BELMATT
HEALTHCARE TRAINING

Mental Capacity Act & DOLS

SESSION AIMS

This course will enable participants to have a greater understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

LEARNING OBJECTIVES

At the end of the session participants will in relation to MCA & DOL's be able to:

List the functions of the Mental Capacity

Describe the groups that will be affected by the legislation

Explain what is meant by the term 'best interests'

Explain the role of Lasting Power of Attorneys

Describe the function of the Court of Protection

Explain the Deprivation of Liberty Safeguards

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EXERCISE 1

When making a best interest decision what do you think you should take into account?

_____
_____
_____

EXERCISE 2

Assessing Capacity

Tom was involved in a fall at a building site accident that resulted in a brain injury. He is a single man aged 27. He has been recovering in hospital and has made good progress in recovering from his injuries. However, he is still very confused, his speech is incomprehensible and he often wanders away from the ward.

The rehabilitation team has recommended that he is transferred to a specialist rehabilitation unit and this is further away from his family. His family are very concerned about the distance the unit is from their home. Tom has to be assessed to see if he has the capacity to agree to the transfer.

A range of tests is carried out including a semi-structured interview and a cognitive screening test with a psychologist. Information is collected from ward staff and family members.

Tom's responses show that he cannot focus on information supplied or on the interview for more than a couple of minutes. He cannot write or draw his responses when given materials to do so. Tom does not communicate any understanding of what has happened to him or show that he considers that he has a problem that requires further treatment.

Do you think that Tom has the capacity to agree to the transfer to the rehabilitation unit?

_____
_____

Who is the decision maker?

_____
_____

Note: When answering take into account his capacity to make major decisions of this sort in the future and other factors that must be considered in deciding what will happen to him.

EXERCISE 3

Deprivation of Liberty Discussion Questions

Isn't Deprivation of Liberty always a bad thing?

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Does DOLS affect everyone living in a care home that lacks capacity?

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Do care homes need an authorisation to use physical restraint?

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What if the door to the care home is locked?

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_____

What do I do if I think someone is deprived of their liberty without an authorisation?

_____

_____

MENTAL CAPACITY ACT 2005

The Mental Capacity Act (MCA) 2005 was introduced to provide a legal framework for working with people over 16 who may lack capacity to make decisions about their care and treatment. It is intended to empower people to make their own decisions where they are able and protect people who lack capacity by keeping them central to decision-making.

Health and social care professionals have a legal duty to consider the MCA Code of Practice when working with people whose ability to make an informed decision may fluctuate and can be shown to lack capacity to make a particular decision e.g. to consent to care or treatment.

The Act affects a whole range of people and is therefore a very important piece of legislation.

Professionals they think will be affected by this legislation include:

- People working in a professional capacity, e.g. doctors, nurses dentists and social workers
- People who are paid to care or support, e.g. home care workers and care assistants
- Anyone who is a deputy appointed by the Court of Protection
- Anyone acting as an independent mental capacity advocate (IMCA)
- Anyone carrying out research involving people who may lack capacity.

The people the Act is there to protect include:

- People with dementia
- People with learning disabilities (especially severe learning disability)
- People with brain injury
- People with severe mental illness
- People suffering temporary loss of capacity, example because somebody is unconscious because of an accident or anaesthesia or because of alcohol or drugs or may have an infection.
- and anyone planning for their future.

THE ACT HAS FIVE PRINCIPLES

Presumption of capacity - A person must be assumed to have capacity unless it is established that they lack capacity.

Must offer support to make a decision - A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.

Unwise lack of capacity - A person is not to be treated as unable to make a decision merely because they make an unwise decision.

The 'Best Interests' principle - An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

The least restrictive principle - Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Understanding the term 'lack of capacity'

- An individual lacks capacity if they are unable to make a particular decision.
- This inability must be caused by an impairment or disturbance in the functioning of the mind or brain, whether temporary or permanent.
- Capacity can vary over time and depends on the type of decision. It is time and decision specific.

The Act defines 'a person who lacks capacity' as a person who lacks capacity to make a specific decision for themselves at the time the decision needs to be made.
It is not acceptable to just record: The individual lacks capacity. An assessment of capacity must be focussed on a specific decision or set of related decisions.

A person would lack capacity if they are unable to make a decision because they cannot:
Understand (relevant) information about the decision - Relevant information includes the nature of the decision, the reason why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all.

Section 3(2) of the Act outlines the need to provide information in a way that is appropriate to the individual.
Retain that information in their mind. A person must be able to hold the information in their mind long enough to use it to make a decision. Chapter 4 of the code of practice explains that people who can only retain information for a short while must not automatically be assumed to lack the capacity to decideit depends on the decision.

THE ACT HAS FIVE PRINCIPLES

Weigh or use that information as part of the decision-making process or; in addition to understanding relevant information, people must have the ability to weigh it up and use it to arrive at a decision. Sometimes a compulsion may cause a person to inevitably arrive at one decision. Although they understand the information, they cannot use it as part of the decision making. Also, as a result of an impairment of the mind or brain, some people might make impulsive decisions regardless of information they have been given or their understanding of it.

Communicate their decision (by talking, sign language or by any other means).

Note: this will only apply if a person is unable to communicate their decision in any way at all.

In all cases of assessing we should start from a presumption of capacity. Capacity should be assessed if it is in doubt. That may be due to:

- a person's behaviour
- a concern raised by a third party
- a person has already been shown to lack capacity to make other decisions

For each new decision the starting point must be that the person has the capacity to make the decision.

Before acting for someone who lacks capacity, the person administering the care or treatment must have a reasonable belief that the person lacks capacity to make the decision at the time the decision needs to be made. Capacity assessments must be reviewed for each new decision, and if there is any reason to consider that a person's capacity may have changed. (CoP 4.26 — 4.29 has more guidance about fluctuating capacity and reviewing capacity assessments.)

Things you can do to help their clients make a decision:

- Provide all relevant information using simple language or other formats e.g. pictorial, large print etc
- Don't give more detail than required
- Include information on the consequences of making, or not making, the decision
- Provide information on options
- Consult with family and care staff on the best way to communicate and known information about the person's previous views about the particular decision wanting to be made
- Be aware of any cultural, ethnic or religious factors that may have a bearing
- Make the person feel at ease
- Try to choose the best time of day for the person
- Try to ensure the effects of any medication are considered
- Take it easy-one decision at a time
- Don't rush
- Be prepared to try more than once i.e. can the decision be left to another time.

THE ACT HAS FIVE PRINCIPLES

Where an assessment is required the person carrying this out will usually be the person who is directly concerned with the person at the time the decision needs to be made, i.e. the person about to provide care or treatment, or commission a health or social care package. (MCA Code of Practice (CoP) chapter 4.38)

It might be necessary to seek professional opinion on the person's capacity e.g. social worker, psychiatrist, psychologist, speech / language therapist, etc.

However, the final decision about a person's capacity must be made by the person intending to make the decision and not the professional who is there to provide advice. (CoP chapter 4.42)

There are important documents that must be taken into account. These are any 'Advance statements' that an individual has made with regard to ensuring their wishes are taken into account in the future. This is often referred to as 'advance care planning'. The purpose is to enable an individual to make choices and decisions about their future care and support in case there is a time when they are unable to make these decisions for themselves, e.g. in the later stages of dementia. This can ensure that an individual is not given any care or treatment that they do not wish to receive but will receive the care they wish to have.

It is good practice for professionals to carry out a proper assessment of a person's capacity to make particular decisions and to record the findings in the relevant professional records such as care plans, clinical notes, or CPA documents.

A Mental Capacity Assessment Form is one way of recording a capacity assessment. Various Social Services throughout the UK have also devised their own forms and it is advisable to check what is available locally.

Whatever system they use the recording should always include details of the decision to be made; how the person was assisted to make the decision; and specific assessment of ability to make the decision. (CoP 4.14)

If a person is assessed as lacking capacity to make a specific decision at the time it needs to be made, any decision made on that person's behalf must be made in their best interest. Guidance on making best interest decisions is available in chapter 5 of the code of practice. The Act itself also includes a list of things which must be considered in making a best interest decision.

The best interest decision maker is the person purposing to take the action or make the decision. Decisions may be made using multi-disciplinary consultation, but there will be one decision maker. That will usually be the person responsible for carrying out the decision e.g. if a person is to have surgery then the surgeon would be; if a person is to have a bath then the care worker would be; for social services care plans the care professional proposing the plan would be; etc.

THE ACT HAS FIVE PRINCIPLES

As with capacity assessment, best interest decisions taken by an individual decision maker can be recorded in a variety of formats: case recordings, clinical notes, care plans, review paperwork, or using your organisations agreed capacity assessment standard form. The recording should always include what factors were taken into account and who was consulted (CoP 5.15). The decision maker must always consider the best interest checklist.

Best interest decisions may be taken as part of a multi-agency meeting (CoP 6.17), especially where there is a dispute (CoP 5.68). The decision may then be recorded in the form of meeting notes or minutes. The chair of the meeting may not be the decision maker. The chair may help the group reach a consensus decision and resolve disputes, however, the decision maker must be satisfied that the decision is in the person's best interest and the least restrictive option before proceeding.

Any decision or act must be in a person's best interests and the least restrictive option!

Working out someone's best interests cannot be based simply on age, appearance, condition or behaviour. All relevant circumstances should be considered when working out someone's best interests. (CoP 5.18 - 5.20)

Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision.

If there is a chance the person will regain the capacity to make a particular decision, it may be possible to put off the decision until later.

The person's past and present wishes and feelings, beliefs and values should be taken into account. Also the views of other people who are close to the person (including any attorney or deputy) should be considered.

Special considerations apply to decisions about life-sustaining treatment.

The Act does provide protection from liability for decision makers providing care and treatment to those who lack capacity if they follow the principles of the Act.

The decision maker must have a reasonable belief that the person lacks capacity to give permission for the action and that the Act is in the person's best interest. It does not provide a defence in cases of negligence or people who do more than their experience or qualifications allow. (CoP 6.24)

THE ACT HAS FIVE PRINCIPLES

One issue that is covered by the Act is the use of restraint The MCA defines restraint as:

- the use or threat of force to help to do an act which the person resists, or
- the restriction of the person's liberty of movement whether or not they resist. (CoP 6.40)

Physical restraint may be lawfully used on someone who lacks capacity to consent to the restraint in that person's best interest. If it is necessary to prevent harm to the person, the least restrictive option, and proportionate to the risk of harm. The amount and type of restraint must be proportionate to the likelihood and seriousness of harm (CoP 6.41).

The code gives further guidance on what is considered a proportionate response (CoP 6.47). Restraint which is permissible under the Act is covered by section 5 protection from liability. If restraint is used, there must always be a clear record made of the event including evidence that the level of restraint was proportionate including information about the risk to the person.

This protection does not extend to the use of physical restraint to protect staff or other residents from harm. That is subject to other legislation and may be permissible under common law (CoP 6.43). Staff should also follow the policy of their organisation on the use of restraint.

The use of restraint must always be in line with best practice, subject to care standards, individual risk assessments, and CQC guidance. Health and social care staff should refer to other guidance as issued by the department of health and regulations and standards (CoP 6.42).

DEPRIVATION OF LIBERTY SAFEGUARDS

The Deprivation of Liberty Safeguards was introduced as an amendment to the MCA 2005. They came into effect in April 2009. They aim to protect the human rights (article 5 right to liberty and security) of people who lack mental capacity to consent to the care they receive in registered care homes or hospitals. There is a DoLS Code of Practice to supplement the main MCA

Code of Practice. Deprivation of Liberty is a legal term defined by case law and the Human Rights Act. It should not be confused with restrictions of movement, liberty, or freedom which are permissible under the Mental Capacity Act if they are necessary in a person's best interest. It applies to persons who are over age 18.

To determine if a deprivation of liberty is occurring, consider the specific situation of the individual and the whole range of factors involved such as type, duration, and effects of any restrictions on the individual's freedom of movement.

The difference between a deprivation of liberty [needs to be authorised] and restriction of movement [permissible under the Mental Capacity Act] is the degree or intensity of the restriction and not the nature or substance. (European Court of Human Rights, 2004, HL v the United Kingdom) Decision makers should consider the factors in Chapter 2 of the DOLS code of practice.

In order for a person to be lawfully deprived of their liberty in a hospital or care home, it must be authorised by the responsible NHS or local authority according to the Deprivation of Liberty Safeguards (DoLS).

If a person must be deprived of their liberty outside the DoLS process, this must be specifically authorised by the Court of Protection.

To request an authorisation, a care home or hospital ward must send an application to a responsible NHS or Local Authority. This was changed under the Health and Social Care Act 2012 with the abolition of the Primary Care Trusts.

Following authorisation, the person or representative can request a review or apply to the Court of Protection to challenge the authorisation.

Following the Supreme Court Judgement on 20 March 2014, health and social care staff must be aware of how they should now judge whether a person might be deprived of their liberty.

DEPRIVATION OF LIBERTY SAFEGUARDS

It is clear that the intention of the Court was to extend the safeguard of independent scrutiny. The Court said, “a gilded cage is still a cage” and that “we should err on the side of caution in deciding what constitutes a deprivation of liberty.” They also said that a person living in supported living might also be deprived of their liberty and this is still being reviewed.

The Supreme Court has confirmed that there are two key questions to ask:
1. Is the person subject to continuous supervision and control, and 2. Is the person free to leave.

It is now clear that if a person lacking capacity to consent to the arrangements is subject both to continuous supervision and control and not free to leave, they are deprived of their liberty. It may not be a deprivation of liberty, although the person is not free to leave if the person is not supervised or monitored all the time and is able to make decisions about what to do and when that are not subject to agreement by others.

The Supreme Court ruled that the following factors are not relevant to whether or not someone is deprived of their liberty.

1. The person’s compliance or happiness or lack of objection;
2. The suitability or relative normality of the placement (after comparing the person’s circumstances with another person of similar age and condition); or
3. The reason or purpose leading to a particular placement though of course all these factors are still relevant to whether or not the situation is in the person’s best interests and should be authorised

Your Questions Answered:

Isn’t Deprivation of Liberty always a bad thing?

Answer: Deprivation of Liberty may be the only option available to keep a person safe. It must be authorised and subject to safeguards to be lawful. It can only be authorised if it is necessary to prevent harm, proportionate to the risk of harm, and in a person’s best interest.

Does DOLS affect everyone living in a care home that lacks capacity?

Answer: Not everyone who is placed in a care home without the ability to consent will be deprived of their liberty. It will depend on the circumstances of the admission and the type of care required. In making best interest decisions as part of care plans, care homes should consider whether a person is at risk of deprivation of liberty and regularly review restraint and restrictions used.

DEPRIVATION OF LIBERTY SAFEGUARDS

Do care homes need an authorisation to use physical restraint?

Answer: Occasional use of restraint is unlikely to constitute deprivation of liberty or require a DOLS authorisation. It may be one contributing factor.

Where the restriction or restraint is frequent, cumulative and on-going, or if there are other factors present, the care home should consider whether the care has moved beyond restraint which is permissible under the MCA and now constitutes deprivation of liberty. If so, a DoLS authorisation would be required.

What if the door to the care home is locked?

Answer: Preventing a person from leaving a care home or hospital unaccompanied because there is a risk that they would try to cross a road in a dangerous way, for example, is likely to be seen as a proportionate restriction or restraint to prevent the person from coming to harm. That would be unlikely to constitute a deprivation of liberty. Similarly, locking a door to guard against immediate harm is unlikely, in itself, to amount to a deprivation of liberty.

What do I do if I think someone is deprived of their liberty without an authorisation?

Answer: First, discuss your concerns with the care home manager. Encourage them to apply for a DOLS authorisation if needed. If you cannot reach an agreement, report your concern to the Local Authority.

POWER OF ATTORNEY

The appointment of a person with Power of Attorney helps in terms of making decisions about an individual who may no longer have capacity. These fit into the following types:

Power of Attorney (donee): is a person appointed by an individual (donor) while they still have capacity to make certain decisions on their behalf.

Enduring Power of Attorney: is a person appointed under the old system (pre2007) to make decisions about a donor's financial affairs. These will be valid after 2007 if registered with the office of the public guardian. These do NOT give the attorney power to make decisions about health and welfare on behalf of the donor.

Lasting Power of Attorney: Is a person or persons (CoP 7.11) appointed under the new system introduced by the Mental Capacity Act to make certain decisions on behalf of the donor. LPAs MUST also be registered with the office of the public guardian BEFORE they can be used. LPA forms must be completed before the donor loses capacity. People who are acting as LPAs have a duty to have regard to the MCA code of practice and must act in the donor's best interest. They cannot overrule a valid Advance Decision made after they were appointed.

There are three types of individuals who will have Lasting Power of Attorney:

- Finance LPA: A donee appointed to make decisions on behalf of the donor about property and affairs (CoP 7.36);
- Welfare LPA: A donee appointed to make personal welfare decisions on behalf of the donor including healthcare and medical treatment decision (CoP 7.21); and
- Finance and Welfare LPA: A donee appointed to make decisions in both areas as above.

MENTAL CAPACITY ACT CHECKLIST

This checklist will help managers and staff to easily identify if your service is developing Mental Capacity Act compliant care and support plans. Staff might consider incorporating elements of the checklist into their own monitoring forms.

CONSENT	YES	NO	COMMENT
Evidence of the person's informed consent to their care and support.			
Evidence of why the person was assessed as lacking the capacity to consent.			
COMMUNICATION AND CONTROL	**YES**	**NO**	**COMMENT**
A description of any special communication Needs			
Where the person has limited communication ability, other non-verbal communication methods that the person may use.			
Where the person has limited communication ability, other non-verbal communication methods that the person may use			
How the person is supported to understand and be involved in decisions about their care and support. This includes the nature of the decision, the options available and the consequences of each decision.			
Information about what is important to that person, their wishes and preferences			
What the person would like to achieve from their care and support.			
A person's social history, including any key events or achievements			
If the person appears to lack capacity to make a specific decision for themselves at the time it needs to be made, an assessment of capacity should be made in relation to that particular decision.			

How the person's liberty and choices about their care and support are promoted.			
Information about the person's views.			
How the person was supported to be involved in the decision about their care and support. This includes keeping them informed about any decisions made about them.			
DECISIONS	YES	NO	COMMENT
Information against each element of the 'best interests' checklist			
Details of the options that were considered together with the associated risks and benefits of each.			
A clear explanation of why a particular option was decided upon			
If restrictions are imposed, when these will be reviewed and how.			
INVOLVEMENT	**YES**	**NO**	**COMMENT**
The person or their family/friends are able to tell you how they were involved in developing the care and support plan and that they felt (and feel) listened to.			
The person and their chosen representative are aware of the care and support plan and have seen a copy			
The care and support plan clearly explains how care and support will be delivered.			

PERON-CENTERED PLANNING	YES	NO	COMMENT
What the person would like to achieve with their care and support, their goals and aspirations for the future.			
What is important to the person about how they live their lives now. For example, what they enjoy doing, their interests, likes and dislikes, who is important to them, who they like to see, where they like to go, their preferred routines (such as when they like to get up and go to bed, whether they like a bath or a shower).			
Details of key life events and dates to assist with chronological orientation.			
How best to support and involve the person in decision-making.			
Essential information for continuity of care and for use in emergencies.			
Roles and responsibilities so that the person receives coordinated care support to meet their needs.			
Where a person lacks capacity to express their choices, how their families and others who are interested in their welfare have been consulted.			
What outcome the person wants and any other options considered.			
The associated benefits and risks of each option.			

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