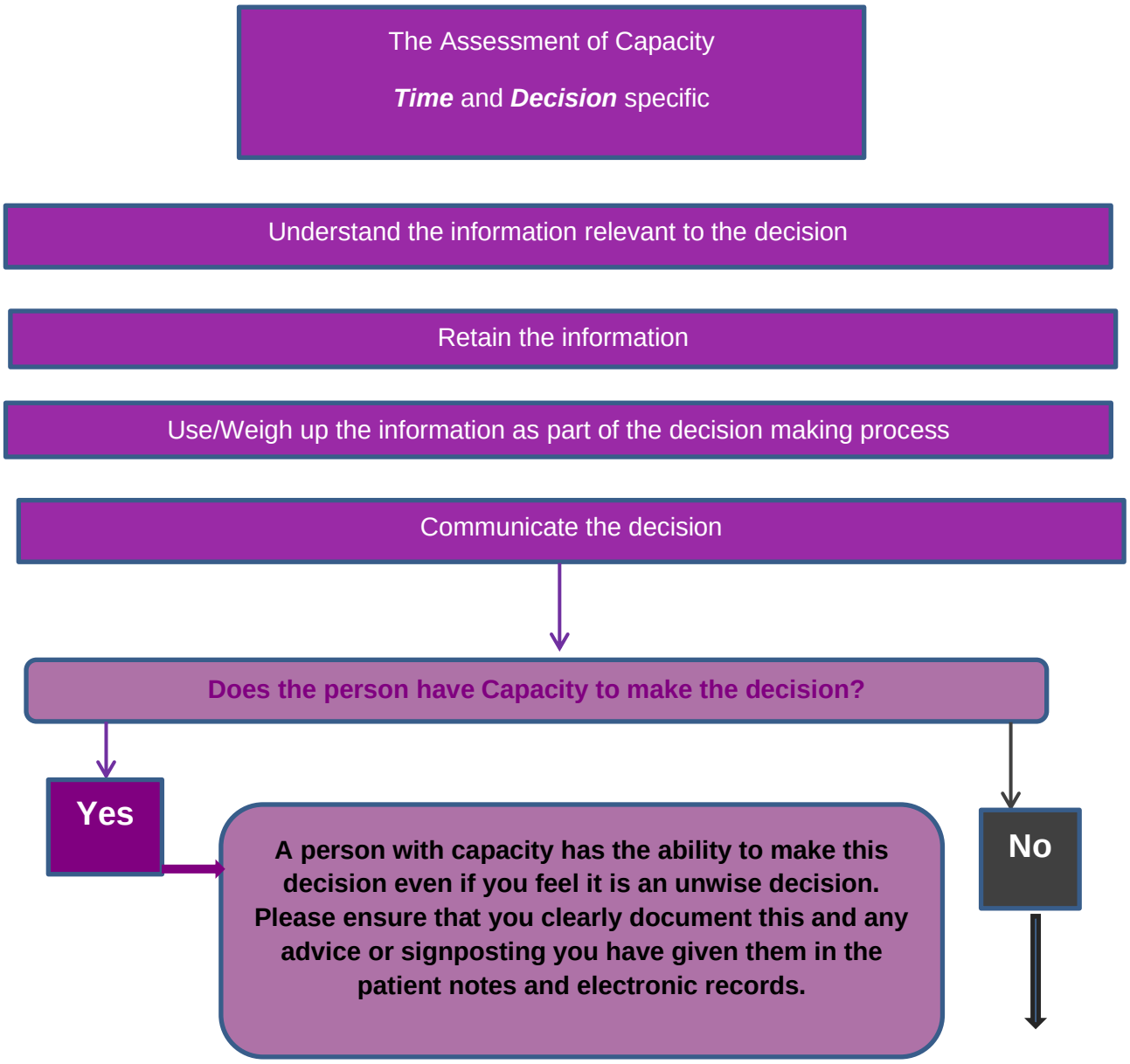
Relevant person - is a person who is, or may become, deprived of their liberty in accordance with the deprivation of liberty safeguards.

Restraint - Section 6 of the Act sets out limitations on section 5. It defines restraint as the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of the harm. Appropriate use of restraint falls short of deprivation of liberty, e.g., preventing a person from leaving a ward because they would try to cross a road in a dangerous manner is likely to be seen as a proportionate restriction or restraint, similarly, locking a door to guard against immediate harm is unlikely, in itself, to amount to deprivation of liberty.

Supervisory Body (DOLS) - A primary care trust or local authority (Social Care & Health) that is responsible for considering a deprivation of liberty request received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty. In the case of hospital patients, where a PCT is commissioning the patient's care or treatment then the PCT is the supervisory body. In all other cases, the supervisory body is the PCT for the area in which the relevant hospital is located. In the case of care homes, the supervisory body is the local authority for the area in which the person ordinarily resides. If the person has no ordinary place of residence – they are of no fixed abode – then the supervisory body is the local authority for the area in which the care home is situated.

Supervisory bodies will receive applications from managing authorities for standard authorisations of deprivation of liberty. Deprivation of liberty cannot lawfully begin until the supervisory body has given authorisation, or the managing authority has itself given an urgent authorisation.

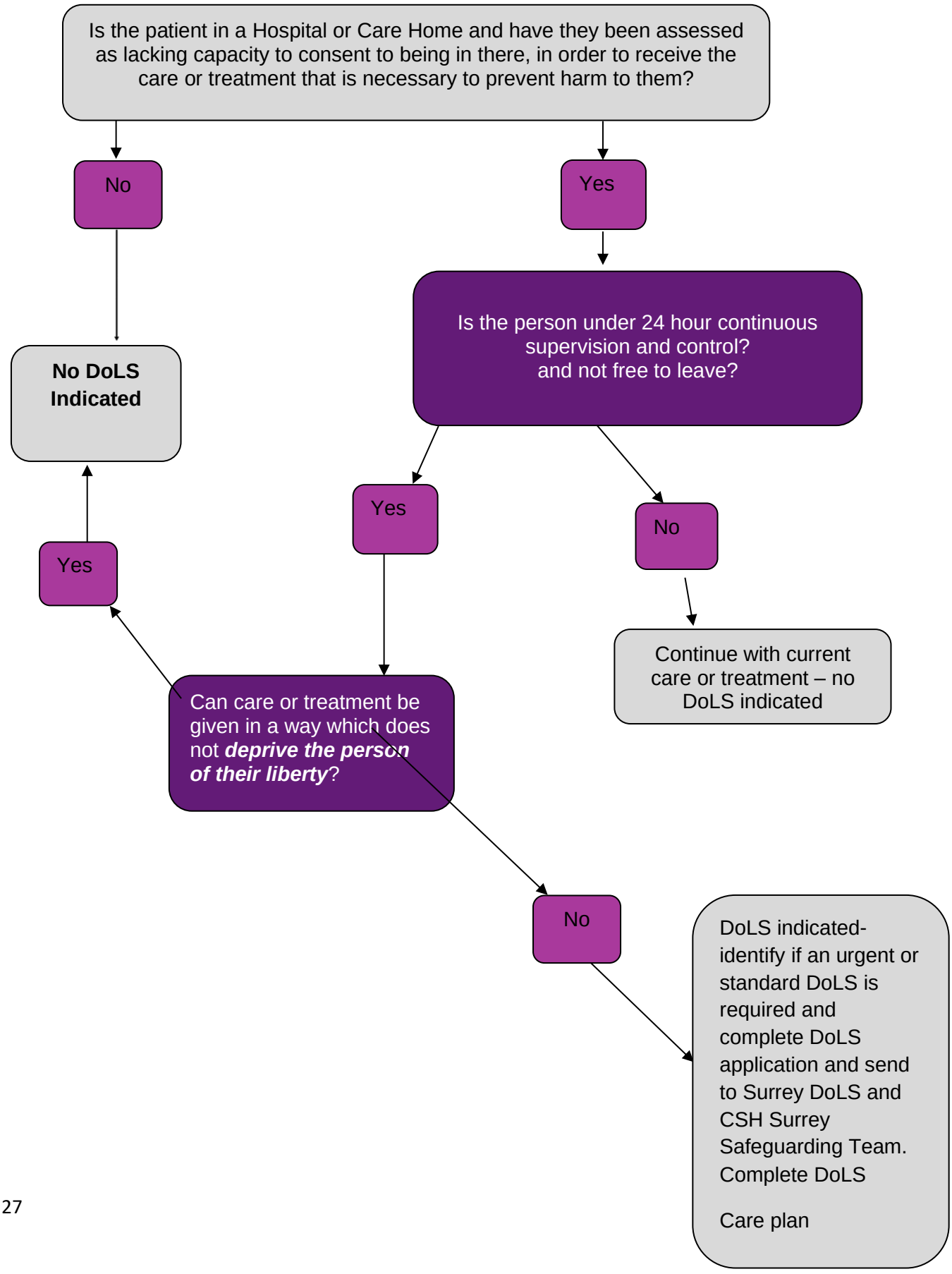
Appendix 2 - Assessment of Capacity - Do you have reason to question someone's capacity to make a decision? If so, you need to complete a mental capacity assessment. Remember, capacity is decision and time specific.



You must now apply the principles of best interest

- **Do not make assumptions based on appearance, race age or medical condition**
- **Encourage the person to participate as much as possible**
- **Consider if they may regain capacity in the future and whether the decision could be put off until later**
- **Consider the person's past and present beliefs, values and wishes**
- **Take into account the views of other i.e. carers, relatives, friends and advocates**
- **Consider the least restrictive option**

Appendix 3 - MCA (Mental Capacity Act) DOLS (Deprivation of Liberty Safeguards) Process



Equality impact assessment tool

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation - Straight, Lesbian, Gay and Bisexual etc.	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
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?**	No	
6.	**What alternative is there to achieving the document/guidance without the impact?**	No	
7.	**Can we reduce the impact by taking different action?**	No	

CSH Surrey Policy and Procedure Ratification Tool

1.0	**Document Title & Reference number**		
1.1	Guidance on Mental Capacity Act and Deprivation Liberty Safeguards (DoLS) Version 3.2		
1.2	Ref number	SG10	
2.0	**Document Author (Name & Job Title)**		
2.1	Name	**Jane Stapleton**	
2.2	Job title	**Adult Safeguarding Advisor**	
3.0	**Reason for Development/Review: * Please delete as applicable**		
	Requirement for new document identified: Annual Review Review date due: February 2019		
4.0	**Does this document replace or supersede an existing policy Yes / No**		
	If yes please provide details:		
5.0	**Summary Overview**		
6.0	**Approval process**		
6.1	Executive Sponsor	**Director of Quality**	
6.1	Approval Forum	**Safeguarding Committee**	
6.2	Date of Approval:	**15/2/19**	
7.0.	**Ratification Checklist**		
7.1	Lead Author details are clearly stated		Yes
7.2	Author/ Approval demonstrate appropriate qualifications/experience to develop this document		Yes
7.3	The purpose for the document is clear		Yes
7.4	The scope of the document is clear		Yes
7.5	Content supports rationale		Yes

7.6	Content is clear and unambiguous	Yes
7.7	Responsibilities clearly stated	Yes
7.8	Auditable standards or processes of monitoring compliance and implementation are clearly stated	Yes
7.9	Any associated risks have been clearly documented	Yes
7.10	There is an appropriate update evidence base including references / NICE etc	Yes
7.11	External Regulation Requirements (e.g. CQC/HSE/NHSR/ NHSI) have been reflected	Yes
7.12	Reference to consent requirements is evident if applicable	Yes
7.13	Training and/or competencies requirements are clearly stated	Yes
7.14	There is clear cross reference to related documents/data sources including cross reference to related CSH documents	Yes
7.15	Consultation processes, dates and those involved including co-owners and public where appropriate have been recorded	N/A
7.16	Corporate Image: Pages, entries and sections are clearly numbered. Arial 11 and above has been used	Yes
7.17	Document control – Reference and Version numbering are correct	Yes
7.18	Review date is clearly stated (one/two or three years)	Yes

8.	**Ratification**	
8.1	Ratification Forum	Policy Working Group
8.2	Ratification Date	18/03/2019