Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

POLICY NAME:	**Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS)**
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LINKS TO ANY OTHER POLICIES/PROCEDURES:	
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MANAGER RESPONSIBLE FOR REVIEW (Must be Authors Line Manager)	**Deputy Chief Nurse**	

The WWL Way

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AT ALL TIMES, STAFF MUST TREAT PATIENTS WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.

1 INTRODUCTION

1.1 The Mental Capacity Act 2005 (the Act) provides the legal framework for people who lack capacity to make their own decisions, or who have capacity and want to make preparations for a time when they may lack capacity in the future. Everyone working with and / or caring for a person aged 16 and over must comply with this Act when making decisions or acting for that person when they lack the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

1.2 The Act's starting point is to confirm in legislation that it should be assumed that any person aged 16 or over has full mental capacity to make their own decisions (the right to autonomy), unless it can be shown that they lack capacity to make a specific decision for themselves at the material time it is needed. This is known as the presumption of capacity.

1.3 The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. But the Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make their own decision(s). The underlying philosophy of the Act is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves is made in their best interests.

2. DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

2.1 The Deprivation of Liberty Safeguards (DoLS) are an addition to the MCA, introduced and published by the Ministry of Justice, establishing new statutory duties which came into effect on 1st April 2009. These safeguards provide positive protection for adults in hospitals or care homes who lack capacity to consent to the care or treatment they need. This amounts to a deprivation of their 'liberty', a legal concept whose origins lie in the European Convention on Human Rights (ECHR). Article 5.1 of the ECHR states that everyone has a right to liberty and security of person and that no one shall be deprived of their liberty except in accordance with a procedure prescribed by law. In all legal cases, there is a process by which the detention of people may be authorised, reviewed and under which they may appeal to a Court of Protection to release them.

2.2 The Deprivation of Liberty Safeguards (DoLS) were introduced following a test case (*HL V UK*, known as the Bournewood case) when it was recognised that a particular group of people who were in hospitals and care homes may have been unlawfully deprived of their liberty. This was because they were unable to consent to their care and treatment and accommodation. A person should only be deprived of their liberty in a safe and correct way and this should only be done when it is in the best interests of the person and there is no other way to look after them. In March 2014, a Supreme judgment, P v Cheshire West and Chester, introduced a Dols 'acid test' in deciding whether an incapacitated adult is being deprived of their liberty. This was expanded to 3 questions listed below. Although the mental capacity act is to protect those aged 16 and over, the DoLs is for those aged 18 and over. The 3 questions relating to the Acid Test are as follows:-

2.2.1 Can the person consent to care and treatment?
2.2.2 Is the person under continuous control?
2.2.3 Is the person free to leave, should they wish to (not just if they are attempting to) If the answer to these 3 questions are yes, then the person is being deprived of their

liberty and an urgent Dols application should be submitted by the completion of a Form 1 Adass Form. A copy is forwarded to the MCA/Dols lead (AdultSafeguarding@wwl.nhs.uk), and a copy sent to the Dols team at the persons Local authority (DOLS@wigan.gov.uk).

3 PURPOSE

3.1 The purpose of this policy is to provide staff working within Wrightington, Wigan and Leigh NHS Teaching Hospitals (WWLTH) with direction to enable the effective implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards. This will ensure a patients' rights is upheld and that staff act in the patients' best interests at all times. All staff including bank, agency and volunteers working with adults within WWLTH have a duty to be aware of its provisions and to act in compliance with the law.

3.2 This policy identifies who can make decisions, in which circumstances and what actions must be taken that allow a person to lawfully provide care and treatment to someone who lacks capacity. This policy also sets out the actions to be taken if a patient presents with a valid Power of Attorney (PoA) or an Advance Decision Document (living will) and advanced right to refuse treatment (ADRT). This policy ensures that WWLTH has implemented processes and standards to ensure compliance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards 2009.

4. SCOPE

4.1 This policy is applicable to all Trust staff and Bank, Agency and Locum staff who are involved in the care of patients who meet all of the following criteria:-

4.1.1 Where they are aged 16 or over **and;**

4.1.2 Where there are doubts about the person's mental capacity to make their own care, treatment and accommodation decisions **and;**

4.1.3 Where staff are required to make decisions on behalf of the person who lacks capacity to make those decisions for himself/herself.

4.2 All staff who have **direct clinical contact** with patients must complete the Trust's Mental Capacity Act and Deprivation of Liberty Safeguards training.

5. DUTIES AND RESPONSIBILITIES

Everyone acting in connection with the provision of care or treatment must understand the principles of the MCA as they have a responsibility and duty of care to assess capacity as part of their role. All staff must make every effort to ensure patients are supported to make as many decisions as possible for themselves.

6. KEY RESPONSIBILITIES OF THE TRUST IN ITS ROLE AS MANAGING AUTHORITY

6.1 **Managing Authority**

6.1.1 To ensure that care is delivered in as least restrictive means as viable that is proportionate and necessary to prevent harm to any patient.

6.1.2 To ensure that consideration is given to the mental capacity of all patients and their ability to consent to services which are provided and whether care actions are likely to result in a deprivation of liberty.

6.1.3 To ensure staff are aware of the MCA and DoLS Framework.

6.1.4 To ensure that procedures for an application for an urgent and standard authorisation are followed.

6.1.5 To ensure a new authorisation is applied for prior to the expiry of the current one.

6.1.6 To maintain records and ensure that all relevant staff are made aware of whether an authorisation is granted or refused.

6.1.7 To maintain a system to retain copies of all DoLS forms they complete and receive

6.2 **Inform the Care Quality Commission of a DOLs authorisation –**
WWLTH must inform the Care Quality Commission (CQC) about the outcome of applications to deprive a person of their liberty. The MCA/Dols lead is responsible for uploading this information via the CQC portal, as soon as an outcome is known

6.3 **The Trust Board**
The Trust Board is ‘’the managing Authority’’ but responsibility is delegated to appropriate clinical staff. It will ensure staff have an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 and have access to advice about Mental Capacity and the relevant codes of practice.

6.4 **Chief Executive**
The Chief Executive of the Trust has executive overall responsibility for the Trusts compliance with the Mental Capacity Act 2005 and the application of DoLS framework, the operational responsibility for the application of this policy and DoLS framework is devolved to the Director of Nursing and the Medical Director.

6.5 **Chief Nurse and Medical Director**
The Chief Nurse and Medical Director are jointly responsible for the operational responsibility for the application of this policy and dols framework.

6.6 **Divisional Heads of Nursing**
The Divisional Heads of Nursing are responsible for ensuring that structures and processes are in place to enable staff to carry out their duties under the regulations. Along with all other managers and officers of the trust, they are responsible for ensuring they are familiar with the requirements of the regulations, are trained and competent to carry out their legal obligations when the need arises and trained and competent to advise and instruct their staff. Each Division or Corporate Directorate is responsible for carrying out its own Training Needs Analysis and putting it into effect through the use of appraisal and personal development plans.

6.7 **Matron, Ward/Unit manager/Community Team Leaders**
The Matron, Ward/Unit manager/Community Team Leaders will take responsibility for ensuring staff are compliant in their training and application of the Mental Capacity Act, including the appropriate use of Dols, accurate documentation, communication and liaison with carers/families

6.8 **All Clinical Staff**
All Clinical Staff must be competent in the assessment of capacity and application of DoLs. They must document all their actions in the Patients health records and must inform the Consultant and the MCA/Dols lead of the decisions made (the Trust complies with the Caldicott Principles and the Data Protection Act). They should be knowledgeable in how to assess restrictive practices, ensuring the least restrictive option is always chosen.

7. CAPACITY ASSESSMENT

7.1 In carrying out any intervention the **five guiding principles of the Act** must be followed:-

7.1.1 **Principle 1: A presumption of capacity**
Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. It cannot be assumed that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

7.1.2 **Principle 2: Individuals being supported to make their own decisions**

A person must be given all practicable help before anyone treats them as not being able to make their own decisions. Every effort must be made to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that the person is involved as far as possible in making decisions.

7.1.3 **Principle 3: Unwise decisions**
People have the right to make decisions that others might regard as unwise or eccentric; a person must not be considered to lack capacity because of this. We should acknowledge that everyone has their own values, beliefs and preferences which may not be the same as those of other people.

7.1.4 **Principle 4: Best interests**
Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

7.1.5 **Principle 5: Less restrictive option**
Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention must be weighed up in the particular circumstances of the case.

7.2 When implementing the five principles in practice all staff must work in partnership with others, including, the person, family/carers, other agencies, and relevant others.

7.3 **When to Assess Capacity**

7.3.1 The trigger for assessment of capacity is that a **decision has to be made.** The starting point must always be to assume that a person has the capacity to make a specific decision. If there are doubts about the person's capacity then a capacity assessment must be carried out. Assessment of capacity can be informal through daily conversation, but on occasions where there is concern about an individual's ability to understand health/treatment information, the assessment must be formalised and documented. Doubts about capacity may arise because the person has a diagnosis of impairment in mind or brain function. Staff should carry out the following:

7.3.1.1 **TWO STAGE TEST**
Does the person have an impairment of, or a disturbance in, their mind or brain which is affecting the way it works? For example; dementia, delirium, brain injury / damage, hypoxia, depression, significant learning disabilities, the symptoms of alcohol or drug use, mental disorder. (It doesn't matter whether the impairment or disturbance is temporary or permanent). If so, does that impairment or disturbance mean that the person is unable to make the specific decision at the time it needs to be made?

7.3 **Emergency Situations (including ECC)**
It is accepted in law that in an emergency situation it would be inappropriate to lose valuable time formally assessing capacity and that emergency treatment must take precedence. Any treatment provided must always be in the patient's best interests in accordance with the MCA 2005.

7.4 **Who Can Assess Capacity?**
Anyone can assess capacity. The best person to assess capacity is dependent on the decision to be made. The Act requires a person to be named as the decision maker, and this person is responsible for ensuring the Act's requirements are followed and documented. For most day-to-day decisions, this will be the person caring for them at the time a decision must be made. This may be the doctor regarding treatment, the nurse regarding medication and the therapist for assessment. The more complex decisions are

likely to need more formal assessments and a professional opinion on the person's capacity will be necessary. This could be, for example, from a Doctor, a psychiatrist, psychologist, a speech and language therapist, district nurse, health visitor, occupational therapist or social worker. However, the final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person. Where an element of doubt exists when determining whether a patient has capacity and / or where a dispute exists (with family members for example) it is always best practice to seek a second opinion from another appropriate professional and to fully record this in the healthcare notes.

7.5 **Assessing stage 2 of the test – the ability of the person to make the decision**

7.5.1 Can the person generally understand the information relevant / salient to the specific decision and why they need to make it?
7.5.2 Can the person retain the information, for the time it takes to make a decision?
7.5.3 Can the person use and weigh up the information
7.5.4 Can the person communicate their decision in any way? (by talking, using sign language or any other means)
7.5.5 The first three points should be applied together. If a person cannot do any of these three things, they will be treated as unable to make the decision. The fourth only applies in situations where people cannot communicate their decision in any way.

7.6 **Supporting People with Decision Making**

Before deciding that someone lacks capacity to make a particular decision, it is important to take all practical and appropriate steps to enable them to make that decision themselves. In addition, steps (such as helping individuals to communicate) must be taken in a way which reflects the person's individual circumstances and meets their particular needs.

7.7 **Providing relevant information**

7.7.1 Does the person have all the **relevant** information they need to make a particular decision?
7.7.2 Is the information in the easiest and most appropriate form for the person concerned?
7.7.3 If they have a choice, have they been given information on all the alternatives?

7.8 **Communicating in an appropriate way**

7.8.1 Could information be explained or presented in a way that is easier for the person to understand (for example, by using simple language or visual aids)?
7.8.2 Have different methods of communication been explored if required, including non-verbal communication?
7.8.3 Could anyone else help with communication (for example, a family member, support worker, interpreter, speech and language therapist or advocate)?
7.8.4 Are there particular times of day when the person's understanding is better?
7.8.5 Are there particular locations where they may feel more at ease?
7.8.5 Could the decision be put off to see whether the person can make the decision at a later time when circumstances are right for them?

7.9 **Supporting the person**

7.9.1 Can anyone else help or support the person to make choices or express a view?
7.9.2 Might the person benefit from having another person present?

8 INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)

8.1 The aim of the IMCA service is to provide independent safeguards to people who lack capacity to make certain important decisions and who have no one apart from paid staff to support, represent or be consulted. An IMCA must be requested, for those lacking capacity who have no family, friends or unpaid carers who would be appropriate.

8.1.1 They support he person and represent their views and interest to the decision maker
8.1.2 Obtain and evaluate information
8.1.3 As far as possible ascertain the persons wishes, feeling and beliefs
8.1.4 Ascertain alternative courses of action
8.1.5 Challenge the decision maker if necessary.

8.2 Online request for an IMCA is made via the Family Welfare website by the decision maker.

9 WHAT PROOF OF LACK OF CAPACITY DOES THE ACT REQUIRE?

The Act requires the assessor 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. This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question.

10 FLUCTUATING OR TEMPORARY CAPACITY

The Act makes it clear that persons can fluctuate in and out of capacity and this does not prevent them from being able to make a decision. It follows from this the person best disposed to assess capacity in an Acute Hospital setting will be those treating the patient on a regular basis and not necessarily an external specialist (e.g. a psychiatrist) who may only see the patient for a snapshot in time.

11 RECORDING THE MENTAL CAPACITY ASSESSMENT

It is good practice for professionals to record the findings of a formal mental capacity assessment. WWLTH has a standardised Mental Capacity Assessment form on HIS and SystemOne.

12 BEST INTEREST INTEREST DECISIONS

Recording of best interest decisions should be completed on HIS and SystemOne, on the Best Interest pages. The decision maker should ensure that the notes of the meeting are done within the meeting if possible. The decision maker should inform the meeting of all the available options and the risks and benefits surrounding each one. After discussion, the decision maker should state clearly his decision and clear rationale surrounding that decision. If any review is required, clear timescales should be documented.

13 COURT OF PROTECTION

An application to court may also be **required** where the proposed procedure or treatment is to be carried out using a degree of force to restrain the person concerned and the restraint may go beyond the parameters set out in the Mental Capacity Act 2005. In such a case, the restraint will amount to a deprivation of the person's liberty and the authority of the court will be required to make this deprivation of liberty lawful. Support and guidance can be obtained from the WWLNHSTH legal services department.

14 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

15 INCLUSION AND DIVERSITY

The document has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and, as far as we are aware, there is no impact on any protected characteristics.

16 MONITORING AND REVIEW

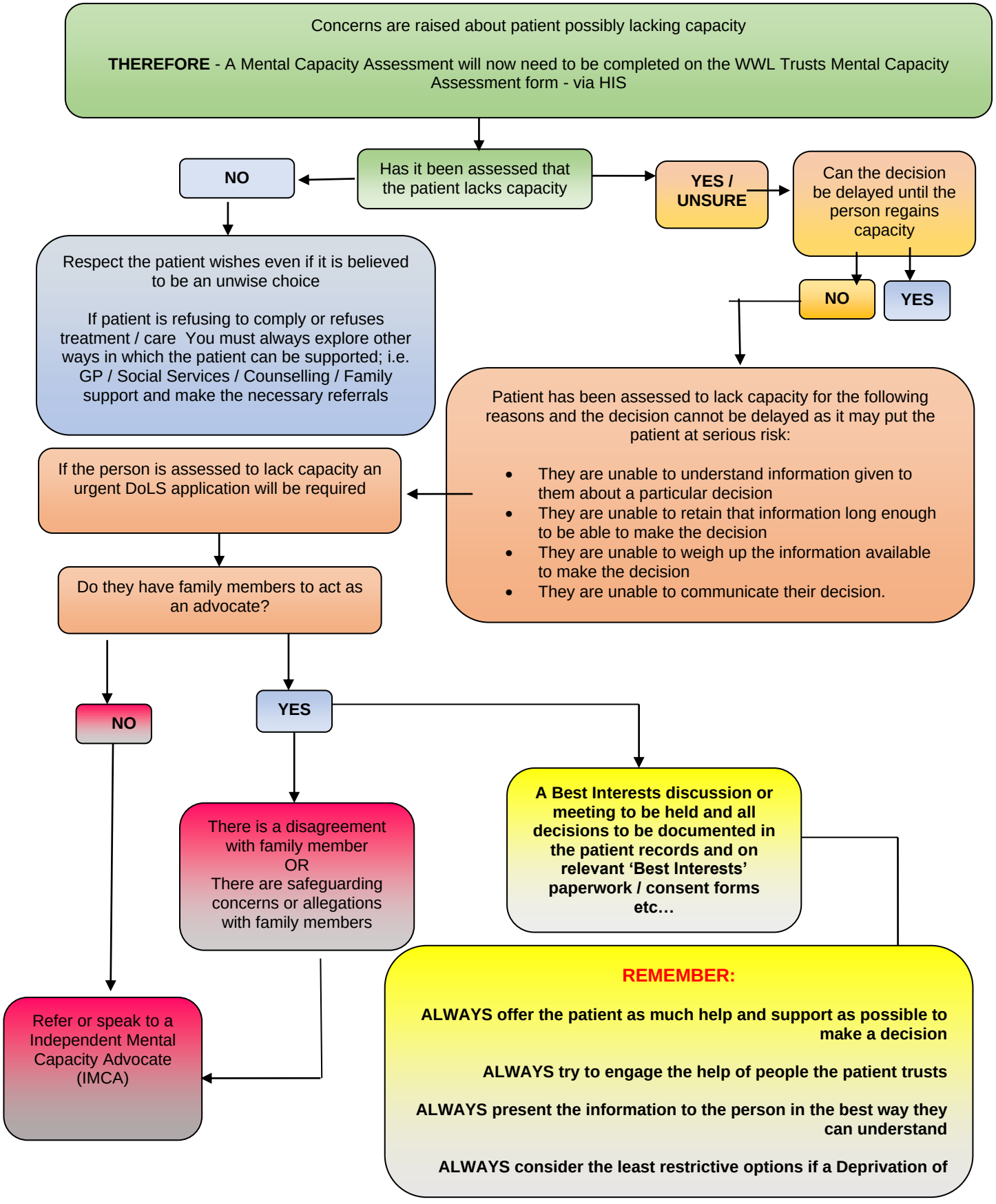
The Dols/MCA lead and Named Lead for Safeguarding Adults will be responsible for monitoring the effectiveness of this policy. This will be achieved by an ongoing evaluation of the processes and a yearly review of the policy. The compliance of this policy will be monitored by the Named Lead for Safeguarding Adults through feedback from the Supervisory Body

17 ACCESSIBILITY STATEMENT

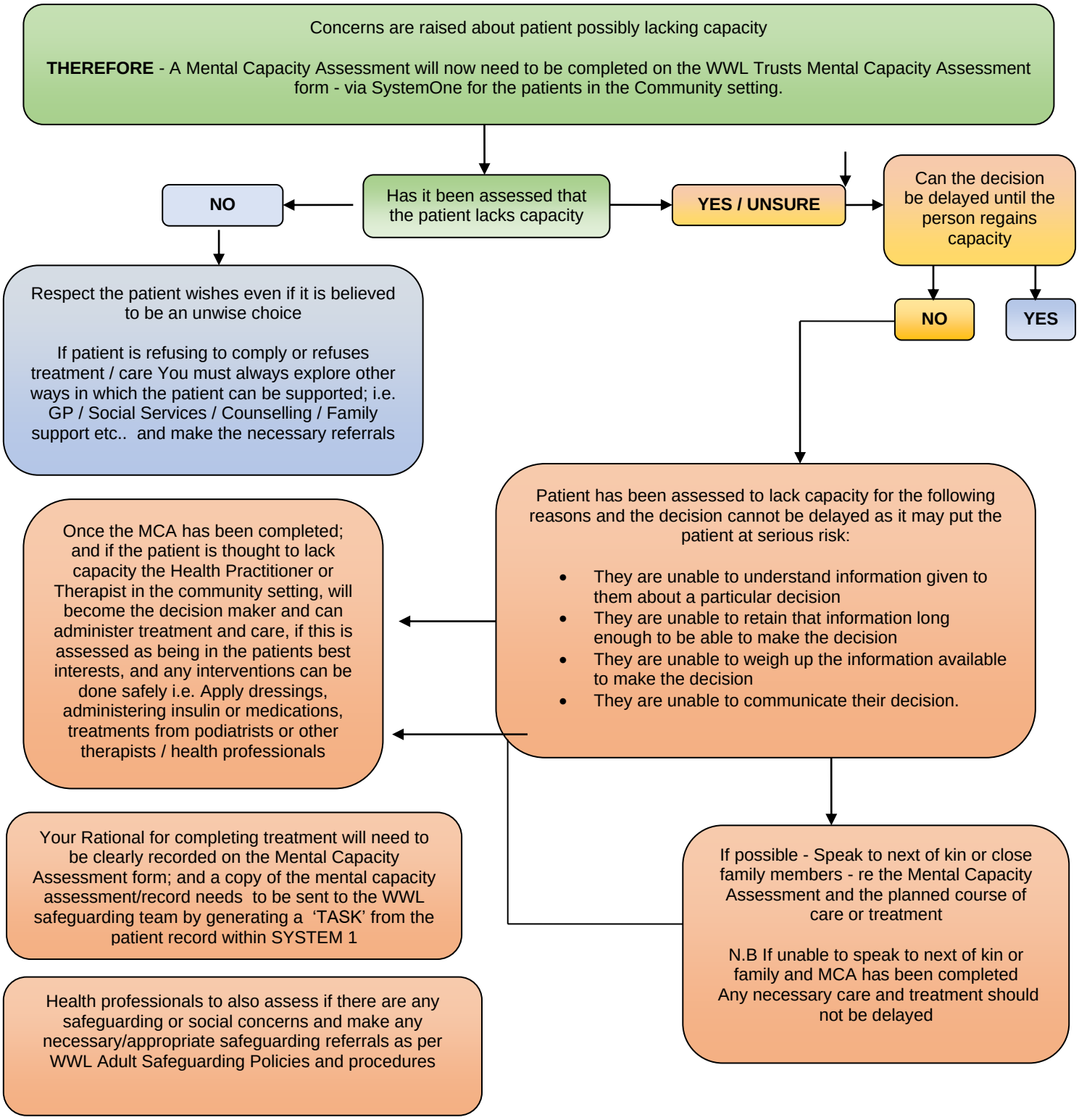
This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd.

For more details, please contact the HR Department on 01942 77 3766 or email equalityanddiversity@wwl.nhs.uk

Appendix 1 Mental Capacity Assessments in the Acute Setting



Appendix 2 Mental Capacity Assessments in the Community Setting



Appendix 3 Deprivation of Liberty Safeguards
Clinical Ward Referral Flow Chart

ASK THE FOLLOWING QUESTIONS:

- Has a Mental Capacity Assessment been completed? **IF NOT, COMPLETE IMMEDIATELY**
- Does the patient lack the capacity to make an informed decision on their current treatment/care?
- Will the patient be free to leave the ward?
  (*NB: this applies even if the patient is not attempting to leave*)
- Is the patient under 'constant supervision and control'?
  (NB: this includes 24 hour cover on a ward)

NO

An application cannot be made as the patient has the capacity and understanding to agree or refuse the proposed care/treatment

↓

Continue with MDT arrangements/plans

YES

Application for an urgent DoLS authorisation must be made to the DoLS team with a copy to the Safeguarding Team (Form 1)
Please complete the extension to the urgent and the standard request at the same time of application

↓

Record on HIS in "DoLs Notes" and then Email completed forms to:

Safeguarding Team:
Adult Safeguarding@wwl.nhs.uk
and
MCA/DoLS Team:
dols@wigan.gov.uk

NB. If the patient is transferred from another Trust Hospital site or there is a significant change in the patients care or level of restriction required – a new application MUST be made.
If the patient is discharged to a care home – the home MUST be informed that the patient had been subject to a DoLS.

When DoLS has been in place for 10 days and if no Best Interest Assessment (BIA) has been made, contact the Local authority to request a BIA. It is imperative the DoLS IS NOT ALLOWED to lapse without a BIA. Contact the DoLS Team on: 01942 828787

For further help contact Safeguarding Team.

For DoLS Applications to other Local Authorities please see below:

Bolton – Dols@wigan.gov.uk
West Lancashire – CSC.acscustomerservices@lancashire.gov.uk
Salford – Dols@salford.gov.uk

For other Local Authorities please contact the Safeguarding Team

Appendix 4

Equality Impact Assessment Form

STAGE 1 - INITIAL ASSESSMENT

For each of the protected characteristics listed answer the questions below using **Y** to indicate Yes and **N** to indicate No	**Sex** (male / female / transgender)	**Age** (18 years+)	**Race / Ethnicity**	**Disability** (hearing / visual / physical / learning disability / mental health)	**Religion / Belief**	**Sexual Orientation** (Gay/Lesbian/	**Gender Re-Assignment**	**Marriage / Civil Partnership**	**Pregnancy & Maternity**	**Carers**	**Other Group**	**List Negative / Positive Impacts Below**
Does the policy have the potential to affect individuals or communities differently in a negative way?	n	n	n	n	n	n	n	n	n	n	n	
Is there potential for the policy to promote equality of opportunity for all / promote good relations with different groups – Have a positive impact on individuals and communities.	y	y	y	y	y	y	y	y	y	y	y	
In relation to each protected characteristic, are there any areas where you are unsure about the impact and more information is needed?	n	n	n	n	n	n	n	n	n	n	n	**If Yes**: Please state how you are going to gather this information.

Job Title	**MCA Lead**			**Date**	May 2021

IF 'YES an NEGATIVE IMPACT' IS IDENTIFIED - A Full Equality Impact Assessment STAGE 2 Form must be completed. This can be accessed via http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp

Please note: As a member of Trust staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete an Equality Impact Assessment. By stating that you have NOT identified a negative impact, you are agreeing that the organisation has NOT discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in Equality Legislation.

Appendix 5

POLICY MONITORING AND REVIEW ARRANGEMENTS

Para	Audit / Monitoring requirement	Method of Audit / Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
	Quarterly MCA and DOLS Audit	MCA and DOLS Lead. Random Sample of 50 patients aged over 65 years	MCA and DOLS Lead	Quarterly	SEG	Quarterly Audit Report	SEG and Audit Department