Cornwall Partnership NHS
NHS Foundation Trust

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Title:	**Guidance for the Management of Patient's who Lack Capacity (including Deprivation of Liberty Safeguards)**
Purpose:	Guidance on application of MCA and DoLS within CFT
Applicable to:	All clinical staff.
Document Author:	P Belcher MHA Advisor
Ratified by and Date:	Ellen Wilkinson – Medical Director 1 April 2015
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Expiry Date:	April 2018 *3 years after ratification unless there are any changes in legislation or changes in clinical practice*
Document library location:	Mental Health Act

Related legislation and national guidance:	• MCA 2005. • MHA 1983 (amended 2007) • DoLS 2007
Associated Trust Policies and Documents:	• Advance Decisions and Advance Statements • Deprivation of Liberty Safeguards (DoLS) a brief guide for wards and community
Equality Impact Assessment:	The Equality Impact Assessment Form was completed on 31.03.15
Training Requirements:	Training shall be based on individual staff needs. Team Managers to discuss with staff in team meetings and be featured in Cascade and Executive Briefing. *The organisation trains staff in line with the requirements set out in its training needs analysis and published in its Corporate Curriculum.* *Training which is categorised as statutory or essential must be completed in line with the training needs analysis and Corporate Curriculum.* *Compliance with statutory and essential training is monitored through the Learning and Development team with monthly manager's reports and staff individual training records twice yearly.*

	Training reports are also submitted quarterly through the Trust Quality and Governance Committee Meeting. *Staff failing to complete this training will be accountable and could be subject to disciplinary action.*
Monitoring Arrangements:	MHA dept. audit mental capacity assessments MHA dept. monitor and report DoLS applications in inpatient wards
Implementation:	This policy supports existing practice. No specific implementation required. Awareness will be raised via training

Version Control

Version	Date Reviewed	Changes	By Whom
	March 2015		V. Slavin
This document Replaces:			
MHA/010 - Guidance for the Management of Patients who lack capacity and require Health and Social Service Interventions			

This document **can** be released under the Freedom of Information Act.

Contents

1. Introduction

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who are not able to make their own decisions. It makes it clear who can take decisions on behalf of others, in which situations, and how they should go about this. It enables people to plan ahead for a time when they may lose capacity.

Guidance on the Act is provided in the Code of Practice for the MCA and the Code of Practice for Deprivation of Liberty Safeguards.

2. Five key principles of MCA

1. A person is assumed to have capacity to make a decision unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under MCA for or on behalf of a person who lacks capacity must be done, or made, in their best interests
5. Before the decision is made we must consider whether the purpose can be achieved in a way that is less restrictive of the person's rights and freedom of action.

3. Purpose

This policy provides advice and guidance on how and when a formal assessment of capacity should be carried out. This includes routine or ongoing assessments of capacity as part of everyday care, and occasions when a more formal assessment is necessary.

This policy must be considered when any act in relation to care, carried out by our staff, requires a user of our services, their carers or relatives to make a decision or choice. It should be considered when carrying out any act mandated by any other policy.

4. Scope

This policy applies to staff working in CFT with people over 16 years of age who may not be able to make their own decisions.

5. Who should assess capacity?

All frontline health professionals may have a responsibility for assessing capacity and making best-interest decisions.

In many cases, the assessment of capacity is straightforward and, should be performed by the worker responsible for the particular decision in relation to which capacity is being assessed.

In complex cases, for example where the individual's decision-making capacity appears to fluctuate rapidly or is particularly difficult to assess, it may be necessary to obtain the opinion of a psychiatrist. In these cases, it is good practice for the psychiatrist to assess capacity jointly with the responsible professional who can explain the care decision to be made and the implications of a decision.

Consultant Psychiatrists have a particular responsibility to carry out assessments of capacity in borderline and other difficult cases, particularly when specifically asked to do so by staff, and in some set situations such as when requested to do so by the Court of Protection.

Where the service user is subject to multi-disciplinary care, the professional with greatest responsibility for the decision in relation to which capacity is being assessed (the 'decision-maker') should be the person who assesses capacity. Where this is in doubt agreement should be sought within the multidisciplinary team.

Where a service user has been referred to the Court of Protection, either for a one-off decision or for the appointment of a Deputy, the Court will normally require an assessment of capacity to be carried out by a doctor.

6. When should Mental Capacity be assessed?

Care and treatment, particularly in mental health settings, is often not a one-off treatment (like as an operation or other medical intervention) but consists of on-going care over a period of weeks or months. The assessment of capacity must necessarily be a continuous and on-going process.

All professionals involved in the provision of care and treatment must assure themselves that the person either continues to have capacity or, if they do not have capacity, that the care and treatment given is necessary and in the person's best interests in accordance with the MCA. It is good practice for this routine assessment of capacity to be noted in the clinical record.

When a patient faces an important decision, in relation to care and treatment or something arising from it or in relation to their financial affairs and there are any doubts about the ability of the patient to give a valid consent to the decision a formal assessment of capacity must be carried out.

It is not possible to list all the eventualities when a formal assessment of capacity is required and professional judgement must be exercised. The following represent some examples where a formal capacity should be recorded:

- admission to hospital
- significant change of accommodation (as defined by the Mental Capacity Act 2005)
- information sharing (i.e. where personal information about the service user may be given to a third party)
- decisions in relation to the management of finances, property or affairs
- where consideration is being given to a referral under DoLS
- relationships (especially sexual relationships) where lack of capacity could indicate the possibility of abuse
- first medical treatment and any significant change in treatment (including any treatment certified under S4/S4A of the MHA)
- where patient has not appealed to tribunal against detention but appears to object and may lack capacity to appeal.

If in doubt staff should seek advice from their manager/senior colleague MHA/MCA office.

7. Assessing capacity

The decision maker has responsibility for carrying out an assessment and recording it. Capacity is assessed in regard to a specific decision at a particular time. For each different decision a new assessment should be made.

The recording process for Capacity Assessments is via RIO. All capacity assessments should be recorded in the appropriate field which is: 'MCA information sharing and consent' / 'Mental Capacity Assessment'.

8. RIO Capacity assessment checklist

- Specify the decision type
  what is the decision to be made? Record the specific decision
- Does the individual have an impairment of mind or brain?
  record details of the impairment and how long it is likely to last.
  when is it planned to review this?
- Can the person (with all practicable support) understand information relevant to the decision?
  record the evidence and how this conclusion was reached
- Can they retain the information long enough to make the decision?
  record the evidence and how this conclusion was reached
- Can they weigh up the information to make the decision?
  record the evidence and how this conclusion was reached
- Are they able to communicate the decision by any means?
  record the evidence and how this conclusion was reached

If the person is unable to complete one of these steps due to mental impairment the person lacks capacity to make this specific decision at this particular time.

If person is assessed to lack capacity decision makers must;

- consider if the decision can be delayed until capacity is regained
- follow any valid advance directive that applies and consider any advance statement
- consult with their Attorney or Court Appointed Deputy if applicable.
- consult family or friends who are concerned with patients welfare and IMCA where appropriate.

9. Best Interests

The law provides protection to decision makers as long as they follow the principles of the MCA, assess capacity, and reasonably believe that on balance the person lacks capacity, and they make a decision on behalf of the person that they reasonably believe to be in the person's best interests (see Chapter 5 of the MCA Code of practice).

10. Best Interests checklist

Decision makers must consider the statutory checklist (MCA code of practice Ch 5) and address all relevant issues.

Has a capacity assessment relating to the decision been completed?

- Can the decision wait until the person regains capacity to make it?
- Have you tried to involve the person as far as practicable?
- Have you found out as far as practicable about the person's past and present wishes and preferences in relation to the decision? Their beliefs and values and previous choices?
- Have you checked for any valid advance statement that applies to the decision?
- Have you considered any relevant written statement made when the person had capacity?
- Is this an 'excluded decision' under the MCA?
- Have you considered whether there is a way of acting that is less restrictive of the person's rights and freedoms?
- Have you consulted all relevant people? (Record/update contact details of these people in the 'capacity contacts' field)
  - Family and friends who are concerned with person's welfare
  - Anyone previously named by person as important
  - Advocate, Attorney or Court Appointed Deputy,
  - IMCA if one has been appointed
- If the decision is about life sustaining treatment are you clear that the decision is not motivated by a desire to bring about the person's death?

11. Resolving disputes

The decision maker has an obligation to consult and take into the account the views of other people. The objective of consultation is to try and establish the views, wishes, beliefs and values of the person. There is no duty to follow what is said by those consulted if, in the decision maker's opinion, their views are not in the person's best interests.

If there is any disagreement or doubt a formal Best Interests meeting may be required in order to reach a consensus. If a consensus is not reached at any best interests meeting then the matter may need to go to the Court of Protection and the Trust's legal department should be consulted for advice.

12. Recording Best Interest decisions

After making the decision, decision making should be recorded fully in the RIO Best interest decision field (MCA Information sharing and consent/Best Interests Considerations), showing how the decision maker came to the conclusion that the decision made was in the person's best interests. (Please note a capacity assessment must be recorded immediately before Best interests record can be completed).

13. Decisions which can never be made for a person who lacks capacity

The Act does not permit decisions to be made on someone else's behalf on any of the following matters:

- consenting to marriage or a civil partnership
- consenting to have sexual relations
- consenting to a decree of divorce on the basis of two years' separation
- consenting to the dissolution of a civil partnership

- consenting to a child being placed for adoption or the making of an adoption order
- discharging parental responsibility for a child in matters not relating to the child's property, or
- giving consent under the Human Fertilisation and Embryology Act 1990.

14. Independent Mental Capacity Advocate

An Independent Mental Capacity Advocate (IMCA) is a specialist advocate who can only be appointed when certain criteria are met

The duties of an IMCA are to:

- Support the person who lacks capacity and represent their views and interests to the decision-maker
- Obtain and evaluate information
- As far as possible, ascertain the person's wishes and feelings, beliefs and values
- Identify alternative courses of action
- Obtain a further medical opinion, if necessary.
- The IMCA cannot be a decision maker.

An IMCA must be appointed to support a person who lacks capacity and has no family or friends to consult and where:

- It is proposed that the person needs serious medical treatment provided by the NHS (excluding treatment under Part4 of the MHA 1983)
- It is proposed that the person is moved into long term care of more than 28 days in hospital (where this is not a requirement under the MHA 1983)
- It is proposed that the person is to be moved (for more than 8 weeks) to different accommodation, such as a hospital or a care home (where this is not a requirement under the MHA 1983)
- An IMCA may also be appointed in cases of adult protection and care reviews.

Young people, aged 16 and 17 must be referred to the IMCA service if they:

- Have no family member, friend or existing advocate who can support them in making a decision in their best interests
- Lack capacity in relation to a decision
- May be facing major or life changing decisions

All Health and Social Care staff must be aware that IMCAs have statutory right of access to records which the record holder considers may be relevant to the advocates' role. Clinicians and practitioners should be prepared to give such access to files and notes. Those responsible for patient records should ensure that third party information and other sensitive information not relevant to the decision at hand remains confidential.

15. Advance Decisions

People who have capacity to decide and are over 18 may make an advance decision to refuse a specified treatment which will come into effect at a time when they no longer have capacity to

refuse or consent to treatment. A valid advance decision has the same effect as if the person still had capacity and could make the decision now.
Any valid advance decision should be uploaded to RIO and information added to Consent fields. Steps should be taken to make sure other professionals know about the advance decision. One way to do this is to incorporate the information into a care plan.

16. Advance Decisions and the Mental Health Act

The Mental Health Act does allow treatment of detained patients (and CTO patients recalled to hospital) without their consent in some circumstances. So the MHA may sometimes be used as the framework to treat when there is a valid advance decision refusing treatment.
Clinicians should try to comply with the patient's wishes where possible (e.g. by using a different form of treatment that is not refused by the advance decision) even where the MHA allows treatment without consent.

17. When an Advance Decision is not legally binding

An 'advance decision' is not binding if:

- At the material time person who made it still has capacity to give or refuse consent to the treatment being proposed.
- Not valid e.g. the person withdrew the AD at any time when they had capacity, or have done something clearly inconsistent with the AD
- Not applicable to the treatment or if treatment is not the treatment specified in the AD
- Any circumstances specified in the AD are absent, or there are reasonable grounds for believing that circumstances exist which the person did not anticipate at the time of the AD and which would have affected his/her decision
- An LPA is created after the AD which gives the attorney the authority to give or refuse consent to the treatment to which the AD refers.

An advance decision is not applicable to life-sustaining treatment unless it is verified by a statement to the effect that it is to apply to that treatment even if life is at risk and the decision is in writing, signed and witnessed.

18. Lasting Power of Attorney (LPoA)

A Lasting Power of Attorney lets an individual appoint someone to make decisions on their behalf. There are two types:

- Health and welfare
- Property and financial affairs

.
Where an attorney has been authorised to make health and welfare decisions the following applies:

- The attorney only has authority to make decisions if the person lacks capacity
- If the person has an advanced decision made prior to the appointment of an attorney, the attorney can decide whether to override the advance decision.
- If the advance decision was made after the appointment of the attorney it must stand.

19. Interface between MHA and MCA

The MCA applies to people subject to the MHA in the same way as it applies to anyone else, with four exceptions:

- If someone is detained under the MHA, decision-makers cannot normally rely on the MCA to give treatment for mental disorder or make decisions about that treatment on that person's behalf
- If somebody can be treated for their mental disorder without their consent because they are detained under the MHA, healthcare staff can treat them even if it goes against an advance decision to refuse that treatment
- If a person is subject to guardianship, the guardian has the exclusive right to take certain decisions, including where the person is to live, and
- Independent Mental Capacity Advocates do not have to be involved in decisions about serious medical treatment or accommodation, if those decisions are made under the MHA.

20. Choosing between the MHA and MCA as framework for admission and treatment

Practitioners must be able to identify the legal framework that governs a patient's assessment and treatment and authorise any appropriate deprivation of a patient's liberty. The legal framework is not static and may change as the patient's circumstances and needs change.

For a person who lacks capacity and who suffers from mental disorder for which they require assessment and/or medical treatment in a hospital setting, but who does not object to being accommodated in a hospital setting or receiving that treatment, both detention under the MHA Act or detention under MCA and a DoLS authorisation/DoL order will in principle be available. In this situation, decision-makers must determine which regime is the more appropriate. (AM v SLAM 2013).

Professionals may need to think about using the MHA to detain and treat somebody who lacks capacity to consent to treatment (rather than use the MCA), if:

- It is not possible to give the person the care or treatment they need without doing something that might deprive them of their liberty

- The person needs treatment that cannot be given under the MCA (for example, because the person has made a valid and applicable advance decision to refuse an essential part of treatment)
- The person may need to be restrained in a way that is not allowed under the MCA
- It is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might then refuse to give consent)
- The person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so, or
- There is some other reason why the person might not get treatment, and they or somebody else might suffer harm as a result.

(MHA code of practice)

Decision makers must decide which of the two frameworks will be the least restrictive way to provide the care that is needed. This will be based on individual circumstances and may change over time as the patient's condition and needs change. So it is possible that a person may start an admission detained under MHA, and then be discharged from section to be detained under MCA / DoLS.

Responsible clinicians must continually keep this issue under review and if necessary change the legal framework so that the least restrictive framework is used at all times. Clinicians should also consider the implications of changing one framework to another. Whilst changes can be made, there may be time constraints and additional stresses for the patient in the process of the change over and this also needs to be considered when making the decision.

It is important that any consideration of admission under the MCA and DoLS and decision on whether this is inappropriate is recorded in the patient's medical notes, with reasons.

21. Deprivation of Liberty Safeguards

DoLS were introduced to compliment the MCA and provide an alternative lawful authority for detention and treatment where the person lacks capacity to consent. DoLS are intended to ensure that deprivation of liberty should only take place when it is in the best interests of the person concerned. They provide a framework for making this decision and a process for review and appeal.

DoLS are applicable to patients in hospitals and care homes in England and Wales who:

- Suffer from a mental disorder or disability of mind
- Lack capacity to give consent to the arrangements for their care or treatment
- Can only be given that care and treatment in circumstances that amount to a deprivation of their liberty
- Require such a regime as a necessary and proportionate response in their best interests to protect them from harm.
- And where there is no less restrictive alternative

22. Deprivation of Liberty

The "acid test" in deciding whether an incapacitated adult is being deprived of their liberty comprises two key questions:

- Is the person subject to continuous supervision and control?
- Is the person free to leave?

To be deprived of their liberty, an incapacitated adult must be subject to both continuous supervision and control and not be able to leave their placement, even if the person is showing no objection. Factors that are irrelevant are:

- Patient's awareness of DOL
- Patient's compliance,
- Reason or purpose behind the placement
- The patient's disability, and the relative normality, quality and normality of a placement

There is a significant likelihood that a patient residing on a ward under the MCA is going to be deprived of their liberty. Most of our wards would satisfy the test that the patient is under continuous supervision and control and not free to leave. The starting point will always be that any individual residing in a ward under the MCA should have a DoLS authorisation).

If someone is deprived of their liberty on a ward and they are ineligible for a DoLS authorisation or there is any issue preventing a DoLS authorisation, it will be for the Trust's legal department to consider whether the matter needs to go to the Court of Protection and contact with the Trust solicitor (via MHA office) should be made immediately, so that the process can start urgently without delay.

23. In the community

At present Deprivation of Liberty safeguards can only be applied to people who are being cared for in hospital or a registered care home setting**.**

If a person is living in another setting where their care is connected to the state such as having some elements coordinated by a local authority or NHS Trust, including supported living arrangements, and if the care plan is depriving the incapacitated person of their liberty, the Court of Protection is the only way to grant legal authorisation. The application process should be directed and requested through whoever is commissioning the package of care.
The Supreme Court has advised that in cases with any doubt as to whether the deprivation of liberty safeguard threshold is met, an application should be applied for to prevent unlawful deprivation.

24. Eligibility for DOLS

The 6 qualifying requirements for DOLS are

- Aged 18 or over
- Suffering from a mental disorder as defined under MHA
- Lacks capacity to decide on accommodation in hospital care and treatment

- That DoL is in their best interests, to protect them from harm and is proportionate to the likelihood and seriousness of the harm
- That they are 'not ineligible' for DoLS , this includes:
  - already subject to detention under a section of MHA
  - require treatment and object and could be detained under mental health act
- There is no valid advance decision by the patient or valid and conflicting decision by a done or deputy.

For many patients who are unable to consent to arrangements for their treatment and care in hospital the Mental Health Act will be the appropriate legal framework for detention. But for a proportion of patients who lack capacity it is always necessary to consider the use of the Mental Capacity Act as an alternative.

The two key criteria for considering MCA as an alternative to MHA are:

- The person lacks the capacity to consent to arrangements for their assessment and treatment

- The person is not objecting to being accommodated in a hospital setting or receiving treatment.

Detention under MCA to psychiatric hospital will usually involve a deprivation of liberty which must be authorised by use of DoLS.

25. Least Restriction

The starting point when considering a deprivation of liberty must always be to consider whether assessment or treatment could be provided in a different way that does not involve a deprivation of liberty. it may be possible to amend the care plan to reduce the restrictions which would constitute a deprivation.

If there is no way to reduce the restrictions of the care plan and the patient lacks capacity then any Deprivation of Liberty must be authorised by the DoLS process, or authorised through the Court of Protection.

26. Authorisation

There are two types of authorisation, standard and urgent.

Wherever possible the 'managing authority' which is the hospital or care home, should make an application for a standard authorisation in advance (using DoLS Form 4).

Where this is not possible and it is necessary to deprive someone of their liberty before the standard authorisation can be processed the Managing Authority (the hospital) must give itself urgent authorisation Urgent authorisation is time limited (7 days with a possible extension for a further 7 only).

The Managing Authority must apply for standard authorisation at the same time.

Once the application is received the Cornwall Council DoLS team will arrange the 6 assessments and decide whether a deprivation of liberty exists or will exist and if it can be authorised.

27. When to apply

Ideally an authorisation should be in place before or as soon as deprivation of liberty occurs, Authorisation can be sought in advance and it is permissible to delay discharge from Mental Health Act section while awaiting authorisation. No-one can be deprived of their liberty without a legal framework

28. Urgent Authorisation

In circumstances that may amount to a deprivation of liberty in a care home or hospital setting, the managing authority, the hospital or care home, must grant itself an Urgent Authorisation and at the same time make an application to the Cornwall Council for a Standard Application.

In order to grant an Urgent Authorisation the hospital or care home should be confident that the person is over 18 and ensure that:

- There is an up to date and documented mental capacity assessment -the person must have been assessed as lacking capacity to make decisions about arrangements for their care and residence.
- The person is suffering from a mental disorder and this has been confirmed by a suitably qualified health professional.
- The restrictions that form part of the care plan are in the person's best interests and are therefore necessary, proportionate and the least restrictive option available.
- The restrictions for which the authorisation and standard application apply form part of a written care plan.
- The reason why it is necessary to deprive the person of their liberty (what risks of harm are being addressed and the significance and likelihood of that harm) is documented.

Urgent authorisation cannot be granted if the patient is or appears to be ineligible for DOLS. (See eligibility above)

An urgent authorisation lasts for no more than 7 days, but can be extended at the managing authority's request for up to a further 7 days. During this time the local authority (Cornwall Council DoLs team) must finish the full assessment for a standard authorisation.

Forms are available from MHA/MCA office and should be returned by email to CFT MHA/MCA dept. for forwarding to the DoLS team. MHA/MCA office will confirm receipt and authorisation when received.

Once Form 1 is complete, the following steps must be taken:

- Inform the patient. Give a copy to the patient and any IMCA (if one is instructed) . Once an authorisation (Urgent or Standard) is in place the person then has a right to challenge this decision. They can do this either locally (team review) or via the Court of Protection.

- Do everything practicable to explain to the individual deprived of their liberty, orally and in writing what the effect of the urgent authorisation is.
- Inform the patient's family, friends and carers about the urgent authorisation so that they can support the person. This may be done in person, by telephone, email or letter.
- Record the steps taken to inform the above and their views, in the clinical record.

29. Extension of Urgent Authorisation

Prior to the expiry of the urgent authorisation the ward must check whether standard authorisation assessments will be completed within the 7 days. If necessary an extension of up to 7 more days can be granted. This must be requested in advance of expiry via MHA office, by email or telephone. The request and reasons for it must be recorded in the patients' clinical record.

30. Standard Authorisation

If a possible deprivation of liberty has been identified the ward manager / person in charge of the ward must request a standard authorisation (Form 4).

Forms are available from MHA office and should be returned by email to CFT MHA / MCA dept. for forwarding to the DoLS team. MHA / MCA office will confirm receipt and authorisation when received.

Once Form 4 is complete, the following steps must be taken by the ward.

- Inform the patient and their Relevant Person's Representative (RPR) if there is no one to act as an interested person, an IMCA will become involved. Give a copy to the patient and any IMCA (if one is instructed). Once an authorisation (Urgent or Standard) is in place the person then has a right to challenge this decision. They can do this either locally (team review) or via the Court of Protection.
- Do everything practicable to explain to the individual deprived of their liberty, orally and in writing what the effect of the urgent authorisation is.
- Inform the patient's family, friends and carers about the urgent authorisation so that they can support the person. This may be done in person, by telephone, email or letter.
- Record the steps taken to inform the above and their views, in the clinical record.

NB If at any time Cornwall council DoLS team advise they will be unable to complete their assessment within the time stated (21 days for standard authorisation or 14 days where urgent authorisation has been made) the Trust Legal department must be notified immediately (via MHA/MCA office)

31. DoLS Assessment Process

At least two trained professionals are involved in the assessment process:-

32. The Best Interest Assessor (BIA)

This is most often a qualified social worker, but it could be a nurse, occupational therapist or psychologist who has completed the training to be a qualified BIA. They will decide if a person is being deprived of their liberty and also advise on how to reduce the restrictions, any conditions of the authorisation and how long the authorisation should be for.

33. The Mental Health Assessor

This will be a doctor and will usually be a psychiatrist, geriatrician or general practitioner with experience in dealing with mental disorders. They will have had extra training in the DoLS process and will decide if the person suffers from a "mental disorder" or not.

Following completion of 6 assessments the DoLS assessor will give a decision.

If no deprivation of liberty is occurring care can continue. If authorisation is granted a copy of the authorisation must be uploaded to patient record. Any conditions for the managing authority must be noted and adhered to. A care plan specifying the conditions must be put in place.

If a deprivation of liberty is occurring but cannot be authorised due to one of the assessment criteria not being met then the care must be urgently reviewed to ensure no unlawful deprivation of liberty takes place. The action to be taken will depend on individual circumstances and reason for refusal. In the case of a deprivation of liberty on the ward not being authorised by the DoLS team, the Trust's Legal department must be notified immediately (via MHA office) so that an application to the Court of protection can be considered, if appropriate.

34. Notification of application to Deprive someone of their liberty under DoLS

MHA office will complete statutory notification to CQC on receipt of the outcome of application.

35. Suspending Standard Authorisation

Where a standard authorisation is in place and the person is also subject to a section of the Mental Health Act that may conflict with it, the MHA will take priority and the authorisation should be suspended. E.g. if the person is detained under MHA following a further MHA assessment.

Form 14 is used to suspend the authorisation Forms are available from MHA office and should be returned by email to CFT MHA dept. at cpn-tr.mhacornwall@nhs.net for forwarding to DoLS team. MHA office will confirm receipt and authorisation when received.

If the conflict is removed (e.g. by discharge from MHA) Form 15 can be used to reinstate the authorisation if within 28 days following suspension.

36. Duration of Authorisation

The maximum duration of DoLS authorisation is 12 months but in practice many authorisations are for shorter periods.
If the patient is transferred to another hospital or care home a new DoLS authorisation is needed. They are not transferable.

37. Review of Standard Authorisation

The purpose of the review procedure is to determine whether

- the person still meets qualifying requirements for being deprived of their liberty
- any conditions attached to the standard need to be varied

The Supervisory Body must carry out a review if one is requested by

- the person being deprived of their liberty (the 'relevant person')
- the 'relevant person's representative
- the Managing Authority (i.e. the hospital)

The Managing Authority must request a review if:

- The authorisation is nearing expiry and need for continuing deprivation of liberty is uncertain
- The person no longer meets the no refusals, mental capacity, mental health or best interests requirements.
- The person no longer meets eligibility because they object to treatment and meet criteria for detention under the MHA
- There has been a change in the persons situation and because of that it would be appropriate to change the conditions attached to the authorisation
- The reasons that the person meets the qualifying requirements are different from those recorded when the authorisation was given.

A Review is requested on Form 19 Forms are available from MCA/MHA office and should be returned by email to CFT MCA/MHA dept. for forwarding to DoLS team. MCA/MHA office will confirm receipt and authorisation when received.

38. Court of Protection

The Court of Protection is a specialist court set up by the MCA to deal with complex cases involving individuals lacking capacity. It operates on a 24-hour basis.

The Court of Protection may make a welfare order to authorise a deprivation of liberty under the MCA (DoL order). DoL orders may also authorise treatment.

An application to the Court of Protection for a DoL order should be considered in complex cases. In addition, in certain cases a DoL order is the only way to authorise a deprivation of liberty under the MCA:

If the deprivation of liberty is to occur in a place other than a hospital or care home then no DoLS authorisation can be given. In an appropriate case, the Court of Protection can issue an order to authorise a deprivation of liberty in a person's own home or in the community (e.g. under supported living arrangements)

39. Relevant Person's Representative

The supervisory body will appoint a representative for every person subject to a DoLS authorisation. This is the Relevant Person's Representative (RPR). This will usually be a family member or friend but could be a paid representative if the person has no-one. The Hospital must ensure that the patient and their RPR are informed of

- The authorisation
- The right to request a review
- The complaints procedure
- The right to apply to the court of protection to seek variation or termination of the authorisation
- The right to an IMCA (if RPR is not a paid representative)

40. Independent Mental Capacity Advocate (IMCA)

Responsibility for appointing an IMCA sits with the Supervisory body

The hospital must inform the Supervisory body of need to instruct an IMCA:

- If there is no-one other than a professional carer to be considered in regard to the best interests assessment
- During any gap in the appointment of RPR
- When there is an RPR but they are not believed to be acting in the persons best interests
- Where without an IMCA the patient and RPR would be unable to exercise their rights
- Where the person or their RPR requests an IMCA

41. Community

For patients who are under the CPA on the community caseload who are being care co-ordinated by CFT or transferred to a care home or hospital setting, the care co-ordinator must consider the legal framework that supports the care plan, consider the least restrictive option to deliver the care and ensure the managing authority has acted where indicated recording this in the RIO records.

Once transferred into the community, the care provider becomes the managing authority and is responsible for making the applications for standard authorisation and granting urgent authorisation. As soon as a patient is considered for discharge it is the responsibility initially of the ward, then the care coordinator to inform the new provider/managing authority of the intended framework for the person so they can get these arrangements in place before the patient transfers into their care. it is not for the Trust to provide legal advice but to provide appropriate and supportive handover of care.

Care plans of patients under the CPA approach and where the Trust simply has a care coordinator role, should have their care plans considered for the least restrictive options. If there are any questions over whether or not the individual is being deprived of their liberty then this will need to be considered by those commissioning the care package/supported living arrangement etc. and it is the responsibility of CFT staff to inform the commissioner of the possible deprivation. If there are any concerns staff should contact the Trust legal department (via MHA office) for advice.

42. Restraint

Section 5 of the MCA makes provision for the restraint of a person as a last resort, providing certain criteria are satisfied. Restraint covers a wide range of actions, including the use of force, or the threat of force to do something that the person concerned resists.

As with all actions under MCA restraint must be in the person's best interest:

- Staff must reasonably believe that it is necessary to undertake an action which involves restraint in order to prevent harm to the person lacking capacity
- Any restraint must be a proportionate response in terms of both the likelihood and seriousness of that harm.

Using excessive restraint could leave staff liable to a range of civil and criminal penalties

43. Training

Training on MCA is mandatory for all new clinical staff. Existing staff are expected to update every year.

44. Audit and review

Managers Committee.

45. Confidentiality

An assessment of capacity may require the sharing of information amongst health and social care professionals. If a person lacks capacity to consent to disclosure staff should consider whether it

would in the patient's best interests to disclose the information. Only as much information as necessary should be divulged.

The Act places a duty on those assessing capacity to consider taking into account the wishes and feelings of others who may be involved with a patient, for example as a carer or family member. Although these individuals may be involved in both the capacity assessment and any subsequent best interest decision making process, only as much information as is needed should be disclosed. In most circumstances very little of the patient's actual medical records should be disclosed.

Where an attorney under a personal welfare LPA has been appointed they will be entitled to have access to health and social care information and will also determine if information can be disclosed. Staff must normally consult with them before sharing any information.

Where it is not possible to consult, for example, because urgent treatment is necessary, staff must act in the patient's best interests and advise the attorney of any action taken as soon as practicable.

Under 18s

The application of the MCA to children and young people
Within the MCA's Code of Practice, 'children' refers to people aged below 16. 'Young people' refers to people aged 16–17. This differs from the Children Act 1989 and the law more generally; where the term 'child' is used to refer to people aged under 18.

Children under 16
The Act does not generally apply to people under the age of 16

Young people aged 16–17 years
Most of the Act applies to young people aged 16–17 years, who may lack capacity to make specific decisions but there are three exceptions:-

- Only people aged 18 and over can make a Lasting Power of Attorney
- Only people aged 18 and over can make an advance decision to refuse medical treatment.
- The Court of Protection may only make a statutory will for a person aged 18 and over.

46. Criminal Offence

Section 44 of the MCA identifies a criminal offence of wilful neglect or ill treatment of an adult lacking capacity by anyone responsible for that person's care, attorneys of Lasting Power of Attorneys or Enduring Power of Attorneys, or deputies appointed by the court.

Neglect or ill treatment can include a range of circumstances such as physical abuse including assaults, deprivation, for example, of basic necessities such as food and clothing. The penalties for being found guilty of this offence range from a fine to a maximum five year prison sentence.

In all cases where there is suspicion of a section 44 offence in the first circumstance members of staff should alert their line manager or on call manager immediately and follow the current Adult Safeguarding Procedure**.** Consideration should be given to whether it is necessary to involve the police.

47. MHRT

In order to safeguard compliance with the MHA and Human Rights Act in regard to the right to review by a tribunal mental capacity to be able to apply to the MHRT must be assessed for all newly detained patients.

If the patient does not have capacity, consideration must be given to their wishes and if appropriate, assistance provided to facilitate a Tribunal Hearing (whether this is through the Nearest Relative or the Secretary of State).

Equality Impact Assessment Proforma Initial Screening

Name of Procedural document to be assessed:		**Mental Capacity Act including Deprivation of Liberty policy**	
Section:		Mental Health Act	
Officer responsible for the assessment:		Phil Belcher	
Date of Assessment:	24.02.15	Is this a new or existing procedural document?	N

1. Briefly describe the aims, objectives and purpose of the procedural document.	The policy is intended; To raise awareness amongst ward staff of the requirements of the application of the Mental Capacity Act (MCA) and to recognise and minimise any potential deprivation of liberty safeguards and ensure the appropriate legal frameworks are in place To help staff by providing guidance on the principles of the MCA the process of the Deprivation of Liberty safeguards (Dols)
2. Are there any associated objectives of the procedural document? Please explain.	As above
3. Who is intended to benefit from this procedural document, and in what way?	All staff and ultimately patients
4. What outcomes are wanted from this procedural document?	An understanding of the legal framework and process which needs to be followed.
5. What factors/forces could contribute/detract from the outcomes?	N/A
6. Who are the main stakeholders in relation to the procedural document?	All staff
7. Who implements the procedural document, and who is responsible for the procedural document?	This will be delivered by clinical managers. Process is already in place so should already be embedded.

8. Are there concerns that the procedural document **could** have a differential impact on RACIAL groups?		**N**	
What existing evidence (either presumed or otherwise) do you have for this?			
9. Are there concerns that the procedural document **could** have a differential impact due to GENDER		**N**	
What existing evidence (either presumed or otherwise) do you have for this?			
10. Are there concerns that the policy **could** have a differential impact due to DISABILITY?		**N**	
What existing evidence (either presumed or otherwise) do you have for this?			
11. Are there concerns that the policy **could** have a differential impact due to SEXUAL ORIENTATION?		**N**	
What existing evidence (either presumed or otherwise) do you have for this?			
12. Are there concerns that the procedural document **could** have a differential impact due to their AGE?		**N**	
What existing evidence (either presumed or otherwise) do you have for this?			
13. Are there concerns that the procedural document **could** have a differential impact due to their RELIGIOUS BELIEF?		**N**	
What existing evidence (either presumed or otherwise) do you have for this?			

14. Are there concerns that the procedural document **could** have a differential impact due to their MARRIAGE OR CIVIL PARTNERSHIP STATUS? (This MUST be considered for employment policies).		**N**	
What existing evidence (either presumed or otherwise) do you have for this?			
15. Are there concerns that the procedural document **could** have a differential impact due to GENDER REASSIGNMENT OR TRANSGENDER ISSUES?		**N**	
What existing evidence (either presumed or otherwise) do you have for this?			
16. Are there concerns that the procedural document **could** have a differential impact due to PREGNANCY OR MATERNITY?		**N**	
What existing evidence (either presumed or otherwise) do you have for this?			
17. How have the Core Human Rights Values of: • Fairness; • Respect; • Equality; • Dignity; • Autonomy Been considered in the formulation of this procedural document/strategy If they haven't please reconsider the document and amend to incorporate these values.	This document has been drafted to compliment the new case law surrounding deprivation of liberty which addresses equality for those individuals who lack capacity.		

18. Which of the Human Rights Articles does this document impact?	The right: • To liberty and security; • To freedom of expression; Not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention;	**Y**	**N**
What existing evidence (either presumed or otherwise) do you have for this?	This is in the spirit of the MCA as described in the guidance. To provide liberty and minimise restrictions. Freedom of expression : To assist as far as possible an incapacitous person to make express and indicate their own decisions		
How will you ensure that those responsible for implementing the Procedural document are aware of the Human Rights implications and equipped to deal with them?	Through team managers discussions with staff		

19. Could the differential impact identified in 8 – 13 amounts to there being the potential for adverse impact in this procedural document?		**N**	N/A
20. Can this adverse impact be justified on the grounds of promoting equality of opportunity for one group? Or any other reason?		**N**	Please explain for each equality heading (questions 8 –13) on a separate piece of paper.
If Yes, describe why, and then proceed to a full EIA.			
21. Should the procedural document proceed to a full equality impact assessment?		**N**	
If No, are there any minor further amendments that should take place?			
22. If a need for minor amendments is identified, what date were these completed and what actions were undertaken		**N**	

Signed (completing officer) Phil Belcher ..... Date 24.02.15

Signed (Service Lead) ..... Date .....