Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

Context and /or Aims

The Learning Support Centre believe in a client led approach. Some clients The Learning Support Centre work with may lack capacity to make decisions and/or will want to prepare for when they lack capacity in the future. Clients may also lack capacity to consent to treatment that might deprive them of their liberty, where their care or treatment is in their best interests or will protect them from harm.

The purpose of this policy is to support The Learning Support Centre in ensuring that those clients receive high quality care, that their rights are upheld and that the company complies with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009.

Policy Statement

Mental Capacity Act 2005

- The Mental Capacity Act 2005 (MCA 2005) provides a statutory framework for people who lack capacity to make decisions, or who have capacity and want to prepare for a time when they may lack capacity in the future.

- It sets out who can take decisions, in which situations, and how they should go about it. It applies to all those involved in providing health and social care in England and Wales.

- The Act is supported by a Code of Practice 2007 which gives guidance on its implementation.

- The Act sets out how capacity should be assessed and procedures for making decisions on behalf of people who lack mental capacity. The underlying philosophy of the MCA is that any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests

- The Act covers day to day decisions such as what to eat and wear, and more complex or life changing decisions such as whether to undertake major surgery.

The Mental Capacity Act 2005 defines lack of capacity in the following way:

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

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

The Act assumes that a person has capacity until it is proven otherwise, there is a two-stage diagnostic test which should be used when determining if a person may lack capacity under the definition provided by the Act.

Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

If yes, a four-stage functional test is undertaken to assess a person's ability to make a decision for themselves. It is more likely than not that a person will be unable to make a decision if they cannot:
Understand the information about the decision to be made.
Retain that information in their mind.
Use or weigh that information as part of the decision-making process, or
Communicate their decision (by talking, using sign language or any other means).

Capacity **is decision and time specific**, in other words assessing capacity refers to assessing a person's ability to make a particular decision at a particular moment in time, rather than being an overarching judgement about an individual's ability to make decisions in general.

The Five Statutory Principles

Principle 1 a person must be assumed to have capacity unless it is established that they lack capacity.
Principle 2 a person is not to be treated as unable to make a decision unless all steps to help them to do so have been taken without success. Individuals should be given support to make their own decisions and all practical steps should be taken to make that possible. Support might include:

- Different forms of communication e.g. non-verbal such as sign language.
- Information in different formats, e.g. photographs or flash cards.
- Treating a medical condition that may be affecting an individual's capacity.
- A structured programme to improve capacity to make particular decisions, especially relevant for individuals with learning disabilities

Principle 3 a person is not to be treated as unable to make a decision merely because he makes an unwise decision. People have a right to make a decision that others do not agree with. If there is concern a person is acting in a way that isn't consistent with previous behaviour, or they are making decisions that may put them at risk of harm, then a mental capacity test should be undertaken

Principle 4 an act done or decision made, under the Act for or on behalf of a person who lack capacity must be done, or made in, the persons **best interests**.

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

Principle 5 before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed **can be as effectively achieved in a way that is less restrictive of the person's rights and freedom** of action.

Staff are expected to understand how the MCA 2005 works for those people with cognitive difficulties such as Dementia but also how to proceed when lack of mental capacity is temporary. Those working in health and care services must have regard to the Act and the principles within it.

Deprivation of Liberty Safeguards (DoLS) 2009

- The DoLS were created as part of the Mental Capacity Act to help protect vulnerable people who lack capacity to consent to treatment that might deprive them of their liberty, where care or treatment is in their best interests or will protect them from harm.

- DoLS are an extra protection for vulnerable people to ensure that deprivation is only used when necessary, and that any deprivations are lawful.

- The Act recognises that in some cases there is no other way to provide treatment and care other than by depriving a person of their liberty. The Act provides a legal process for this deprivation which makes sure that it is unavoidable and in the persons' best interests.

- The DoLS only relate to people aged 18 or over and those adults that are not detained under the Mental Health Act 1983.

A person may only be deprived of their liberty if:

- It is in their own best interests to protect them from harm.
- It is an appropriate and proportionate to the threat of harm.
- There isn't an option that is less restrictive.

The legality of deprivations of liberty may change in light of legal developments arising from case law. There have been a number of Supreme Court Rulings that have affected the implementation of the Act. This policy reflects legal developments up to the date of publication. The DoLS Code of Practice 2009 defines the difference between a deprivation of, and restriction upon, liberty, as one of degree or intensity. A person's treatment and care may move along the scale of restriction of liberty and deprivation over time and circumstances. It is therefore, important for DoLS to be reviewed.

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

Case law has helped determine factors that might indicate a person is subject to deprivation rather than restriction or restraint.

The Law Society has provided a comprehensive set of liberty restricting measures that can be used to help front line staff understand if a deprivation is occurring.

http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

The emphasis of the DoLS is to avoid depriving a person of their liberty if possible by choosing a less restrictive delivery of care or treatment. Implementing the MCA should reduce the numbers of DoLS applications that need to be made.

To enable compliance, all staff within The Learning Support Centre taking part in regulated activities will be required to attend mandatory training at commencement of employment and then as refresher every 3 years;

The Learning Support Centre Ltd will be required to have appropriate monitoring arrangements in place to ensure providers and commissioners on behalf of The Learning Support Centre Ltd are meeting their contractual responsibilities.

Scope of the Policy

This Policy is mandatory and applies to all Learning Support Centre staff (temporary and permanent) taking part in regulated activity, all those carrying out regulated activity must have regard to the Act and the principles within it.

Requirements for Implementation

The policy will be implemented by procedures which will:

- **Protect** clients by ensuring staff are trained and supported to respond appropriately and sensitively to concerns over lack of mental capacity;
- **Support** clients who may have who may lack capacity to make decisions
- **Work with clients, local authorities' colleges, universities, parents, and medical professionals** where appropriate, to ensure communications and actions are undertaken

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

Procedure for Assessing Mental Capacity

Assessing Capacity and Best Interest Decision Making

Mental Capacity Act 2005 (c.9)

A person lacks capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. The definition makes clear that capacity is **time and decision specific.** The legislation is flexible and recognises that some people may be able to make some decisions while lack capacity to make others and that this state may change over time.

The Act challenges a blanket assumption that because a person may not have the mental capacity to for example, to organise their finances, that they don't have mental capacity to decide what treatment or care they receive. A person may be able to make day to day decisions but lack capacity to make decisions that are more complex.

Consent and Capacity

Capacity should be **assessed** when a person's mental capacity to consent to their treatment or care is in doubt. Capacity may be called into question for a number of reasons including:

- An individual's behaviour or circumstances.
- Where concern about capacity has been raised by someone.
- Where a person has been previously diagnosed with an impairment or disturbance that affects the way their mind or brain works.
- A previous mental capacity assessment has shown lack of capacity to make a decision.

You must have **reasonable belief** that the individual lacks mental capacity to have legal protection under the MCA 2005 for making decisions on a person's behalf.

To have reasonable belief you must take certain steps to establish that the person lacks mental capacity to make a decision or consent to an act at the time the decision or consent to act is needed.

You must establish and be able to show that the decision or act is in the person's best interests.

A mental capacity assessment must be completed using the two and four stage tests outlined in the Policy, context all concerns regarding a client's mental capacity should be flagged with the Support Coordinator immediately, who will give guidance on next steps to support the client.

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

A mental capacity assessment helps demonstrate that on a balance of probabilities it is more likely than not that the person lacks capacity. Not all decisions will need a formal mental capacity assessment. Consent for the person's care plan will cover many day to day decisions, but there will be times when a formal mental capacity assessment should be undertaken.

Examples include but not exclusive to:

- Use of bed rails
- Use of restraint
- Any invasive procedures
- Covert medication
- Any procedures where the resident is touched
- Medical photography
- Research.

There may be times when the involvement of other professionals and colleagues in carrying out a mental capacity assessment is required and/or best interest's decision. If the decision to be made is complex or may have serious consequences, if there is disagreement about a person's capacity, or if there are safeguarding issues.

Occasionally the LSC may have a client who objects to having a mental capacity assessment. Where this happens, it is good practice to explain what the mental capacity assessment is and how it will help to protect their rights. There should be no undue pressure for the person to have the assessment, as a person has the right to refuse.

If it's clear that the person lacks the mental capacity to consent to the assessment then the assessment can usually go ahead as long the assessment is in the person's best interests.

Consent and Care Planning

Where it has been shown that a person lacks mental capacity to consent to a care plan through the capacity test, then **consent to the care plan** should be achieved through a best interest's decision. The care plan should show how lack of mental capacity was established and a best interest's decision made, with evidences.

Care plans are reviewed to ensure that decisions agreed within it as part of the best interest's decision making and less restrictive option are still appropriate. If the person is being protected by Deprivation of Liberty Safeguards then the records will also reflect this.

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

Consent to care is critical to delivering lawful care**.** For a client to be able to give informed consent they need to have:

- Been given all the relevant information about their care, treatment or support
- Understand the different options and possible consequences of each
- Be free from duress and understand they have the right to refuse
- Be able to weigh up the options and use this information to make a decision and communicate this

Consent for everyday care can be verbal or implied, for example opening the mouth for food, raising arms ready to be dressed.

It is very important to remember that although friends and family will be consulted in best interests' decision making, decisions about serious treatment or changes of accommodation **cannot** be made by the next of kin or relative unless they have been given legal authority to do so. Families should be consulted about the care plan and views taken into consideration, but this is not the same as consent.

Best Interest Decisions Mental Capacity Act 2005 (c.9)
Once a capacity assessment has been completed and lack of capacity has been demonstrated, the care or treatment decision in question should be made following the best interest principle. The MCA 2005 states that a decision cannot be made merely on the basis of:
(a) The person's age or appearance, or,
(b) A condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests

The Code of Practice 2007 provides a checklist of things to be weighed up when making a decision in a person's best interests. Following this checklist and acting in line with the statutory principles will afford legal protection for decision makers.
This includes:

- Encouraging participation in the decision making.
- Trying to understand what the person would have wanted if they had capacity.
- Trying to find out the views of the person who lacks capacity by talking to the person's family, friends and other health professionals.
- Not making assumptions about what is in a person's best interests based on age, appearance, condition or behaviour.
- Considering whether a person might regain capacity and if so whether the decision can wait until such time.
- Consulting others about their views including an Independent Mental Capacity Advocate (IMCA) where appropriate.
- Avoiding decisions that are restrictive of a person's rights.

It is not uncommon for friends and family to have different views about the treatment or care of a loved one. It is very important to keep good records, including a completed best interest's decision form, notes of any best interest's decision meetings, and involvement of family, friends and advocates. Disputes may be resolved through getting a second opinion, mediation or referring to the Court of Protection for a ruling.

The **best interest decision maker** is the person who will establish what is in the best interests of the individual lacking mental capacity. Usually this is the person who assesses the person's capacity to make a decision and is the person who is directly concerned with the individuals care at the time the decision needs to be made.

Day to day decisions are usually made by the person most directly involved in the individuals care.

Decisions for medical treatment would usually be the clinician responsible for the treatment. Decisions about nursing or care planning would usually be the nurse or carer. Where there is a health and welfare or property and financial affairs lasting power of attorney (LPA) or deputy appointed by the Court of Protection, the decision maker will be the appointed attorney for decisions within the scope of their authority. Attorneys may be asked to produce evidence that the LPA covers the decision in question. The Office of the Public Guardian may be contacted directly if there are concerns**.**

Advance Decisions

Some clients may wish to plan ahead for their health and social care knowing that there may be a time in the future when they are unable to consent. There are different ways a person can do this:

Verbally – Conversations with family, friends, and healthcare professionals about their wishes and preferences.

An advance statement or preferred priorities for care form. This is a non-legally binding document that those involved in treatment and care should take into consideration when making a best interests decision. It is a statement of the views and wishes of the individual, and might reflect treatment preferences.

An **Advance Decision** (to refuse treatment life and non-life threatening) is a legally binding document that allows an individual over the age of 18 to refuse a specific treatment in the future when they lack the capacity to consent, or refuse, that treatment, even if this results in death, as long as they have capacity to make the decision at the time it is being made.

Under the Mental Capacity Act 2005, a valid and applicable advance decision has the same effect as a decision that is made at the time by a person who has capacity.

For an advance decision to refuse treatment to be valid, health professionals must try to establish if:

- The client has done anything since making the advance decision that would clearly suggest that they no longer agree with the advance decision.
- The client has withdrawn the advance decision.
- Power has been given to an attorney to make the same treatment decision as covered in the advance decision.
- The client would have changed their mind if they had known more about the current circumstances.

For an advance decision to refuse life sustaining treatment to apply, the client must no longer have capacity to make the decision for themselves. The advance decision must also:

- State exactly what treatment is to be refused.
- Set out the circumstances when the refusal should apply.

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

- State that the refusal is to apply even if there is a risk to life.
- Be in writing.
- Be signed by the client refusing the treatment or by another person in the client's presence and by their direction.
- The signature must be witnessed and signed in the presence of the client.

An advance decision which is not in relation to life sustaining treatment does not need to be in writing to be legally binding. The Court of Protection may be asked to decide whether the advance decision exists, is valid or applicable to the current situation, if the advance decision is called into question. While a decision is being made by the court, life sustaining treatment or treatment necessary to prevent a client's deterioration may still be provided. Advance decisions can only be made to refuse treatment; not to demand a treatment choice.

A Lasting Power of Attorney (LPA) the MCA 2005 allows a person to give statutory authority to another (known as an attorney or donee) to make decision(s) on their behalf through a lasting power of attorney.

There are two types of lasting power of attorney:

- Health and welfare and
- Property and finance.

A health and welfare LPA can be created while a person still has capacity to give authority to an attorney to make decisions when they are no longer able to consent to treatment or care. The attorney may be given power to make decisions about day to day care, consenting or refusing medical treatments, moving accommodation, refusing life sustaining treatment and more.

All lasting power of attorneys should be checked either with the Office of the Public Guardian, or the attorney can be asked to provide a copy, this is to ensure that it has been registered and valid, and to clarify what decisions the attorney is allowed to make under the terms of the LPA. For example, they may have been given authority to make choices about accommodation but not to refuse treatments.

A lasting power of attorney must be registered with the Office of the Public Guardian before it is valid and can only be used once the person who made it no longer has capacity. Records must reflect whether an LPA has been registered, and what decisions are given to the attorney.
Advance care planning is voluntary but can be used to help people retain control of their treatment and care. Advance care planning can only be undertaken by a person who has capacity. Discussions relating to advance care planning should be formally recorded.

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

Independent Mental Capacity Advocate IMCA

The IMCA is an independent safeguarding service created under the Act to give support to very vulnerable clients who lack mental capacity to make decisions about serious medical treatments and changes of accommodation, and who also have no friends or family that can be appropriately consulted during the best interest's decision-making process.

An IMCA **must** be instructed if it has been established that a person lacks mental capacity and has no network of friends and family that can be consulted in making the best interests decision relating to:

- An NHS body proposing to provide serious medical treatment
- An NHS body or local authority proposing to arrange accommodation (or change of accommodation) in hospital or care home, and
- The person will stay in hospital longer than 28 days, or
- They will stay in the care home for more than eight weeks

IMCAs **may** be instructed to support someone who lacks capacity concerning:

- Care reviews, where no one else is available to be consulted
- Adult protection cases, in such cases and IMCA may be appointed

The information provided by the IMCA must be taken into account by the decision maker.

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

Restraint

The Act defines use of restraint in Section 6(4) as:

- Use of force-or threaten to use force-to make someone do something they are resisting, or
- Restrict a person's freedom of movement, whether they are resisting or not.
- The Act only provides protection from liability in using restraint only under certain conditions:
- The person taking action must **reasonably believe** that restraint it necessary to prevent harm to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts must be **proportionate** response to the likelihood of serious harm.
- Less restrictive options should always be considered before restraint. The Act describes a proportionate response as one that means using the least intrusive type and minimum amount of restraint to achieve a specific outcome.

Record Keeping

Assessments of capacity for day to day decision making or consent to care do not need to be formally recorded, but it is good practice for these everyday decisions to be part of the persons care plan. Formal mental capacity assessments to assess the mental capacity for an individual to make a particular decision at a particular time should be kept in the relevant client's records.

Interface with the Mental Health Act 1983

The Mental Capacity Act provides a framework for decision making on behalf of people who lack capacity to decide for themselves. The issue of capacity (or more accurately lack of capacity) is central to the operation of this Act. Statutory provisions only come into play if a person lacks capacity for the specific decision in question.

The Mental Health Act provides a framework for treating mental disorder in the absence of consent, whether due to lack of capacity or valid refusal of treatment, if the criteria for detention are fulfilled. Unlike the Mental Capacity Act capacity is not central to the operation of the Mental Health Act.

The Mental Capacity Act does not allow decisions to be made on behalf of people who have capacity to make them themselves. People subject to the Mental Health Act may have capacity to make decisions about their mental health treatment, but the Mental Health Act allows this to be overridden in certain circumstances.

This is a complex area and if there is doubt whether Mental Health Act applies then further advice should be sought from the GP.

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

Process for Deprivation of Liberty Safeguards

The DoLS was developed to help protect vulnerable people who lack capacity to consent to treatment that might deprive them of their liberty, where this care or treatment is in their best interests or will protect them from harm, therefore it is important to be aware of the process in place when DoLS is required. The managing authority is the person registered under part 2 of the Care Standards Act 2000 where the provider is a care home or private hospital.

A supervisory body is responsible for receiving the requests for authorisation, commissioning the assessments and where agreed authorising the request for deprivation. For care homes, the supervisory body is the local authority where ordinary residence is established or where a person is of no fixed abode, the borough of the care home.

There are two types of authorisation, **standard** and **urgent.** A standard authorisation is used where it is anticipated that a deprivation is going to occur within 28 days, and so should be done in advance of any deprivation. It is important to remember that an authorisation only **permits** a deprivation; **it does not mean that a person MUST be deprived** of their liberty.

An urgent authorisation should be made when a person needs to be deprived of their liberty in their own best interests before a standard authorisation can be processed. A standard authorisation should then be requested within 7 days of the urgent authorisation.

A deprivation of liberty must be in a person's best interests, which means that as part of the process those with an interest in the person's health and welfare should be consulted and given an opportunity to give their views. Where the person has no interested party outside of those providing care or treatment then the supervisory body will instruct an IMCA.

Under the terms of the Act an assessment must be made by the supervisory body within **21 days** of an application for a standard authorisation. Where there is already an urgent authorisation in place then the assessment needs to take place before the urgent authorisation expires.

Urgent authorisations can only be given for 7 days; this may be extended by the supervisory body for a further 7 days in exceptional circumstances.

Once all the assessments have been completed by the supervisory body a decision will be made to authorise the deprivation or not. Where a deprivation is authorised, it will be time limited in line with the recommendations of the assessor.

If the person under the DoLS moves to another hospital or care home then a new application for DoLS will need to be made. This should happen in advance of the move.

All authorisations should be kept in the person's care records, it is important that friends, family and carers are kept up to date and that an effort is made to help the person subject to the DoLS understand the effect of the authorisation and their right to challenge.

The relevant person's representative RPR is appointed by the supervisory body for each person who has a standard DoLS authorisation. The role of this person is to maintain contact with the person subject to DoLS and represent and support them in any matters relating to the deprivation. It is important that the RPR is informed of:

- the effect of the authorisation,
- their right to request a review,
- their right to make a complaint and the procedure for doing so,
- Their right to apply to the Court of Protection and their right to request an IMCA.

DoLS should be kept under review. Where capacity fluctuates it is important to recognise where capacity has returned in the longer term. Where capacity returns for short periods of time the authorisation should remain in place.

The CQC must be informed of any DoLS applications and that the managing authority (care home or hospital) must inform the coroner where a person is subject to DoLS and dies as this is deemed to be death in custody at present.

Review and Maintenance of Policy

This policy will be subject to a routine annual review, and will also be subject to alteration if required through the creation of additional national policy, legislation or guidance and / or local guidance. If revised, all stakeholders will be alerted to the new version. The review will be conducted by the Registered Manager and other relevant personnel.

Monitoring of policy

Implementation of the policy will be monitored through the Support Coordinators.

Policy Title	Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009 Policy and Procedure
Issue date (m/y)	08/2014
Author	Donna Welburn, Operations Manager
Approved by	Laura Cook, Managing Director
Last review	08/2016
Review date (m/y)	08/2017

Related Documents

Mental Health Capacity Act 2005
Care Standards Act 2000
Safeguarding Vulnerable Groups Act 2006
Safeguarding Procedure
Care Staff handbook
Equality Policy