Livewell Southwest

Mental Capacity Act including Deprivation of Liberty Safeguards Policy

Version No.1.6
Review: March 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

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Reader Information

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Document review history

Version no.	Type of change	Date	Originator of change	Description of Change
V.0.1	First draft for consultation.	December 2014	Mental Capacity Act Lead	First draft for consultation.
V.0.2	Second draft following feedback received during consultation period	January 2015	Mental Capacity Act Lead	Second draft following feedback received during consultation period
V.1.	Ratified	21st January 2015	Integrated Safeguarding Lead for Adults and Children	Minor amendments following January 2015 PRG meeting
V.1.1	Amendments	5th March 2015	Mental Capacity Act Lead	Minor amendments.
V.1.2	Amendments	3rd June	Mental	Amendments to forms and

		2015	Capacity Act Lead	policy re deprivation of liberty forms changing.
V.1.3	Amendments	August 2015	Mental Capacity Act Lead	
V.1.4	Amendments	November 2015	Mental Capacity Act Lead	Reference to Day Patients, Table for help in determining MCA or MHA should be used and Invitation Letter Templates
V.1.5	Amendments	February 2016	Mental Capacity Act Lead	Reference to chapter 13 of the revised Mental Health Act Code of Practice and Organisational change of name
V.1.6	Amendments	January 2017	Mental Capacity Act Lead	Reference to Care Act 2014. Capacity Assessment Tool to Appendix. Clarification to Reference in MHAct Revised Code of Practice Relating to DoLS Eligibility. Update contact addresses.

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Mental Capacity Act including Deprivation of Liberty Safeguards Policy

1. Introduction

1.1 This policy uses the term ‘person’ to denote people at age 16 and above whilst the term `young person` refers to specifically to persons between 16 and 18 years of age. Persons in relation to Livewell Southwest means any person who is receiving health services from Livewell Southwest from any clinical areas. Persons are often referred to as patients, service users and clients for example, depending on the clinical setting, but for the purpose of this policy individuals will be referred to as person or persons.

1.2 This policy guides the practice of staff employed by Livewell Southwest describing their roles and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards introduced into the Mental Capacity Act in 2007 and provides guidance to staff to be able to undertake a full assessment of the persons needs in regards to capacity and how to identify their capacity needs. There are separate Policies for Safeguarding Adults and Safeguarding Children. If any staff member is concerned that an adult or a child is being abused, they should refer to these Policies.

1.3 The policy is written for all staff in Livewell Southwest involved in the care, treatment and support of persons mainly but not exclusively over the age of 16 who are unable to make all or some decisions for themselves, (some sections apply to only those persons aged 18 or over, reference will be made in the specific sections where this applies).

1.4 Livewell Southwest provides a range of physical, mental health and learning disability services to an age range that covers the ante-natal period, through childhood, adolescence, adulthood and the older adult. It includes end of life, which is associated with all life stages but most commonly, older adulthood.

1.5 Livewell Southwest has a cohort of core services that wrap around persons or people to deliver a community based provision to people living and working in localities. It also provides a number of city wide services including in-patient settings.

1.6 All of the services include staff members that provide services directly to young persons, adults and older people who live and work in a range of locality based settings.

1.7 The Mental Capacity Act 2005 Code of Practice provides detailed guidance for all people working with and/or caring for persons who lack capacity and Livewell Southwest staff should refer to this Code of Practice for areas not covered by this Policy and for additional guidance as and when required (see link for PDF version at the end of the Policy under further useful reading and links).

1.8 All professionals will be responsible for ensuring that their practice reflects the local and nationally agreed policies, standards and good practice guidance.

2. Purpose

2.1 The purpose of this document is to describe the process and good practice required to ensure that all staff within the Organisation are compliant with the law as set out in the Mental Capacity Act 2005 as it is delivered in Livewell Southwest. This includes:-

- Principles underpinning practice within the Mental Capacity Act.
- Workforce development (training for all staff).
- When to seek guidance about the practice of working within the Mental Capacity Act.
- Accountabilities.
- Keeping the appropriate records.
- The relevant processes to follow within the various stages within the Mental Capacity Act and how to access good practice examples and the relevant templates.
- Gain an understanding of the law in relation to the Mental Capacity Act and for staff to be able to identify clinical practice that may require application of the good practice as outlined in the Mental Capacity Act 2005 Code of Practice guidance and the 2007 DoLS Code of Practice to ensure we are acting lawfully.
- Monitoring effectiveness.

3. Duties

3.1 **The Chief Executive** is ultimately responsible for the content of all policies and their implementation and holds Executive responsibility for all practice under the Mental Capacity Act within Livewell Southwest.

3.2 **The Livewell Southwest Mental Capacity Act Lead** is responsible for the development of the Mental Capacity Act Policy and ensuring that policies and procedures in relation to the Mental Capacity Act are understood, adopted and applied by all staff and will liaise with the training and development department to ensure relevant training is available for staff.

3.3 **Locality Managers** are responsible for identifying, producing and implementing Livewell Southwest policies relevant to their area of work and will be responsible for ensuring that all staff conform to the standards set out in this policy. The Locality Managers with advice from the Livewell Southwest Mental Capacity Act Lead monitor constraints to compliance and effectiveness, advising and implementing strategies to support improvement to practice.

3.4 Deputy Locality Managers and Service Managers are responsible for adherence to policy and ensuring that the practice of the Mental Capacity Act is undertaken on a regular basis as per this policy. They are responsible for highlighting good practice and sharing that good practice such that learning may be disseminated

across Livewell Southwest. In addition Deputy Locality Managers are the Lead Officers for safeguarding adults within their Locality and as such are accountable in holding an overview and management oversight of adult safeguarding activity in their Locality including practice relating to the Mental Capacity Act.

3.5 Line Managers are responsible for adherence to policy and supporting staff to understand and work within policy. They are responsible for highlighting good practice and sharing that good practice so that learning may be disseminated across Livewell Southwest as well as addressing shortfalls with individuals via line management.

3.6 Clinical Staff are responsible for practice and operating within the scope of this policy. Staff members remain accountable for their own professional judgement and clinical practice. They are responsible for ensuring they are working within The Mental Capacity Act 2005 Code of Practice and always acting in the best interest of patients, escalating any concerns about practice and highlighting good practice.

3.7 Each document is to have an Editor who will nominate an Author with appropriate knowledge and experience. For the purpose of this document the editor and the author is the Livewell Southwest Mental Capacity Act Lead.

4. Definitions

Livewell Southwest	A Community Interest Company established to deliver health services to the population of Plymouth and some surrounding areas.
Court of Protection Responsible Local Authority	The Court of Protection in English law is a superior court of record created under the Mental Capacity Act 2005.
Livewell Southwest Mental Capacity Act Lead	Designated person specific responsibility for leading on the Mental Capacity Act based within the Livewell Southwest Safeguarding Team.
Supervisory Body	The Authority responsible for authorising deprivation of liberty applications for people who lack capacity in hospital or registered nursing or residential care homes
Managing Authority	The person/body with the management responsibility for identifying and obtaining authorisation for depriving the person of their liberty.
Livewell Southwest Legal Team	The legal firm contracted by Livewell Southwest to provide legal advice.
Best Interest Assessors	Staff employed with specific responsibility for undertaking DoLS Assessments which are allocated by the Responsible Local Authority (Locally the BIA's are employed by Livewell Southwest).

Local Authority DoLS Officer	Person in the Responsible Local Authority with delegated responsibility for Deprivation of Liberty Safeguards.
Deprivation of Liberty	The legal term used to describe restrictions that amount to a deprivation of liberty under Article 5 of the Human Rights Act on a person who lacks capacity.
Independent Mental Capacity Advocate (IMCA)	Suitable trained Professional with specific delegated legal responsibility to represent the feelings and wishes of the person who lacks capacity normally used when a person who lacks capacity has no family involvement or someone who can act as a befriender in regards to life changing decisions.
Best Interests Discussions	A discussion that takes place between those involved in the care /support of the person who lacks capacity to consider what is in the person`s best interests.
Best Interests Meeting	A formal meeting that takes place with those involved in the care/support of the person who lacks capacity to consider what is in the person`s best interests.
Decision maker	The person who is responsible for making the decision in the best interests of the person who lacks capacity.

5. Mental Capacity Act: the framework

5.1 Philosophies and Values Underpinning the Mental Capacity Act:-

- Staff members will have the appropriate level of training for their practice.
- Working within the legal framework of Mental Capacity Act is a responsibility of all staff working with patients who may lack capacity.
- Mental Capacity Act practice reflects an ethos of equal opportunity, embraces diversity and promotes anti-oppression in the work place, particularly on account of age, race, gender, sexual orientation, or ability.
- Mental Capacity Act practice recognises that there are increased risks for people who lack capacity and forms a framework to ensure they are visible within Livewell Southwest and their needs are being considered in line with the law.
- This policy is underpinned by the principle that each staff member remains accountable for their own professional practice including the decisions relating to the Mental Capacity Act. The line managers and Deputy Locality Manager will be accountable for the advice they give and any actions they take.
- Staff will be supported to work within the auspices of this policy. Staff members who judge that they are not being supported to do so, should

discuss their concerns with a line manager or use the Livewell Southwest Whistleblowing Policy.

5.2 Principles Underpinning The Mental Capacity Act:-

5.2.1 Since 2005 The Mental Capacity Act has provided a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. The 5 Key principles of the ACT are:

1. ***Presumption of Capacity*** *- a person must be assumed to have capacity unless it is established that he/she lacks capacity to make a decision.*
2. ***Maximising decision making*** *- A person is not to be treated as lacking capacity unless all practical efforts to help them achieve capacity have been made.*
3. ***Unwise decisions*** *- A person is not to be treated as lacking capacity because he/she makes an unwise decision.*
4. ***Best Interests*** *- An act done (or decision made) under the Mental Capacity Act for (or on behalf of) a person who lacks capacity must be done or made in his /her best interests.*
5. ***Least restrictive option*** *- Before an Act is done or a decision made on behalf of a person lacking capacity it should be considered whether these purposes can be achieved in a way that is less restrictive of that persons rights and freedoms.*

5.2.2 In addition Livewell Southwest have also agreed the following principles relating to practice:

- That staff are autonomous practitioners who can make informed decisions about the Mental Capacity Act.
- That staff will describe and record their analysis and clinical judgement about their practice, maintaining high quality records.
- Effective communication and engagement will be expected.
- Seamless multi-agency working.
- Excellent and transparent information sharing will take place in all decision making.
- Learning from analysis of incidents that fall within the Mental Capacity Act.

5.3 What is the purpose of Mental Capacity Act Practice?

5.3.1 Mental Capacity Act practice is an accountable process that is described within policy and is law.

5.3.2 For practitioners involved in day-to-day work with adults who lack capacity, the opportunities and ability to critically and openly reflect upon the work that they are engaged in is essential in enabling them to deliver their responsibilities to ensure that what they are doing is lawful and in line with good practice as outlined in the Act. Effective line management is important to promote good standards of practice and to support individual staff members to make decisions that are lawful and in line with Good Practice and Livewell Southwest Policy.

5.3.3 What is Mental Capacity- Capacity is the voluntary and continuing permission of a person over the age of sixteen to agree a course of action or inaction based on adequate knowledge of the person, nature, likely effects and risks of the proposed action or inaction including, the likelihood of its success and any alterations to it. Individuals will be assumed to have capacity unless there is clear evidence to the contrary.

5.4 Who does the Mental Capacity Act apply to?

5.4.1 Any person over the age of 16 who has been assessed as lacking capacity in regards to an issue specific decision as a result of an impairment of, or a disturbance in the functioning of the mind or brain. (Deprivation of Liberty Safeguards (DoLS) only apply to persons aged 18 and over (see section 8 on DoLS). It does not apply to any person who has capacity.

5.5 How do we assess capacity?

5.5.1 The Mental Capacity Act states that all person's over 16 years of age should be assumed as having capacity unless having applied the 4 step test there is a reasonable belief that the person lacks capacity in regards to a specific issue.

5.5.2 The 4 step test is as follows:

1. Be able to understand the information in relation to the decision.
2. Be able to retain that information for long enough to be able to communicate their view.
3. Be able to weigh up that information.
4. Be able to communicate the decision (by talking, using sign language or any other means).
   (The Department of Health has recently issued guidance stating that DoLS applications are not required for patients who are unconscious and have no other mental disorder as unconsciousness alone is not a mental disorder, and therefore would not meet the criteria for DoLS).

   If a person is not able to meet the criteria in ANY one of the 4 steps then it is likely they lack capacity, however, the Act also states that all reasonable steps should be taken to assist the person in all 4 steps (using pictures, total communication, easy read materials for example).

5.5.3 Any Health or Social Care Professional can assess the capacity of someone they are working with as long as they use the process outlined above and record their rationale for the outcome. Many Health and Social Care Professionals make day to day decisions on behalf of people who lack capacity e.g. what the person might wear, have to drink, where to go etc. and a formal process is not required in these instances however, the basic principles outlined in the Mental Capacity Act such as, empowering the individual who lacks capacity to be involved in the choices as much as possible and all decisions should always be the least restrictive option and always in the persons best interests.

5.5.4 For more complex decisions which may involve life changing scenarios such as, where that person should live, what prescribed medical treatment that person should have, then a more formal process is required and full consultation with all those involved in the persons care/support should take place, (including relevant family members and/or advocates), the decision maker should be clearly identified and whoever the decision maker is should fully record who they have consulted with, what the views were and their rationale for making the decision.

5.5.5 The consultation can be in the form of a best interest discussion or for more serious decisions or where there is not likely to be a consensus reached, then it is best practice for a formal best interest meeting to take place which should be minuted and documented in the persons medical notes (see section 5.10 below on Best Interest meeting). If a best interest discussion has taken place instead of a formal meeting then the decision maker should record a summary of the consultation process, (as described above), in the persons medical notes. There is no specific template or form to record a Capacity assessment unless it is being used for legal purposes in the Court of Protection for example, in which case a COP 3 form should be used and the relevant part of the COP 10 form should be completed (these forms can be obtained from the Mental Capacity Act Lead on telephone number 01752 434058 or via our Legal Team, (capacity assessments that may be used in legal proceedings should be undertaken by psychiatrists or Medical Practitioners only). However, a capacity assessment tool is included in the appendix within this Policy which Health and Social Care Professional's may find helpful and there is also an anonymised good practice example of a capacity assessment is shown in Appendix A to assist health professionals in undertaking a capacity assessment. Other guidance has been produced by the British Medical Association and British Psychological Society for example whilst clinical areas may prefer to design their own assessment tool as one Organisational Tool will not suit all purposes but the good practice example and or the capacity assessment tool in Appendix A should be used as a guide.

5.6 How do we decide who the decision maker is and are there any decisions that are not covered by the Mental Capacity Act?

5.6.1 This is not always obvious as it will depend on a number of factors and the specific circumstances of each case. For day to day non-life changing decisions this will often be the carer most involved in the persons care. However, more complex or life changing decisions involving health professionals, often it is the person prescribing the treatment or intervention, or the person responsible for the care plan or commissioning the care but in some cases it can be the family member or carers, further advice can be sought from the Livewell Southwest Mental Capacity Act Lead if unsure or if there is disagreement on who the decision maker is. Some decisions are excluded from the Mental Capacity Act which includes: voting, marriage, sexual relationships and divorce. Restraint does come under the Mental Capacity Act but Livewell Southwest has a specific Policy in relation to restraint/physical intervention and more detail is covered within that specific Policy which is called Physical and Non-Physical Intervention

2013. The Act defines restraint as using (or threatening to use) force to do an act which the person resists or restricting the movement of someone who lacks capacity whether or not the person resists. Restraint/physical intervention can be verbal or physical and includes the use of sedation. The Act only allows a limited degree of restraint/physical intervention when carrying out care or treatment only if there is reasonable belief that it is necessary to prevent harm to the person and must be proportionate to the likelihood and seriousness of harm. The restraint/physical intervention must not be frequent, cumulative or ongoing as this may amount to a deprivation of liberty in which case an authorisation should be sought.

5.7 Family involvement

5.7.1 When following the best interest process the feelings and wishes of the individual who lacks capacity should be taken account of and for more complex non-day to day decision making a family member or someone independent from Statutory Agencies who knows the individual and is involved in the person`s care or interested in the person`s welfare should be consulted with and their views taken into consideration. For those people who lack capacity who have no family involvement and no-one independent, (this is often referred to as `unbefriended`), from Statutory Agencies who knows them well enough to be able to give a view on their behalf the view of an advocate should be sought, and for any issues relating to accommodation and serious medical treatment then this would be an Independent Mental Capacity Advocate (IMCA). The view of an IMCA can also be sought when it is felt that the relative is not appropriate to consult with. *(Refer to Chapter 10 of the MCA Code of Practice for further information about the role of the IMCA)*.

5.8 The importance of following Guidance in the Code of Practice

5.8.1 It is vitally important that all Health Professionals follow the Good Practice Guidance as outlined in the Mental Capacity Act 2005 Code of Practice for people who lack capacity to consent to their treatment as to not do so could be unlawful if treatment is given without consent or in the case of someone who lacks capacity to consent without the process outlined in the Good Practice Guidance being followed. We are required to work within the statutory principles set out in Section 1 of the Mental Capacity Act 2005 and more particularly to apply Section 4 of the Act to our actions for people who cannot make decisions for themselves (refer to link to PDF version of the Mental Capacity Act 2005 at the end of the policy). Staff should also ensure they are compliant with guidance set out in the Care Act 2014.

5.9 Unwise decisions

5.9.1 A person with mental capacity can disagree with the views of the professionals involved in their care. Persons who have involvement with Health Services may take a contrary view to professional opinion and this should be supported if they have mental capacity to make the decision even if in the view of health professionals it is an unwise decision. Our staff should accept the right of

Persons they work with to make lifestyle choices and to refuse services provided they are doing so with mental capacity and from an informed position.

5.10 When should you hold a Best Interest Meeting?

5.10.1 Where assessments of mental capacity relate to day-to-day decisions and caring actions (such as what clothes to wear or what to eat) the Mental Capacity Act Code of Practice advises that no formal capacity assessment procedure or recorded documentation will be needed. The Act provides protection from liability for actions taken as long as those actions can be understood to have been in a person's best interests. As the seriousness of the decision and/or the action increases then the need for a clear documented record increases.

5.10.2 A best interests meeting may be needed following a formal recorded assessment of mental capacity in relation to the following sorts of decisions:

- Where to live, if a significant change is envisaged.
- What care services support to receive at home?
- Whether to report a criminal or abusive act.
- Where the person concerned is repeatedly making decisions that place him/her at risk or could result in preventable suffering or damage.
- Having serious medical treatment such as a Peg fitted or a limb removed for example – whilst noting that permission for some serious medical treatments, for example: sterilisation can only be granted by the Court of Protection.

5.10.3 These examples are not exhaustive and each situation needs to be judged on its merits, using professional judgment. Clarity is provided in the Mental Capacity Act Code of Practice where it gives guidance, on pages 59 -60, on where professionals should be formally involved.

5.10.4 Where there is, or is likely to be, a dispute as to how to serve the best interests of the person who lacks mental capacity, there is recourse in law to the Court of Protection. The Court will however expect to see evidence of professional decision-making and best interests recording having already taken place, and this is another reason why holding a best interest meeting will be useful in ensuring that the decisions needing to be made are clearly understood.

We would expect that a best interest meeting is held and formally recorded in the medical notes where:

- The decision that needs to be made is complicated or has serious consequences for the person.
- There is a conflict of opinion between the assessor and the person being assessed or the conflict of opinion with family members involved.
- The person being assessed is expressing different views to different people, anticipating what they think they want to hear.
- A person lacking capacity is repeatedly making decisions that put them at risk or could result in suffering or damage.

5.11 What is a Best interests meeting

5.11.1 A formal best interests meeting may be required to plan the decisions needed where the issues facing the Person who lacks capacity are very complex. There may be a range of options and issues that require the considered input of a number of different staff as well as those with a personal and/or legal interest in the needs of the person lacking mental capacity. Making sense of these issues and options may only be properly covered and addressed through holding such a meeting, and clearly recording the discussions.

5.11.2 A best interests meeting should mean that the decision-making process is transparent, clearly recorded, and can stand up to subsequent scrutiny. In addition a best interests meeting should ensure that person who lacks capacity is empowered and protected from random or unsound decision-making.

5.11.3 Making a decision in a person's best interests requires:

- The Act's statutory principles and best interest checklist are properly considered.
- The person, even though lacking mental capacity, remains central to the decision or decisions needing to be made and he or she are involved in the decision-making process where possible.
- That relevant professional and informal networks are properly consulted.
- There is a clear structure to the meeting, promoting partnership working, the sharing of relevant information, the positive expression of different views, and an analysis of the risks and benefits attached to different options.
- Taking into consideration all relevant circumstances, including the person's beliefs and values, past and present wishes, and any written statements the person made when he/she had capacity. This may include an Advance Decision to refuse treatment or an Advance Statement of preferences in which case the person has already made the decision that relates specifically to the advanced decision at the time they had capacity.
- Deciding whether the decision can be delayed until the person regains capacity to make the decision for him/herself, if this is a possibility.
- Considering other factors which might have influenced the person's decision such as the person`s beliefs and values and previous choices that they have been given.
- Consulting with others such as partners, carers, family members, and other relevant people where it is practicable to do so.
- Not being motivated by a desire to bring about the person's death when the decision relates to life-sustaining treatment.

5.11.4 Where a decision cannot be made, for whatever reason, the best interests meeting will also have decided what further actions may be required to expedite future decision-making, by whom and in what timescale.

5.12 Urgent situations

5.12.1 If the situation is very urgent, a meeting may not be possible and decisions will have to be made based on the information available - including the availability of people for consultation. The doctrine of necessity* may be invoked in an emergency situation not otherwise covered with statute. Actions in the person's best interest can be made providing the professional 'reasonably believes' a person lacks capacity and that the proposed treatment/action is necessary to save their life or to prevent a significant deterioration in their condition without formal documentation of the capacity assessment and best interests decision.

5.12.2 There is no clear indication as to how long it would be acceptable for decisions to be made under the doctrine of necessity. It is sensible to assume that as soon as someone's capacity can be formally assessed and their best interests decided, then this is what should happen. If the proposed treatment is not so urgent then processes within the Mental Capacity Act should always be followed.

5.12.3 (*Doctrine of necessity – This is the legal term to cover necessary actions by Health Professionals under Common Law).

5.13 The best interests meeting – who should attend?

5.13.1 This needs to be considered by the person who is identified in the Mental Capacity Act Code of Practice as the 'decision maker'. Discussion with whoever is chairing the meeting is also advisable.

5.13.2 Anyone who attends a best interests meeting must be clear about their role and the contribution they can make in the meeting. They should also come prepared with relevant information, and be prepared to contribute this to the discussion. Agreement should be reached about how to include the contribution of any person who is unable to attend, so that the meeting can still serve its purpose, rather than be unduly delayed.

5.13.3 Careful consideration should be given so as not to exclude people who may have an interest. Those people may include:

- The person assessed as lacking mental capacity.
- Family members, parents, carers and other people interested in the welfare, if this is practical and appropriate.
- Any person who holds an Enduring Power of Attorney (pre-October 2007) or one or both of the two Lasting Powers of Attorney (from October 2007) made by the person now lacking capacity.
- Any advocate who is involved including the statutory Independent Mental Capacity Advocate (IMCA) Service).
- Any Deputy appointed by the Court of Protection who can make decisions on behalf of the person lacking mental capacity.
- Any professional person who can contribute to the outcome of the Best Interest meeting.

5.14 The Best Interest Meeting - Preparing for the meeting and supporting attendees

5.14.1 For some, being invited to a Best Interest meeting can lead to that person experiencing feelings of increased anxiety and uncertainty about what may be expected of them during it.

5.14.2 It is important that the person who is convening the meeting communicates clearly with those who have been invited at the earliest possible opportunity. This is particularly relevant when the person deemed to lack capacity is attending and for any family members, people appointed with Power of Attorney and Carers etc.

5.14.3 Whoever chairs the meeting should use the checklist below to prepare for the meeting. The chair would not normally be the decision maker but be someone not directly involved in the decision who is suitably experienced in being able to effectively facilitate such a meeting where competing views and opinions may be expressed, this avoids any possible conflict of interest, but the decision maker should attend the meeting wherever possible. Generally the chair would be a professional of at least band 6 or above, however the more complex the decision and the more likelihood of a consensus view not being reached then the more senior and the more experienced the Chair should be.

5.15 The Best Interest Meeting – how is it recorded?

5.15.1 The best interest meeting needs to be structured and recorded in such a way that it is clear who attended (and those who were unable to attend) what discussions took place, and what outcomes were agreed. Whilst the notes should record the issues and the discussion that took place, the emphasis needs to be on an analysis of the risks and benefits attached to the different options and the identification of those responsible for undertaking the agreed actions as well as the timescales within which those actions will be taken.

5.15.2 The notes should clearly identify the name of the person who has prepared the record together with the name of the organisation on whose behalf the notes have been prepared.

(See best interest Minute template in Appendix 2).

5.16 Confidentiality

5.16.1 Attendance, and the subsequent sharing of information relating to the person lacking mental capacity, must always happen in line with the Data Protection Act 1998 requirements and should be provided on a need-to-know basis. It may be appropriate for some contributors to only attend part of the meeting, or provide information through earlier discussion or in writing.

5.17 Best Interest Meeting Checklist

5.17.1 Prior to meeting:

1) Has lack of capacity been established?
   Yes – how, formal assessment, has the four step test been applied
   By who?

   No – if complex issue with possibility it could end up in legal proceedings then this will need to be completed prior to the meeting. If less complex you can establish a view at the meeting from those present and can proceed as long as there is agreement and that the issue has been disclosed with the person who lacks capacity prior to the meeting and their views and wishes established as much as is reasonably if possible. If not clear or there is a lack of agreement regarding capacity then meeting should not proceed and a formal assessment should be undertaken. If the person has capacity or lack of capacity has or cannot be established then a Best Interest Meeting cannot take place.

2) Establish whether there is Court Appointed Deputyship for Health and Welfare or Lasting Power of Attorney for welfare or any advance decision in place if so further advice may be required from legal team.

3) Ensure you have expert advice available around specialist areas if you are making best interest decisions on these areas. Either invite the expert to the meeting or obtain advice prior to the meeting.
   i.e. Restraint/physical intervention, communication, specialist areas of physical health, alcohol or drug expertise, risk of falls etc.

4) Ensure all those involved in the person's care are invited including family representation or IMCA, (see 5.7 on IMCA involvement). If they cannot attend obtain a view or report that can be shared at the meeting.

   - Clarify what decisions need to be made in the person's best interests and who the decision maker is.

5.17.2 At the meeting:

Introduction:

- Chair to introduce all present and apologies and agree a minute taker if not already identified.
- Clarify capacity and summarise the capacity assessment if you have one.
- Clarify who the decision maker is and what the decision relates to specifically.

- Give or ask someone who knows the person best to give a brief introduction about the person including their needs and a bit about the person e.g. where they live, what they like to do, who they live with etc.
- Ask family to supply a picture of the person that can be shared at the meeting if possible.
- Ensure all present have the opportunity to give a view.
- Ensure that decision being discussed is the least restrictive option, discuss other options that might seem less restrictive if necessary.
- Attempt to establish the feelings and wishes of the person who lacks capacity where possible.
- Ensure that the meeting is person-centred on the individual and his/her best interest and not what might be best for Organisations or other family members.
- Clarify who will receive a copy of the minutes.

5.17.3 If consensus reached then meeting can be concluded and best interest decision agreed or not agreed.

5.17.4 **Options if consensus not reached:**

5.17.5 If consensus not reached then it is down to the decision maker to weigh up all the views and come to a decision but they will have to document their rationale if they make a decision in the person's best interests where consensus is not reached at the best interest meeting. If there is a dispute with the family and/or the individual the decision is being made about it may not be lawful to proceed but an interim plan may need to be agreed and implemented, further advice should be sought from the MCAct Lead as a referral to the Court of Protection may need to be considered.

5.17.6 Alternatively the decision maker may decide that issue being decided on is not in the person's best interests – again rationale will need to be documented if consensus not reached.

5.18 Dispute resolution

5.18.1 Dispute resolution is not a new concept. Occasionally and it is only occasionally, complex multi-agency decision making proves challenging in terms of ownership of the specific decisions needed to support persons who lack mental capacity. Sometimes finding an agreed way forward is unclear and tensions and disputes arise. This may particularly be the case when more than one agency has responsibility for the work needed to achieve a best interest decision. This is not helpful either for the person who lacks capacity or for on-going working relationships between Agencies. Whilst recognising that this list is not exhaustive, examples of where disputes are emerging in relation to Mental Capacity Act decisions include the following scenarios:

- Hospital discharge planning and adult safeguarding.
- Peg feeding.
- Family disputes that result in change for the person who lacks capacity not able to take place.
- Concerns over the mental capacity or mental health of others, such as family members, who have an interest in the care and/or treatment of the person lacking capacity.
- A decision to challenge a decision via the Court of Protection is being considered prior to a local dispute resolution being attempted.

5.18.2 Where the best interests decision-making process has either become 'stuck' or has revealed an area of uncertainty, or there is dispute or difference between key agencies, then dispute resolution has an important role to play.

5.18.3 The suggested way forward for staff within Livewell Southwest is to seek advice from the Mental Capacity Act Lead for Livewell Southwest. Some examples of when the process can become stuck are as follows:

- No consensus could be reached about what is in the person's best interest and the Decision Maker cannot or is unwilling to decide.
- Parties cannot or refuse to abide by the decision reached by the meeting.
- Legal action is threatened.
- The decision is contentious.
- The person is at risk of significant harm if the Best Interest Decision is not followed.
- The decision taken is not in line with the feelings and wishes of the individual for whom the decision is being made.

5.18.4 If the dispute needs to be resolved urgently – because for example a person lacking mental capacity is at risk of harm we should consider whether an urgent referral to the Court of Protection is needed. If this is the case, it is imperative that staff contact the Livewell Southwest Mental Capacity Act Lead or if that person is not available the Lead Director in this area as Legal Advice may need to be sought.

6. Record Keeping

6.1 Livewell Southwest is in the process of transferring existing clinical information systems into a single electronic record on SystmOne. This new system will include a clear process for recording activity relating to the Mental Capacity Act. Some clinical areas can now access a Court of Protection/DoLS Template on SystmOne and any recording in regards to Mental Capacity Act, Court of Protection/DoLS can be recorded on this template to ensure clinical records relating to this area are all in one place to reduce time spent trawling through the tab journal to find the relevant notes. To access the template go on the clinical tree on the main SystmOne page, open up assessments, then specialist assessments, open the Safeguarding folder and open the DoLS template and complete your notes.

As long as you have the correct patient/client open you can save your notes when completed and it will save them in that patients records. Plans are in place to introduce a DoLS node to SystmOne, similar to the one that currently exists for Mental Health.

If the clinical area that you work in does not have access to SystmOne then until that time activity relating to the Mental Capacity Act should be included as a contact on existing systems and included in the written medical record (for those services that have written records).

7. Training Implications

7.1 It is essential that staff members are properly trained to deliver high quality Mental Capacity Act practice.

7.2 Training on the Mental Capacity Act is included within Livewell Southwest Adult Safeguarding Training to which all staff members who are employed by Livewell Southwest will attend at induction and as part of a mandatory annual update.

7.3 More detailed training on the Mental Capacity Act is provided within the Level 2 Adult Safeguarding Training for all clinical staff who work with people over the age of eighteen who will attend within two months of their employment commencing and repeat this every three years during the period of their employment. This training was updated In November 2014 to reflect current good practice and any recent changes in the Law and will be reviewed and updated as and when any other significant changes take place.

7.4 Whole day training on Mental Act and DoLS is provided three times annually and can be booked via the Training Department at Beauchamp and a condensed training session can be requested via the Mental Capacity Act Lead by individual teams.

8. Deprivation of Liberty Safeguards

8.1 Who does this apply to:

The Deprivation of Liberty Safeguards apply to any person aged eighteen and over who lacks capacity to consent to the care/support/ treatment/intervention that is going to be depriving them of their liberty. Authorisation must be sought if a deprivation of liberty is felt to be in the person who lacks capacity best interests. How you obtain authorisation will vary depending on the circumstances.

8.2 What is a deprivation of liberty?

CHESHIRE WEST SUPREME COURT JUDGEMENT

Since March 2014 a Supreme Court Ruling on the Cheshire West case has meant that authorisation for some care/support arrangements has been extended. To help Professionals decide which cases this applies to use the following guide:

Apply the following questions and if the answer is 'Yes' to all 3 questions then it's likely that a Legal Framework is required:

1. Is the person in Hospital (not under the Mental Health Act), Registered Nursing/Residential Care and over 18 years of age

↓

YES

2. Do they lack Capacity to Consent to the care arrangements *

↓

YES

3. Do they have 1:1 support **OR** are under continuous/close supervision or constant monitoring and control and are not free to leave on their own if they wanted to ? *

↓

YES

Then a Deprivation of Liberty Authorisation needs to be considered (DoLS). Consider Self-Authorisation and/or refer to the Responsible Local Authority (Supervisory Body) for a DoLS Assessment for a Standard Authorisation

OR

1. Is the person in Supported Living or any other community living arrangement and over 18 years of age?

↓

YES

2. Do they lack capacity to consent to the care arrangements*

↓

YES

3. Do they have 1:1 support **OR** are under continuous/close supervision or constant monitoring and control and are not free to leave on their own if they wanted to?*

↓

YES

Then a Court of Protection Authorisation needs to be considered. Seek legal advice via Livewell Southwest Mental Capacity Act Lead

*Use 4 step test to assess capacity

1) Can the person understand the information relevant to the decision?
2) Can they retain the information?
3) Can they use and weigh up the information to arrive at a decision.
4) Can they communicate their decision.

(MUST BE ABLE TO FULFILL ALL 4 STEPS TO HAVE CAPACITY)

*whether they are physically capable of leaving on their own is not the primary issue to consider, it is the principle that is important.

The Supreme Court in the Cheshire West case also ruled that the previously acid test or relative normality could no longer be used to determine whether there is a deprivation of liberty and that even if a person appears compliant with the care/support arrangements then they still are likely to be being deprived of their liberty if they meet the criteria in the guidance above. Helpfully the Supreme Court has also helped define what they mean by continuous supervision or constant monitoring and control in as much as stating that this is seen as anyone who is has 1:1 support or who is subject to periodic checks or is continuously observed, however, this is still a slightly grey area and further guidance can be sought from the Livewell Southwest Mental Capacity Act Lead if necessary.

It is also possible that if a number of restrictions are placed on a person within their care plan this may also amount to a deprivation of liberty whereas individual restrictions may not be seen necessarily as a deprivation of liberty in law. This is usually determined by the intensity and degree of the restrictions but again this is a slightly grey area within the law but further advice can be sought from the Livewell Southwest Mental Capacity Act Lead if necessary.

8.3 How do you obtain authorisation for a deprivation of liberty?

8.3.1 For persons in Hospital, Registered Nursing or Residential Care Homes, or in anywhere that is registered for care under the Care Standards Act 2000.

8.3.2 Authorisation would usually be obtained from the responsible Local Authority who would be the Supervisory Body. The Registered Manager for the Registered Care Facility (the Managing Authority) is responsible for making the application although this is often delegated to a senior member of staff. There are standardised Forms for making the application to the Local Authority (Supervisory Body) which can be accessed via the hyperlinks below. The Livewell Southwest Mental Capacity Act Lead must also be informed that an application has been made (copies of all DoLS forms should be either sent to the Safeguarding Administrator at the Safeguarding Office within the Admin Block Mount Gould Hospital via internal post or sent electronically to the Safeguarding

Inbox email address (Livewell.SafeguardingAdults@nhs.net) as Livewell Southwest are required to keep a central data base of all DoLS applications). Copies of all DoLS applications and correspondence should be kept in the persons Medical notes and on SystmOne for those clinical areas that have access to it. Where clinical areas have access to SystmOne once any DoLS authorisation has been confirmed this should be flagged on SystmOne, (please refer to the SystmOne champion in your clinical area for advice on how to do this). Any correspondence with Livewell Southwest legal representation relating to DoLS should be kept separate from the medical records.

8.3.3 The application to the Local Authority is called an application for a Standard Authorisation. In the interim period while the application is being processed by the Local Authority and allocated to a Best Interest Assessor, the Managing Authority can make an urgent self authorisation which can last up to seven days (see hyperlink for form below).

8.3.4 An urgent self authorisation should always be made if the person is currently being deprived of their liberty. If the deprivation of liberty is likely to take place at some future point then an urgent self authorisation will only be needed at the point where the deprivation of liberty takes place. (The urgent self authorisation is only required to cover the interim period of the deprivation of liberty until the outcome of the Local Authority Standard Authorisation is known). A Standard Authorisation must be applied for at the same time as an Urgent Self Authorisation (the Urgent Self Authorisation is unlawful if the Standard Authorisation is not applied for at the same time).

8.3.5 If the outcome of the Local Authority Standard Authorisation is not known after the seven days urgent self authorisation expires then an application to the Local Authority for an extension lasting up to seven days can be made (see hyperlink for form below). The extension request must be made before the seven days urgent self authorisation expires, it can`t be granted retrospectively. The Local Authority will decide whether to grant the request for a seven day extension.

8.3.6 For Standard Authorisation applications to the Local Authority (Supervisory Body) the Local Authority will allocate a Best Interests Assessor who will undertake an assessment and once complete inform the Managing Authority whether Standard Authorisation has been authorised or not and how long authorisation is granted for, (the maximum is for 12 months but can be renewed although this will need to be requested from the Local Authority by making another Standard application if required, prior to the original Standard Authorisation expiring. The Managing Authority must inform CQC of the outcome by way of a standard notification form only once the outcome is known. Unless it is a new admission for the same person an urgent Self-Authorisation cannot be made once a Standard Authorisation has been in place only a further Standard Authorisation.

8.3.7 It is the responsibility of whoever is making the application on behalf of the Managing Authority for authorisation (this can be by way of delegated

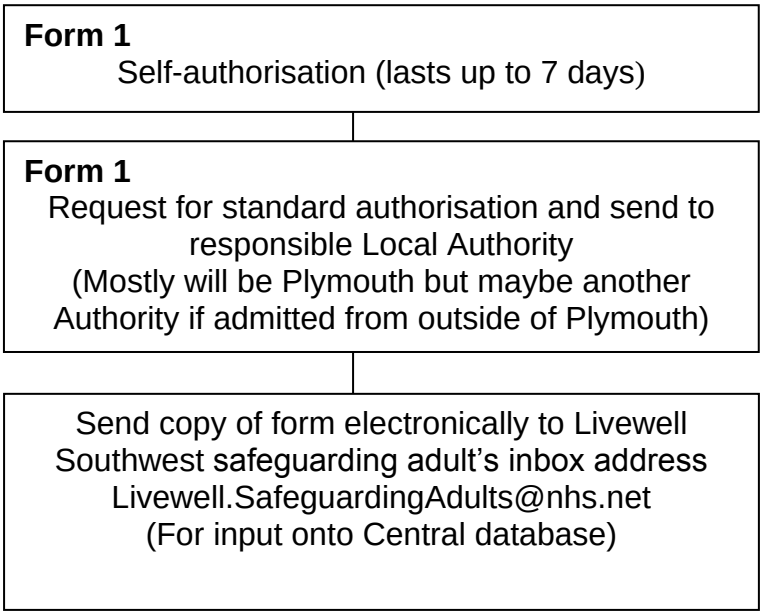
responsibility by whoever the registered Manager is with the CQC to ensure they have deprivations of liberty authorised, if the Local Authority (Supervisory Body) are not able to respond within the timescales, (seven days for urgent self authorisations and a further seven days for extensions, if granted), then a risk assessment must be undertaken using the Livewell Southwest Risk Assessment Tool as a guide and if the outcome is high the MCAct Lead or responsible Director must be informed as further action may be needed to cover the interim period of Un-Authorised Deprivation of Liberty whilst awaiting the allocation of a Best Interest Assessor. Under our duty of Candour the nearest relative or next of kin of the patient should be informed by the ward prior to any application for a deprivation of liberty and at the point where any deprivation of liberty becomes unauthorised. To ensure any application is lawful we are required to take all reasonable steps to consult with family members, however if all reasonable steps have been taken and contact has not been possible then the application should proceed and consultation should take place as soon is reasonably possible afterwards. A record of the consultation should be made in the medical records and the right to appeal explained. If any objection from a family member is expressed then further advice should be sought from either the Livewell Southwest Mental Capacity Act Lead or the DoLS Lead Officer for the Responsible Local Authority. If the relative who objects has Court Appointed Deputyship for Health and Welfare or Lasting Power of Attorney covering health and welfare for the person being deprived of their liberty, then only the Court of Protection can authorise the Standard Authorisation.

Deprivation of Liberty Process for Livewell Southwest Hospital Wards

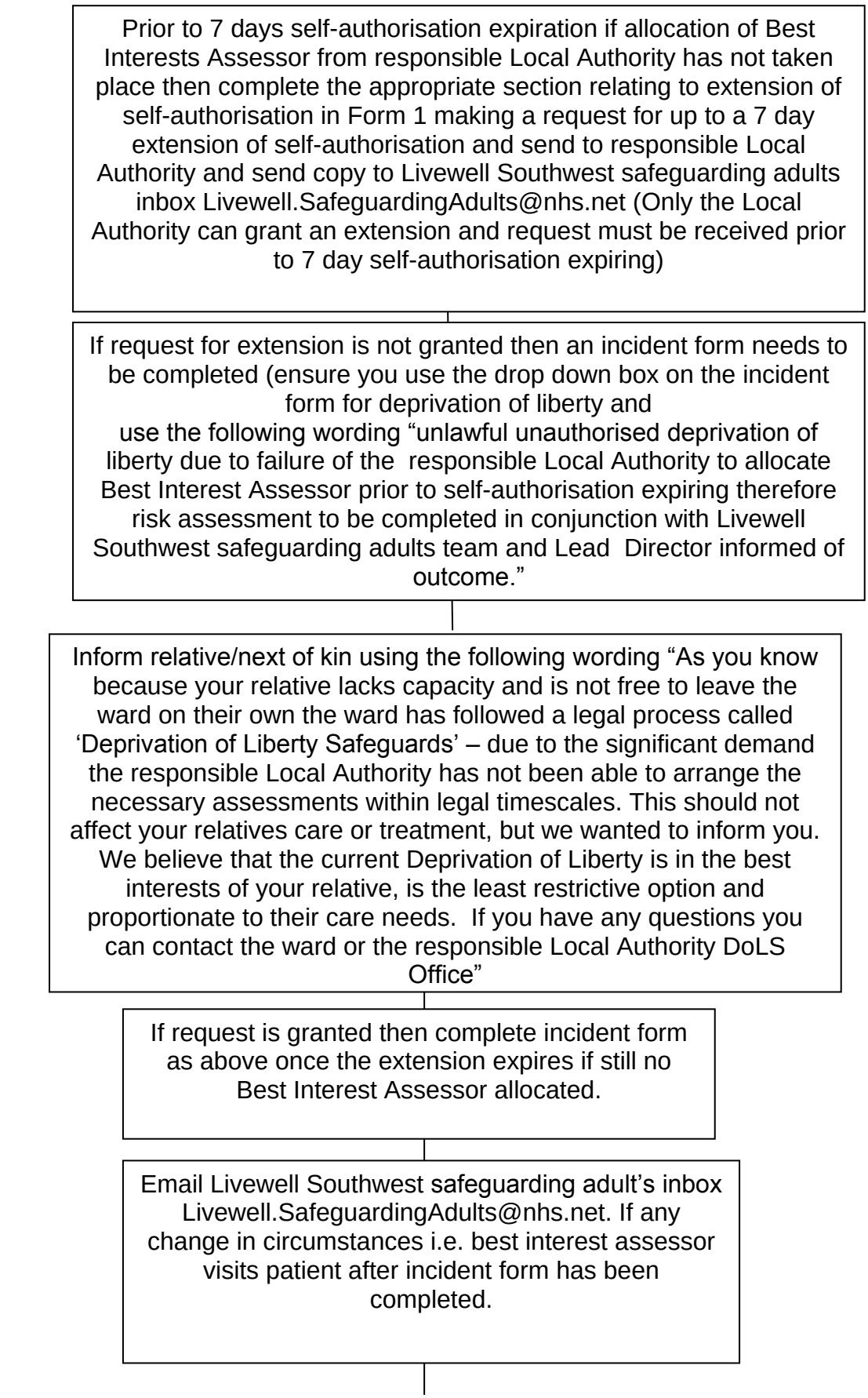
Once Patient has been assessed as lacking capacity and a deprivation of liberty is taking place (usually on admission), then complete the following:

(All forms are available on Livewell Southwest Intranet under Templates and Forms re: Deprivation of Liberty).

A



B


Prior to 7 days self-authorisation expiration if allocation of Best Interests Assessor from responsible Local Authority has not taken place then complete the appropriate section relating to extension of self-authorisation in Form 1 making a request for up to a 7 day extension of self-authorisation and send to responsible Local Authority and send copy to Livewell Southwest safeguarding adults inbox Livewell.SafeguardingAdults@nhs.net (Only the Local Authority can grant an extension and request must be received prior to 7 day self-authorisation expiring)
If request for extension is not granted then an incident form needs to be completed (ensure you use the drop down box on the incident form for deprivation of liberty and
use the following wording “unlawful unauthorised deprivation of liberty due to failure of the responsible Local Authority to allocate Best Interest Assessor prior to self-authorisation expiring therefore risk assessment to be completed in conjunction with Livewell Southwest safeguarding adults team and Lead Director informed of outcome.”
Inform relative/next of kin using the following wording “As you know because your relative lacks capacity and is not free to leave the ward on their own the ward has followed a legal process called ‘Deprivation of Liberty Safeguards’ – due to the significant demand the responsible Local Authority has not been able to arrange the necessary assessments within legal timescales. This should not affect your relatives care or treatment, but we wanted to inform you. We believe that the current Deprivation of Liberty is in the best interests of your relative, is the least restrictive option and proportionate to their care needs. If you have any questions you can contact the ward or the responsible Local Authority DoLS Office”
If request is granted then complete incident form as above once the extension expires if still no Best Interest Assessor allocated.
Email Livewell Southwest safeguarding adult’s inbox Livewell.SafeguardingAdults@nhs.net. If any change in circumstances i.e. best interest assessor visits patient after incident form has been completed.

If a Local Authority Standard authorised deprivation of liberty expires then the process needs to start again by completing a Form 1 as described above as only self-authorised deprivations of liberty can be extended not standard authorisations but keep in mind as referred to above, once a standard authorisation has been in place a further urgent self-authorisation cannot be put in place

C

If responsible Local Authority have allocated a Best Interest Assessor but outcome is not known prior to self-authorisation expiring, then complete an incident form as above but change wording to read "Unlawful unauthorised deprivation of liberty due to outcome of Best Interest assessment by responsible Local Authority not known prior to self-authorisation expiring, therefore risk assessment to be completed in conjunction with Livewell Southwest safeguarding adult's team and Lead Director informed."

Email Livewell Southwest safeguarding adult's inboxLivewell.SafeguardingAdults@nhs.net If any change in circumstances i.e. outcome becomes known.

D

Inform CQC of outcome by way of appropriate notification form only once outcome is known, not before and send to HSCA_notifications@cqc.org.uk and a copy to Livewell.SafeguardingAdults@nhs.net

8.3.8 The Care Quality Commission (CQC) has requirements in respect of standards which health and social care organisations must reach to be compliant with the MCA 2005 and to avoid sanctions. General guidance including a Summary of regulations, outcomes and judgement frameworks can be found at CQC Essential Standards of Quality and Safety.

Section 4 of the Health and Social Care Act 2008 requires CQC to have regard to "the need to protect and promote the rights of people who use health and social care services (including, in particular persons who are deprived of their liberty in accordance with the MCA 2005)". The first two outcomes in 'Guidance about compliance with the Health and Social Care Act 2008' (Registration Requirements) regulations 2009 are specifically and deliberately aligned with the MCA Codes of Practice:

- Respecting and involving people who use services and
- Consent to care and treatment.
- They focus on rights, involvement, taking decisions, individualised care planning and review.

CQC states in "Essential Standards of Quality and Safety" (2009) that all people who use services should be protected from abuse, or the risk of abuse, and their human rights be respected and upheld. Specifically, CQC standard 7 states that all agencies must:

- Make sure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual
- Where applicable, only use Deprivation of Liberty Safeguards when it is in the Best Interests of the person who uses the service and in accordance with the MCA 2005.

The Care Quality Commission 'Essential Standards of Quality and Safety' can be accessed via www.cqc.org.uk

8.3.9 If a person is being discharged from a Livewell Southwest Hospital bed to a Registered Nursing or Residential Care Home and might require a DoLS then it is the responsibility of that Care Home to make the application as they will be the Managing Authority, however, this should be discussed with the Care Home at a discharge planning meeting. Livewell Southwest staff should not be instructing Independent Providers to be making DoLS applications but can draw their attention to consider it. A third party referral for a DoLS application can also be made by any health professional to the Responsible Local Authority on behalf of a person who lacks capacity but this should only take place following a discussion with the Independent Provider and if following that discussion the Health Professional still is of the view that a deprivation of liberty is taking place but the Independent Provider does not agree (in this circumstance it would be advisable to consult with the Livewell Southwest Mental Capacity Act Lead prior to making a third party referral on behalf of a person who lacks capacity).

8.4 What happens if the person is transferred to another non Livewell Southwest hospital and then returns?

8.4.1 If the person subject to a DoLS is transferred to another ward or another hospital for more than 24 hours then advice from the Responsible Local Authority DoLS Officer should be sought as a new application may need to be made. If the person returns within 24 hours then a new application is not required unless the ward they were transferred to obtained authorisation for a DoLS in which case a new authorisation would be required as the previous DoLS would become invalid at the point where the DoLS on the new ward starts (there cannot be two DoLS Authorisation running at the same time.

8.5 Do we still need a DoLS application if a relative has Court Appointed Deputyship for Health and Welfare for the person being deprived of their liberty or Lasting Power of Attorney for welfare for that person?

8.5.1 Yes, a DoLS application would still be required as Lasting Power of Attorney for Welfare cannot authorise a Deprivation of Liberty. The usual process would apply, however, if the relative who has Lasting Power of Attorney for Welfare objects to the application then authorisation can only be made by the Court of Protection and not the Local Authority.

8.6 How do we know which Local Authority is responsible for the Standard Authorisation application?

8.6.1 Local Authority (Supervisory Body) responsibility for DoLS Authorisations is initially determined by Ordinary Residency, i.e. where the person ordinarily resides is usually where their home address is. However, there are some exceptions to this and it can be quite complex but advice can be sought from the DoLS Officer at Plymouth City Council, or from the Livewell Southwest Mental Capacity Act Lead if necessary. For example if a person is admitted to a Livewell Southwest Hospital Bed from a Registered Residential Care Home in Plymouth, but their placement is funded by another Local Authority other than Plymouth, then the funding Local Authority would be the responsible Local Authority (Supervisory Body) for the DoLS Standard Authorisation application. Another example would be a person who is homeless and responsibility in this instance would be the Local Authority where the person was registered with a GP, if they are registered.

8.7 Is authorisation for a Deprivation of Liberty required for a Registered Hospital Day Unit patient who lacks capacity to consent to their treatment/care and is not subject to the Mental Health Act?

8.7.1 Yes, Deprivation of Liberty Safeguards will still apply if the person meets the criteria as outlined in section 8.2 therefore, authorisation will need to be sought. However, as the duration of any deprivation of liberty is likely to be significantly less than an inpatient stay, more emphasis is on the nature and intensity of any restriction to help determine whether a deprivation of liberty is actually taking place rather than just being a restriction which would not require authorisation.

Although the Supreme Court has never specified how long the duration of a restriction would be before it is considered a deprivation of liberty, there is considerable guidance available that can assist us in determining when a restriction would be considered a deprivation of liberty although there is very little guidance that relates specifically to this group of patients but the general principles apply.

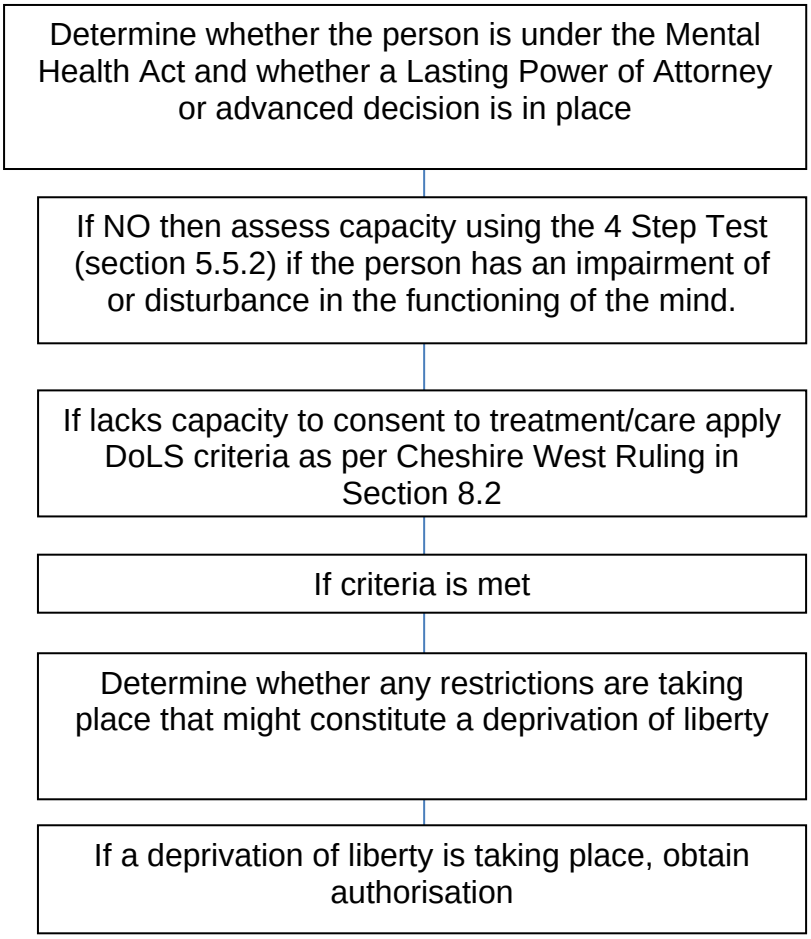
These include any restraint of an intensity or duration that is likely to have a significant effect on the person and any administration of medication against the persons will or given covertly. Either of these scenarios is likely to be

considered a deprivation of liberty and therefore, authorisation would be required as outlined in Section 8.3.7
Further advice can be sought from the Livewell Southwest Mental Capacity Act Lead if necessary.

If it is determined that a restriction is taking place rather than a deprivation of liberty then authorisation does not need to be sought, it can be agreed under best interests as long as it is the least restrictive option and all involved in the persons care agree it is in their best interests in line with good practice guidance, as outlined in the Mental Capacity Act Code of Practice. The rationale for the decision should be recorded in the person's medical notes.

As in all situations, in all environments, in an emergency situation, Health Professionals can undertake a vital act under the law of necessity which the Health Professional undertaking it reasonably believes it is necessary to prevent a serious deterioration in the person's condition.

For Hospital Day Units they should follow the following process:



For Hospital Clinics the same principles apply but authorisation from the Local Authority would only be given for clinics that are registered as Hospital Units. If not registered as a Hospital Unit then only the Court of Protection can authorise a deprivation of liberty.

In most circumstances interventions and treatment for patients who lack capacity to consent to that treatment can be made under best interests using the process described in this Policy and the Mental Capacity Act Code of Practice.

Deprivation of Liberty Authorisation for persons not in Hospital or Registered Care i.e. living in their own home or in Supported Living:

8.7.2 The criteria to determine whether there is a deprivation of liberty is the same as above in 8.1 but the process for obtaining authorisation is different. Authorisation cannot be given by the Local Authority (Supervisory Body); authorisation can only be given by the Court of Protection which requires an application from a solicitor acting on behalf of the Managing Authority. The Livewell Southwest Mental Capacity Act Lead must be informed of all potential Court of Protection applications as legal advice must be sought via the Mental Capacity Act Lead. Livewell Southwest will only be responsible for making Court of Protection applications for those cases where the person`s care /support arrangements are fully funded by Health (usually but not exclusively under Continuing Heath Care (CHC) or Section 117 Aftercare).

8.7.3 Detailed information is required for the Livewell Southwest Solicitor to make the Court of Protection application and the care co-ordinator would usually be responsible for gathering this information but this would be a decision taken by the Service Manager responsible for the clinical team responsible for the person who is being deprived of their liberty, (see checklist below for a guide on the information usually required but this may vary depending on the circumstances of each individual person but the Livewell Southwest Lead On the Mental Capacity Act can advise).

8.8 Checklist Guide for Court of Protection Applications for person's in Supported Living:

- COP 3 form and the relevant part of the COP 10 form for assessment of capacity (to be completed by Consultant or Registered Medical Practitioner).
- Notification of relevant people to be consulted.
- Up to date and most recent Needs Assessment.
- Up to date and most recent Care Plan setting out the nature of the care arrangements and treatment plan and include elements that amount to a Deprivation of Liberty and what risks there are to the person if the care/ support were not in place or if the deprivation of liberty was not authorised.
- Up to date and most recent Risk Assessment e.g. risk areas, such as swallowing, epilepsy and behaviour management.
- Completion of COP 10 Form by Care Co-ordinator or Consultant summarising the person's needs and how they are met.
- IMCA or Advocates report.
- Any Best Interests Meeting minutes or evidence of best interest discussions or consultation.
- Family members supporting statement.
- Individual Service Specification

9. Interface between the Mental Health Act and the Mental Capacity Act

9.1 The revised Mental Health Act Code of Practice issued in April 2015 includes a chapter relating to the Mental Capacity Act (chapter 13). This contains useful guidance as to which framework, Mental Capacity Act or Mental Health Act should be used. Anyone who lacks capacity but are objecting to their care/treatment are not eligible for DoLS if that care/treatment is related to their mental disorder and the care/treatment they are receiving is delivered within a registered mental health hospital/unit so only the Mental Health Act can be used to deprive them of their liberty. The Code of Practice does not specify what the criteria for objecting is, but the following can be used as a guide in determining whether the person is objecting to their care and treatment:

- Is the person refusing medication or is administration of medication covertly necessary?
- Is the person stating that they want to leave the ward on a regular basis and will not respond positively to reassurance?
- Is the person physically attempting to leave the ward and will not respond positively to reassurance?
- Is the person actively resisting care/treatment attempts by way of their actions either verbally or physically?

The above does not apply to patients in non-mental health registered hospitals/units and does not apply to care/treatment not related to the person's mental disorder.

9.2 The Mental Capacity Act Code of Practice makes it clear that an individual does not lack capacity simply because they are subject to the Mental Health Act. There may well be circumstances in which either legal framework apply and health professionals will have to use their judgment in each individual case (refer to the relevant Codes of Practice for more detailed guidance). There may also well be circumstances in which both legal frameworks would apply i.e. if authorisation is required for a physical health procedure that might cause a Deprivation of Liberty for someone under the Mental Health Act who lacks capacity to consent to their treatment (The Mental Health Act would only cover treatment required in relation to the persons mental health not physical health).

9.3 However, the MCA cannot be used if the person retains capacity. Professionals should always consider the least restrictive option, the MHA can be more restrictive but there are some advantages for the person for whom the MHA is being used rather than the MCA, such as access to a Tribunal depending on the Section of the MHA being used. (Case Law may change at short notice in this area, so please seek advice from Livewell Southwest MCAct Lead and Livewell Southwest MHAct Lead for further advice if necessary).

The table below may be helpful in determining whether to use the Mental Health Act or Mental Capacity Act

	YES	NO
Is the person under 16?	Only the MHA can be used. Although the MCA applies to persons 16 years and over, DoLS only applies to persons 18years or over.	Either the MHA or the MCA can be used.
Does the person have a mental disorder?	Either the MHA or the MCA can be used.	The MCA can be used if the person has an; *„impairment of or disturbance in the functioning of the brain".*
Is the proposed treatment for mental disorder?	Either the MHA or the MCA can be used.	If the person lacks capacity; only the MCA can be used.
Do they have capacity to consent to treatment?	Only the MHA can be used to treat them if they refuse treatment for their Mental Illness.	Either the MHA or the MCA can be used. **Note:** if the persons" capacity will be regained in the near future – the MCA will be of limited use.
Do they meet the criteria for detention under the MHA?	If they meet the criteria for detention under the Mental Health Act and are in a unit registered to use the Act then the Mental Health Act ~~must~~ should be used. However if the person is not in a place registered to use the Mental Health Act, the use of Deprivation of Liberty Safeguards may apply.	Only the MCA can be used. **Note:** this could include Deprivation of Liberty Safeguards under the MCA.
Do they have an Advance Decision refusing treatment for mental disorder?	To override an Advance Decision, the MHA would have to be used. **Note:** special rules apply to electro-convulsive therapy	Either the MHA or the MCA can be used.
Does their Lasting Power of Attorney or Deputy or Court of Protection ruling refuse treatment for mental disorder?	To override this detention under the MHA would have to be used. **Note:** special rules apply to electro-convulsive therapy.	Either the MHA or the MCA can be used.
Is the person objecting to treatment for mental disorder?	The MHA should be used*.	Either the MHA or the MCA can be used.
Is restraint needed because of the risk of harm to others?	The MHA should be used. (The Mental Capacity Act only applies to cases of harm to self).	Either the MHA or the MCA can be used.

Is the person objecting to their care or treatment?	Not eligible for DoLS only MHA can be used if care/treatment is related to their mental disorder and they are in a registered mental hospital/unit.	Either the MHA or the MCA can be used.

10. Monitoring

The policy will be monitored by the Mental Capacity Act Lead and reviewed on an annual basis. Any amendments will be made in consultation with Deputy Locality Managers and Lead Officers.

5 Standards for implementation of MCA
5 Standards for Implementation of MCA

Form 1: Request for standard authorisation and urgent authorisation
Form 1: Request for Standard & Urgent Authorisation

Further Standard Authorisation Request
Form 2: Request for Further Standard Authorisation

Form 14: Suspension of a Standard Authorisation
Form 14: Suspension of a Standard Authorisation

Form 15: Notice that a Suspension has been lifted
Form 15: Notice that a Suspension has been Lifted

Form 19: Request for a Review by Managing Authority
Form 19: Request for a Review by Managing Authority

Guide for Managing Authorities
Guide for Managing Authorities

How to identify Deprivation of Liberty
How to Identify Deprivation of Liberty

Urgent Authorisation Information
Urgent Authorisation Information

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Professional Practice Safety and Quality

Date: 24th March 2016

APPENDIX A	Mental Capacity Act- Assessing Capacity The process used to ascertain reasonable belief regarding H`s Mental Capacity in regards to oral feeding was the four step process outlined in the Mental Capacity Act 2005 Good Practice Guidance within the Code of Practice which is as follows: · to understand the information relevant to the decision · to retain the information relevant to the decision · to use or weigh up the information; or · to communicate the decision (by any means). Understand information relevant to the decision H has Agenesis of the Corpus Callosum. This is a rare congenital birth defect in which there is a complete or partial absence of the corpus callosum, the band of tissue connecting the two hemispheres of the brain. The brain fails to develop normally resulting in disconnected brain hemispheres which lead to difficulties expressing, understanding and communicating. H has a severe learning disability. He can only understand limited words and is unable to reliably communicate verbally. H is unable to make his own basic decisions. He can only make choices in his life on a very minimal basis and all his need are anticipated for him. H has awareness of only a limited range of needs and basic risks. He is unable to make choices on most issues, even with supervision, prompting or assistance. H is unlikely to be able to understand the question of whether or not he should be orally fed. If he was asked if he should receive food orally, using relevant symbols or photographs H would not show any signs of understanding the question. However H can demonstrate that he wants to eat and would put a spoon of food or drinking cup to his mouth. H needs 24 hour /constant substantial support to assess and appreciate basic risks and to keep him safe from harm. It is therefore expected that H would not be able to understand information given to him regarding oral feeding. Retain information long enough to make the decision H has shown that he recognises people important to him, routines and places. H would not be able to demonstrate in any way that he could hold complex information in his mind long enough to use it to make an effective decision. This would also include short time retaining of information. H would also be unable to demonstrate through any communications that he had retained information regarding the decision in question.

	Even with items such as notebooks, photographs, posters, videos and voice recorders it is not expected that H would record and retain information. <u>Weigh up the information in order to make a decision?</u> For H to have capacity, he must have the ability to weigh up information and balance the issues to arrive at a decision. H is unable to make his own decisions on most aspects of his life. He can only make very few choices in his life on a very minimal basis for example; he will pick up a beaker to drink (which then needs to be done with assistance). H does not show signs of understanding even the most basic of risks. If H was given food orally he would not be able to identify risk of having food this way. H would show no signs of understanding the complexity or the risk involved with him receiving food orally even with supervision, prompting or assistance. H is not presently expected and has not demonstrated any examples that he is able to make decisions about key complex aspects of their lives. H has 24 hour care as he is unable to independently make these decisions. H displays limited awareness of needs and no verbal or non-verbal behaviour to show he understands any basic risks. H would not identify a boiling kettle or a fire as a risk. It is therefore expected that H would not respond to or understand any relevance of the decision in question. <u>Communicate the decision</u> If H is happy then he will smile, if he is sad then he will bite his finger and rock backwards and forwards. He will express his needs through using various noises and gestures, but people need to know him to understand what he means and often this becomes a process of elimination. H cannot accurately or consistently communicate using symbols or photographs. H is unable able to reliably communicate even with supervision, prompting or assistance. It is reasonably believed that H would not be able to reliably communicate or make a decision regarding oral feeding. **Following the guidance contained in the Mental Capacity Act 2005 it is reasonably believed that H would not have the capacity to decide whether or not he should receive oral feeding.** **Signed** **Date**

Patient Name: **NHS Number:**

Mental Capacity Assessment

Patient
Name: _____ NHS Number: _____
Address: _____ Date of Birth: _____
_____
Telephone: _____ Mobile: _____

1. Summary of situation/circumstances that have led to the person's capacity being considered

2. What is the specific decision to be taken?
If this is a review please detail previous decision about capacity.

Assessment of Capacity

3. Is there an impairment of or disturbance in the functioning of the person's mind or brain?
Yes
No

4. Is the impairment or disturbance sufficient to impact on the cognitive ability of the person to make a particular decision when they need to?

5. Is the person able to understand the information related to the decision?
Yes

Rationale

6. Are they able to retain the information related to the decision?
Yes
No

Rationale

7. Are they able to use or weigh the information whilst making the decision?
Yes
No

Rationale

8. Are they able to communicate their decision by any means? For example; use of pictures, facial expressions, gestures, objects or reference

Yes
No

Rationale

9. Does the person lack the capacity to make this specific decision?

Yes
No

Rationale

10. Were all reasonable steps taken to maximise the person's capacity to make the decision?

Yes
No

11. Comments regarding outcome of question 10

12. Can the decision be delayed because the person is likely to regain capacity in the near future?

Yes
No – Person is not likely to regain capacity

Advanced Decisions

13. Is there any advanced decision relevant to this decision?

Yes
No

14. Details of where this documentation is held

15. Does the person have an advanced statement of wishes?

Yes
No

15. Does the person have an advanced statement of wishes?

Yes
No

16. Details of where this is held

Patient Name: NHS Number:

Consulting Others

17. Did the individual identify someone they wanted their care and treatment discussed with?
    Yes
    No

18. Does the person have a relative/befriender?
    Yes
    No

19. What relationship is the relative/befriender to the person?

20. Does the relative/befriender have Power of Attorney?
    Yes
    No

21. Have you discussed this with the relative/befriender?
    Yes
    No

22. Does the person have someone other than relative/befriender who can help them make the decision?
    Yes
    No

23. If not, have you referred to an IMCA?
    Yes
    No

24. Any additional comments?

25. Capacity Assessment Outcome Summary

APPENDIX B

Best Interest Meeting Template

Individual's Name	
DOB	
NHS No	

Date	Venue

Attendees:	Name	Signature	Designation	Email or Address	Minutes Dissemination

Brief introduction to the individual:	

Decision to be made (Focus of meeting):	

Decision maker:	

Current wishes of individual, if known:	

How was capacity assessed (in accordance with the Mental Capacity Act 2005) and what is the outcome:	

Is the person likely to regain capacity (Risks involved with waiting)	

Have professionals met the individual to ensure reports are up-to-date?	

What has been done to assist the individual to take part in the decision? E.g, supported communication, chance to visit the venue ahead of time (if attending)	

If individual is present	If individual is not present
• All information available in an accessible format, or a client-friendly version is produced • Large name badges • Profession explanation document • To help reduce anxieties, Chair should ensure: - There is water on table - That attendees know where the toilets are, etc. - That regular breaks are allocated	• Is there a visual representation of the individual in the room? For example A4 picture of individual in middle of meeting table (Helping to keep the meeting person-centred)

Any indications from the past as to the likely wishes of the individual? (Verbal/Writing)	

What would/does the individual think are the important factors here?	

Views and involvement of others, e.g: • Health professionals • IMCA • Lasting Power of Attorney • Independent Advocate	

Views of family members following professionals'	

opinions	

Any other contributing factors e.g, individual's compliance?	

List possible options being considered in regard to decision being made and their impact on the individual's health, welfare, social and emotional well-being:	

What decision has been made?	

Is the decision the least restrictive/intrusive? If not, then give rationale	

Outcome Plan: (inc. dates and person(s) responsible)	Action by NAMED individual(s)	By whom? By when?

Is there any dispute? How will this be managed? What options are available?	

How will decision be communicated to the individual and by whom?	

Professionals offer to meet individual after BIM to further explain if necessary and to repair relationship if damaged.	

Date of next meeting if required.	

Template Invite Letters

APPENDIX C

Letter to Professionals

Dear **Name**

Re: Patient (Insert Name) DOB: 00/00/0000

I would like to invite you to attend a Best Interest Meeting to be held on

Date: ……..
Time: ……
Venue: ……

The Best Interest Meeting will ensure the legal framework set out within the Mental Capacity Act 2005 is complied with. The Mental Capacity Act provides a safeguard for individuals who lack capacity to make their own decisions. The Act directs everyone on what steps need to be followed before decisions can be made for a person who has been assessed as lacking the mental capacity to make a required decision for them self.

(**Insert Patient Name**) has been assessed as lacking the mental capacity to make the decision specifically in relation to ……..…

The purpose of the Best Interest Meeting is to allow all the people who have an interest in the welfare of (**Insert Patient Name**) the opportunity to sit down together to discuss and consider the pros and cons of all the possible options available.

Currently the potential options appear to be:

1. ……
2. ……
3. ……

If you feel I have missed an option that should be considered please let me know so we can discuss its inclusion prior to the meeting.

The aim of the BI meeting is to ensure that all relevant information is considered and an informed best interest decision is made.

The other attendees at this meeting will be:

1. Name Title
2. Name Title
3. Name Title

If you are unable to attend please ensure your views are represented by way of one of the following:

- Written Report
- By way of a Colleague
- By informing the Chair of your views in advance of the meeting.

Yours sincerely

Appendix D

Letter to Family

Dear **Name**

Re: Patient (Insert Name) DOB: 00/00/0000

I would like to invite you to attend a Best Interest Meeting to be held on
Date: ……
Time: ……
Venue: ……

The Best Interest Meeting will ensure the legal framework set out within the Mental Capacity Act 2005 is complied with. The Mental Capacity Act provides a safeguard for individuals who lack capacity to make their own decisions. The Act directs everyone on what steps need to be followed before decisions can be made for a person who has been assessed as lacking the mental capacity to make a required decision for themself.

(**Insert Patient Name**) has been assessed as lacking the mental capacity to make the decision specifically in relation to……..….

The purpose of the Best Interest Meeting is to allow all the people who have an interest in the welfare of (**Insert Patient Name**) the opportunity to sit down together to discuss and consider the pros and cons of all the possible options available.

Currently the potential options appear to be:

1…….
2……..
3.…….

If you feel I have missed an option that should be considered please let me know so we can discuss its inclusion prior to the meeting.

The aim of the BI meeting is to ensure that all relevant information is considered and an informed best interest decision is made.

The other attendees at this meeting will be:

1. Name Title
2. Name Title
3. Name Title

It is important that you feel supported to express your views and opinions but you may feel you do not wish to or are unable to attend the Best Interest Meeting. If this is the case please could I ask that you write your views and opinions in a letter to reach me no later than --/--/-- and I will ensure that the meeting representatives give consideration to your opinion. Alternatively I can arrange for a telephone conversation

or appointment to meet you to discuss your views.

Regardless of your intention to attend the Best Interest Meeting if you have any concerns or questions relating generally to the Mental Capacity Act or the Best Interest Meeting process I am happy to offer you support prior to the meeting if this would be helpful. Please call me on …….. and arrangements can be made to facilitate this.

I look forward to hearing from you in the near future and to us working together in identifying the Best Interest Decision for (**Insert Patient Name**) .

Yours sincerely

Appendix E

Invitation to Lasting Power of Attorney

Dear [**Insert Name**]

As you are aware the Mental Capacity Act provides a safeguard for individuals who lack capacity to make their own decisions. The Act directs everyone on what steps need to be followed before decisions can be made for a person who has been assessed as lacking the mental capacity to make a required decision for them self.

[**Insert Patients Name**] has been assessed as lacking the mental capacity to make the decision specifically in relation to……..….

We have seen documented evidence that has been verified with the Office of the Public Guardian and identifies you as having the legal authority for [**Insert Patients Name**] as LPA/Deputy (delete as appropriate) to act in the role of decision maker relating to the following decision (insert) …….

We believe that the decision that you need to make would benefit from the Local Authority/Health department (delete as appropriate) convening a Best Interest Meeting that will ensure the legal framework set out within the Mental Capacity Act 2005 is complied with.

The purpose of the Best Interest Meeting is to allow all the people who have an interest in the welfare of [**Insert Patients Name**] and you as the decision maker, the opportunity to sit down together to discuss and consider the pros and cons of all the possible options available.

Currently the potential options appear to be:
1…….
2……..
3.…….

I am writing to invite you to consider attending a Best Interest Meeting on [**Insert Date / Day**], to be held in [**Insert Venue**] at [**Insert time**] for this purpose. To ensure the best decision is made for (insert person's name) we believe this meeting is essential to ensure that you have access to all relevant information. Your attendance will be very much appreciated but if you feel unable to attend then the minutes of this meeting will be forwarded to you, to inform your final decision.

The Mental Capacity Act Code of Practice chapter 5, 7 & 8 (link below) will help you to understand how to work out the best interests of a person who lacks capacity to make a decision at the time it needs to be made.

http://www.direct.gov.uk/prod_consum_dg/groups/dg_digitalassets/@dg/@en/@disabled/documents/digitalasset/dg_186484.pdf

The other attendees at this meeting will be:
1. Name Title

2. Name Title
3. Name Title

If you have any concerns or questions relating generally to the Mental Capacity Act or the Best Interest Meeting process I am happy to offer you support prior to the meeting if this would be helpful. Please call me on …….. and arrangements can be made to facilitate this.

It is envisaged through the dialogue at this meeting an appropriate course of action will be agreed upon which will be in [**Insert Patients Name**] best interests. Where there is a dispute as to how to serve the best interests of the person who lacks mental capacity, there is recourse in law to the Court of Protection. The Court will however expect to see evidence of professional decision-making and best interests recording having already taken place, and this is another reason why holding a best interests meeting will be useful in ensuring that the decisions needing to be made are clearly understood.

I look forward to hearing from you in the near future and to us working together in identifying the Best Interest Decision for [**Insert Patients Name**].

Yours sincerely

Abbreviations used in this Policy:

IMCA – Independent Mental Capacity Advocate
BIM – Best Interest Meeting
DOLS – Deprivation of Liberty Safeguards
Cof P – Court of Protection
COP – Court of Protection
MCA – Mental Capacity Act
LA – Local Authority
CHC – Continuing Healthcare
MHA –Mental Health Act

Useful links and further reading:

MENCAP `Know Your Rights on the Mental Capacity Act` www.mencap.org.uk

Working with the Mental Capacity Act 2005 92nd edition). S Richards and A F Mughal.

Assessment of Mental Capacity: Guidance for Doctors and Lawyers (Second Edition 2004) The British Medical Association and The Law Society. BMJ Books.

Deprivation of Liberty Safeguards Code of Practice.

Health and Social Care Act 2008
http://www.legislation.gov.uk/ukpga/2008/14/contents

Mental Capacity Act Code of Practice.pdf

Mental Capacity Act 2005.pdf