NHS
Bolton Clinical Commissioning Group

Mental Capacity Act 2005 / Deprivation of Liberty Safeguards 2009
Policy and Procedure

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The CCG is committed to an environment that promotes equality, embraces diversity and respects human rights both within our workforce and in service delivery. This document should be implemented with due regard to this commitment.

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Version Control Sheet

Version	**Date**	**Reviewed By**	**Comment**
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Contents

1 Policy Statement

NHS Bolton Clinical Commissioning Group (CCG) aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The purpose of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty (DoLS) 2009 for CCGs is in relation to commissioner's duties to ensure provider services are delivered in accordance with the MCA 2005 and DoLS legislation and that the rights of those who use services are promoted and protected. NHS Bolton CCG has responsibility for commissioning high quality care and treatment. The CCG must ensure providers understand the MCA 2005 / DoLS 2009 and supporting Codes of Practice apply it to practice and monitor compliance.

Fundamentally the NHS Bolton CCG will want to ensure;

- The MCA / DoLS 2009 is given a high profile and priority within the NHS Bolton CCG
- Compliance and who this will be achieved is a key part of the tendering process
- Ongoing compliance is monitored in detail through performance review and quality monitoring processes.

2 Introduction & Aims

The Mental Capacity Act (2005) provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves, or have the capacity and want to make decisions for a time when they may lack capacity in the future. The Act covers a wide range of decisions made and actions taken on behalf of people who may lack capacity to make specific decisions for themselves.

3 Definition

Abbreviation	Acronym
Mental Capacity Act	MCA
Mental Health Act	MHA
Independent Mental Capacity Advocate	IMCA
Office of the Public Guardian	OPG
Court of Protection	CoP
Lasting Power of Attorney	LPA

The Mental Capacity Act (2005) Code of Practice defines the lack of capacity as:

'A person who lacks capacity to make a particular decision or take a particular action for themselves at a time the decision or action needs to be taken'.

The policy endeavours to ensure that NHS Bolton CCG employees who have responsibility for delivery direct patient care meet their statutory responsibilities for those who lack capacity to consent to care and treatment.

The Deprivation of Liberty Safeguards (DoLS, 2009) is an amendment to the Mental Capacity Act 2005.

4 Codes of Practice

There are two codes which provide practitioners with guidance in relation to decisions made under the MCA, these are:

- Mental Capacity Act Code of Practice (2007)[1]
- Deprivation of Liberty Safeguards Code of Practice (2009)[2]

NB: Both the main code and the supplementary DOLS code have a statutory force[3].

5 Supporting legislation and Guidance

- The European Convention on Human Rights (ECHR)1956
- Children's Act 1989, 2004
- Human Fertilisation and Embryology Act 1990
- Human Rights Act 1998
- Mental Capacity Act 1995
- Mental Health Act 1983 (Amended 2007)
- Care Standards Act 2000
- Care Act 2014 and supporting statutory guidance
- Serious Incident Framework March 2013
- Safeguarding Adults. The Role of Health Services 2011
- Equality Act 2010
- NHS Act 2006
- Mental Health Code of practice 2014
- Case law: Cheshire west[4]

[1] www.gov.uk/government//...mental-capacity-act-code-of-practice
[2] http://www.royalgreenwich.gov.uk/downloads/file/810/dols_code_of_practice
[3] https://www.gov.uk/.../DH_Note_re_Supreme_**Court_DoLS**_Judgment.pdf

[4]http://www.familylaw.co.uk/system/uploads/attachments/0008/4029/Cheshire_West_UKSC_19_Judgment.pdf

- Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (DATE)

6 Responsibilities of NHS Bolton CCG

- That they meet their statutory responsibilities for people who lack capacity to consent to care and treatment.
- That all relevant employees are aware of their responsibilities under the MCA 2005.
- That staff operate at all times in accordance with the MCA 2005 and the accompanying statutory code of practice.
- That an appropriate MCA/DoLS Policy is in place which complies with the Act and corresponding Statutory Code of Practice.
- That their organisation complies with Care Quality Commission (CQC) requirements for training MCA and DoLS (Outcome 7)

7 Care and Treatment of People Who Have a Mental Disorder

The Mental Health Act (MHA, 1983, amendment 2007) the Mental Health Act Code of Practice (2015) and the Mental Capacity Act (2005) have different purposes but should be considered in parallel where appropriate.

The **MCA (2005)** has a broad scope and provides a legal framework for acting and decision making which applies in many situations where adults are unable to make decisions themselves

.

The **MHA (1983 amendment 2007)** provides a much narrower legal authority for the admission to hospital and treatment (where appropriate, without consent) of people with a mental disorder because of the risk posed to themselves or others.

The **MCA (2005)** does not apply to Mental Health treatment for people detained under the Mental Health Act but may still apply to decisions around their physical health treatment.

8 Five Statutory Principles of the Mental Capacity Act

The Mental Capacity Act sets out 5 statutory principles, the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives.

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity.
2. A person must not be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision because he/she makes an unwise decision.
4. An act done or a decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.
5. Before any action is taken, or any decision is made, regard must be given 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.

9 Testing for Capacity: Time and Decision Specific

Stage one: **Diagnostic Test:**

- Does the individual have the signs, symptoms or behaviours that indicate an impairment or disturbance in the functioning of their mind or brain (either permanent or temporary)

Stage two: Functional Test consider if the individual is able:

- To <u>understand</u> the information relevant to the decision

- To retain that information (for long enough - this is professional judgement)
- To use or weigh that information as part of the process making the decision
- To communicate the decision (whether by talking, using sign language or any other means

For some people, their ability to meet some or all of these criteria will fluctuate over time and it is therefore important that abilities to make decisions are reviewed regularly.

An individual may be competent to make certain decisions, but at the same time not have the capacity to make other, more complex decisions.

10 Acting in Best Interests and Reaching a Best Interests Decision

Principle 5 of the Mental Capacity Act is that any action undertaken or decision made on behalf of someone who lacks mental capacity must be undertaken or made in the individual's best interest.

The only exception may be when an individual who lacks capacity has made an Advanced Decision to refuse specified treatment (See section 14). Examples of best interest decisions may include:

- Giving covert medication
- Restraint physical mental
- Dispute with family
- Change of accommodation
- Changes to care and treatment

(This is not an exhaustive list) and the outcome recorded as per local Best Interest Guidance. The following web link provides additional information on the local multi-agency procedures.

http://www.proceduresonline.com/bolton/asg/

11 Who can make the decisions?

A range of people may act as the 'decision maker' on behalf of the individual who lacks the capacity to decide on an issue for themselves. The decision maker will depend on the type of decision to be made e.g. in the context of healthcare decisions, the decision maker is most likely to be a doctor or healthcare member of staff responsible for carrying out the treatment/ procedure..

Once the 'decision maker' has been determined, they must work through the best interest "checklist" as locally agreed and come to a determination of what is in the individual's best interest.

The MCA requires the decision maker to consult with anyone who knows the person who may lack capacity and every effort must be made to encourage and enable the individual who lacks capacity to take part in the decision making.

12 Advance decisions

If a person (who lacks capacity) made an advanced decision to refuse medical treatment at a time when he/she had capacity. This will prevent a healthcare professional from giving him / her the same treatment in his / her best interest as long as the advanced decision remains **valid** and **applicable** to present circumstances.

Advanced care planning is a process by which people can plan ahead to make decisions and express preferences about what they wish to happen with their

care and treatment if they lost capacity to make decisions for themselves and other people to make decisions for them. They can:

- Appoint someone to make decisions for them regarding health and welfare via a Lasting Power of Attorney authorisation (See section 16)
- Refuse specific treatments in advance if they want to by making an advanced decision to refuse treatment
- They can nominate people they would like to be consulted when decisions are being made about them

Individuals can write down a statement containing their wishes and preferences for their future care but may also have made a verbal decision. Practitioners must assure themselves that such decisions (written or verbal) are valid and applicable.

NB For further detail around advanced decisions, see Chapter 9 of the MCA Code of Practice (2007)

End of Life Decisions

It is useful to have information around the person's preferences for care at the end of life as this can inform decision making if the person loses capacity and may influence when a DOLS is required.

Seek advice if further support is needed from your local MCA / DoLS lead in your local authority.

13 Do Not Resuscitate (DNAR) / Cardiopulmonary Resuscitation (CPR)

- DNACPR decisions should only be made for an individual who does not have capacity, if the decision is believed to be in their best interests (as defined by the MCA).
- DNACPR decisions must never be motivated by a desire to bring about the patient's death. Professionals should seek to establish the incapable

person's wishes, preferences, beliefs and values by talking to those closest to the individual and/or the person with LPA or an Independent Mental Capacity Advocate (IMCA) before making a DNACPR decision.

- Input of the family or others close to the patient lacking capacity should be based on what they believe the patient would have wanted – not their own wishes.
- Decisions should reflect current circumstances i.e. what the individual would have wanted at that time given the circumstances they faced.
- Every effort should be made to involve and enable the individual in the decision making.
- Practitioners should tell the people closest to the individual lacking capacity if they reach a DNACPR decision and explain the reasons to them.

If there is a dispute as to an incapacitated patient's best interests when CPR is to be withheld or withdrawn then the patient or those close to them should be offered a second opinion. In the relatively rare circumstances where the patient or those close to them continue to fundamentally disagree with the clinical team, legal advice should be sought and the courts can be asked to intervene where there is time to do so.The decision whether or not to attempt CPR involves far more than the factual matter of probabilities of success. It must take account of what the person wants or what he or she considers being in their future best interests. A consideration of best interests must include not only clinical issues, but also the advantages and disadvantages of the options in relation to the patient's welfare, family life and social, recreational and daily living activities. It should also take into account the patient's religious or spiritual beliefs and views which may be relevant and significant to the patient.

How a patient in these situations decides whether CPR is in their best interests is unique to them. A patient with capacity has the right to make a decision that appears irrational or eccentric or unwise. Indeed, such a decision, if made with

capacity, will be binding if it is recorded as an Advances Decision to Refuse Treatment (ADRT)[5].

14 Lasting power of attorney (LPA) regarding property and affairs

Enduring Power of Attorney has been replaced following the introduction of the MCA 2005, by a Lasting Power of Attorney (LPA, whilst they have capacity) for finance and/ or Health and welfare. This must be registered with the office of the public guardian.

This applies to individuals over 18 years old and who have the capacity at the time to understand the decision to be made.

Further Information can be sought from the Office of the Public Guardian Website[6].

15 Court of Protection and Court Appointed Deputies

If there is a significant disagreement on the outcome of the capacity test or the "best interests" decision, or concern about the conduct of a person acting under an LPA, an application to the Court of Protection may be appropriate. The court itself can make a decision, or it can appoint a "deputy" to oversee relevant aspects of the case. Relatives, local authorities or other people may apply to the court to be appointed as a deputy to enable them to make decisions on behalf of a person who already lacks mental capacity and are unable to appoint an LPA.

The LPA and Court appointed deputies updated information needs to be recorded in the patient's medical records.

[5] Ref: NHSE Unified DNACPR Adult Policy Nov 2014

[6] www.publicguardian.gov.uk/forms/registering-ipa.lpa

16 Independent Mental Capacity Advocate (IMCA)

The MCA (2005) establishes an advocacy service to provide safeguards for people who:

- Lack Capacity to make a decision at the time it needs to be made and are unbefriended.
- Moving the individual to a different care setting.
- Representing the views of the patient in adult safeguarding cases.

In relation to **serious medical treatment**

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17 Deprivation of Liberty Safeguards (DoLS)

Before a DoLS is applied for, there are two questions that should be asked, this is known as the **Acid test:**

1. Is the person subject to continuous supervision and control and
2. Is the person free to leave

If these areas are in question, an application for DoLS should be made by the Managing Authority (Care Home/ Hospital) to the Supervisory Body (Local Authority). For those living in the community (i.e. supported living) these applications are made to the Court of Protection.

Examples of what constitutes a deprivation of liberty are:

- Using locks or key pads which stop a person going out or into different areas of a building
- The use of some medication, for example, to calm a person

- The person loses autonomy because they are under continuous supervision and control
- Staff exercises complete and effective control over the care and movement of a person for a significant period.
- Requiring a person to be supervised when out
- Holding a person so that they can be given care or treatment
- Bedrails, wheelchair straps, and splints
- The person having to stay somewhere against their wishes
- The person having to stay somewhere against the wishes of a family member
- Restricting contact with friends, family and acquaintances, including if they could cause the person harm. The person is unable to maintain social contacts because restrictions place on their access to other people
- Physically stopping a person from doing something which could cause them harm
- Removing items from a person which could cause them harm

18 Notifying the Coroner

NB: Any patient who dies whilst under an Active Deprivation of Liberty Safeguard must be reported to the coroner[7].

19 Training

- NHS Bolton CCG Continuing Health Care Team and relevant staff who are employed by Bolton CCG have a responsibility both to keep up to date and undertake appropriate personal professional development.

20 NHS Bolton CCG MCA / DoLS Lead

The MCA / DoLS Lead is Kaleel Khan, T: 01204 462204 E:kaleelhan@nhs.net

[7] ://www.judiciary.gov.uk/wp-content/.../**guidance**-no16-dols.pdf

21 Useful Links

https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

http://www.proceduresonline.com/bolton/asg/

http://www.publicguardian.gov.uk/mca/code-ofpractice.htm

http://www.dca.gov.uk/legal-policy/,mentalcapacity/publications.htm

http://www.dh.gov.uk/en/socialcaredeliveringadultsocialcare/mentalcapacity/mentalcapacityactdeprivationoflibertysafeguards/index.htm

22 Appendix 1

Glossary

The **Mental Capacity Act 2005 (MCA)** is the statutory framework for acting and making decisions on behalf of individuals over 16 years old who lack the capacity to make particular decision for themselves or who have the capacity and want to make preparations for a time when they may lack capacity in the future.

The **Deprivation of Liberty Safeguards** (DOLS) is an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.(DOLS)The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can be asked if a person can be deprived of their liberty.

Consent is the voluntary and continuing permission of the person to the intervention or decision in question. It is based on adequate knowledge and understanding of the purpose, nature, likely effects and risk of that intervention or decision, including the likelihood of success of that intervention and any alternative to it. Permission given under any unfair or undue pressure is not consent.

Decision Maker is anyone who is making welfare or health decision on behalf of another person. This can be a carer or a relative who makes decisions about everyday matters. More serious decisions should be made by people in more senior roles. Decisions regarding a change of accommodation should be made by the multi-disciplinary team.

Independent Mental Capacity Advocate (IMCA) these are a type of advocacy introduced by the MCA 2005.The IMCA is to help vulnerable people to make important decisions about serious medical treatment and changes in accommodation and who have no family or friends that would be appropriate to consult about these decisions**.**

Restraint is the use of threat or force and may be proportionate or unlawful.

Enduring power of Attorney (EPA) is the legal authorisation to act on someone else's behalf. This has now been replaced by the LPA but if in place before 2007 is still legally viable.

Lasting Power of Attorney (LPA) enable an individual to grant authority to one or more persons to make decisions on their behalf in relation to health, welfare, property or financial matters specified in the LPA document. These powers can include giving or refusing consent to medical examination and/or treatment as specified in the LPA.

Covert medication involves the administration of medication in a disguised form for example in food or drink when a person is refusing treatment necessary for their physical or mental health. The patient lacks capacity in relation to the planned intervention.

Mental Health Act (MHA) was first introduced in 1983(further amendment in 2007) and sets out how you can be treated if you have a mental disorder. It affects those over 18 years old.