Torbay and South Devon NHS
NHS Foundation Trust

Title: Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.	
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Links to policies:	Production and Control of Clinical Policies, Guidelines, Protocols and Standard Operating Procedures -Mental Capacity Act 2005 Code of Practice -Mental Capacity Act 2005 Policy -Mental Capacity Practice Guidance -Deprivation of Liberty Safeguards Policy -Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. -Restraint Policy

The Mental Capacity Act Code of Practice Policy, Practice Guidance, Information booklets and assessment and recording forms can be accessed on icon

https://icon.torbayandsouthdevon.nhs.uk/areas/mental-capacity-act/Pages/default.aspx

The Deprivation of Liberty Safeguards Code of Practice, Policy, Information Booklets and forms can be accessed on icon:

https://icon.torbayandsouthdevon.nhs.uk/areas/DOLS/Pages/default.aspx

	Contents	**Page No**
1.	Purpose of the document	3
2.	Scope of this SOP	4
3.	Competencies required	4
4.	Restriction and Restraint of an incapacitated patient using the Mental Capacity Act 2005	4
5.	Mental Capacity Assessment Outcomes	7
6.	Best Interest Decisions (Statutory Requirements)	7
7.	Care and Treatment Planning	9
8.	The Deprivation of Liberty Safeguards - Scope - Acid Test	10
9.	Emergency Situations	12
10.	Making an application, the forms and the legal framework	12
11.	Where to send applications to deprive a person of their liberty	14
12.	Deprivation of Liberty Safeguards Assessment (what to expect)	16
13.	Death of a patient who is deprived of their liberty within a granted Standard Authorisation	18
14	Care Quality Commission Outcomes and Regulations	19
15.	Monitoring Tool	20
16.	References	20
17.	Appendices	21
	Appendix 1:- FACE Assessment Form	22
	Appendix 2:- Best Interest Checklist	24
	Appendix 3:- Clinical Commissioning Group Guidance for Inpatient Providers On Deprivation Of Liberty	25
	Appendix 4:- Form 1 ‘Request for a Standard Authorisation and Urgent Authorisation’	37
	Appendix 5:- Form 2 ‘Request for a Further Urgent Authorisation’	44
	Appendix 6:- Form 10 ‘Review’	46
	Appendix 7:- Form 12 ‘Notification of death whilst deprived of liberty’	50
18.	Amendment History	51

1. Purpose of the document

At times, patients can present as confused and disorientated whilst in a hospital environment and engage in behaviours that may place them at risk of harm, such as attempting to leave the ward area or hospital grounds independently without help and support, wandering within the ward area.

If a patient is presenting as confused it may be because they are experiencing an; **i*mpairment of or disturbance in the functioning of their mind or brain'.*** Examples of impairment or disturbance in the functioning of the mind or brain may include the following:-

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning disability
- The long term effects of brain damage
- Physical or medical conditions that can cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury
- The symptoms of drug or alcohol use.

At such times staff may be required to make decisions and/or take actions to prevent a patient (for whom there is a duty of care) from suffering significant harm.

In circumstances, where a patient is determined to be suffering from an ***'impairment of or disturbance in the function of the mind or brain'*** staff must implement the Mental Capacity Act 2005 (MCA 2005) and where any actions by the staff have the effect of depriving an incapacitated person of their liberty, also implement the Deprivation of Liberty Safeguards (DoLS 2009).

It is a statutory requirement for all staff to implement both the MCA (and DoLS where necessary) in circumstances where there is a reason doubt capacity to consent and there is evidence of ***'impairment of or disturbance in the function of the mind or brain'***. This is to ensure the rights, views and opinions of the incapacitated patient remain central within any decision making process, and the staff are protected when engaging in acts taken in connection with care and treatment.

This document has been developed to support and protect patients who may lack capacity to consent to restrictive measures which are deemed necessary to protect them from harm. The document will also support hospital staff in ensuring their professional practice remains MCA/DoLS compliant. It incorporates national guidance, such as the 'Codes of Practice' and relevant Court of Protection case law, and local guidance developed by the Clinical Commissioning Group, alongside access to relevant forms and local team contact details.

This guidance is applicable to all hospitals within Torbay and South Devon NHS Foundation Trust.

It should be read in conjunction with both the MCA and DoLS Codes of Practice, (which hold statutory force) it does not replace statutory guidance. Staff must comply with the guidance provided within each Code or be able to provide cogent reasons why they have decided to depart from it.

Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.

Staff will be placing themselves at a higher risk of litigation if they do not follow the statutory Codes of Practice.

The MCA code of practice can be accessed on icon.
https://icon.torbayandsouthdevon.nhs.uk/areas/mental-capacity-act/Pages/default.aspx

The DoLS Code of practice which can be accessed on icon
https://icon.torbayandsouthdevon.nhs.uk/areas/DOLS/Pages/default.aspx

2. Scope of this SOP

- Patients aged 18 years plus
- Assessed as lacking the mental capacity to consent to restrictive care or treatment measures which are deemed necessary, in their best interest, to protect them from harm.
- Accommodated in a hospital within Torbay and South Devon NHS Foundation Trust.

This document will be applicable to all qualified staff who propose restrictive measures are necessary for a patient assessed as lacking the mental capacity to consent to them.

3. Competencies Required

1. Mental Capacity Act levels 1 and 2 (as a minimum)
2. Deprivation of Liberty Safeguards Level 1 and 2 (as a minimum)

4. Restriction and Restraint of an incapacitated patient using the Mental Capacity Act 2005

Section 5 of the MCA 2005 allows for actions to be taken to protect an incapacitated person from harm. However, section 6 of the Act imposes important limitations on acts which can be carried out with protection from liability under section 5

The key areas where acts might not be protected from liability are the following:-

- Where there is inappropriate use of restraint
- Where a person who lacks capacity is deprived of their liberty. (see section 8 of is document. for further information)

Section 6 (4) of the Act states that someone is using restraint if they:-

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

It is important that staff recognise that any action intended to retrain a person who lacks capacity will not attract protection from liability unless the following 2 conditions are met:

- The person taking the action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity

- The amount and type of restraint used and the time it lasts must be a proportionate response to the like hood and seriousness of the harm.

The MCA 2005 is concerned with preventing harm to the patient; however, common law imposes a duty of care in respect of all patients to whom services are provided. Therefore if a person lacks capacity to consent, has challenging behaviour, or is in the acute stages of illness causing them to act in a way which may cause harm to others, staff may under common law take appropriate and necessary action harm to restrain or remove them, in order to prevent harm, both to the person concerned and to anyone else.

In such circumstances, and where other people may be at risk of harm, staff should:-

- Call security for additional support
- Where security staff are not available, call the police if necessary
- Consider whether the patient requires a Mental Health Act assessment

The MCA 2005 Code of practice provides comprehensive guidance entitled *'What protection does the Act offer for people providing care or treatment'* within Chapter 6. It is strongly recommended that staff read this chapter.

In short:-

When employing restrictive measures, under the Act, staff must be able to clearly demonstrate the following factors:

- The person lacks the mental capacity to consent to the intervention
- The intervention is a proportionate response to the risk of harm, and the seriousness of that harm
- The intervention is absolutely necessary
- The intervention must be the least restrictive option available
- The intervention must be in place for the shortest possible time
- The intervention must be in the patient's Best Interest

Implementation in practice

In situations where the ward staff becomes aware that a patient may be experiencing an' *impairment of or disturbance in the functioning of the mind'* and they are subject to arrangements for their care and treatment that have a restrictive nature to them for which consent would be required, some examples may include:-

- The use of bed rails

- Sensor mats
- Increased levels of observation

The person in charge must ensure:-

- There is evidence of a risk assessment that clearly evidences the risk of harm that the patient may be exposed to. It is good practice to also incorporate information to inform of the seriousness of that harm/risk, and the probability of it occurring.

  NB
- Solid evidence of risk will help toward providing a clear rationale for implementing measures with a restrictive nature. It will also enable the staff member to clearly evidence that they have taken a proportionate response to the identified risk/harm and the seriousness of risk/harm and evidence in support of the statutory requirement (set out above) in respect of reasonable belief that restraint is necessary in the first place.

- Consideration is given to the 5 key principles as set out within the Mental Capacity Act 2005 these being:-

  1. A person cannot be assumed to lack capacity unless it is established that they lack capacity
  2. A person cannot be treated as unable to make a decision unless all practicable steps to help him/her have been taken without success
  3. A person is not to be treated as unable to make a decision merely because she/he makes an unwise decision
  4. An act done or decision made under the Act for or on behalf of a person who lacks capacity must be done , or made , in her/his best interest
  5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

  (Further information regarding the principles can be found in the MCA 2005 section 1 and the MCA code of practice page 19).

- If following full consideration of the 5 key principles (as set out above) there remains doubt regarding a patient's mental capacity to consent to the restrictive intervention, a clearly documented and robust mental capacity assessment is completed specific to the intervention.

  The MCA 2005 Code of Practice provides comprehensive information regarding assessing capacity 'entitled *'How does the Act define a person's capacity to make a decision and how should capacity be assessed'* within Chapter 4. It strongly advised staff read this chapter.

  There are no statutory forms upon which to record a mental capacity assessment. It is possible to record the assessment process within the Patient's clinical notes, as long as the process is fully implemented, as per statutory requirement, and clearly recorded.

Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.

To support the assessment process Torbay and South Devon NHS Foundation Trust provide access to an assessment tool which will ensure the correct procedure has been followed. The use of the tool is recommended and attached as Appendix 1

The assessment and recording tool can be also be accessed electronically via icon: **https://icon.torbayandsouthdevon.nhs.uk/areas/mental-capacity-act/Pages/default.aspx**

The staff member who is responsible for undertaking the Mental Capacity Act assessment will be the person who is proposing that it is necessary for the patient to be subject to the restrictive measures to protect them from harm.

5. Mental Capacity Assessment Outcomes

Once a mental capacity assessment has been complete staff will be required to act on the outcome.

- If the assessment outcome indicates the patient has capacity to make the decision specific to the proposed intervention (with a restrictive nature) the MCA 2005 can no longer be implemented. In such circumstances the staff will be required to seek informed consent, record consent within the clinical notes and continue with the intervention remaining mindful of the associated risks and risk management plan.

- If the person is assessed as lacking mental capacity to make the specific decision, staff will be legally bound to continue with the Implementation of MCA 2005 and to make a 'Best Interest' decision to implement the proposed intervention.

6. Best Interest Decisions (statutory requirement)

Generally, the Decision Maker will be the professional who is proposing the treatment is necessary. However, it may be the case that the patient has made some prior arrangement (whilst they had capacity) and appointed a person/or people with the right to consent to health and welfare decisions on their behalf when they capacity to make the decision themselves, or provided information to inform of any treatment that they wish to refuse within an 'Advance Decision' to refuse Treatment.

Therefore, it is imperative that Staff identify the following;

- Any person who has been appointed with a registered Lasting Power of Attorney (LPA) for Health and Welfare decisions? An Attorney appointed within a Health and Welfare Power of Attorney will most likely have the right to act as the Decision Maker and make the required Best Interest decision. (Request to see the LPA formal documentation and check it to identify any areas of decision making which the Attorney has been excluded from)
- Any person who has been appointed by the Court of Protection as a Court Appointed Deputy to make health and welfare decisions. A Court Appointed Deputy may have the authority to act as the Decision Makers and make the required decision. (Request to see formal documentation as above).
- Any valid and applicable Advance Decision to refuse medical treatment, as staff must ensure that they are not proposing restrictive measures for an intervention that the patient has previously refused within an Advance Decision. Valid and applicable Advance Decisions are legally binding (Request to see any written Advance Decision)

The MCA Code of Practice contains comprehensive guidance regarding Advance Decisions, such as 'what does Valid and applicable mean?' and Advance Decisions and life sustaining treatment. This is within Chapter 9 entitled *'What does the Act say about advance decisions to refuse treatment*?'
Chapter 7 provides information about Lasting Power of Attorney 'entitled '*What does the Act say about Lasting Power of Attorney?*' It is recommended that staff read both Chapters.

In circumstances where there is neither an Attorney acting under a Lasting Power of Attorney or a Court Appointed Deputy (as set above,) and there is no relevant Advance Decision, the Decision Maker will be the professional proposing the intervention is necessary, however it is legal requirement that they consult with any Family, Friends or Carers who have an interest in the welfare of the patient, and take their views and opinions into consideration as part of the decision making process.

When making a Best Interest decision to implement restrictive measures, such as increased observation levels, placing a patient in a side ward with observations, the use if sensor mats/cushions as a few possible examples, the Decision Maker must consider the following:-

- The statutory Best Interest Checklist which sets out what aspects must be considered during the decision making process. The checklist is designed to ensure that the patient (lacking capacity) remains central to the decision process and does not become subject to overtly controlling decisions made by Decision Makers in isolation. The Statutory Best Interest Checklist is attached as Appendix 2.

- The MCA 2005 Code of Practice provides comprehensive guidance detailing the statutory requirements of a decision making process, within Chapter 5. It is strongly recommended that Decision Makers read the Best Interest Checklist and Chapters 5 and 6 of the Code of Practice if proposing restrictive measures are necessary.

  Both can be accessed electronically via Icon: -
  https://icon.torbayandsouthdevon.nhs.uk/areas/mental-capacity-act/Pages/default.aspx

In all cases where restriction or restraint is being proposed, staff must:-

- Be clear that the intervention taken is a proportionate response to protect the person lacking capacity from harm, taking into consideration the seriousness of the harm.(evidencing the risk of harm using the information contained in the completed risk assessment)

- Be clear that the intervention is in place for the shortest possible time and only when absolutely necessary. It would be best practice to record on the care plan the times that the intervention can be implemented and in which situations.

- Be clear that there is no less restrictive option available.

Staff should also consider providing an information booklet about the Mental Capacity Act to:-

- The person lacking capacity
- Any family members/carers etc.
- Any person interested in the welfare of the person lacking capacity

Information booklets including an easy read version can be accessed on icon:
https://icon.torbayandsouthdevon.nhs.uk/areas/mental-capacity-act/Pages/default.aspx

7. Care and Treatment planning

In circumstance where a Best Interest decision has been made, the person in charge must ensure there is a Best Interest care/treatment plan is in place. It would be best practice to include the following information:

- The assessed risk, seriousness of harm and the probability of it occurring
- Reference to the completed mental capacity assessment
- Any known/observed triggers leading to the patient requiring an intervention with a restrictive nature.
- Any known/observed steps that can be taken to de-escalate, support and reassure the person lacking capacity
- References to the MCA 2005, why it is deemed to be a proportionate response, to protect the person from harm, the other options considered, why it is deemed to be in Best Interest only after having considered other less restrictive options.
- Who may act as the Decision Maker and who should be consulted within the patient's circle of support
- How often the care plan must be reviewed and by whom to ensure it is still relevant and necessary.

The care plan must be kept within the Patients clinical notes and accessible to all staff involved in any acts in connection with care and treatment.

8. The Deprivation of Liberty Safeguards

Section 5 of the MCA 2005, allows action to be taken to ensure a person who lacks capacity to consent receives necessary care and or/treatment. The Act provides protection for staff who are able to demonstrate that they have worked within the framework of the Act.

Although Section 5 of the MCA 2005 permits the use of restriction and restraint of an incapacitated person, example may include the occasional use of bed rails/sensor mats, Section 6 (5) confirms that there is no protection under the Act for actions that result in someone being deprived of their liberty as defined by Article 5 (1) of the European Convention on Human Rights.

This applies not only to public authorities, such as hospitals, but also everyone who might otherwise get protection under section 5 of the Act. It also applies to Attorney's and Deputies, they cannot give permission for an action that takes away a person's liberty.

The Deprivation of Liberty Safeguards is an amendment to the MCA 2005. They provide a legal framework to protect those who may lack the capacity to consent to the arrangements for their treatment or care and where levels of restriction or restraint used in delivering that care are so extensive as to be depriving the person of their liberty.

8.1. The Scope of DoLS:-

- Aged over 18
- Lack the capacity to consent to the arrangements for their care or treatment
- Are receiving care or treatment within a hospital or care home
- Are receiving care or treatment in circumstances that amount to a Deprivation of Liberty in order to protect them from harm and it appears to be in their best interests
- Have a mental disorder but their detention is not already authorised under the Mental Health Act or inconsistent with an obligation placed on them under the Mental Health Act 1983.

On March 19th 2014 the Supreme Court determined what would constitute a deprivation of a person's liberty within a landmark ruling (referring to it as the Acid Test).

8.2 The Acid Test:-

Therefore in circumstances where a patient has been assessed as lacking the mental capacity to consent to be accommodated within the hospital to receive care and or treatment, the patient is deemed to be deprived of their liberty when the twin ingredient set out below, has been met:

- The patient is ***not free to leave*** the hospital
  And
- The patient is under ***Continuous Supervision and Control***

To support hospital staff to implement DoLS the Clinical Commissioning Group (CCG) has provided guidance written by Browne Jacobson Legal firm. The Guidance is entitled *'Clinical Commissioning Group Guidance for Inpatient Providers on Deprivation of Liberty'* The guidance is attached as Appendix 3 and can be accessed electronically via icon:-
https://icon.torbayandsouthdevon.nhs.uk/areas/DOLS/Pages/default.aspx

Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.

It is strongly recommended that staff read the CCG Guidance for providers.

The CCG guidance for providers does not replace the Code of Practice for Deprivation of Liberty Safeguards (which holds statutory force) but should be read in conjunction with it.

The Code of practice can be accessed electronically via icon:-
https://icon.torbayandsouthdevon.nhs.uk/areas/DOLS/Pages/default.aspx

To further support providers to understand DoLS and identify when a deprivation of liberty may occur, the Law Society have developed a guidance tool entitled '*Deprivation of Liberty' A Practical Guide'*

This guide does not replace the DoLS Statutory Code of Practice but should be read in conjunction with it.

Deprivation of Liberty- A practical Guide' can be accessed electronically via icon:-
https://icon.torbayandsouthdevon.nhs.uk/areas/DOLS/Pages/default.aspx

The Law Society Guidance provides a chapter specific to hospital environments. It recognises that the difficult issue is to identify the point at which the level and intensity of the restraint used amounts to a deprivation of liberty.

The chapter focuses on deprivation of liberty of those lacking the capacity to consent to care, treatment and confinement in a hospital setting for purposes of treatment of physical disorders. This includes NHS hospitals and treatment by the independent sector / private hospitals, but also transfer to hospital in the first instance by ambulance, and care in the hospice setting.

Scenarios to support learning cover the following in respect of Hospitals:-

- Conveyance by ambulance to or from a hospital
- ICU
- Acute Ward
- Accident and Emergency

It is strongly recommend that staff read this guidance.

9. Emergency Situations

Within the guidance the Law Society emphasise the following:-

- Emergency life-sustaining interventions and the provision of emergency care to a patient lacking consent to such treatment **should always be given** as clinically required and **there should never be any delay** for prior deprivation of liberty authorisation to be sought.

- It is likely that the immediate provision of life-sustaining treatment to an incapacitated patient in a true emergency situation will not be considered to be a deprivation of liberty (either in the ambulance or in the A&E setting)

Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.

But that:

- As the patient transitions from the initial emergency treatment to on-going care the risk of deprivation of liberty increases with the increasing duration of such treatment (or other such treatment as identified as clinically necessary).

Implementation in Practice

The person in charge of the patient's care must have an overarching view of the care/treatment arrangements in place, the restrictive measures contained within them, how long they have been in place and whether the patient has consented to them.

Where a patient is assessed as not having the mental capacity specifically to consent to be accommodated within the hospital for the purpose of receiving care /treatment and a best interest decision has been made, the following 'Acid Test' must be applied and the twin ingredient met to determine whether a deprivation is occurring:-

The patient is both

- Not free to leave
  and
- Under Continuous Supervision and Control'

10. Making an Application, Forms and Legal framework

In circumstances where the person in charge believes a patient already in their care requires, or is already subject to, restrictive measures that amount to a deprivation of their liberty i.e. they are **Not free to leave and are under Continuous Supervision and Control**' they must undertake the following steps:-

Complete a Form 1, which provides:-

- **A section to** enable the hospital to commence an **Urgent Authorisation**, i.e. once signed and dated the hospital self -authorise the DoL for a period of 7 days and place an immediate legal framework around the restrictive care arrangements

An Urgent Authorisation is only applicable if the patient is already accommodated within the hospital, lacks capacity to consent to their accommodation and care, and is already subject to arrangements that have the effect of depriving them of their liberty.

- **A section to** enable the hospital to request an extension of the Urgent Authorisation for a further 7 days, in the event of the necessary assessments remaining incomplete.

Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.

When an Urgent Authorisation is commenced by the hospital, a request for a Standard Authorisation must also be completed alongside.

- **A section to** enable the hospital to request a Standard Authorisation.

Please note

In circumstances where the patient has not yet been admitted into the hospital, however the hospital is aware that a person will be admitted within the next 28 days, and the patient will require arrangements that will have the effect of depriving them of their liberty, the hospital can make a request for a Standard Authorisation, only. It is not necessary to place an Urgent Authorisation as the patient is not yet in the hospital and therefore not yet deprived of their liberty.

In Summary, Form 1 provides for the following:

- The ability for the hospital to self- authorise an Urgent Authorisation for 7 days
- The ability to request an extension of the Urgent Authorisation
- The Ability to request A Standard Authorisation.

Form 1 must be completed fully and signed and dated. Incomplete forms will be returned to the hospital to be amended.

Form 1 must include as much information as possible in respect of the nature and type of the restrictive measures, why they are necessary, how long they have been in place. It is also good practice to inform of the intensity and impact the arrangements have upon the patient.

In circumstances where it is necessary for the hospital to request a further Standard Authorisation (when an already granted Standard Authorisation is about to cease to be in force) the hospital will be required to complete Form 2 within a timescale to enable all necessary assessment to take place prior to the expiry date.

Once a Standard Authorisation has been granted, the patient, the hospital, Attorney, Deputy, IMCA, Representative, can request a Review of the purpose of the Standard Authorisation or any conditions which have been set within it.

Some examples of when the hospital will need to request a review are:

- In situations when the patient:
- Has regained mental capacity
- No longer has a mental disorder,
- Has been detained under the Mental Health Act
- Their circumstances have now changed (restrictions no longer necessary) and it is no longer in their best interest to be deprived of their liberty,

Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.

A request for a review can be made using Form 10

Form 1 is attached as Appendix 4
Form 2 is attached as Appendix 5
Form 10 is attached as Appendix 6

All DoLS Forms (including Forms 1 and 2 and 10) can be accessed electronically via icon:
https://icon.torbayandsouthdevon.nhs.uk/areas/DOLS/Pages/default.aspx

It is a requirement of the legislation that the staff inform the patient, their family, anyone appointed as an Attorney or Court Deputy, Carers, of the application and provide relevant information about the process. DoLs Information booklets and leaflets (also available in easy read and in other languages) can be accessed via icon:

https://icon.torbayandsouthdevon.nhs.uk/areas/DOLS/Pages/default.aspx

11. Where to send applications to deprive a person of their liberty

Under the DoLS process Hospitals are referred to as the Managing Authority and Local Authorities (to whom the applications are sent) are referred to as the Supervisory Body.

Applications forms will need to be sent to the Supervisory Body (Local Authority) within which the patient is ordinarily resident.

- For applications for patients who are ordinarily resident within Torbay application forms should be submitted to:
  The Deprivation of Liberty Safeguards Team
  3rd Floor Union House,
  Union Street,
  Torquay
  Devon
  TQ1 3YA

Email: Secure NHS email only: **dolstorbay@nhs.net**

Telephone: 01803 219832

Fax: 01803 219863

- For applications for patients who are ordinarily resident within Devon application forms should be submitted to:
  The Deprivation of Liberty Safeguards Team
  County Hall Annexe
  Topsham Road
  Exeter
  Devon

EX2 4QR

Email **dols@devon.gov.uk**

Telephone: 01392 381676

Fax: 01392 383327

- For applications for patients who are ordinarily resident within in Plymouth, application forms should be submitted to
  The Deprivation of Liberty Safeguards Office
  Windsor House
  Tavistock Road
  Plymouth
  PL6 5UF

Email: **dols@plymouth.gov.uk**

Telephone: 01752 308889

In situations where the patient is deemed to be of 'No Fixed Abode' the application should be sent to the Local Authority DoLS Office within which the Hospital is situated.

IMPORTANT

A deprivation of liberty authorisation, whether Urgent or standard, relates solely to the issue of deprivation of liberty. It does not give authority to treat people, nor to do anything else that would normally require their consent. The arrangements for providing care and treatment to people in respect of whom a deprivation of liberty authorisation is in force are subject to the wider provisions of the Mental Capacity Act 2005.

12. DoLS Assessment (what to expect)

Once Form 1 has been submitted to the Supervisory Body, the Supervisory Body will commission 2 different assessors to undertake 6 different assessments. All of the six qualifying criteria assessments must be met to enable the Supervisory Body to grant an Authorisation.

The 2 different assessors will be:-

- Mental Health Assessor
- Best Interest Assessor

The six assessments that they will complete are:-

- Age Assessment
- No Refusals Assessment

- Mental Capacity Assessment
- Mental Health Assessment
- Eligibility Assessment
- Best Interest Assessment.

The assessors will require access to the following:-

- The patient
- The clinical notes
- The care plans and risk assessments
- The contact details of all significant interested persons.
- Any valid and applicable Advance Decisions to refuse medical treatment
- Any Advance Statements
- Evidence of any documentation held for Health and Welfare Lasting Power of Attorney or Court Appointed Deputies.
- Treating clinicians

On completion of the assessment process the Supervisory Body will inform the Hospital (Managing Authority) of the outcome, this will be either:-

- A granted a Standard Authorisation to enable the deprivation of liberty to occur lawfully
- A refusal to grant the Standard Authorisation and a rationale for this decision

Once a Standard Authorisation is granted the Hospital (Managing Authority) maintain a responsibility for the following:-

- To inform the patient and other significant people of the outcome. There are specific information booklets available on icon written for the patient, the family. There are also information booklets in easy read format and leaflets available in different languages.
- Explain to the patient that they have the right to appeal the Standard Authorisation.
- To regularly review the arrangements in place and remove any unnecessary restrictive measures as soon as possible.
- To inform the Care Quality Commission
- To inform the Supervisory Body if the patient's circumstances change, they object to the arrangements in place for their care and or treatment, or they are discharged from the hospital.

Please note:-

If a family member, carer or other person who has an interest in the welfare of the person lacking capacity is requesting that the person is discharged into their care, and this request is being denied by the hospital, immediate advice must be sought from the Nurse Manager, who can seek support from the MCA /DoLS Leads. Advice should be sought in respect of a possible Article 8 (ECoHR Right to respect of privacy and family Life) breach occurring as a consequence of the care/treatment arrangements placed by the hospital.

An authorisation to deprive a person of their liberty is concerned with protecting the patient's Article 5 Rights (ECoHR Right to Liberty) it does not provide a framework within which potential breaches of

Article 8 can be authorised. Such cases will require legal support and a possible application to the Court of Protection.

During out of hours the on call Duty Manager must be informed and can be accessed via the Torbay Hospital Switchboard Tel: 01803 614567

If a decision is made to lock the door of a ward area, or that of the hospital, to protect a person from harm, the person in charge must ensure that other people receiving care and treatment within the ward area are provided with relevant information, such as:-

- Why the door must be locked at this time (considering all aspects of confidentiality)
- How long it may be necessary
- How they can exit the hospital should they wish to.
- The doors will open automatically in the event of a fire

The person in charge must continuously review the restrictive measure to identify:

- If it is still necessary
- The impact care plan is having on the person lacking capacity.
- Identify if anyone is objecting to the care plan such as the patient, family, LPA

13. Death of a patient who is deprived of their liberty within a granted Standard Authorisation

In the event of a person dying whilst they are deprived of their liberty under a granted Standard Authorisation, the person in charge must undertake the following actions as soon as possible (and certainly within a 24 hour timescale).

- Inform the Coroner's office
- Inform the Hospital Manager
- Inform the Supervisory Body
- Inform the Care Quality Commission. .

The Hospital (Managing Authority) can use Form 12 to notify the Coroner's office of a death.
Form 12 is attached as Appendix 7 and also accessible electronically via icon:

https://icon.torbayandsouthdevon.nhs.uk/areas/DOLS/Pages/default.aspx

Coroner' office contact details for Torbay, South Devon and Plymouth

- Senior Coroner's Office: Telephone: 01803 380704

Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.

- Corners Officers within Torbay Hospital: Telephone: 01803 655255 or 01803 6552005
- Email: torbaycoronersofficers@devonandcormwall.pnn.police.uk

Hospital staff must remember that the deprivation of a person's liberty is a very serious matter and should not happen unless it is absolutely necessary, and in the best interests of the person concerned.

14. Care Quality Commission Outcomes and Regulations

Item	%	Exceptions
CQC Essential Safety and Quality Standards outcomes: **Outcome 1**: Respecting an involving people who use services **Outcome 2** : Consent to care and treatment **Outcome 4:** Care and Welfare of people who use services **Outcome 7:** Safeguarding People who use services from abuse. **Outcome 10:** Safety and Suitability of Environment **Outcome 18**: Notification of a death of a person who uses services.		

15. Monitoring Tool

Standards:

Item	%	Exceptions

Equality Statement.

The Trust is committed to preventing discrimination, valuing diversity and achieving equality of opportunity. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics (as governed by the Equality Act 2010): Sexual Orientation; Gender; Age; Gender Reassignment; Pregnancy and Maternity; Disability; Religion or Belief; Race; Marriage and Civil Partnership. In addition to these nine, the Trust will not discriminate on the grounds of domestic circumstances, social-economic status, political affiliation or trade union membership.

The Trust is committed to ensuring all services, policies, projects and strategies undergo equality analysis. For more information about equality analysis and Equality Impact Assessments please refer to the Equality and Diversity Policy

16. References

- Clinical Commissioning Group: Guidance for Inpatient Providers (2015)
- Department of Constitutional Affairs: Mental Capacity Act 2005 Code of Practice (2007).
- Department of Constitutional Affairs: Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of practice to supplement the main Mental Capacity Act 2005 code of Practice. (2009)
- FACE: Mental Capacity Assessment v2 (2207)
- Law Society: Deprivation of Liberty, A Practical Guide (2015)
- Mental Capacity Act 2005

17. Appendices

- Appendix 1:- FACE Assessment Form
- Appendix 2:- Best Interest Checklist
- Appendix 3:- Clinical Commissioning Group Guidance for Inpatient Providers On Deprivation of Liberty
- Appendix 4:- Form 1 ‘Request for a Standard Authorisation and Urgent Authorisation’
- Appendix 5:- Form 2 ‘Request for a Further Urgent Authorisation’
- Appendix 6:- Form 10 ‘Review’
- Appendix 7:- Form 12 ‘Notification of death whilst deprived of liberty’

Appendix 1:-

Name:	Main ID:	Completed by:

FACE Mental Capacity Assessment

What prompted this assessment? *(I.e. summary of relevant history)*

Details:

What is the specific decision to be taken? *(If this is a review, detail previous decision about capacity)*

Details:

Key roles	Closest person	Lasting Power of Attorney (LPA) – health and welfare	Enduring Power of Attorney (EPA)/ LPA – financial	Court of Protection Deputy *(CPD)*	Other
Name					
Tel. No.					
Role					

Determination of capacity *(This is a **specific**, not general determination. Note any documentation referenced)*

Is there an impairment of or disturbance in the functioning of the person's mind or brain?	*Permanent impairment*	☐	*Fluctuating impairment*	☐	*Temporary impairment*	☐	*No*	☐

Details:

Is the person able to understand information related to the decision? *Yes* ☐ *No* ☐

Details:

Are they able to retain information related to the decision? *Yes* ☐ *No* ☐

Details:

Are they able to use or weigh the information whilst considering the decision? *Yes* ☐ *No* ☐

Details:

Are they able to communicate their decision by any means? *Yes* ☐ *No* ☐

Details:

A 'No' answer in any of the 4 domains above constitutes incapacity. If all 'Yes' go to Assessment Summary.

Were all reasonable steps taken to maximise the person's capacity to make the decision? *Yes* ☐ *No* ☐

Details:

Can the decision be delayed because the person is likely to regain capacity in the near future?	*Yes*	☐	*Not likely to regain capacity*	☐	*Not appropriate to delay*	☐

Details:

Who was consulted about the determination? *(Give names and roles. If case conference held detail attendees)*

Details:

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Name:	Main ID:	Completed by:

Advance decisions to refuse treatment *(Note any documentation referenced)*

Is there an advance decision relevant to the decision?	*No*	☐	*Yes*	☐	*If yes select option and give details*	*Similar treatment*	☐	*Similar circumstances*	☐

Details of similar treatment or circumstances:

Advance decision type	*Written*	☐	*Verbal*	☐	Date of advance decision	

What was the decision? *(Give details. If advance decision was verbal, detail to whom, in what circumstances)*

Details:

Is this decision still applicable?	*Yes*	☐	*No*	☐	*If 'No' select option below and give reasons (check guidance)*

Withdrawn	☐	*Unanticipated circumstances*	☐	*LPA/EPA granted regarding decision*	☐	*Inconsistent behaviour*	☐	*Detained under Mental Health Act 1983*	☐	*Other*	☐

Details:

Determination of best interest *(Note any documentation referenced)*

IMCA required?	*No*	☐	*Yes*	☐	Name		Tel. No.	

What is most important to the person as regards this decision? *(Current and past views, e.g. written statement)*

Details:

Views of interested others *(E.g. family, friends, carers, LPA, IMCA, CPD, etc. Give names and roles. If no-one justify)*

Details:

Views of professionals involved

Details:

Describe any possible conflicts of interest with regard to this decision

Details:

Assessment summary *(Remember any judgment about mental capacity is specific to this decision)*

Decision requires arbitration?	*No*	☐	*Independent mediation*	☐	*Court of Protection*	☐

Considering all the factors what final decision has been reached? *(If arbitration required detail)*

Details:

I confirm that this decision is the least restrictive option or intervention possible. Special considerations for life-sustaining treatment have been considered or are not applicable. This decision has not been biased by age, appearance, condition, gender or race. Every effort has been made to communicate with the person concerned.

Decision-maker		Role			
Organisation		Telephone no.			
Signature		Electronic	☐	Decision date	

FACE Mental Capacity Assessment Version 2 — Page 2 of 2

Appendix 2:-

Best Interest Checklist

It is recognised that most significant decisions regarding someone who lacks capacity will be made in the context of a multidisciplinary discussion.
However, the 'decision maker' is the person who is proposing to take action so in the case of medical treatment it is the doctor, if nursing care the nurse, if social care then social worker and so on.

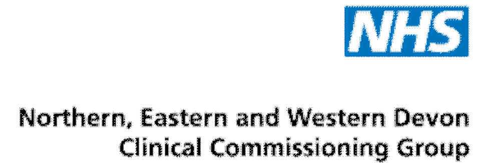
Section 4 of the Mental Capacity Act sets out a checklist of factors to be considered by the decision maker whilst considering the best interests of the person. A brief summary is given below but reference should be made to the Mental Capacity Act Code of Practice.

Factors to be considered

- No decision is made solely on the basis of a person's age, appearance or other aspect of behaviour that might lead others to make unjustified assumptions.
- All relevant circumstances
- Likelihood of regaining capacity – could the decision be delayed?
- As far as possible encourage the person to participate.
- If life-sustaining treatment then the decision must not be motivated by a desire to bring about their death.
- Is it possible to ascertain the persons past and present wishes and feelings?
- Is it possible to ascertain their beliefs and values?
- The views of other people in particular anyone formerly named by the person to be consulted, those involved in caring for the person, those interested in their welfare, donees of a lasting power of attorney or any court deputy. Consultation with Independent Mental Capacity Advocate if one is required.

Decisions must be clearly recorded in the case notes.

Appendix 3:-



Clinical Commissioning Group Guidance for Inpatient Providers On Deprivation Of Liberty

Background

This document is designed to provide you with some broad guidance following the Supreme Court's decision in the case known as *Cheshire West*, where the court looked at what it is for a person to be "deprived of liberty".

This guidance is aimed at providers of inpatient health services and has been produced following a joint collaboration between NHS Northern, Eastern and Western Devon CCG, NHS South Devon and Torbay CCG and NHS Kernow CCG

It is not intended to represent legal advice and each organisation is responsible for obtaining its own advice on individual cases of concern, as well as ensuring that it has robust policies in place that defines for its own purpose who they consider is deprived of liberty and how lawful authority should be sought.

The MCA 2005 – restraint / restriction of liberty

It is important to remember, that under the Mental Capacity Act 2005 ("the MCA"), where a person lacks capacity and an act(s) needs to be undertaken in their best interests, it can still be lawful to restrain a person in order to carry out that act.

Under section 6 MCA, two conditions must be met to lawfully restrain P:

1. You must reasonably believe that it is necessary to do the act in order to prevent harm to the person; and
2. The act must be a proportionate response to the likelihood of P suffering harm and the seriousness of that harm.

Harm is not just confined to physical harm and could be emotional, psychological or even financial harm. Any response has to be proportionate to the risk of the harm arising and the seriousness of that harm.

Restraint is defined under the MCA as the use or threat to use force to secure the doing of an act which P resists, or restricting P's liberty of movement, whether or not P resists.

You must have a "reasonable belief" that the act is necessary, which you will need to be able to justify with evidence if necessary, so ensure clear and contemporaneous documentation is kept.

Ensure as well that any restraint or restrictions are kept under close review and clearly documented on each occasion it is implemented.

You must ensure that you have a clear policy on restraint / restriction / safehold and review it in light of the Cheshire West decision, the impact of which will mean that far more people are deprived of their liberty when previously it may have been thought that there were only restrictions placed upon them.

What is a "deprivation of liberty"?

Other than in very specific circumstances, the MCA does not permit a deprivation of liberty. The term "deprivation of liberty" should not however be seen in a negative light. It is a phrase which originates from Article 5 of the European Convention of Human Rights, which protects everyone's right not to be "deprived of liberty".

There are three elements to a deprivation of liberty:

1. An "objective element" of a person's confinement to a certain limited place for a non-negligible length of time; and

2. The "subjective element" of a lack of valid consent; and

3. The confinement must be the responsibility of the state ("imputable to the state")

Where a person is receiving care in a care home or hospital, it is highly likely that the measures are "imputable to the state". If you are in any doubt, you should seek advice but the circumstances where imputability to the state would not be found will be rare.

The condition that there must be a lack of valid consent would be met where the person lacks capacity to consent to the measures, care or arrangements in place. If the person has capacity and consents, there is no deprivation of liberty.

The *Cheshire West* case, and this guidance, concerns itself largely with what the "objective element" means.

New requirements under Cheshire West

In March 2014, the Supreme Court handed down Judgment in the *Cheshire West* case. The case concerned 3 separate people with learning disabilities and who were accommodated in community and foster placements by their Local Authorities.

They all lacked capacity in respect of where to live and the measures put in place by their Local Authorities to keep them safe.

There was no dispute that the 3 people lacked the requisite capacity. It was also not in dispute that the arrangements put in place were in their best interests. The question addressed by the Supreme Court was whether the arrangements put in place by the Local Authorities represented a deprivation of liberty.

The Supreme Court held that all 3 had been deprived of their liberty by the arrangements put in place for their care and accommodation by their Local Authorities.

The Supreme Court set out what is now described as the "acid test" for deprivation of liberty.

The acid test

The acid test consists of three components, which must be met, to determine whether the person is deprived of their liberty.

The acid test is therefore defined as:-

Where the person lacks capacity to consent to the arrangements / care plan in question AND the person is ***"under continuous supervision and control and not free to leave"***

The person must be both under continuous supervision and control and not free to leave.

If the arrangements are such that the person is under continuous supervision and control but is free to leave, it is not a deprivation of liberty.

Likewise, if a person is not under continuous supervision and control but is not free to leave, it is not a deprivation of liberty.

However, where there is a risk that a person is deprived of liberty, this alone should trigger an assessment and detailed consideration of whether the person is deprived of liberty and if so and how lawful authorisation should be sought.

You should err on the side of caution if in doubt, as an assessment could afford the person important safeguards.

"Continuous supervision and control"

You will have to review each case on its own facts when considering this issue and in particular whether the support provided to a person who lacks capacity means that s/he is in fact under continuous supervision and control.

Remember that if so, this does not mean you are necessarily doing anything wrong, it should just be an indicator that you may need to review the level of support provided.

There are no hard and fast rules as to what represents continuous supervision and control, but you should assess cases on their own merits and assess the risk that measures in place in any given package of care could reach the relevant threshold.

You will need to consider the care plan as a whole, including:

- Is the person subject to 1:1 nursing care and/or supervision
- Any restrictions on the person's movement or contact

- Measures taken to support the person, even if intended to support them living as independent a life as possible
- Pharmacological input
- Whether you know where the person is all the time and know what they are doing

Consider as well whether each and every measure is necessary to safeguard the individual's wellbeing – are there any less restrictive options?

If not, the person may well be under continuous supervision and control.

You should ensure relevant cases are properly assessed and escalate and seek advice on individual cases as necessary.

"Not free to leave"

The question is not whether the person is free to leave the unit temporarily for, e.g. social activities, outings etc., only to return to the unit afterwards but whether they are free to leave on a permanent basis and live elsewhere.

The fact that a person is not physically able to leave due to their condition, whether because of a physical or mental disability is not relevant - You must ask yourself what you would do if the person left of their own accord, or if family or friends attended to say they were taking the person away.

Would you seek to bring the person back or stop them leaving? If so, it is likely that the person is not free to leave.

Again, you must ensure relevant cases are properly assessed and escalate and seek advice on individual cases as necessary.

What is not relevant to whether the person is deprived of their liberty?

Equally important is what you should not take into account when assessing whether a person is deprived of their liberty, including:-

- That the person is compliant or not objecting to the placement or arrangements in place;
- The "relative normality" of the placement or arrangements in place;
- The reason or purpose of the placement or arrangements in place.

The crux of the Cheshire West case was that people with disabilities have the same human rights as everyone else – human rights have a "universal character".

Therefore, if a person is unable to express any dissatisfaction as to the placement / measures in place, or appears to be "happy" or "compliant", this is not relevant to whether or not there is a deprivation of liberty.

Likewise, if the person is in the same, or similar placement to other people with similar disabilities, and so, given the nature of those disabilities, it is "relatively normal" for them, this is irrelevant to whether or not there is a deprivation of liberty.

Also, the purpose of the placement, i.e. to keep the person safe and secure, is irrelevant to whether or not there is a deprivation of liberty.

All of the above may be relevant to whether or not the placement and deprivation of liberty is in that person's best interests, but they are not relevant to whether or not there is actually a deprivation.

Consider what is in the care plan for the person - what is important is the measures taken and whether they are such that the person is *under continuous supervision and control and not free to leave*.

Degree / intensity

Whether measures taken reach the threshold of "the acid test" and so tip a restraint or restriction of liberty into a deprivation of liberty will depend on the degree and intensity of the measures rather than their nature and substance.

When making this distinction, the courts have focused on the type, duration, effects and manner of implementation of the measures in question rather than necessarily the *measures themselves*. You have to consider what the "concrete situation" of the individual is.

When doing so, it is essential that you look at each individual case on its own merits rather than cohorts of people in a particular environment or trying to compare the case you are looking at with other ones you have dealt with before or even read about in case law.

The emphasis should remain on good practice under the MCA and its associated Code of Practice. Consider the basic principles of the MCA with particular focus on taking the least restrictive option where possible. If restrictions can be reduced but the person's best interests can still be met, then this should be done where possible. Also you should be considering whether the person's capacity can be enhanced so as to enable them to make the decision themselves.

You should also make sure that you have your own robust procedures, policies, training and education programme in place to ensure you and your staff are alert to whether arrangements amount to a deprivation of liberty in light of *Cheshire West*. Seek advice where necessary.

The CQC issued a briefing to providers following the Cheshire West case, which can be found here.

In circumstances where you are unsure of whether a person is being deprived of their liberty, you should escalate the query and seek your own legal advice where necessary.

Practical issues

Capacity

If a person has capacity in respect of the placements and arrangements in place and agrees to them, even if they would otherwise meet the acid test, there is no deprivation of liberty. Equally, if the person has capacity and objects (and cannot be detained under the Mental Health Act 1983), then they must be allowed to leave, even if you consider that their decision is unwise

It will be important therefore, in particular in the acute setting, to keep a person's capacity under review. If at any stage, they regain capacity, than their consent for the placement and ongoing measures must be sought.

In doing so, you will need to ensure you comply with the relevant provisions of the MCA and Code of Practice.

Careful care planning at a time when a patient has capacity should include discussions around possible measures which will be necessary at time when the patient may lack capacity, such as at end of life or in an Intensive / High Dependency Care setting. Consent for measures which would otherwise be a deprivation of liberty could be sought at this stage, potentially avoiding the need for an application under the Deprivation of Liberty Safeguards or to the Court of Protection.
Refer to Appendix 1 for more detail on undertaking capacity assessments.

How should the deprivation of liberty be authorised?
In a care home or hospital ("the Managing Authority"), an application to the relevant Local Authority (the "Supervisory Body") under the Deprivation of Liberty Safeguards should be made.
The relevant Supervisory Body will be responsible for arranging the 6 assessments under the Deprivation of Liberty Safeguards and, if appropriate, issuing a Standard Authorisation to the Managing Authority.
In urgent situations, the Managing Authority can obtain an Urgent Authorisation, which is valid for a maximum of 14 days to allow the 6 assessments under the Deprivation of Liberty Safeguards to be undertaken and a Standard Authorisation granted.
This guidance is not aimed at community placements, but where a person is not in a care home or hospital, then authorisation from the Court of Protection must be sought. Advice should be sought in these cases.
Refer to Appendix 2 for more detail on the Deprivation of Liberty Safeguards.

What if an Urgent Authorisation has expired?
An Urgent Authorisation can provide immediate authority for a deprivation of liberty in a care home or hospital. It can be granted for 7 days, and extended to 14 days if required.
The Managing Authority should continue to review the patient's care plan and keep under consideration the patient's capacity to consent to the care arrangements in place and whether any restrictions can be reduced to the extent that there is no longer a deprivation of liberty.
This should be clearly be recorded in the patient's records.
If an Urgent Authorisation has expired and measures are still in place which could constitute a deprivation of liberty, but the Supervisory Body has not been able to complete the necessary assessments and grant a Standard Authorisation, you should seek legal advice on what steps to take as it will depend on the individual circumstances of the case.
Managing Authorities should ensure that they continue to escalate the urgency of the situation to the Supervisory Body and keep a clear record of all communications.
Managing Authorities should continue to review the patient's capacity and the care arrangements in place. Consideration should be given to re-assessing the level of measures in place to ascertain whether fewer restrictions would still provide a safe level of care to the patient.
If the restrictive measures in place increase, then you should again escalate this to the Supervisory Body.
If the arrangements in place remain the same such as you consider there continues to be a deprivation of liberty but no assessments have taken place, you should seek legal advice.
It is not lawful to "re-grant" an Urgent Authorisation after the 14 day period has expired.

Care planning and risk assessments

Any care planning for a person who does, or may, lack capacity in respect of the placement and arrangements in place for care, must include a careful assessment of that person's mental capacity and whether any measures in place do, or may, represent a deprivation of liberty as defined by the "acid test".

You must assess whether restrictions can be reduced but without compromising the person's safety, but if not, care planning will need to include how the deprivation of liberty should be authorised.

The care plan and any risk assessments must be carefully documented, setting out the pros and cons of any discussion and the decision reached.

End of life care

It can be particularly difficult to consider issues around deprivation of liberty in circumstances where a person is coming to the end of life. It could appear overly intrusive and insensitive to ask for assessments of a person under the Deprivation of Liberty Safeguards in such cases.

However, if the "acid test" is met and there is no valid consent then the deprivation of liberty needs to be authorised.

If the person has capacity to consent to the arrangements for their care and consents to those arrangements, there is no deprivation of liberty.

The Department of Health have recently indicated that in their view, if a person has capacity to consent to the arrangements for their care at the time of their admission or at a time before losing capacity, and does consent, this consent covers the period until death and as such, there is no deprivation of liberty.

The Department of Health also state that an exception would be if the care package to which the person consented changes to impose significant additional restrictions or which included care contrary to the previously expressed wishes and preferences of the individual.

In such cases, the consent previously provided is unlikely to cover the change in care and an application under the Safeguards would be necessary if there is a deprivation.

Where the "acid test" is met, however, and there is no valid consent, then the deprivation of liberty must be authorised.

The care arrangements, the person's capacity to consent to those arrangements and any subsequent loss of capacity must be clearly and contemporaneously recorded in the care record.

Consideration should therefore be given at the earliest opportunity as to whether or not care and arrangements which are in place or likely to be required are likely to represent a deprivation of liberty and should form part of the care planning arrangements and treatment escalation plans. With careful care planning, it may be possible to avoid a deprivation of liberty. You should therefore discuss this issue with the person and / or their family at a time when other end of life care planning arrangements are being discussed.

Ensure that you carefully consider and complete a Treatment Escalation Plan, which directs you to discuss care planning with the patient and if they lack capacity, to make decisions about their care in accordance with the MCA.

If necessary, advise the person that, at a time they have capacity, they can create a Lasting Power of Attorney or make an Advance Decision, both of which are mechanisms for decisions to be made at a time when a person lacks capacity. Again, these can form part of the care planning discussions and arrangements at an early stage.

Remember that under the MCA, an Advance Decision is technically an advance decision to refuse treatment rather than, for example, an Advance Decision to agree to a deprivation of liberty.

An Advance Decision can form part of wider care planning which can be created when a person has capacity in respect of the decision. If there is already an Advance Decision or Lasting Power of Attorney in place, you should ask for a copy and if there are any doubts as to validity or applicability, you should seek further advice from your Safeguarding Lead or legal team.

Documentation

It is essential that at all times you keep clear and contemporaneous records of all aspects of the patient's care, including assessments of capacity, best interests (including any best interests meetings and decisions made), care planning and consideration of whether measures taken under the care plan represent a deprivation of liberty, and steps taken to obtain authorisation for that deprivation of liberty. You should also clearly record discussions with the person and where relevant, their friends, relatives and carers.

In particular when making a best interests decision, the risks and benefits of each treatment option should be clearly recorded together with the views expressed by all those consulted, including the patient. You may wish to consider adopting a "balance sheet" approach or document the pros and cons in table form, which should be added to the best interest's documentation.

DoLS and Coroners

The Chief Coroner has recently issued guidance to Coroners on the Deprivation of Liberty Safeguards, which includes reference to circumstances where a person dies whilst under an Authorisation or Court authorised deprivation of liberty. The guidance can be found here.

The chief Coroner's Guidance suggests that where a person dies and is deprived of their liberty which is authorised either under the Deprivation of Liberty Safeguards or by the Court of Protection, the person has died whilst in "state detention" for the purposes of the Coroners and Justice Act 2009. The Coroners and Justice Act 2009 states that where a person whilst in state detention, a Coroner must hold an Inquest.

The death and fact of the Authorisation must therefore be reported to the relevant Coroner's office.

It will be for the Coroner to decide whether to hold a full Inquest, but in light of the Chief Coroner's Guidance, it is likely one will be held where a person dies whilst under the Deprivation of Liberty Safeguards.

Where a person dies and an Urgent Authorisation has expired or the determination of the Court is awaited on the issue of deprivation of liberty, or there is a Standard Authorisation in respect of a care home and the person is removed to hospital and dies there (or in transit), the position is less clear. Individual advice may have to be sought.

However, the Chief Coroner's Guidance states that in the latter case, Coroners should err on the side of caution in deciding that the Authorisation may extend from the care to the hospital and so an investigation should be commenced.

Whilst the Chief Coroner's Guidance also states that a person is not in state detention until the deprivation of liberty is authorised, in such circumstances, it may be safer to report the death and issues around DoLS to the Coroner, for him / her to consider further. 1

Interface between the Mental Capacity Act and Mental Health Act

A person who is detained under the Mental Health Act is still assumed to have capacity to make decisions unless it is demonstrated otherwise. However, if a person is detained under the Mental Health Act, then there is already a lawful process and procedure in place to authorise the deprivation of liberty.

Whilst an assessment will need to take place in each case, in light of the decision in Cheshire West, it is likely that a person admitted for treatment of his / her mental health could only truly be admitted to

a psychiatric hospital "informally" is s/he has the requisite capacity. If the person is assessed as lacking capacity, and is not detained under the Mental Health Act, then an assessment under the Deprivation of Liberty Safeguards (if the person is in a hospital or registered care home) or application to the Court of Protection (if not in a hospital or registered care home) will have to be considered.

Broadly speaking, if a person is detained under the Mental Health Act, then that person will be "ineligible" under the Safeguards. In certain circumstances, the courts have held that the Mental Health Act has "primacy" over the Mental Capacity Act, but this is not a general principle to be applied between the two statutory regimes.

Where it is not clear whether you should be using the Mental Health Act or the Safeguards, you should seek advice on the specific circumstances of the case as it is a complex area and very fact specific.

1 Note that the Senior Coroners for Exeter and Greater Devon, Torbay and Plymouth and Cornwall have confirmed that they wish to be notified only about those deaths where an Authorisation is in fact in place. This includes patients who were under a DoLS in the community and died in hospital before the authorisation in relation to the community is rescinded. You should seek clarification in all other Coronial Jurisdictions.

Depending on the part of the Mental Health Act used, treatment for the person's mental disorder can be authorised even if that person has the requisite capacity in respect of that treatment and refuses.

It has to be remembered, however, that even if an Urgent or Standard Authorisation under the Deprivation of Liberty Safeguards is granted, this does not provide a similar authority to treat the person without a valid consent. It only allows a lawful deprivation of liberty.

You must therefore still apply the relevant principles and provisions of the Mental Capacity Act if a patient is subject to an Authorisation under the Deprivation of Liberty Safeguards and needs treatment. You must in particular consider whether the patient has capacity in respect of the treatment or intervention proposed, and if not, whether or not to provide it is in the patient's best interests.

The eligibility criteria under the Deprivation of Liberty Safeguards and the interface between the MHA and MCA are complex areas and you should seek advice from your legal team on individual cases where necessary.

Emergency measures

There is no definition or clear fixed period of what represents a "non-negligible" length of time for a deprivation of liberty to arise. The courts have not yet specifically looked at a situation where someone is receiving life sustaining emergency treatment in the context of deprivation of liberty. It is unlikely, however, that restrictions used in a true emergency situation would represent a deprivation of liberty.

Section 4B MCA does allow a deprivation of liberty where necessary to provide life sustaining treatment or to undertake "*any vital act*" which is reasonably believed necessary to prevent a serious deterioration in a person's condition. This part of the MCA can only be used "*while a decision as respects any relevant issues is sought from the court*".

However, the longer the restrictions are in place, the greater the likelihood that they will represent a deprivation of liberty and so you must ensure the position is kept under close review and the necessary application under the Deprivation of Liberty Safeguards (or to the Court of Protection) is made.

Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.

Treatment should still be provided to the patient in their best interests and the issue of whether or not the measures taken represent a deprivation of liberty should be considered as a separate issue and the appropriate Authorisation sought if necessary. Necessary treatment should not be delayed simply because any deprivation of liberty authorisation has not been obtained.

Local arrangements for escalation

Please use your organisation's internal arrangements for escalation of issues relating to DoLS and potential requirements for legal advice regarding individual patients.

Some useful links / resources

The Mental Capacity Act -
http://www.scie.org.uk/publications/reports/70-mental-capacity-act-and-care-planning/index.asp
http://www.scie.org.uk/publications/mca/

The Mental Capacity Act Code of Practice –
https://www.gov.uk/government/collections/mental-capacity-act-making-decisions

Law Society - Deprivation of liberty: a practical guide –
http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

England and Wales Court of Protection Decisions –
http://www.bailii.org/ew/cases/EWHC/COP/

Mental Health Law Online –
http://www.mentalhealthlaw.co.uk/Mental_Health_Law_Online

ADASS – Deprivation of Liberty Safeguards Forms –
http://www.adass.org.uk/mental-health-Drugs-and-Alcohol/key-documents/New-DoLS-Forms/

Appendix 1 – Undertaking capacity assessments

One of the basic principles of the MCA is that everyone is assumed to have capacity unless demonstrated otherwise.

Sections 2 and 3 MCA set out the relevant test which should be used to assess whether a person lacks capacity. Section 2 states that:

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

Note "*at the material time*" – capacity must be assessed on the person's ability to make a specific decision at the time it needs to be made.

As well note "*in relation to the matter*" - the test for capacity is a functional one, i.e. a person could have capacity to make certain decisions but not others. In the context of a deprivation of liberty, the question is therefore whether the person has mental capacity to decide where to live and agree to the care arrangements in place. Because the test is a functional one, remember that a person may be assessed as lacking capacity in respect of where to live and agree to the care arrangements, but retain capacity in respect of other decisions.

The MCA states as well that capacity must not be assessed based simply upon the person's age, appearance, assumptions about their condition or any aspect of their behaviour.

The test for capacity is sometimes referred to as a two stage test:
1. Does the person have an "impairment" or "disturbance" of the mind or brain, e.g. dementia, neurological injury, mental illness, learning disability, unconscious?
2. If so, is it causing an inability to make a decision?

The MCA states that a person is unable to make a decision for himself if he is unable to:
1. Understand the information relevant to the decision
2. Retain that information
3. Use or weigh that information as part of the process of making the decision, or
4. Communicate his decision (whether by talking, using sign language or any other means).

The MCA emphasises that the information must be provided to the person in a way he will understand, even if that necessitates sign language, visual aids and such like. This may not be strictly relevant to every patient but the relevant information must certainly be explained to the patient in layperson's terms – you should you should consider each person's level of understanding on an individual basis.

Also consider whether there is any way P's capacity be "maximised" to allow him to make the decision himself, which is another of the basic principles of the MCA, i.e. a person should not be assessed as lacking capacity until all practicable steps have been taken to enable him to make the decision himself.
The MCA also states that the "information relevant to the decision" includes information about the consequences of either making the decision or not making the decision.

It is essential that the assessment of capacity is clearly recorded in the medical records, including of course the decision reached by P. Use the wording of the act, i.e. what is the impairment of the mind or brain? Does P understand the information, can he retain it and can he weigh it in the balance to reach a decision? And can P communicate that decision?

You must also keep the person's capacity under close review in case the person regains capacity and so is able to make the relevant decision themselves.

Appendix 4:-

Case ID Number:					
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1 **REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION**					
Request a **Standard Authorisation** only ***(you DO NOT need to complete pages 6 or 7)***					
Grant an **Urgent Authorisation** ***(please ALSO complete pages 6 and 7 if appropriate/required)***					
Full name of person being deprived of liberty				Sex	
Date of Birth *(or estimated age if unknown)*				Est. Age	
Relevant Medical History (*including diagnosis of mental disorder if known*)					
Sensory Loss		Communication Requirements			
Name and address of the care home or hospital requesting this authorisation					
Telephone Number					
Person to contact at the care home or hospital, (including ward details if appropriate)	Name				
	Telephone				
	Email				
	Ward (if appropriate)				
Usual address of the person, (if different to above)					
Telephone Number					
Name of the Supervisory Body where this form is being sent					
How the care is funded	Local Authority *please specify*				
	NHS		Local Authority and NHS (jointly funded)		
	Self-funded by person		Funded through insurance or other		
REQUEST FOR STANDARD AUTHORISATION					
THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED: *If standard only – within 28 days* *If an urgent authorisation is also attached – within 7 days*					

PURPOSE OF THE STANDARD AUTHORISATION

- *Please describe the care and / or treatment this person is receiving or will receive day-to-day and attach a relevant care plan.*
- *Please give as much detail as possible about the type of care the person needs, including personal care, mobility, medication, support with behavioural issues, types of choice the person has and any medical treatment they receive.*

- *Explain why the person is or will not be free to leave and why they are under continuous or complete supervision and control.*
- *Describe the proposed restrictions or the restrictions you have put in place which are necessary to ensure the person receives care and treatment. (It will be helpful if you can describe why less restrictive options are not possible including risks of harm to the person.)*
- *Indicate the frequency of the restrictions you have put in place.*

INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT		
Family member or friend	Name	
	Address	
	Telephone	
Anyone named by the person as someone to be consulted about	Name	

their welfare	Address	
	Telephone	
Anyone engaged in caring for the person or interested in their welfare	Name	
	Address	
	Telephone	
Any donee of a Lasting Power of Attorney granted by the person	Name	
	Address	
	Telephone	
Any Personal Welfare Deputy appointed for the person by the Court of Protection	Name	
	Address	
	Telephone	
Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005	Name	
	Address	
	Telephone	

WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED *Place a cross in EITHER box below*	
Apart from professionals and other people who are paid to provide care or treatment, this person has no-one whom it is appropriate to consult about what is in their best interests	

There is someone whom it is appropriate to consult about what is in the person's best interests who is neither a professional nor is being paid to provide care or treatment	
WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION *Place a cross in one box below*	
The person has made an Advance Decision that is valid and applicable to some or all of the treatment	
The Managing Authority is not aware that the person has made an Advance Decision that may be valid and applicable to some or all of the treatment	
The proposed deprivation of liberty **is not** for the purpose of giving treatment	

THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT (1983)				
Yes		No		*If **Yes** please describe further e.g. application/order/direction, community treatment order, guardianship*

OTHER RELEVANT INFORMATION
Names and contact numbers of regular visitors not detailed elsewhere on this form:
Any other relevant information including safeguarding issues:

PLEASE NOW SIGN AND DATE THIS FORM			
Signature		Print Name	
Date		Time	
I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION *(Please sign to confirm)*			

RACIAL, ETHNIC OR NATIONAL ORIGIN *Place a cross in one box only*			
White		Mixed / Multiple Ethnic groups	
Asian / Asian British		Black / Black British	

Not Stated		Undeclared / Not Known	
Other Ethnic Origin *(please state)*			

THE PERSON'S SEXUAL ORIENTATION *Place a cross in one box only*			
Heterosexual		Homosexual	
Bisexual		Undeclared	
Not Known			

OTHER DISABILITY

While the person must have a mental disorder as defined under the Mental Health Act 1983, there may be another disability that is primarily associated with the person. This is based on the primary client types used in the Adult Social Care returns.

To monitor the use of DoLS, the HSCIC requests information on other disabilities associated with the individual concerned. The presence of "other disability" may be unrelated to an assessment of mental disorder or lack of capacity. Place a cross in one box only

Physical Disability: Hearing Impairment		Physical Disability: Visual Impairment	
Physical Disability: Dual Sensory Loss		Physical Disability: Other	
Mental Health needs: Dementia		Mental Health needs: Other	
Learning Disability		Other Disability (none of the above)	
No Disability			

RELIGION OR BELIEF *Place a cross in one box only*			
None		Not stated	
Buddhist		Hindu	
Jewish		Muslim	
Sikh		Any other religion	
Christian (includes Church of Wales, Catholic, Protestant and all other Christian denominations)			

ONLY COMPLETE THIS SECTION IF YOU NEED TO GRANT AN URGENT AUTHORISATION BECAUSE IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS ALREADY OCCURING, OR ABOUT TO OCCUR, AND YOU REASONABLY THINK ALL OF THE FOLLOWING CONDITIONS ARE MET

URGENT AUTHORISATION ***Place a cross in EACH box to confirm that the person appears to meet the particular condition***	
The person is aged 18 or over	
The person is suffering from a mental disorder	
The person is being accommodated here for the purpose of being given care or treatment. ***Please describe further on page 2***	
The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment	
The person has not, as far as the Managing Authority is aware, made a valid Advance Decision that prevents them from being given any proposed treatment	
Accommodating the person here, and giving them the proposed care or treatment, does not, as far as the Managing Authority is aware, conflict with a valid decision made by a donee of a Lasting Power of Attorney or Personal Welfare Deputy appointed by the Court of Protection under the Mental Capacity Act 2005	
It is in the person's best interests to be accommodated here to receive care or treatment, even though they will be deprived of liberty	
Depriving the person of liberty is necessary to prevent harm to them, and a proportionate response to the harm they are likely to suffer otherwise	
The person concerned is not, as far as the Managing Authority is aware, subject to an application or order under the Mental Health Act 1983 or, if they are, that order or application does not prevent an Urgent Authorisation being given	
The need for the person to be deprived of liberty here is so urgent that it is appropriate for that deprivation to begin immediately before the request for the Standard Authorisation is made or has been determined	

AN URGENT AUTHORISATION IS NOW GRANTED

This Urgent Authorisation comes into force immediately.

It is to be in force for a period of: ________ days

The maximum period allowed is seven days.

This Urgent Authorisation will expire at the end of the day on: ________

Signed		Print name	
Date		Time	

REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION *If Supervisory Body is unable to complete the process to give a Standard Authorisation (which has been requested) before the expiry of the existing Urgent Authorisation*

An Urgent Authorisation is in force and a Standard Authorisation has been requested for this person.

The Managing Authority now requests that the duration of this Urgent Authorisation is extended for a further period of [ ] DAYS (***up to a maximum of 7 days***)

It is essential for the existing deprivation of liberty to continue until the request for a Standard Authorisation is completed because the person needs to continue to be deprived and exceptional reasons are as follows (*please record your reasons)*

Please now sign, date and send to the SUPERVISORY BODY for authorisation

Signature		Date	

RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED

This part of the form must be completed by the **SUPERVISORY BODY** if the duration of the Urgent Authorisation is extended. **The Managing Authority does not complete this part of the form.**

The duration of this Urgent Authorisation has been extended by the Supervisory Body.

It is now in force for a **further** [ ] days

Important note: The period specified must not exceed seven days.

This Urgent Authorisation will now expire at the end of the day on: [ ]

SIGNED (on behalf of the Supervisory Body)	Signature			
	Print Name			
	Date		Time	

Appendix 5:-

Case ID Number:

DEPRIVATION OF LIBERTY SAFEGUARDS FORM 2
REQUEST FOR A FURTHER STANDARD AUTHORISATION

Full name of person being deprived of their liberty		Sex	
Date of Birth *(or estimated age if unknown)*		Est. Age	
Name and Address of Managing Authority (care home or hospital) requesting this authorisation			
Person to contact at the care home or hospital, (include ward details if appropriate)	Name		
	Telephone		
	Email		
	Ward (*if appropriate)*		

THE PURPOSE OF THE AUTHORISATION is to enable the following care and / or treatment to be given:

- *Please describe the care and / or treatment this person is receiving or will receive day-to-day and attach a relevant care plan.*
- *Please give as much detail as possible about the type of care the person needs, including personal care, mobility, medication, support with behavioural issues, types of choice the person has and any medical treatment they receive.*

THE DATE FROM WHICH THE STANDARD AUTHORISATION IS SOUGHT:

A further Standard Authorisation is required to start on this date so it is force immediately after the expiry of the existing Standard Authorisation.			
OTHER RELEVANT INFORMATION			
Please include details of any changes previously given in Form 1 e.g. in the care plan, medical information, person's behaviour or visitors.			
Signature		Print name	
Date		Time	
I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A FURTHER STANDARD AUTHORISATION *(Please sign to confirm)*			

Appendix 6:-

Case ID Number:			
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 10 **REVIEW**			
Full name of person being deprived of liberty			
Date of Birth *(or estimated age if unknown)*		Est. Age	
Name and address of care home or hospital where the person is deprived of liberty			
Name and address of organisation or person requesting the review			
Contact details of organisation or person requesting the review	Name		
	Telephone		
	Email		
Name of the Supervisory Body where this form is being sent			

A REVIEW OF THE CURRENT AUTHORISATION IS REQUESTED ON THE FOLLOWING GROUNDS *(place a cross in all boxes that apply)*	
The person no longer meet the Age, No Refusals, Mental Capacity, Mental Health or Best Interests requirements, or the reason why they meet the requirements has changed	
The conditions attached to the Standard Authorisation need to be varied because there has been a change in the person's circumstances	
Please give details:	

REVIEW TO CEASE A DOLS AUTHORISATION	
The Managing Authority requests a review, because the person is, or is about to be discharged so the Standard Authorisation will no longer be required. This is on the grounds that the person no longer meets the best interest's requirement.	
The person has left / is due to leave the care home on	
The person is due to be / has been discharged from hospital on	
The person's new address is	
This follows a best interest decision (attached) made on	
It is no longer in their best interest to be accommodated in this care home or hospital because:	

Signed *(on behalf of the Managing Authority)*	Signature	
	Print Name	
	Date	

SUPERVISORY BODY'S DECISION with regard to whether ANY QUALIFYING REQUIREMENTS ARE REVIEWABLE

The Supervisory Body has decided to refuse the request for a review for the following reasons:

This review is therefore complete and the existing Standard Authorisation will continue to be in force until:

The Supervisory Body has decided that at least one of the qualifying requirements is reviewable, as a result of which the following review assessments were carried out:

REQUIREMENT	MET	NOT MET	CHANGE OF REASON
Age requirement			
No Refusals requirement			
Eligibility requirement			
Mental Health			
Mental Capacity			
Best Interests requirement			

OUTCOME OF REVIEW (select one option below)

At least one of the requirements were not met and the Standard Authorisation will therefore cease with effect from:

Based on the assessments that were carried out, the reasons given in the Standard Authorisation as to why the person meets the requirements have been varied as described above.

All the review assessments carried out concluded that the person continues to meet the requirements to which they relate. The Standard Authorisation continues to be in force until:

subject to any variation in conditions shown below:

1	
2	
3	
4	
5	
6	

REVIEW OF CONDITIONS – Please note that the conditions can be reviewed alone without the need for a review of best interests or other requirements

There has not been any **significant** change in the person's circumstances and any changes there have been do not result in the need to vary the conditions. Therefore the existing conditions remain in force.	
The Supervisory Body has decided to vary the conditions either because of a significant change or because some change has occurred which makes this appropriate. The new conditions are described below.	

1	
2	
3	
4	
5	
6	

Signed *(on behalf of the Supervisory Body)*	Signature	
	Print Name	
	Date	

Appendix 7:-

Case ID Number:			
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 12 **NOTIFICATION OF DEATH WHILST DEPRIVED OF LIBERTY**			
Full name of person who was deprived of their liberty			
Date of Birth (*or estimated age if unknown)*		Est. Age	
Date of Death			
Location of person at time of death			
Name and address of the care home or hospital where the person was being deprived of their liberty			
Name and contact details of family member/RPR			
Name of the Supervisory Body			
Person to contact at Supervisory Body	Name		
	Telephone		
	Email		
Contact details of the GP	Name		
	Address		
	Telephone		

SUBMITTING THIS NOTIFICATION
Before the doctor has signed the Death Certificate, the **Managing Authority must send a copy of this notice to the local Coroner's Office.** This is so the Coroner can commence an investigation under Section 1(2) (c) of the Coroner's and Justice Act 2009.

As soon as practicable the Managing Authority must also give a copy of this notice to the following:
1. The Supervisory Body for the hospital or care home
2. Any IMCA instructed for the person
3. Every person named by the Best Interests Assessor in their report as an interested person whom they have consulted in carrying out their assessment

Signed *(on behalf of the Managing Authority)*	Name	
	Print Name	
	Date	

18. Amendment History

Issue	Status	Date	Reason for Change	Authorised
Version 2	draft	02/11/2015	- To reflect important key case law - To provide Law society Guidance - To provide CCG Guidance - To provide new forms	
Version 2	Revised	6 May 2016		Care and Clinical Policies Group

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

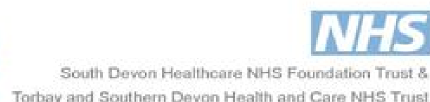
> **"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)**

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.



Rapid Equality Impact Assessment *(for use when writing policies and procedures)*

Policy Title (and number)	**Restriction/Restraint of an incapacitated person and the Deprivation of Liberty Safeguards within a hospital environment.**				
Policy Author	Nicola Griffin /Tracey Cunningham				
Version and Date (of EIA)	Version 2 Date 31/03/2016				
Associated documents (if applicable)					
RELEVANCE: Does the aim/purpose of the policy relate to each of the aims of the Public Sector Equality Duty?					
• **Eliminate unlawful discrimination or other conduct prohibited by the Equality Act 2010**					Yes ☒ No☐
• **Advance equality of opportunity between people from different groups**					Yes ☒ No☐
• **Foster good relations between people from different groups**					Yes ☒ No☐
SIGNIFICANCE AND IMPACT: Consider the nature and extent of the impact, not the number of people affected.					
Does the policy affect service users, employees or the wider community? (if no, proceed to sign off)					Yes ☒ No☐
Does the policy affect service delivery or business processes?					Yes ☒ No☐
Does the policy relate to an area with known inequalities (deprivation/unemployed/homeless)?					Yes ☒ No☐
EQUALITY ANALYSIS: How well do people from protected groups fare in relation to the general population? ***PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below***					
Is it likely that the policy/procedure could treat people from protected groups less favorably than the general population? (see below)					
Age	Yes ☐ No☒	Disability	Yes ☐ No☒	Sexual Orientation	Yes ☐ No☒
Race	Yes ☐ No☒	Gender	Yes ☐ No☒	Religion/Belief (non)	Yes ☐ No☒
Gender Reassignment	Yes ☐ No☒	Pregnancy/ Maternity	Yes ☐ No☒	Marriage/ Civil Partnership	Yes ☐ No☒
Is it likely that the policy/procedure could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers; travellers; homeless; convictions; social isolation; refugees)					Yes ☐ No☒
Please provide details for each protected group where you have indicated 'Yes'.					
What if any, is the potential for interference with individual human rights?					

<table>
<tr><td colspan="3">(consider the FREDA principles of Fairness/ Respect/ Equality/ Dignity/ Autonomy)</td></tr>
<tr><td colspan="3">This document links directly with the protection of Article 5 of the Human Rights Act 1998.</td></tr>
<tr><td colspan="3">RESEARCH AND CONSULTATION</td></tr>
<tr><td colspan="3">What is the reason for writing this policy? (What evidence/ legislation is there?)</td></tr>
<tr><td colspan="3">Landmark Supreme Court Ruling</td></tr>
<tr><td colspan="3">Who was consulted when drafting this policy/procedure? What were the recommendations/suggestions?</td></tr>
<tr><td colspan="3">Associate Director of Adult Social Care
Operational Lead for Safeguarding Adults Torbay Health Social Care community Teams
Safeguarding Adult/MCA/DoLS leads within Torbay acute Hospital
Safeguarding Adult/MCA/DoLS lead within South Devon Community Hospitals
Best Interest Assessors within the Safeguarding Adults Team in Torbay

Clinical Policy Group.</td></tr>
<tr><td colspan="3">ACTION PLAN: Please list all actions identified to address any impacts</td></tr>
<tr><td>Action</td><td>Person responsible</td><td>Completion date</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
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</table>

AUTHORISATION			
Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net
For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation