

**Lincolnshire NHS Provider Trust's Mental Capacity Act
 & Deprivation of Liberty Safeguards
 Policy and Procedure for LPFT**

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1 Introduction

- 1.1 The Mental Capacity Act 2005 (MCA) introduced statutory responsibilities and applies to everyone who works in Health and Social Care and is involved in the care, treatment or support of people over the age of 16, living in England or Wales, who are unable to make all or some decisions for themselves. The MCA came fully into force on 1 October 2007. The Deprivation of Liberty Safeguards (MCA DOLS) came into force on 1 April 2009.
- 1.2 Whilst the Act has significant implications for Health and Social Care, it is a very positive step towards protecting the rights of vulnerable people, whilst safeguarding practitioners and clinicians from liability.
- 1.3 The Deprivation of Liberty safeguards 2007 (DoLS) are an amendment of the Mental Capacity Act 2005. These safeguards came into force in April 2009 to protect the interests of an extremely vulnerable group. The Deprivation of Liberty safeguards are in addition to, and do not replace, other safeguards in the Mental Capacity Act 2005. This means that decisions made, and actions taken, for a person who is subject to a Deprivation of liberty authorisation must fulfil the requirements of the Mental Capacity Act first in the same way as for any other person
- 1.4 MCA and DoLS have been subject to Equality and Diversity Impact Assessment nationally by the Department of Justice, which included consultation with groups in Lincolnshire. Equality and Diversity is therefore implicit within the Policy.
- 1.5 **Principles of the Act**
The whole Act is underpinned by 5 principles. These are referred to throughout a Code of Practice and are a measure by which standards of best practice should be judged:
 - 1.5.1. Assume Capacity
Every adult has the right to make their own decisions if they have capacity to do so.
 - 1.5.2 Practical steps to maximise decision making capacity
A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
 - 1.5.3 Unwise decisions
A person is not to be treated as unable to make a decision because he or she makes what others may consider to be an eccentric or unwise decision.
 - 1.5.4 Best Interests
Any act done or decision made, under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in his/her best interests.
 - 1.5.5 Least Restrictive Alternative
Before an act is done, or a 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 for the person's rights and freedom of action.
 - 1.5.6 The Act also works on the basis that capacity is decision specific, which means capacity should be determined in relation to a specific decision a person is being asked to make. It is rare that a person will have no capacity for any decision making.

2 Purpose & Scope

2.1 This policy provides detail on how MCA and DoLS legal obligations will be met in Lincolnshire and more specifically within the NHS Trusts of Lincolnshire.

2.2 The MCA addresses the duties of staff that provide care for individuals **who are 16 years and over** who may lack capacity to make some or all of their decisions.

2.3 The Deprivation of Liberty Safeguards will only apply to people who:

- **Are 18 years and over**
- Are being cared for in a hospital or registered care home for the purpose of care and/or treatment.
- Lack the capacity to consent to these arrangements for their care/treatment
- Are not detained (or able to be detained) under the MHA (Department of Health (2007) The Mental health Act 1983 as amended by Mental Health Act 2007)
- Have a mental disorder

2.4 Excluded Decisions

The MCA lists certain decisions that can never be made on behalf of a person who lacks capacity. There will be no question of an attorney consenting or the Court of Protection making an order appointing a deputy to provide the requisite consent.

The decisions that can never be made on behalf of someone who lacks capacity are:

- Consenting to marriage or civil partnership
- Consenting to sexual relations
- Consenting to a divorce
- Consenting to the dissolution of a civil partnership
- Consenting to a child being placed for adoption
- Consenting to the making of an adoption order
- Discharging parental responsibility to matters not relating to a child's property
- Giving consent under the Human Fertilisation and Embryology Act 1990
- Voting at an election for any public office or referendum

3. Duties

3.1 Duties within the Trust

Individual/Group:	Responsibilities:
Chief Executive	As Accounting Officer of the Trust the Chief Executive has ultimate responsibility for adherence to legislation and policy.
Board of Directors (LPFT)	Responsibility for ensuring compliance with appropriate legislation. To act as Managing Authority for DoLS.
Director of Nursing, AHP's and Quality (LPFT)	Executive Director lead for MCA & DoLS.
Quality Committee (LPFT)	To ratify approval of policy. responsibility for development, implementation, review and monitoring effectiveness of these policy and procedures on behalf of the Board, receiving assurance via legislative committee, an annual report and annual safeguarding declaration.
Legislative Committee (LPFT)	To approve the Policy. Ensure this policy is reviewed on a bi-annual or as required basis. To monitor the effectiveness of, and compliance with, the policy, making recommendations for changes and actions as appropriate. To monitor compliance with relevant training.
Consultant Nurse for Safeguarding and MCA (LPFT)	To ensure that advice is available to staff on the interpretation of the MCA and the Code of Practice To report on DoLS activity internally & externally as appropriate. Ensure appropriate training is available to staff on the MCA & DoLS. To provide reports to the Safeguarding & Mental Capacity Committee on policy compliance and other related issues. Ensure that policies and procedures are in place to ensure that the MCA and DoLS including Managing authorities duties are carried out appropriately. To disseminate changes in case law and national guidance to appropriate staff. To provide regular reports to the appropriate committee and ensure that training compliance is on the agenda
Corporate & Legal Services	To access external legal advice on MCA and DoLS as required (see legal advice procedure)
Divisional Managers	Ensure staff are released to attend training To promote best practice and ensure staff are aware of and adhere to this policy and the Act. Ensure compliance with conditions attached to DoLS authorisations.
Safeguarding & Mental Capacity Act Practitioners (LPFT)	Provide advice to staff on interpretation of the MCA & DoLS and the Codes of Practice. To develop & deliver MCA & DoLS training to staff. Appropriately report non-compliance with policy and procedure. To advise on the requirement for legal advice
Ward Managers/Team Leaders/Team Coordinators.	To ensure copies of the Code of Practice and other relevant guidance are available to staff. To ensure their staff are appropriately trained regarding mental capacity and to promote best practice in this area.

	<p>Ensure that policies and procedures are followed and understood as appropriate to each staff member's role and function; and to appropriately report non-compliance with policy.</p> <p>To act as / or delegate the Managing Authority duties and responsibilities for completion of DoLS forms and liaison with the Supervisory Body</p> <p>Ensure compliance with conditions attached to DoLS authorisations.</p>
Safeguarding & Mental Capacity Champions	<p>Support other staff in identification of and appropriate reporting (form completion) of cases that may constitute a DoLS.</p> <p>Support other staff to follow local and national guidance in assessment of capacity and in making choices on behalf of people lacking capacity.</p> <p>Assist with embedding the principles of the MCA within their service.</p> <p>Provide feedback where appropriate on use of MCA and DoLS, specific issues and concerns, and training to Team Managers and the Consultant nurse for Safeguarding & Mental Capacity.</p>
All Clinical Staff	<p>To be familiar with the 5 statutory principles.</p> <p>To follow the legislation as set out in Trust Policy & Procedures</p> <p>To have regard to the Code of Practice</p> <p>Complete Mental Capacity Act & DoLS training as prescribed by the Mandatory Training matrix</p> <p>To undertake capacity assessments as appropriate</p> <p>To act as the decision maker when appropriate</p> <p>To alert their line manager and Trust Safeguarding policy & procedures if they believe anyone is responsible for ill-treatment or wilful neglect of someone who lacks capacity.</p> <p>Ensure capacity assessments and decisions made in the best interests of a Patients are clearly documented</p> <p>To understand Advance Decisions to Refuse Treatment and when they can be overridden.</p> <p>To assist Patients s in making Advance Decisions to Refuse Treatment if appropriate.</p> <p>To Understand and refer to Advance statements when decision making</p> <p>Appropriately report non-compliance with policy.</p> <p>Refer to Advocacy services.</p>
Training Department	<p>Ensure facilities & resources are available to provide appropriate training, and recording & reporting compliance with this.</p> <p>Promote MCA & DoLS training</p>

3.2 Duties of Agencies external to NHS Trusts:

Lincolnshire County Council (Supervisory Body)	<p>To commission Independent Mental Capacity Advocate (IMCA) services for Patients s who lack capacity including those who are deprived of their liberty</p> <p>To act as a Supervisory Body, receiving applications from care homes and wards for authorisation of a deprivation of</p>
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	<p>liberty</p> <p>To ensure relevant person's (paid) representatives are available for those deprived of their liberty who do not have suitable family or friends to act in this role</p> <p>To commission the six assessments to be done following receipt of an application</p> <p>To grant or refuse applications within the statutory time frames</p> <p>To provide a Best Interest Assessor service.</p> <p>To provide a Mental Health Assessor service.</p>
Court of Protection	<p>Make declarations about whether or not a person has capacity to make a particular decision.</p> <p>Make decisions on serious issues about healthcare and treatment on behalf of a person who lacks capacity if necessary.</p> <p>Make decisions about the property and financial affairs of a person who lacks capacity if necessary.</p> <p>Appoint deputies to have ongoing authority to make decisions.</p> <p>Make decisions in relation to Lasting Powers of Attorney (LPAs) and Enduring Powers of Attorney (EPAs).</p> <p>Make declarations about whether an Advance Decision to Refuse Treatment is valid and applicable.</p> <p>To hear appeals regarding deprivation of liberty as requested by the individual themselves or their representative</p>
Person appointed under Lasting Power of Attorney	<p>Make decisions in the best interests of the Patients within their remit of authority.</p> <p>Make decisions regarding whether information can be disclosed.</p>

4. Definitions

- 4.1 **Advance Decision to Refuse Treatment:** At a time when a patient has the capacity to make the decision they may decide that if they lack capacity at some point in the future they do not want to receive specific treatments. If an advance decision relates to life sustaining treatment (such as resuscitation) it must be in writing and witnessed – ideally by a carer or relative or if this is not appropriate an advocate or independent third party- but not by a member of Trust staff unless there are special circumstances.
- 4.2 Advance Decisions to Refuse Treatment must satisfy these 7 criteria:
- The person had mental capacity when it was made
 - The person was 18 or over when it was made
 - It was not made under conditions of undue influence or compulsion
 - The person has made an informed choice which is the result of having relevant information and of careful thought
 - It is clear so that there is no doubt about the individual's intentions
 - It is applicable to the person's condition at the time it comes into force
 - It does not request anything that is against the BMA's code of ethics
- 4.3 The interaction between the Mental Capacity Act and the Mental Health Act means that there are now 3 levels of Advance Decisions:

- 4.3.1. **Level 1:** An advance decision to refuse treatment for physical disorders (e.g. resuscitation, chemotherapy, certain medications such as antibiotics, PEG feeding). These are always legally binding (if valid and applicable) and **MUST** be followed if staff are aware of them.
- 4.3.2. **Level 2:** An advance decision to refuse Electro-Convulsive Therapy (ECT). This can be overridden if the Patients is detained under the Mental Health Act 1983 and the ECT is to be given because it is immediately necessary to save the Patients 's life or prevent a serious deterioration in the Patients 's condition (see section 58A(5) and 62 (1A) of the Mental Health Act 1983). Clinicians are advised though that going against an advance decision may lead them open to challenge so documentation of the justification for overriding must be clear.
- 4.3.3. **Level 3:** An advance decision to refuse specific forms of treatment for mental disorder (e.g. certain medications such as Clozapine). These can be overridden if the patient is detained under the Mental Health Act 1983. Clinicians are advised that alternative forms of treatment should be considered first in line with the Guiding Principles of the Mental Health Act 1983.
- 4.4 Advance Decisions cannot be made to refuse 'basic care', defined by the British Medical Association (BMA) as procedures essential to keep the individual comfortable e.g. warmth, shelter, personal hygiene, pain relief and the management of distressing symptoms.
- 4.5 **Advance Statement:** An Advance Statement details a patient's wishes and feelings should they lack capacity in the future but is not legally binding.
- 4.6 **Best Interest Assessor (BIA) for Deprivation of Liberty only:** The Best Interests Assessor must be a social worker, nurse, occupational therapist or psychologist registered appropriately and with at least 2 years post-qualification experience. They must have undertaken the relevant BIA training.
- 4.7 **Best Interests:** If, following a capacity assessment, an individual is found to lack the capacity to make the specific decision; the decision maker should decide what action is in the Patient's best interests.
- 4.8 **Court Appointed Deputy:** In certain situations where an individual does not have an LPA but a series of decisions needs to be made the Court of Protection may appoint a deputy who then take on the same functions as an attorney either for a specified period or indefinitely.
- 4.9 **Court of Protection:** The specialist court for all issues relating to people who lack capacity to make specific decisions. The Court of Protection is established under s.47 of the MCA.
- 4.10 **Deprivation of Liberty Safeguards (DoLS):** The Deprivation of Liberty Safeguards provide legal protection for people who are, or may become, deprived of their liberty in a hospital or care home. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears unavoidable. There are some circumstances where depriving a person, who lacks capacity to consent to the arrangements made for care or treatment, or their liberty is necessary to protect them from harm, and is in their best interests.

- 4.11 **Independent Mental Capacity Advocate (IMCA):** A specialist advocate who can represent the patient and their best interests if they have no family/friends to speak on their behalf. There is a statutory duty to refer to an IMCA in certain situations:
- 4.12 **Lasting Power of Attorney (LPA):** A Lasting Power of Attorney is a legal document which gives the attorney (or donee as it sometimes called) the authority to make decisions on the patients behalf. There are 2 types of LPA: Personal Welfare and Property & Affairs. To be valid an LPA must be registered with the Office of the Public Guardian.
- 4.13 **Managing Authority:** Managing Authorities under DoLS are hospitals or care homes.
- 4.14 **Mental Capacity:** A person's ability to make a **particular** decision at a **particular** time.
- 4.15 **Mental Health Assessor:** For DoLS; The Mental Health Assessor must be a section 12(2) doctor or a registered medical practitioner with at least 3 years post registration experience in the diagnosis or treatment of mental disorder who has completed the necessary Mental Health Assessor training.
- 4.16 **Relevant Person's Representative (RPR):** Any individual deprived of their liberty under the safeguards need an RPR to support them in any appeal to the court themselves. The representative will normally be a family member or friend but where this is not possible or appropriate the Supervisory Body will arrange for a paid representative to be appointed.
- 4.17 **Restraint / Restriction / Force:** 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, or
 - Restrict a person's freedom of movement, whether they are resisting or not.
- 4.18 **Supervisory Body:** Supervisory Bodies are those organisations that can authorise a DoLS. This will be the Local Authority where the patient is ordinary resident, for most patients this will be Lincolnshire County Council but could be other neighbouring Authorities.

5. Undertaking Capacity Assessment (Appendix 1 Mental Capacity Process)

- 5.1 A lack of capacity cannot be established merely by reference to a person's age or appearance or condition, or an aspect of their behaviour which might lead other to make unjustified assumptions about their capacity.
- 5.2 For the purposes of the Act, a person lacks capacity in relation to a matter if at a material time he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.
- 5.3 Whilst it is essential that health professionals recognise a person's right to safety and exercise their fundamental duty of care, the Act requires that every effort is made to encourage and support people to make their own decisions. Anybody who claims that an individual lacks capacity should be able to provide proof. The need to be able to show, on the balance of probabilities, that the individual lacks capacity to make a particular decision, at the time it needs to be made.

5.4 **Who should assess capacity?**

The individual who makes the decision or intends to undertake the action should assess the patient's capacity. Some assessments can be carried out by multi-disciplinary team members for example where an inpatient needs to access a different department for their treatment decision making should be jointly made by the referrer and the person undertaking the action, i.e. Radiology/Endoscopy.

5.4.1 The following factors may indicate the need for involvement of a more experienced professional with specialist skills and escalation to the Trusts MCA Lead:

- The gravity of the decision or its consequences
- Where the person concerned disputes a finding of incapacity
- Where there is disagreement between family members, carers and/or professionals as to the persons capacity
- Where the person concerned is expressing different views to different people, perhaps through trying to please each or tell them what she\he thinks they want to hear.
- Where the persons capacity to make a particular decision is subject to challenge, either at the time the decision is made or in the future
- Where there may be legal consequences of a finding of capacity
- The person concerned is repeatedly making decisions that put him\her at risk, or that result in preventable suffering or damage

5.5 **Capacity Assessments (Appendix 2 Capacity Assessment)**

5.5.1 A capacity assessment can be triggered in one of many ways, following the establishment of a need for a patient to make a specific decision, e.g:

- a) The persons behaviour/responses suggest they may lack capacity
- b) The persons circumstances suggests they may lack capacity
- c) Someone else has raised concerns over capacity
- d) There have been capacity issues previously
- e) An unwise decision causes concern over capacity

5.5.2 Capacity assessments should begin from the assumption that a person has capacity the member of staff needs to provide evidence of a lack of capacity.

5.6 **The two stage functional test**

A person will be found to be lacking capacity to make a decision if:

5.6.1 **Stage 1** is there is an impairment or disturbance of the function of the persons mind or brain - this could be due to long-term conditions such as mental illness, dementia, or learning disability, or more temporary states such as confusion, unconsciousness, or the effects of drugs or alcohol. If so:

5.6.2 **Stage 2** is the impairment\disturbance is sufficient that the person lacks capacity to make a particular decision. To establish stage 2 the following then needs to be considered:

5.6.3 **The relevant information**

It is not necessary that the patient understands every element of what is being explained to him: What is important is that the patient can understand the 'salient

factors', this means that the onus is on staff to identify the specific decision, what information is relevant to that decision, and what the options are that the patient is to choose between. Further, one must not start with a 'blank canvas'.

5.6.4 Can the person understand information relevant to the decision?

In order to demonstrate 'understanding' a person needs to understand the nature of the decision, the reason why it is needed, and to have an element of foresight about the likely consequences of making or not making the decision?

5.6.5 Can they retain that information long enough to make the decision? Information need only be held in the mind of the person long enough to make the decision?

5.6.6 Can they weigh \ use the information to make a decision?

This requires the person actually engage in the decision-making process itself and to be able to see the various parts of the argument and to relate them one to another. The person must be able to consider and weigh the arguments for and against a proposed action and the likely consequences before making a decision.

5.6.7 Can they communicate by any means the decision?

Can the person communicate a decision?

If there is a NO answer in any of the above four domains above then the test indicates that the person lacks capacity in relation to that decision.

5.6.8 The Act requires only a 'reasonable belief' of the assessor that a person lacks capacity in relation to a decision but Clinicians / practitioners need to be able to identify objective reasons why a person lacks capacity based on the above test.

5.6.9 The capacity assessment should be revisited if the person's condition changes, to ensure it is still relevant and valid.

5.7 Recording of the Capacity Assessments

5.7.1 Capacity assessments can be recorded in notes but must meet the minimal legal requirements. The forms provided will ensure the minimum legal requirements are met and LPFT has a capacity assessment tool on health clinical systems which meets these requirements and easily accessible.

5.8 Capacity Disputes

If an assessor is in any doubt after assessment, or their assessment is challenged, it is entirely proper for them to obtain a second opinion from other trained colleagues. Furthermore, assessments can be undertaken by teams of staff if this is found to be appropriate. In all circumstances this should be fully documented in the notes. Where uncertainties or significant dispute continue this should be escalated via your MCA leads.

5.9 Referral to Independent Mental Capacity Advocacy (IMCA) Service.

5.9.1 The Act places a legal duty on local authorities and the NHS to refer a person to an IMCA in certain circumstances, to support people who lack capacity to make important decisions:

1. Serious medical treatment (starting, withholding or stopping) or
 2. Periods of accommodation in a hospital (28 days or more) or
 3. Moving to a care home (8 weeks continuously or more) or
 4. Where decisions with serious implications need to be made.
- 5.9.2 IMCAs must be involved when a person aged over 16 and has no family, friends or carers (who might contribute to best-interest decision-making)
- AND**
Has been evidenced as lacking capacity in relation to one or more important decisions as above.
- 5.9.3 If there is a need for urgent treatment or an urgent need for a move to hospital, care home or residential accommodation then an IMCA referral should be made with a follow up call regarding the urgency, but the care or treatment undertaken should not be delayed in urgent circumstances.
- 5.9.4 Properly appointed IMCAs have a statutory right of access to records that the record-holder believes to be relevant to the decision. Clinicians and practitioners should allow access to files and notes but only to information relevant to the decision. Those responsible for patient / user records should ensure that third-party information and other sensitive information not relevant to the decision remains confidential.
- 5.9.5 Following referral via the referral to *Total Voice Lincolnshire: Voiceability on 01529 400479* or via <http://www.totalvoicelincolnshire.org/contact-us/> . IMCA involvement and receipt of an IMCA report, the referring staff will be expected to communicate the outcome of the case to the IMCA service.
- 5.10 Best Interests Decisions: Appendix 3 and 4.** If a patient is found to be lacking capacity an action may be undertaken, providing that action is in their best interest.
- 5.10.1 To make a basic or day-to-day decision on behalf of someone lacking capacity, staff should use the Best Interest documentation for everyday decision making, contained within **Appendix 3** of this document which should be appropriately uploaded onto the clinical system for future reference. For more complex decisions staff should refer to the Best Interest Meeting complex decisions documentation in **Appendix 4**.
- 5.10.2 The person making the decision is referred to as the “Decision Maker” and it is their responsibility to work out what would be in the best interests of the person who lacks capacity. For most day to day actions or decisions, the decision maker will be the carer most directly involved with the person at the time. Where the decision involves provision of care and treatment, the most appropriate member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision maker. Ultimately it is up to the professional responsible for the person’s treatment to make sure that capacity has been assessed.
- 5.10.3 When working out what is in the best interests, decision makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacks capacity.
- 5.10.4 It is up to the decision maker to ensure that they have sufficient information in order to make the decision in the patient’s best interests. They must arrange to talk to other professionals involved and the patient’s family and friends. In situations where an

IMCA is involved they will also receive a report from the IMCA as to what may be in the patient's best interests.

5.10.5 Best Interests is not purely what would be 'best' medically in terms of prolonging life but must take into account social, emotional and psychological factors as well as anything that the Patients may regard as important if they were making the decision themselves.

5.10.6 The best interest checklist ensures decision makers:

- **Encourage participation:** do whatever is possible to permit and encourage the person to take part or improve their ability to take part in making the decision
- **Identify all relevant circumstances:** try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.
- **Find out the person's views:** try to find out the views of the person who lacks capacity, including the persons past and present wishes and feelings; these may have been expressed verbally, in writing, or through behaviour or habits. Any beliefs and values, e.g. religious, cultural, moral or political that would be likely to influence the decision in question, any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.
- **Avoid discrimination:** not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour.
- **Assess whether the person might regain capacity:** consider whether the person is likely to regain capacity (e.g. after receiving medical treatment) if so, can the decision wait until then?
- **If the decision concerns life-sustaining treatment:** not be motivated in anyway by a desire to bring about the persons death, they should not make assumptions about the person's quality of life.
- **Consult others:** if it is appropriate and practical to do so consult other people for their views about the person's best interests to see if they have any information about the person's wishes and feelings, beliefs and values. In particular try to consult everyone previously named by the person as someone to be consulted on either the decision in question or on further issues, anyone engaged in caring for person, close relatives, friends and others who take an interest in the persons welfare, an attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney, any deputy appointed by the Court of Protection to make decisions for the person.

5.11 Consultation

The Act promotes consultation and requires transparency in decision making processes in order to protect and empower people from random or unsound decision making.

5.11.1 Family and friends are not decision makers but they can provide important information about current and previously expressed wishes, values, beliefs, culture and how different options might impact on them to inform decision makers about the person.

- 5.11.2 Family and friends may not always agree about what is in the best interests of an individual. If you are the decision maker you will need to clearly demonstrate in your record keeping that you have made a decision on all available evidence, and taken into account all of the conflicting views.
- 5.11.3 Family and friends must be made aware of the pros and cons of the available options during consultation.
- 5.11.4 Consultation can be via a meeting for complex decisions or where there are lots of people to consult. Consultation can also be via direct discussions or telephone contact.

6.0 Confidentiality

- 6.1 A best interest decision may require the sharing of information amongst health and social care workers, family and friends. If a person lacks capacity to consent the disclosure information must be based on the determination of the person's best interests.
- 6.2 The Act places a duty to take into the account the wishes and feelings of others who may have an important role in a person's life but only share as much information as is needed.
- 6.3 Where an attorney under a Health and Welfare Lasting Power of Attorney (LPA) has been appointed, they will be entitled to access to health and social care information and may also determine if information can be disclosed. Staff must consult with an LPA before sharing any information with a third party.
- 6.4 Where it is not possible to consult more widely because, for example, urgent treatment is necessary, staff must still act in the patient's best interest.

7.0 Children and Young People Aged 16 to 17 Years

- 7.1 Most of the MCA applies to people aged 16 years and over, there is an overlap with the Children's Act 1989. For the Act to apply to a young person, they must lack capacity to make a particular decision (in line with the Act definition of lack of capacity described previously). In such situations, either this Act or the Children's Act 1989 may apply, depending on the particular circumstances.
- 7.2 There may also be situations when neither of these Acts provides an appropriate solution. In such cases it may be necessary to look to the powers available under the Mental Health Act 1983, or the High Court's inherent powers to deal with cases involving young people.
- 7.3 There are provisions in the MCA not available to 16 or 17 year olds. These are:
- Making a Lasting Power of Attorney
 - Advance decisions to refuse treatment
 - Making a Will
- 7.4 For very complex capacity cases, it is recommended that staff contact the Trust's Safeguarding & Mental Capacity Team and if necessary a specialist legal opinion can be obtained.

8. Safeguards for People who lack capacity

8.1 The MCA provides new options for people to plan ahead for a time when they may lose capacity. The new Court of Protection also has powers to appoint deputies to act for a person in complex situations. Potentially these new provisions will have an important implication for staff in health and social care, by requiring that attorneys and deputies are involved as decision makers for the person they represent:-

8.2 Lasting Power of Attorney

The MCA allows a person to appoint an Attorney to act on their behalf if they should lose capacity in the future. A Lasting Power of Attorney (LPA) is a formal legal arrangement which allows the Attorney the authority to make specified decisions on behalf of a person who lacks capacity. Existing Enduring Powers of Attorney are also still valid.

8.3 An LPA must be registered with the Office of the Public Guardian before use.

8.4 Property and Financial LPAs deal with finance, and Health and Welfare LPAs deal with personal care issues (including decisions on medical treatment where the LPA is the decision maker). Clinicians should consider discussing LPAs with patients, but must not use undue pressure.

8.5 An LPA can also be verified by an identified hologram on the LPA and unique reference number is intended as proof of validity. The contact details for the Office of the Public Guardian are as follows:

Website: www.guardianship.gov.uk

Telephone: 0845 3302900

Email: custserv@guardianship.gsi.gov.uk

A copy of the LPA must be kept in the patients' healthcare records.

Concerns about an LPA should be communicated to your local safeguarding team but also concerns can be raised via the OPG safeguarding office.

9. Court of Protection

The Court of Protection is the ultimate arbiter for all matters relating to the MCA. The Court has powers of adjudication and will:

- Make declaration about whether or not a person has the capacity to make a particular decision
- Make declarations about the lawfulness, or otherwise, of an act done or yet to be done, including decisions on serious health care issues and treatment
- Make single orders, individual decisions about the property and financial affairs, or about the health and welfare of a person who lacks capacity.
- The court will has the authority to appoint deputies to make decisions for a person who lacks capacity in complex or disputed cases, and where a single determination is not possible.

9.1 Advanced Statement (Appendix 5)

A key principle of the MCA is that people should be encouraged to record their wishes and preferences with regard to the care and treatment they receive for a time in the future when they may lack capacity. This can include a wide range of treatments, or ways in which people would choose to be cared for if they lost capacity. The wishes should be taken into account when providing care and treatment in best interests but they are not legally binding.

9.2 **Advance Decision to refuse treatment (see Lincolnshire Policy)**

The MCA creates statutory rules so that people over 18 years of age may choose to make a decision in advance to refuse treatment (ADRT) if they should lack capacity in the future. This section is designed to be a brief introductory guide to advance decisions. For more detailed information please consult the Trust's Advance Decisions to Refuse Treatment specialist guidance which is available on the intranet.

- 9.3 Healthcare professionals may not be protected from liability if they knowingly act against a valid ADRT. However, the Act does provide for staff to conscientiously object if, in the circumstances, they feel this is appropriate.

10. **Criminal Offence**

- 10.1 The MCA creates two new criminal offences, wilful neglect or ill treatment of an adult lacking capacity.
- 10.2 In all cases where there is a suspicion of an offence, members of staff should alert their line manager immediately and invoke Lincolnshire Safeguarding Adults procedures.

11. **Interface with the Mental Health Act 1983 (as amended by MHA 2007)**

- 11.1 The MCA section 28 provides that the MCA does not apply to any treatment for a medical disorder which is being given in accordance with the rules about compulsory treatment as set out in Part IV of the Mental Health Act 1983 (as amended by Mental Health Act 2007). Staff should be aware that the statutory safeguards which the Mental Health Act 1983 (as amended by Mental Health Act 2007) gives in relation to compulsory psychiatric treatment must always be afforded to those patients to whom the Mental Health Act 1983 (as amended by Mental Health Act 2007) applies.
- 11.2 However, the above does not preclude the use of the MCA in relation to a physical condition. If a patient has capacity to make decisions regarding their physical welfare or has an Advanced Decision regarding physical treatment this must be upheld. **Appendix 6** is an LPFT inpatient decision making process for MHA or MCA.

12. **Clinical Holds - Restraint and Restriction – identification treatment and Management of people with challenging behaviour violence and aggression in Clinical Care Policy 1 (LPFT).**

The Act makes provision for the restraint of an individual providing certain criteria are satisfied.

- 12.1 Restraint can take many different forms such as physical, verbal, mechanical, chemical, environmental, and can include restrictions on contact and privacy.

Examples of these include using covert medication, the use of physical force to prevent someone doing something, the use of mechanical restrictions (e.g. bed sides) and the use of verbal threats. This may include having the external door to a unit locked to prevent a patients wandering off the ward into a potentially dangerous situation. Including the use, or threat, of force to do something that the person concerned resists - for example, by using bed sides. If an assessment of capacity has been undertaken and found the person lacking capacity the restraint must be in the person's best interest.

- 12.2 Physical restraint/Clinical holds can be used but only as a last resort.
- 12.3 If any restraint is required an care plan must be completed in line with policy. Staff must also refer to the Trusts identification treatment and Management of people with challenging behaviour violence and aggression in Clinical Care Policy 1 (LPFT).
- 12.4 The MCA identifies two further conditions which must be satisfied in order for protection from liability for restraint to be available; staff must reasonably believe that it is necessary to undertake an action which involves restraint in order to prevent harm to the person lacking capacity AND any restraint must be a proportionate response in terms of both the likelihood and seriousness of that harm. Using excessive restraint could leave staff and the Trust liable to a range of civil and criminal penalties.

13. Deprivation of Liberty Safeguards in a hospital setting (Appendix 7)

- 13.1 The Deprivation of liberty safeguards will apply to people 18 and over who meet all of the following eligibility criteria:
 - **Mental health assessment** - They suffer from mental disorder as defined in Section 1 of the Mental Health Act 1983, namely a mental disorder is any disorder or disability of the mind, and this excludes dependence on alcohol and drugs. This includes all patients with learning disabilities.
 - **Eligibility** – the person must not be detainable under the MHA or If the proposed authorisation relates to a deprivation of liberty in a hospital wholly or partly for the purpose of treatment of a mental disorder, the relevant individual will be eligible unless:
They object to being admitted to hospital, or to some or all the treatment, **and**
They meet the criteria for an application for admission under section 2 or section 3 of the Mental Health Act 1983.
 - **Age**- they are over the age of 18
 - **No Refusals** – the care arrangements do not conflict with other existing authority for decision-making for that person, such as an advance decision to refuse treatment or LPA
 - **Capacity**; They have been found to Lack the capacity to give consent to the arrangements made for their care and treatment, and
 - **Best Interests** it has been determined that their care (in circumstances that amount to deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights) is considered, after independent assessments, to

be a necessary and proportionate response in their best interests to protect them from harm.

13.2 DoLS cannot be used where:

- The person is under 18 years of age;
- The person has made a valid and applicable Advance Decision refusing a necessary element of treatment for which they were admitted to hospital
- The use of the safeguards would conflict with a decision of the persons attorney or Deputy of the Court of Protection
- The patient lacks capacity to make decisions on some elements of the care and treatment they need, but has capacity to decide about a vital element and has already refused it or is likely to do so.
- A DoLS authorisation cannot be used in order to force treatment or care on a person who has the mental capacity to make a decision about the proposed treatment, care and the manner and location in which it is to be provided.

13.3 The Deprivation of liberty safeguards mean that the 'managing authority' the relevant hospital or care home must seek authorisation from the 'supervisory body' where there MAYBE a DoLS occurring.

14. Avoiding DoLS

Every effort should be made, in commissioning and providing care or treatment, to prevent Deprivation of Liberty. If deprivation of liberty cannot be avoided, it should be for no longer than is necessary.

14.1 Ensure you have taken all practical and reasonable steps to avoid a deprivation of liberty:

- Ensure all decisions are taken and reviewed in a structured way using the tools and information available and record all decisions on how they were made.
- Ensure good care planning - use other agencies and complex case managers and GP's to explore all other alternatives.
- Make a proper assessment of whether the person lacks capacity to decide whether or not to accept the care or treatment proposed in line with the principles of the Mental Capacity Act.
- Before admitting a person to hospital or residential care in circumstances that may amount to deprivation of liberty, consider whether the person's needs could be met in a less restrictive way.
- Take proper steps to help the relevant person to retain contact with family, friends and carers. Where local advocacy services are available, their involvement should be encouraged to support the person, their family, friends and carers.

14.2 Where the deprivation of liberty safeguards are applied to a person in a hospital the supervisory body will be the Local Authority where the person is ordinarily resident. Lincolnshire County Council will be the supervisory body for most patients.

15. Identification of a Deprivation of Liberty

- 15.1 Deprivation of liberty is determined on a case by case basis; therefore, there is no simple definition. Judgments of the European Court of Human Rights and the UK Courts inform decision making and when restraint may amount to a deprivation of liberty.
- 15.2 The Supreme Court has clarified that, for the purposes of Article 5 of the European Convention on Human Rights, there is a Deprivation of Liberty in the following circumstances: “**ACID TEST**”
- The person is under **continuous supervision and control**
and
 - is **not free** to leave,
and
 - The person **lacks capacity** to consent to these arrangements.
- 15.3 **The Supreme Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person’s compliance or lack of objection and the reason or purpose behind a particular placement. It was also held that the relative normality of the placement, given the person’s needs, was not relevant.**
- 15.4 This means that the person should not be compared to anyone else in determining whether there is a deprivation of liberty.
- 15.5 In the situation where the person to be admitted is already subject to a DoLS authorisation in a Care Home, then it is very likely that the Trust will need to apply for DoLS authorisation in order to effect admission. For elective cases this should be applied for in advance of the planned admission date and it is the admitting Clinicians’ responsibility to ensure this is completed.
- 15.6 Other factors for consideration of a potential Deprivation of Liberty are:
- Restraint, including sedation, is used to admit a person to an institution where that person is resisting admission.
 - Staff exercise complete and effective control over the care and movement of a person for a significant period.
 - Staff exercise control over assessments, treatment, contacts and residence.
 - A decision has been taken by the Institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the Institution consider it appropriate.
 - A request by Carers for a person to be discharged to their care is refused –
 - The person is unable to maintain social contacts because of restrictions placed on their access to other people.
 - The person loses autonomy because they are under continuous supervision and control.

- It is important to remember that the above list is not exclusive; other factors may arise in the future in particular cases.

15.7 An additional factor in identification of a potential DoLS is the time frame. Courts have advised that “that the person is confined to a particular restricted place for a non-negligible period of time” We have concluded in most cases a non-negligible period of time will be above 6 days in an acute setting ward unless the restraints required amount to of a total and intense nature where case law has shown that several hours may meet the criteria

16. Authorisation of a Deprivation of Liberty

16.1 The hospital has responsibility for applying for authorisation of deprivation of liberty for any person who **MAY** come within the scope of the deprivation of liberty safeguards.

16.2 There are two types of authorisation: standard and urgent. A managing Authority must request a standard authorisation when it appears likely that, at some time during the next 28 days, someone will be accommodated in its hospital or care home in circumstances that amount of a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights. The request must be made in writing to the supervisory body and a standard authorisation must be given within 21 days.

16.3 Whenever possible, authorisation should be obtained in advance. Where this is not possible, and the managing authority believes it is necessary to deprive someone of their liberty in their best interest before the standard authorisation process can be completed, the managing authority must itself give an urgent authorisation and then obtain standard authorisation within 7 calendar days.

16.4 An extension can be granted by the Supervisory body in exceptional circumstances for a further 7 days

16.5 The request is made using the Deprivation of Liberty Combined Form No 1 & 4 found on Lincolnshire County Council (LCC) Website www.lincolnshire.gov.uk or local Intranet DoLS sites this referral form will be stored.
Send Forms securely via NHS.net account to the DoLS
mentalcapacityresource@lincolnshire.gcsx.gov.uk

16.6 LCC has established a DoLS office which provides a direct point of contact that can be contacted on 01522 554205. The office will be staffed from 9am-5pm Monday to Friday (except Bank Holidays) and supported by an answering machine for out of hours contact.

16.7 A Care Plan to reflect the DoLS must be completed whenever the DoLS is submitted.

16.7 The person and their family must be notified about the application; this can be done using leaflets in **Appendix 8**.

16.8 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.

- 16.9 LCC will currently automatically commission a reassessment 21 days prior to expiry but for other Supervisory bodies you will need to take the following steps to assess whether to seek authorisation. Wards should ensure they are aware when the DoLS expires

17. Challenges

- 17.1 A decision to deprive a person of liberty may be challenged by the relevant person, or by the relevant person's representative, by an application to the Court of Protection. However, managing authorities and supervisory bodies should always be prepared to try to resolve disputes locally and informally. No one should be forced to apply to the Court because of failure or unwillingness on the part of a managing authority or supervisory body to engage in constructive discussion.

18.1 Process for DoLS (Appendix 7)

- 18.1.1 DoLS Authorisation is specific to the Managing Authority that applied for the authorisation. Therefore it is permissible to transfer a patient who is held under a DoLS to another ward within the same building and belonging to the same provider, however any movement should be undertaken in the person's best interest. It would be acceptable to move someone from MEAU to the relevant specialty ward or even to another ward for provision of a side room if this was deemed essential; however they should not be out lied without prior agreement from the safeguarding lead. A new DoLS application would be required to transfer a patient between sites.

- 18.1.2 Wards must notify the CQC once the outcome of each application is known.

18.2 What happens next?

- 18.2.1 The Supervisory Body (local authority) makes arrangements for the required assessments to be undertaken. Clinical staff should support this assessment process but do not undertake the assessments themselves. Access to the medical records will be required by the assessors.

- 18.2.2 The assessments will be undertaken by a Best Interest Assessor and should normally be within the 7-day period of the Urgent Authorisation. If for any reason the assessment process will take longer, then the Supervisory Body will advise the Trust and an Urgent Extension will be required. The clinical team caring for the patient will be given the required form and responsible for applying for any extension.

- 18.2.3 On completion of the assessment process, the Supervisory Body will either grant or deny the DoLS authorisation. The DoLS Office will send the outcome forms to the ward and these forms must be filed in the medical record. A copy forms will also be sent to the Trust Safeguarding Office.

19. A Standard DoLS Authorisation is granted

- 19.1 The care plan should include ongoing review of the treatment plan and the need for a continuing DoLS order.

19.2 A patient held under DoLS may be kept in hospital for the proposed treatment and care until:

- The course of treatment is completed and the patient no longer needs to remain in hospital and can return to their normal place of residence- ward must inform Supervisory Body
- Arrangements have been made for on-going care to continue in another location e.g. care home or specialist hospital
- The DoLS is judged to no longer be required. The clinical team must inform the Supervisory Body.
- The DoLS expires. If continuing treatment and care is required and this would mean that the person continues to be deprived of their liberty then an extension to the Standard Authorisation will be required. DoLS form 4 should be completed again and sent off to the DoLS Supervisory Body as above.

OR

- The person's mental capacity returns and they are able to make their own decision about continuing with treatment and care. In this circumstance the DoLS is no longer valid, even if the person decides to leave hospital or refuses to comply with treatment and care against medical advice.
- A DoLS Authorisation is specific to the Managing Authority that applied for the authorisation. Therefore it is permissible to transfer a patient who is held under a DoLS to another ward within the same location and belonging to the same provider, however any movement should be undertaken in the person's best interest. A move to another building or provider requires a new application.

19.2 As soon as possible and practical after a standard deprivation of liberty authorisation is given, staff will need to ensure that the relevant person and their representative understand:

- The effect of the authorisation their right to request a review.
- The formal and informal complaints procedures that are available to them.
- Their right to make an application to the Court of Protection to seek variation termination of the authorisation.
- Their right, where the relevant person does not have a paid 'professional' representative, to request the support of an IMCA.

19.3 **Relevant Person's Representative**

Where an authorisation is granted, a Relevant Person's Representative is Appointed based on the BIA's recommendations.

The Representative must be given information and has access to documentation in relation to the DOLS and the persons care and treatments to support to assist them in their role.

19.4 **A Standard DoLS Authorisation is refused**

If the authorisation is refused or cannot be granted because the qualifying criteria have not been met, then the treatment and care plan should be reviewed again to see if less restrictive alternatives can be put in place. In this way the patient may consent to remain in hospital and undergo treatment.

- 19.5 Alternatively consideration could be given to whether a different treatment option or care location can be arranged which would be acceptable to the patient e.g. change of antibiotics to allow administration to take place in the community, a less invasive or aggressive therapy, transfer to a facility closer to family.
- 19.6 If the patient refuses all options presented then clinical staff should take steps to reduce the risks of discharge e.g. Liaison with GP, social care and other community services, informing next of kin etc.
- 19.7 However, if there are major concerns about the patients safety should they leave hospital and fail to comply with what is deemed essential treatment and care, senior clinical and legal advice should be sought. In some cases application to the Court of Protection may be required. Requests for legal advice in regard to MCA and DoLS should go through your Safeguarding teams or via on call Managers out of hours.

20. Unauthorised Deprivations of Liberty

- 20.1 If staff are concerned that an unauthorised deprivation of liberty has occurred or is likely to occur within the Trust then a senior clinician should review the situation as a matter of urgency and steps taken to avoid any further, or prevent a potential future deprivation of liberty. In order to achieve this it may be necessary to apply an Urgent Authorisation.
- 20.2 Any deprivation of liberty identified where an Application has not been submitted must be reported as an adverse incident using your incident reporting systems.
- 20.3 All unlawful DoLS will be reported to the Trust Board, the CQC and external Safeguarding partners. The Trust Adult Safeguarding office will coordinate these notifications.
- 20.4 If there is a concern that a deprivation of liberty may be occurring in non-Trust accommodation then staff should discuss the concerns with their line manager as soon as possible and the also the Managing Authority of the care home or hospital. The Supervisory Authority should also be notified.

21. Deprivation of Liberty in “Domestic” Settings (Appendix 9)

- 21.1 The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement in the community. Hence where there is, or is likely to be, a deprivation of liberty in such placements that must be authorised by the Court of Protection. Staff must familiarise themselves with the provisions of the Mental Capacity Act, in particular the five principles and specifically the “least restrictive” principle.

- 21.2 Where Trust staff become aware of a potential DoLS in a domestic setting, they must contact their safeguarding team for specialist advice on action to prevent the deprivation or to seek authorisation by the Court of Protection.
- 21.3 The Court has a streamlined process to authorise such deprivation. The Re X procedure is designed to enable the court to decide applications for a court-authorised deprivation of liberty on the papers only, without holding a hearing, provided certain safeguards are met: Those safeguards include ensuring that:
- The person who is the subject of the application and all relevant people in their life are consulted about the application and have an opportunity to express their wishes and views to the court.
 - The person who is the subject of the application has not expressed a wish to take part in the court proceedings
 - The person who is the subject of the application and all relevant people in their life do not object to the application.
 - There are no other significant factors that ought to be brought to the attention of the court that would make the application unsuitable for the streamlined procedure.

22. Independent Mental Capacity Advocates (IMCA)

- 22.1 If there is nobody appropriate to consult, other than people engaged in providing care or treatment for the relevant person in a professional capacity or for remuneration, Lincolnshire County Council will instruct an IMCA straight away to represent the relevant person.

23. Further Information and Advice

- 23.1 For all MCA queries please contact your Safeguarding Team.
- 23.2 intranet safeguarding has links to all relevant forms and guidance.
- 23.4 For LPFT staff when reading this policy the following Trust policies should also be considered:
- Access & Management of Health & Social Care Record Policies
 - Planning for Future Care Guidance (Adult): Advance Care Planning, Advance Decisions to Refuse Treatment & DNACPR
 - Complaints Policies
 - Confidentiality and Data Protection Policies
 - Consent Policies
 - Incident Reporting Policies
 - Risk management Strategy and Policies
 - Clinical Care Policies
 - Safeguarding Adult Procedures
 - Mental Health Act Policies

The above list is not intended to be exhaustive.

24. Development of Policies and Procedures

24.1 This policy was originally developed by the Mental Capacity Act Working Group and composed by the Corporate and Legal Services Officer.

24.2 the 2015 version, the MCA Policy DoLS Procedures have been combined and reviewed to reflect new Managing Authority processes within the Trust.

25. Monitoring Compliance with and Effectiveness of Policies and Procedures

Systems	Monitoring and/or Audit				
Criteria	Measurables	Lead Officer	Frequency	Reporting to	Action Plan/Monitoring
Staff attend mandatory MCA training	No. of staff completed training	Training Department	Quarterly	Legislative Committee	Legislative Committee
Consideration of capacity	Audit of whether capacity is considered, capacity assessments & best interest decisions evidenced & advanced statement are considered and discussed with service users where appropriate	Consultant Nurse Safeguarding	Annual	Relevant Divisional Management Team (DMT) Meetings	Legislative Committee
Consideration of DoLS and appropriate making of applications and authorisations in line with policy	Audit - Whether DoL are assessed and considered.	Consultant Nurse Safeguarding	Annual	Legislative Committee	Legislative Committee
	Whether applications and authorisations are made in line with policy	Consultant Nurse for Safeguarding	Quarterly	Relevant DMT meetings	Legislative Committee
Use of IMCA service	No. of referrals from LPFT	Advocacy Service	Quarterly	Relevant DMT meetings	Legislative Committee

Standards/Key Performance Indicators

TARGET / STANDARDS	KEY PERFORMANCE INDICATOR
To have all relevant staff trained in MCA / DoLS	Records of number of staff trained
To routinely discuss advance statements with service users as part of care planning	Service user feedback Annual comprehensive audit
To not have people cared for in Trust units in situations which amount to an unauthorised deprivation of liberty	Number of authorisations in place Annual DoLS audit
To ensure compliance with the processes laid out in the legislation	Analysis of SIs, Complaints and Claims Annual comprehensive audit of records

26. References

Advance Decisions to Refuse Treatment; A Guide for Health and Social Care Professionals. The National Council for Palliative Care. Available at: <http://www.adrtnhs.co.uk/>

Mental Capacity Act Code of Practice (2007)
www.dca.gov.uk/menincap/legis.htm#codeofpractice

Deprivation of Liberty Safeguards Code of Practice (2008) available at Trust intranet via <http://sharon/lpft/mha-and-mca/Pages/MentalCapacityAct.aspx>

The Mental Capacity Act Code of Practice: The Code of Practice is the key document to which paid staff have a legal duty to have regard. It can be downloaded at: www.dca.gov.uk/menincap/legis.htm#codeofpractice

Department of Education and Skills (2004) The Children Act 2004, London: The Office of Public Sector Information. Available at http://www.opsi.gov.uk/ACTS/acts2004/en/ukpgaen_20040031_en_1ht

Department of Health (2007) The Mental health Act 1983 as amended by Mental Health Act 2007, London: The Office of Public Sector Information. Available at: <http://www.opsi.gov.uk/acts/acts2007a.htm>

Mid Trent Cancer Network (East Midlands Health and Social Care Community 2007)
Advanced Decisions to Refuse Treatment: Specialist Guidance (Adult)

Ministry of Justice (2007) Mental Capacity Act (2005) Code of Practice, London: The Office of the Public Guardian. Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Ministry of Justice (2008) Mental Capacity Act (2005) Deprivation of Liberty Safeguards Code of Practice to supplement the main Mental capacity Act 2005 Code of Practice, London: The Office of the Public Guardian. Available at <http://www.dca.gov.uk/legal-policy/mental-capacity/publications.htm>

Department of Health (2015) Mental Health Act 1983 ; Code of Practice https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396918/Code_of_Practice.pdf

Department of Health (2014 updated 2017) Care and Support Statutory Guidance Issued under the Care Act <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance>

Department of Health (2014) Positive & Proactive Care; Reducing the need for restrictive intervention https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300291/JRA_DoH_Guidance_on_RH_Summary_web_accessible.pdf

Care Standards Act 2000 http://www.legislation.gov.uk/ukpga/2000/14/pdfs/ukpga_20000014_en.pdf

Health & Social Care Act 2012 <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

Police and Crime Act 2016 <https://www.gov.uk/government/collections/policing-and-crime-bill>

Care Act 2014 <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

27. Equality Analysis Form

Name of Policy/ project/ service	Mental Capacity Act (including Deprivation of Liberty Safeguards) Policy & Procedures				
Aims of policy/ project/ service	To implement & embed the Mental Capacity Act (2005) and local procedures within the Trust				
Is this new or existing?	Existing				
Person(s) responsible	Consultant Nurse Safeguarding & Mental Capacity				
Key people involved	Legislative Committee – Safeguarding & mental Capacity managers, divisional managers				
Who does it affect?	Service users X		Staff X		Wider Community X
Is the policy/ project/ service likely to have an effect on any of the protected characteristic groups? (please tick)					
	Positive	Negative	None	Is action possible to mitigate any negative impact?	Details of action planned (including dates or why action is not possible)
Age			X		
Disability	X				
Sex			X		
Gender Reassignment			X		
Sexual Orientation			X		
Race			X		
Religion and Belief			X		
Marriage and Civil Partnership			X		
Pregnancy and Maternity			X		
Carers	X				

Any other information that is relevant to the equality impact of the policy/ project/ service?

Section 1.5 of policy highlights The MCA has been subject to Equality and Diversity Impact Assessment nationally by the Department of Justice which included consultation with groups in Lincolnshire. Equality and diversity is therefore implicit within the policy.

An assessment that a person lacks capacity to make a decision must never be based simply on:

- their age
- their appearance
- assumptions about their condition, or
- any aspect of their behaviour

Detail any positive outcomes for any of the protected groups listed above
 People affected by the MCA (2015) include those with a disability by way of;
 Neurological Disorder
 Learning Disability
 Mental Disorder
 Dementia
 Stroke
 Head Injury
 Delirium, unconsciousness
 Substance use

Result of Equality Analysis

Based on the information above- what is the outcome of the Equality analysis?

a) No change	X	b) Adjust the activity	<input type="checkbox"/>	c) Stop/remove the activity	<input type="checkbox"/>
Detail any adjustments that are to be made and how these will be monitored					
Person who carried out this assessment					

	Liz Bainbridge – Consultant Nurse Safeguarding & MCA
Date assessment completed	12 th July 2017
Name of responsible Director/General Manager	Anne-Maria Olphert Director of Nursing, AHPs & Quality
Date assessment was signed	12 th July 2017
Date of next review	September 2019

Mental Capacity

A specific decision needs to be taken by a person (aged 16 years or over) who has an impairment of, or disturbance in the functioning of the brain or mind & there is a question over their capacity.
Capacity assessment of the person's ability to make a particular decision at the time it needs to be made. Although it should be assumed that everyone has capacity until assessed otherwise, a decision to undertake an assessment may be triggered because:

- The person's behaviour or circumstances suggest they may lack capacity (**5 Standard times for assessment of inpatients due to a person's circumstances** are identified SHARON > MHA/MCA/DoLS > MCA / DoLS > MCA)
- Someone else has raised concerns
- There have been capacity issues previously.

Capacity assessment undertaken - The 2 stage assessment should be documented on the clinical system. **Duress and coercion** may affect a person's judgement & ability to make a decision. If there is a concern or the case is complex, contact LPFT Safeguarding & Mental Capacity Team: 01522 421548 or safeguardingadvice@lpft.nhs.uk for advice and guidance

Person lacks capacity to make a particular decision
 Does this person have an **Advance Decision (AD)** which refers to this decision to be made?
OR
 Does this person have a registered Enduring or Lasting Power of Attorney (EPA / LPA) or Court appointed deputy who has authority to make this particular decision?
 Check registration via Office of Public Guardian:
www.gov.uk/government/publications/search-publicguardian-registers

Person has capacity to make the decision. Person makes the decision even if this is considered to be an unwise decision.

Consider: Does the decision relate to any of the following?

- NHS body is proposing to provide serious medical treatment, **or**
- NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or care home, & the person will stay in hospital longer than 28 days, or they will stay in the care home for more than 8 weeks, **AND** The person has no-one else to support them (other than paid staff).

Yes
 Follow the direction of the Advance Decision (AD) or Lasting Power of Attorney (LPA).
 An LPA with authority to give or refuse treatment may override an AD if made after the AD.

Yes
 An **IMCA** must be instructed & consulted please contact the Lincolnshire-wide branch of Voiceability, Total Voice, tel: 01522 706580

No
 Consult with the identified person who is able to give an opinion about what is best for them (this is likely to be close friends & family). Consider whether the decision concerns:

- Care reviews, where no-one else is available to be consulted, **or**
- Safeguarding adult cases, whether or not family, friends or others are involved

As IMCAs may also be consulted & instructed in these circumstances.

Arrange a **Best Interest Meeting** or use the **Best Interest form (non-meeting)** so the identified decision maker completes the Best Interest Documentation (SHARON > MHA/MCA/DoLS > MCA / DoLS > MCA > Best Interest Documentation). Record meeting minutes or decision. Refer to MCA Code of Practice 2005 & Policy 6B.

Decision made & documentation recorded in notes. Where there is a disagreement about what is in a person's best interests this should be addressed locally but if all other means to resolve the dispute fail, the Court of Protection might need to rule on the person's best interests. Seek advice from Trust Safeguarding Team: 01522 421548

Two Stage Capacity Test to Assess Capacity

This procedure should be carried out every time a capacity assessment is required. The assessment begins with the recording of some personal information, then moves on to a two stage test for capacity and concludes with some final general questions.

All parts will need to be completed. The form must be signed at the end. If parts 1, 4, 5 and 12 are incomplete the assessment will not be valid.

1. PERSON'S NAME: _____
2. DATE OF BIRTH: _____
3. NHS Nos. _____
4. NAME OF ASSESSOR: _____
5. JOB TITLE: _____
6. DATE: _____

7. PLEASE SUMMARISE BELOW THE DECISION WHICH NEEDS TO BE MADE:

8. ON WHAT GROUNDS DO YOU SUSPECT THERE MAY BE A REASON TO QUESTION THIS PERSON'S CAPACITY:

- | | |
|---|--------------------------|
| The person's behaviour suggests they may lack capacity | <input type="checkbox"/> |
| The person's circumstances suggest they may lack capacity | <input type="checkbox"/> |
| Someone else has raised concerns | <input type="checkbox"/> |
| There have been capacity issues previously | <input type="checkbox"/> |
| Other (please specify) | <input type="checkbox"/> |

Test - Stage 1 - Does the patient have an impairment of or disturbance in the functioning of the brain or mind?

Yes or No (If the answer is NO then capacity is not an issue) If **YES** record nature of disturbance and move to test stage 2.

- | | |
|--|---|
| Neurological Disorder | <input type="checkbox"/> <input type="checkbox"/> |
| Learning Disability | <input type="checkbox"/> <input type="checkbox"/> |
| Mental Disorder | <input type="checkbox"/> <input type="checkbox"/> |
| Dementia | <input type="checkbox"/> <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> <input type="checkbox"/> |
| Head Injury | <input type="checkbox"/> <input type="checkbox"/> |
| Delirium, Unconsciousness | <input type="checkbox"/> <input type="checkbox"/> |
| Substance Use | <input type="checkbox"/> <input type="checkbox"/> |
| Other (please specify) <input type="checkbox"/> <input type="checkbox"/> | _____ |

Test - Stage 2. – a) Practical steps taken to support the patient with decision making.

b) Evidence objective reasons why a person lacks capacity based on the test elements below.

1. Understanding, Does the person understand the information relevant to the decision?

Yes / No. In each case provide evidence below

2. Retain; Can the person retain the relevant information long enough for the decision to be made?

Yes /No In each case provide evidence below

3. Use / Weigh. Can the person use or weigh the relevant information to make a decision?

Yes/ No In each case provide evidence below

4. Communication. Can the person communicate a decision?

Yes /No In each case provide evidence below

I therefore have a reasonable belief that the patient **has/has not** got capacity for this specific decision

(Please delete as appropriate)

Location of further evidence _____

(Please indicate where any further evidence is recorded if appropriate to support your answers

above. For example in 'case notes' or accompanying reports etc.)

Assessment completed by _____

Date and time completed

Second opinion if required

Best Interest Decision form (non-meeting)

This form to be completed for simple day to day decision making. For more complex decisions the best interests meeting form (Appendix 5) should be completed.

Name of service user:
Date of birth:

In making a best interests decision please record down the following information:

Essential information:

1. **Advanced Decision;** Has an Advanced Decision to refuse treatment been made about the decision in question and is it valid, applicable and still relevant? **Record comments below**
2. **Lasting Power of Attorney;** Is a Lasting Power of Attorney (LPA) in place for the decision in question? This must be a health and welfare or a finance & property LPA. If yes, which type, who holds this and is it valid, applicable and registered with Court of Protection? **Record comments below**
3. **Court of Protection Deputy ;** Has any deputy been appointed by the Court of Protection for the decision in question? **Record comments below**

If the answer is yes to any of the above three questions, the checklist need not to be completed.

Regaining capacity Consider whether it is likely that the person may regain capacity at some time in the future and whether a delay in decision making will allow them to make the decision themselves? **If yes, describe the plans that have been made in light of the above.**

IMCA Referral; Is there a requirement to refer to IMCA service? (see guidance)

Please provide a summary of the ‘decision in question’

.....
.....

Please specify who the best interest’s decision maker will be. The decision maker is the person who has the responsibility to work out what would be in the best interests of the person who lacks capacity.

.....
.....
.....

Have any advance decisions been made? Yes No

If so, are they valid and applicable to the current 'decision in question'?

BEST INTEREST ASSESSMENT AND CONSULTATION

User Involvement

a) Written statement; Has any relevant written statement been made by the person when they had capacity? **Please specify**

b) Past and present wishes inc involvement of P and their beliefs and values ; record steps taken to consider as far as is practicable the persons past and present wishes, Beliefs and values likely to influence the person's attitude to the decision? i.e. religious, cultural, lifestyle choices and other factors; that the person would like to have considered in relation to the decision. i.e emotional bonds, family obligations, where to reside and how to spend money? **Please evidence below;**

Consultation with others;

The Act places a duty on the decision maker to consult anyone with an interest in the care of the person who lacks capacity.

Who have you consulted with as part of the best interests process? This will help ascertain the person's values, beliefs and wishes in relation to the decision. **Please list individuals and their role.**

Name (record all those consulted)	Job Title or Relation to Person	View expressed;
<u>Professionals i.e. care home managers and carers</u>		
<u>Family & Friends</u>		
<u>Other interested parties</u>		

Consultation may have been done through varying forms of communication such as direct meeting, telephone conversation, or in writing.

Is there anybody that you intend not to consult as part of this process? If so, please indicate why. (The right to be consulted is not absolute, but there must be reasonable / justifiable grounds for not consulting for example consulting this person may put the relevant person at risk)

Name	Job Title or Relation to Person	Reason not consulted with

All relevant circumstances

What are the costs (including risks) and benefits of making this particular decision/action?

Possible Options	Benefits	Risks/costs

These will be factors of which the person making the determination is aware, and which it would be reasonable to regard as relevant. I.e. levels of pain/ consequences to health / costs/ availability of care

THE DECISION

WHAT IS THE DECISION OR ACTION TO BE TAKEN OR PROPOSED ON BEHALF OF THE PERSON AND THE REASONS FOR REACHING THIS DECISION

Is the best interests decision/action the least restrictive option (as required by one of the five statutory principles of the Act)?

.....

.....

.....

.....

NAME, AND SIGNATURE OF DECISION MAKER/S

Name	Job title or relation to the person	Signature
Date		

APPENDIX 4 Best Interest Meeting Guidance & Forms (adapted from LCC 2014)

Best Interests Meeting Guidance for the Chair

Preparation

- The Chair should request to see all previous best interests meeting minutes and case notes relevant to the case.
- Is the Chair satisfied that all appropriate documentation has been sent to the invitees in advance of the meeting to allow the participants to prepare for the meeting and to seek any necessary advice and guidance?
- Understand any disputes or known challenges, which will help in making decisions about how to best organise and facilitate the case conference.
- Consider whether to request a legal adviser to be present.
- Understand who the essential attendees are and why any other people are considered relevant to consult in the decision.
- Consider how to manage any issues relating to confidentiality and data protection within the meeting.
- Understand what information and guidance has already been provided to the attendees.

The day of the case conference

- The Chair should meet in a quiet area with the person and any family members, LPA/EPA/CoP Deputy prior to the meeting commencing to explain the purpose of the meeting, the legislation to be used, who will be attending the meeting and why, and finally to offer the opportunity for any questions/concerns to be explored.
- As with best interests meetings, the Chair should consider whether this should take place immediately before the meeting, or to consider whether it would be more appropriate to offer the opportunity to meet with the person/family at an earlier stage. Where there are known tensions, open and timely communication between the Chair and the person/family etc. can help to reduce any building tensions and help both parties to plan how to achieve a more relaxed meeting process. This process is especially important in situations where there is dispute.
- The Chair must remain mindful that, at this stage, they should not engage in any level of discussion about the decision to be made, but to remain solely focused on supporting attendees to understand the process and be as comfortable as possible throughout.

Opening the best interest meeting

- Open the meeting by reminding the attendees that the best interest meeting is being held under the principles and provisions as set out in the Mental Capacity Act 2005. The meeting will be paying particular regard to the statutory best interests checklist, and lastly remind all of the need to pay regard to confidentiality. Ask each person to say who they are and why they are attending the case conference.

- The minute taker may find it useful to use the questions set out below as mini headings to capture and clearly record the content of the meeting.

- Inform everyone that the meeting will focus on the decision(s) that is required to be made and no other.

- The following questions should be covered in the meeting and generally in this chronological order:

1. What is the specific decision(s) to be made? (The meeting must agree as this will be the focus of the meeting from this point onwards).

2. Why is it being proposed?

3. What steps have been taken to help the person attend the conference today and be involved in the decision making process?

4. What steps have been taken to support the person in making the decision themselves? Why have these attempts failed?

5. Is there an up to date Mental Capacity Assessment to evidence the person lacks the capacity to make the decision required? If not, the meeting must stop.

6. Is it possible to delay the decision until the person regains capacity and will be able to make the decision themselves. Are there any risks to the person in delaying the decision?

7. Who is the decision-maker? Is an EPA or appropriate LPA/court appointed deputy (CAD) in place who has the relevant authority to make the required decision?

8. Is there a valid and applicable advance decision, or advance statement that is relevant to the decision?

9. What do we already know about the person's values, wants and wishes?

10. What are the available/possible options to be considered? What are the positive and negative aspects of each, keeping the person's views and opinions central and taking into consideration all assessed and known risk?

11. How will the options impact on the following:

Any medical aspects

Any welfare aspects (how they live their lives)

Any social aspects (relationships)

Any emotional aspects (how they may feel or react).

12. What health and social care staff/professionals have been consulted? What are their views and opinions?

13. Is there a report from an Independent Mental Capacity Advocate (IMCA)? If the person reaches the qualifying criteria for an IMCA instruction, it becomes a statutory requirement.

14. If the person has reached the qualifying criteria and an IMCA has not been instructed, why is this case?

15. Is there any feedback from an Independent Advocate?

16. Are there any other reports to be tabled?

17. Now that the family, EPA/LPA/CAD have heard all the relevant information, what are their views?

18. Outcome of decision. The identified decision maker to make the final decision once all reports etc. have been tabled. If in complex cases, the decision-maker may decide that he or she requires additional time to reach his or her decision, this should be communicated to the Chair and the Chair should advise the meeting when the decision will be made and how it will be communicated.

19. Has the decision-maker chosen the least restrictive option? If not what is the rationale for the decision made?

20. Identify any actions, who has responsibility for each action and the timescale within which each must be completed.

If there is continued dispute or challenge at this stage, Chair to provide information on how to progress the matter. It may include an attempt at mediation. In the absence of agreement, the matter will need to be referred to the legal department for advice and potential application to the Court

Best Interests Meeting Agenda

Introductions and Apologies

- Housekeeping
- Outline format of meeting – provide clarity that each person will have the opportunity to contribute
- Information sharing and confidentiality
- Statement of the legal framework

Purpose of the Best Interest Meeting

- Outline background facts
- Clarification of decision(s) required
- Outline mental capacity assessment. If there is no capacity assessment specific to the best interests decision(s), the meeting must stop
- Consider whether the person may regain capacity at a future date, i.e. should the decision be delayed? Is there therapeutic or any other input that may impact on the person's capacity and ability to make the decision

View of the Relevant Person

What is known about the person's:

- Past wishes, feelings
- Present wishes and feelings
- Any relevant written statement made by the person when they had capacity
- Beliefs and values and beliefs
- Any other factors that the person would be likely to consider if they were able to do so

Information from Relevant Parties

- Views from anyone named to be consulted, any LPA, EPA or Deputy of the Court of Protection
- Family members opinion
- Professional opinion
- IMCA (if involved)
- Anyone engaged or caring for the person or interested in their welfare

Discussion of Viewpoints

- Identify and be clear about the options
- Discuss benefits and advantages of each option
- Assess likelihood of each option

Best Interests Meeting Minutes Strictly Confidential

Information Sharing and Confidentiality

This Best Interests Meeting was convened under the Trust's Mental Capacity Act Policy & Procedures. These minutes are strictly confidential; they must not be photocopied and should be transferred and stored securely. Statutory agencies will store electronic copies on a secure database.

Access should only be on a legitimate need to know basis. Additional requests to show these minutes to other people will only be considered by the Chair of the meeting and permission given, if there is a legitimate reason to disclose the information. Minutes of the meeting will be circulated to all attendees and those who have given apologies.

Copies of these minutes may be requested and disclosed in the event of a Data Protection access to records request, subject to exemptions.

Amendments

Please Note: Requests for amendments to these minutes should be forwarded in writing to the Chair of the meeting, within seven days of the circulation date; otherwise they will be taken as an accurate record.

Mental Capacity Act (2005)

If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his/her best interests - Principle 4.

Date:		Venue:		
Name of Service User:		Personal identifier:		
Address:				
Chair:		Decision-Maker:		Minute Taker:
Name	Relationship to Service User	Invited	Present	Apologies
		Yes/No	Yes/No	Yes/No
		Yes/No	Yes/No	Yes/No
		Yes/No	Yes/No	Yes/No
		Yes/No	Yes/No	Yes/No
		Yes/No	Yes/No	Yes/No
Purpose of the Best Interest Meeting:				
Confirmation of Capacity Assessment:				
View of the relevant person:				
Information from relevant parties:				
<p>Best interests decision – Balance sheet approach. Specify the different options that are being considered.</p> <p>In deciding best interests you must explore if there is a less restrictive way to achieve what is in the person’s best interests but you do not automatically have to take whatever is the least restrictive option overall. This is because the least restrictive option might not be the one that is in the person’s best interests.</p>				
Option One. Describe:				
Benefits for the person:				

Risks for the person:
Can this be achieved in a less restrictive way?
Option Two. Describe:
Benefits for the person:
Risks for the person:
Can this be achieved in a less restrictive way?
Option Three. Describe:
Benefits for the person:
Risks for the person:
Can this be achieved in a less restrictive way?
Option Four. Describe:
Benefits for the person:
Risks for the person:
Can this be achieved in a less restrictive way?
Discussion of viewpoints:
Additional information considered by the decision maker in making the best interests decision specified.
Details:

Final Decision. Give the reasons why this option has been selected and why other options have been rejected. If a final decision is not being made on the day the Chair should inform the meeting as to when and how the decision will be communicated.

Details:

Objections

See 5.63 to 5.69 of the Code.

Record here if anyone disagrees with the decision that has been made and how you intend to proceed.

Details:

ACTION PLAN

Action	Responsible Person	By when

Communication Strategy. Record here how interested parties will be advised of the decision.

Where the Court of Protection is not involved, carers, relatives and others can only be expected to have reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned. They must be able to point to objective reasons to demonstrate why they believe they are acting in the person's best interests. They must consider all relevant circumstances.

The Chair has read and approved these minutes and confirms that they are an accurate record of the meeting.

Name:

Designation:

Designation:

Signature:

Signature:

Signature:

My Advanced Statement

Part 1 – Personal Information

Name:

Date of Birth:

Address:

Contact Number:

Please indicate whether you would like this person to hold a copy of this document.

	Yes	No
Consultant	<input type="checkbox"/>	<input type="checkbox"/>
GP	<input type="checkbox"/>	<input type="checkbox"/>
Advocate	<input type="checkbox"/>	<input type="checkbox"/>
Care Co-ordinator	<input type="checkbox"/>	<input type="checkbox"/>
Family member(s) or friend(s)	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No
I would like this statement to be included in my records.	<input type="checkbox"/>	<input type="checkbox"/>
I would like a copy of this statement to be held on a confidential database, in case of loss or damage.	<input type="checkbox"/>	<input type="checkbox"/>

Part 2 – Care and Treatment

a. My wishes for my care and treatment are as follows:

What I want:

What I do not want:

b. In previous situations, this has worked well for me:

c. In previous situations, this has not worked well for me:

d. My individual needs whilst being cared for are as follows:

e. Who I would name as an advocate:

f. Where I would prefer to receive care and treatment:

Part 3 – Personal and Social Statement

Family and Friends

a. Who can/should be informed of my situation:

b. Who cannot/should not be informed of my situation:

Dependents

c. I would like to make arrangements for those that I care for as follows:

Pets

d. I would like to make arrangements for the care of my pet(s) as follows:

Housing/Home

e. I would like to make the following arrangements for my housing/home care needs:

Finances

f. I would like the following arrangements to be made for my finances:

Part 4 – Open Statement

Please use this space to include any information or individual needs, which have not been included in previous parts of the document.

Part 5 – Declaration

I, _____ declare that this document has been completed by myself and/or in accordance with my wishes, at a time when I retain capacity to:

Understand information about treatment options available to me.

Make informed choices and decisions regarding my treatment.

In the event that I become incapable of expressing my choices due to mental health difficulties, it is my wish that this document is referred to as an expression of my choices regarding my mental health care. It is my wish that this document precedes all other ways of ascertaining my intent.

I present this document in the understanding that it will be followed where possible, and in the event that the choices expressed in this document are not followed, I will be provided with a full explanation when I regain capacity.

Signed:

Date:

Witness 1
Name
Address

Witness 2
Name
Address

Signature

Signature

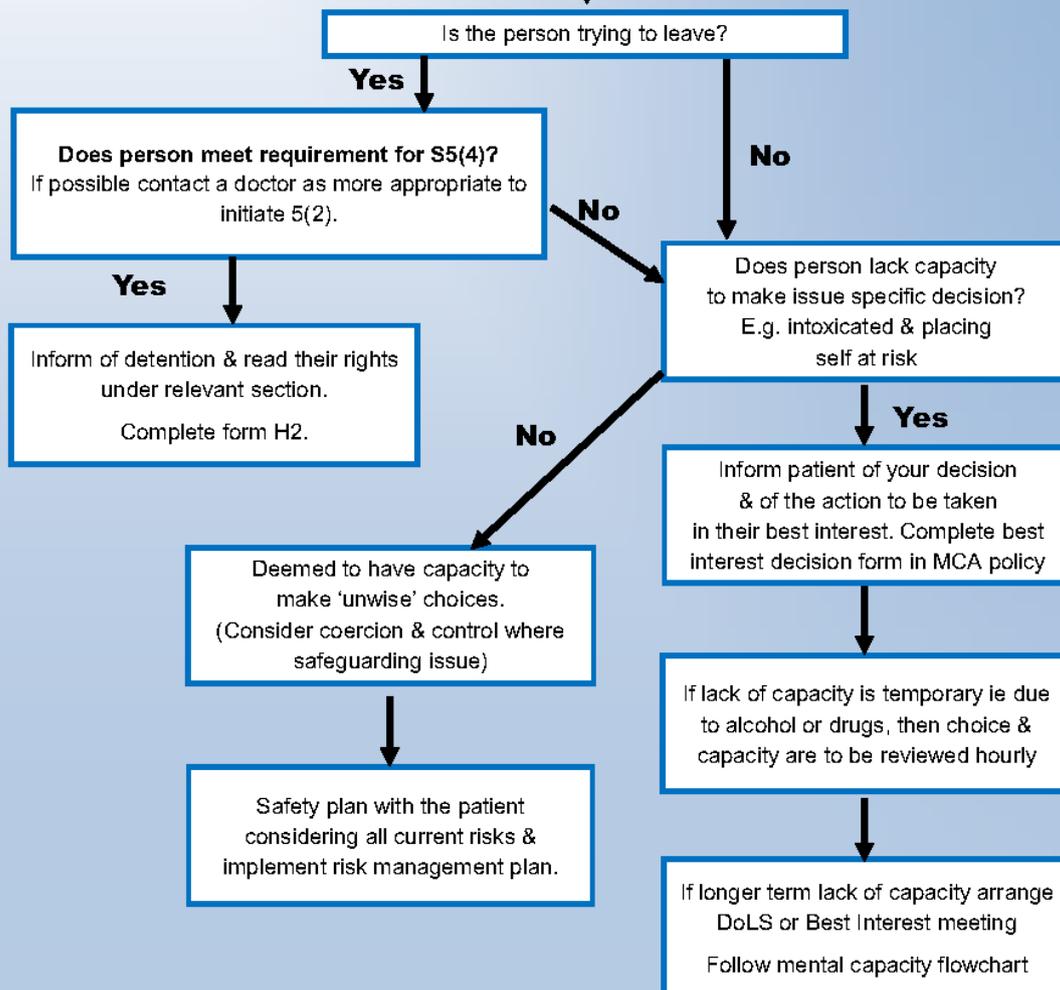
Date

Date

Inpatient Unit Decision Making: MHA or MCA

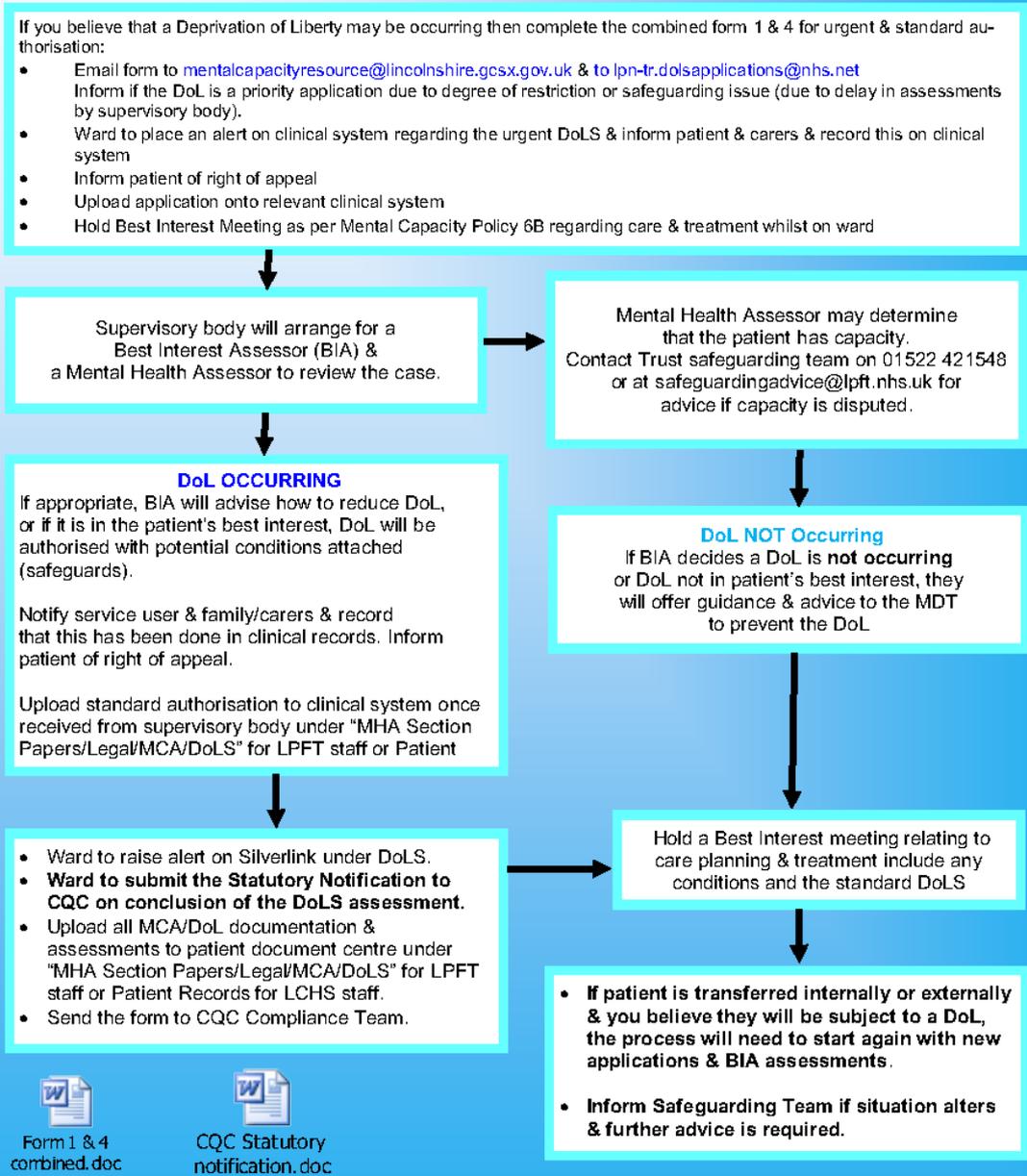
Issue arises

For example person returns to ward under the influence of alcohol or drugs



- In all cases:**
- Record decision making & the rationale, including where a decision is made not to act
 - Update risk assessment & care plan accordingly.

Deprivation of Liberty Safeguards (DoLS) Process (not for patients detained under MHA)



Whilst there is a delay in assessing urgent DoLS authorisations where there is high risk, safeguarding concerns or complexity please contact your safeguarding team on 01522 421548 for support and escalation and the BIA assessment will be completed urgently.

Appendix 8

A DoLS Leaflet for patient & carers has been developed and is currently subject to a pilot prior to Trustwide approval.

For advice or guidance about this area please contact the Safeguarding and Mental Capacity Team on 01522 421548 or via safeguardingadvice@lpft.nhs.uk

Appendix 9

The process for Community DoLS is currently under development.

If you believe you have identified a community DoLS then please contact the Safeguarding and Mental Capacity Team on 01522 421548 or via safeguardingadvice@lpft.nhs.uk for advice and support.