

**Mental Capacity Act (MCA) (2005) Policy and Procedures**

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| **Target Audience-** who does the document apply to and who should be using it. | | All employees of the Trust (including those who deliver services on behalf of Wiltshire Health and Care) | | | | |
| **Accountable Director** | | | | Chief Nurse | | |
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| **Implementation Lead** | | | | Head of Mental Health and Safeguarding Adults at Risk, MCA and Deprivation of Liberty Safeguards (DoLS) | | |
| **If developed in partnership with another agency ratification details of the relevant agency** | | | | NA | | |

**Equality Impact**

Great Western Hospitals NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of health care, the Trust aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed in line with current legislation to ensure fairness and consistency for all those covered by it regardless of their individuality. This means all our services are accessible, appropriate and sensitive to the needs of the individual.

**Special Cases**

Children under 18 years of age. - Most of the MCA (2005) applies to people aged 16 years and over. There is an overlap with the Children Act 1989. For the MCA (2005) to apply to a young person (16-18 years old), they must lack capacity to make a particular decision (in line with the MCA (2005)’s definition of lack of capacity). In such situations either this Act or the Children Act 1989 may apply, depending upon the particular circumstances.

However, there may also be situations where neither the MCA (2005) and the Children Act 1989 provides an appropriate solution. In such cases, it may be necessary to look to the powers available under the Mental Health Act 1983 or the High Court’s inherent powers to deal with cases involving young people.

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# 1 Instant Information – MCA (2005) Mental Capacity Assessment Flowchart

Refer to the five principles of the MCA 2005:

* A presumption of capacity
* Individuals being supported to make their own decision
* Unwise decisions
* Best Interests
* Least restrictive option

Conduct the two-stage capacity test

Can the person make the required decision?

**The two-stage capacity test:**

**Stage one:**  Is there an impairment of, or disturbance in the functioning of the person’s mind or brain? If so,

**Stage two:** Is the impairment or disturbance sufficient that the person lacks the capacity to make the particular decision?

**Can the person:**

* Understand the information relevant to the decision,
* Retain the information,
* Weigh that information as a part of the process of making a decision and
* Communicate their decision (whether by talking, using sign language or any other means?

**(Person must demonstrate all four functions above to be deemed as having capacity for the required decision making).**

Yes

Yes

No

Unclear

For further advice and support please contact

GWH Safeguarding Adults at Risk Team 01793 607345 / 604538

Safeguarding Adults at Risk Facilitator: 01793 607345

Mental Health Act & Safeguarding Adults at Risk Administrator 01793 604538

**APPENDIX C: Mental Capacity Assessment 2 stage test**

Does the person have capacity to make the decision required?

The person will make the required decision

Refer to:  
The MCA (2005)

Best interests’ decision making flowchart.

# 2 Document Details

## 2.1 Introduction and Purpose of the Document

The Mental Capacity Act (2005) (Ref 1) hereby referred to as the MCA (2005) became part of statute in England and Wales in 2007 and applies to everyone who works in health and social care and is involved in the care, treatment or support of people aged 16 years and over who may lack capacity to make decisions for themselves.

The MCA (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. Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with MCA (2005) when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.

It is based on existing good ethical and professional practice and all clinical employees need to have applicable knowledge of the MCA (2005) and understand their role within the practice of the MCA (2005).

The MCA (2005) is underpinned by five key principles which must inform everything that Great Western Hospitals NHS Foundation Trust (the Trust) and employees for Wiltshire Health and Care do when providing care or treatment for a person who lacks capacity.

The MCA (2005) is supported by the Statutory Mental Capacity Act 2005 – Code of Practice (Ref 2) hereby referred to as The Code which provides guidance to anyone who is working with and/or caring for adults who may lack capacity to make particular decisions.

The Code explains in detail what the key features of the legislation are and some of the practical steps that people using and interpreting the law need to take into consideration.

It describes the responsibilitiesof all clinical employees working within the Trust who provide care and treatment for people who lack capacity or who are involved in assessing capacity or in making best interest decisions. Employees of the Trust, have a legal duty to have regard to The Code. This means employees must pay attention to The Code and be able to demonstrate knowledge of the guidance in it.

The purpose of this document is to briefly summarise the main points of the MCA (2005) in relation to:

1. Assessment of capacity and consent.
2. Responsibilities of the Decision-Maker acting in the best interests of the patient.

It will provide the tools to assist those who are responsible for completing the process within the Trust.

It is not the intention for this policy to fully replicate the details of the MCA (2005). More detailed information can be obtained from the websites contained in the further reading section of this Policy.

**This policy is a working document that will be reviewed and amended on a continuing basis to reflect changes in legislation, case law and any changes in arrangements with the Trust’s working partners.**

## 2.2 Glossary/Definitions

The following terms and acronyms are used within the document:

|  |  |
| --- | --- |
| **CCG** | Clinical Commissioning Group |
| **Attorney** | Under the remit of this document within the lasting powered of attorney the word attorney means a person, appointed to act for another in legal matters |
| **Battery** | An intentional unpermitted act causing harmful or offensive contact with the "person" of another. |
| **CQC** | Care Quality Commission |
| **DM** | Decision Maker |
| **DOLS** | Deprivation of Liberty Safeguards |
| **ECHR** | The European Convention for the protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are largely incorporated into UK law by the Human Rights Act 1998.  European Convention on Human Rights Act 1998 |
| **EPA** | Enduring Power of Attorney |
| **Human Rights Act 1998** | A law largely incorporating into UK law the substantive rights set out in the European Convention on Human Rights. |
| **IMCA** | Independent Mental Capacity Advocate |
| **LPA** | Lasting Power of Attorney  There are different types of LPA   * Personal Welfare LPA * Property and Affairs LPA   EPA deals only with Property and Affairs |
| **MCA (2005)** | Mental Capacity Act 2005 |
| **MCA Code of Practice** | The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. The Code describes their responsibilities when acting or making decisions with, or on behalf of individuals who lack capacity. All people who have a duty of care to a person lacking capacity must have regard for the Code. The Code of Practice is available at (Ref 2) |
| **NHS** | National Health Service |
| **The Code** | Mental Capacity Act 2005 Code of Practice |
| **v** | Versus |
| **WH&C** | Wiltshire Health and Care |

# 3 Main Policy Content Details

## 3.1 Principles of the MCA (2005)

The MCA (2005) is underpinned by a set of five key principles set out in Section 1 of the Act:

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 has been assessed otherwise.
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.

1. **Unwise decisions** – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
2. **Best interests** – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests.
3. **Least restrictive option** – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

## 3.2 Consent

Any record of consent be it verbal, non-verbal or in writing must be evidenced as being informed consent. The patient is fully aware (been given the relevant info and had the opportunity to discuss) of the duration, purpose of a particular treatment, risk and benefits of procedure / treatment, and also the consequences of deciding not to have the treatment and the alternatives available.

Patients have a fundamental legal and widely-accepted ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is also a matter of common courtesy between health care professionals and patients. Failure to obtain consent for treatment may result in prosecution for assault or battery. Generally the main distinction between an assault and a battery is that no contact is necessary for an assault, whereas an offensive or illegal contact must occur for a battery.

If an employees feel a patient lacks capacity to consent to care or treatment due to an impairment of the mind a two stage capacity assessment must be completed. If the patient is deemed to lack capacity a best interests decision record should be completed by the decision maker. Exceptions would be if the patient is unconscious or has an altered mental state and the test is required in an emergency to provide life saving treatment.

Further guidance can be located in the Consent for Medical Treatment for All Patients at the Great Western Hospital Policy (Ref 11)

## 3.3 The Test of Capacity

The MCA (2005) sets out a two-stage test of capacity to help determine if a person lacks capacity to make particular decisions.

**Stage 1: Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?**

Stage 1 requires proof that the person has an impairment of the mind or brain, or some sort of disturbance that affects the way their mind or brain works. If a person does not have such an

impairment or disturbance of the mind or brain, they will not lack capacity under MCA (2005) and the second stage of the test must not be undertaken.

Examples of an impairment or disturbance in the functioning of the mind or brain may include the following:

* A mental health condition;
* Dementia;
* Significant learning disabilities;
* The long-term effects of brain damage;
* Physical or medical conditions that cause confusion, drowsiness or loss of consciousness;
* Delirium;
* Concussion following a head injury;
* The symptoms of alcohol or drug use.

***Note: A diagnosis of any of the above does not necessarily equal lack of capacity.***

**Stage 2: Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?**

For a person to lack capacity to make a decision, MCA (2005) says their impairment or disturbance must affect their ability to make the specific decision when they need to. But first, people must be given all practicable and appropriate support to help them make the decision for themselves (see page 19, principle 2of TheCode**.** Stage 2 can only apply if all practicable and appropriate support to help the person make the decision has failed.

The impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

* The loss of capacity is partial;
* The loss of capacity is temporary;
* Their capacity changes over time.

A person may also lack capacity to make a decision about one issue but not about others.

The second stage of the capacity test tests the person’s functional ability to make a specific decision. The following four domains need to be assessed and documented;

1. The person’s ability to understand the information relevant to the decision;
2. The person’s ability to retain the information for duration sufficient to make the decision;
3. The person’s ability to weigh/use information to inform the decision;
4. The person’s ability to communicate their decision by any means; verbally, using sign language, writing/drawing, muscle or facial movements (for instance blinking, hand squeezing etc.).

To apply the second stage of the test appropriately it is important NOT to assess a person’s understanding before they have been given relevant information about the decision. This should include the nature of the decision, the reason why the decision is needed and the likely consequences or outcomes of deciding one way or another or of making no decision at all.

## 3.4 Who can Assess Capacity?

The person who assesses an individual’s capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved in assessing a person’s capacity to make different decisions at different times.

***Therefore:***

1. If the decision to be made involves medical treatment, the doctor responsible for carrying out the particular treatment or procedure will complete the two stage test of capacity assessment and subsequently would be responsible for determining what is in the patient’s best interests if they are assessed as lacking capacity to make their own decision
2. If the decision to be made involves nursing care/ treatment, the nurse responsible for carrying out the particular treatment or procedure will complete the two stage test of capacity assessment and subsequently would be responsible for determining what is in the Patient’s best interests if they are assessed as lacking capacity to make their own decision
3. If the decision to be made involves the patient being moved into residential care, the social worker responsible for the patient will complete the two stage test of capacity assessment and subsequently would be responsible for determining what is in the Patient’s best interests if they are assessed as lacking capacity to make their own decision

## 3.5 What does the MCA (2015) Act mean by Best Interests?

One of the key principles of the MCA (2005) is that any act done for, or any decision made on behalf of, a person who lacks capacity must be done, or made, in that person’s *best interests*. That is the same whether the person making the decision or acting on behalf of the person is a family carer, a paid care worker, an attorney, a court-appointed deputy, or a healthcare professional, and whether the decision is a minor issue – like what to wear – or a major issue, like whether to provide particular healthcare.

As long as these acts or decisions provide sufficient evidence that they are in the best interests of the person who lacks capacity to make the decision for themselves, or to consent to acts concerned with their care or treatment, then the decision-maker or carer will have a level of protection from liability.

### 3.5.1 Exceptions to Best Interest

There are exceptions to best interest, including circumstances where a person has made an advance decision to refuse treatment (see p158 of The Code – Ref 2) and, in specific circumstances, the involvement of a person who lacks capacity in research (see page 202 of The Code - Ref 2). But otherwise the underpinning principle of the MCA (2005) is that all acts and decisions should be made in the best interests of the person without capacity.

Section 4 of the MCA (2005) explains how to interpret the best interests of a person who lacks capacity to make a decision at the time it needs to be made. This section sets out a checklist of common factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity to the specific decision **(these are included at Appendix D**

**Best Interests Decision Record)**. This checklist is only the starting point: in many cases, extra factors will need to be considered (see section 4 of Ref 1).

For easy reference the MCA (2005) Codes of Practice (Ref 2) layout a statutory best interests checklist (Chapter 5, p 71-72) it includes the following guidance:

* Encourage participation of the incapacitated person;
* Identify all relevant circumstances;
* Find out the person’s views, past and present wishes, feelings, beliefs and values;
* Avoid making assumptions about someone’s best interests based on their age, appearance; condition or behaviour;
* Assess whether the person may regain capacity (can the decision be delayed?);
* Consult with others if practicable to do so (anyone named by the person, any appointed attorney or deputy, anyone with a formal or informal caring role, close family and friends). For issues of serious medical treatment and/or where the person is “unbefriended” an Independent Mental Capacity Advocate (IMCA) should be instructed);
* For decisions of life-sustaining treatment best interest decisions should not be motivated to bring about the person’s death. Assumptions about the quality of a person’s life should be avoided;
* Avoid restricting the person’s rights (always consider a range of options and ensure these include the least restrictive).

When interpreting what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision-makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity.

## 3.6 Who is the Decision Maker?

Under the MCA (2005) different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout this policy, as the ‘decision-maker’, and it is the decision-maker’s responsibility to work out what would be in the best interests of the person who lacks capacity.

* Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision-maker;
* Where nursing care of therapy is provided, the nurse or therapist will be the decision-maker;
* If a Lasting Power of Attorney (LPA) (or Enduring Power of Attorney – (EPA)) has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision-maker, for decisions within the scope of their authority.

### 3.6.1 Type of Power of Attorney

There are three different types of power of attorney:

* Personal Welfare LPA

*Having an LPA over someone’s personal welfare may mean the attorney can make decisions about the healthcare and welfare of the person you are looking after. There may be one or more people with this responsibility, who will each be referred to as the person’s attorney.*

* Property and Affairs LPA
* EPA deals only with Property and Affairs

It is no longer possible to create an EPA as they were made under a previous law, Enduring Powers of Attorney Act, 1985 (Ref 10), before the MCA 2005 came into effect in this area. An EPA made before October 1 2007 remains valid.

Both EPAs and LPAs must be registered with the Office of the Public Guardian. LPAs can be registered at any time. Donors can register LPAs while they are able to make decision for themselves.

Where there is an LPA this should be verified with the Office of the Public Guardian. The Trust has responsibility to understand if an LPA or EPA still has the rights to carry out this function and where this function begins and ends.

If a person has the mental capacity to make their own decision a registered LPA attorney does not have the power to make the decision on that person’s behalf.

## 3.7 Recording Assessments

A doctor or healthcare professional proposing treatment should carry out an assessment of the person’s capacity (**Mental Capacity Assessment – Two Stage Test) (Appendix C)** to consent to a **particular** decision at a **particular** time (with a multi-disciplinary team, if appropriate) and record it in the patient’s clinical notes.

There is a need for a clearly documented assessment where:

* A decision has major consequences;
* There may be a dispute with the person, their family, carer, or the care team as to the capacity of the individual;
* The person’s capacity may be subject to challenge;
* There may be legal consequences of a finding of lack of capacity;
* The person is making decisions that put him/herself or others at risk or that result in preventable suffering or damage.

It is good practice as part of a Care Plan to clarify where a person’s mental capacity is known to be impaired and specific help is needed with decisions.

The completed documentation **must** be filed in the patient’s medical notes.

Solicitors should assess a client’s capacity to give instructions or carry out a legal transaction (obtaining a medical or other professional opinion, if necessary) and record it on the client’s file.

If a person is considered to lack capacity in relation to a specific decision that needs to be made employees must complete **the Mental Capacity Assessment (Two Stage Test) (Appendix C) and where applicable a Best Interest Decision Record (Appendix D)** to provide documented evidence of the assessment and best interest decision.

With any condition which fluctuates, is progressive, or responds to treatment, capacity to make a specific decision at a specific time will need to be regularly reviewed. The process must be repeated

i.e. complete Appendix C and Appendix D.

Wiltshire Health and Care employees who record on Sytmone will have access to a capacity assessment and Best Interest Decision record on this system and should record their assessments electronically there. Wiltshire Health and Care employees in an inpatient setting should refer to the

documents recorded in Appendix F which can be found on the Wiltshire Health and Care intranet page under Patient services record, Safeguarding tab

Swindon Community employees who record on Sytmone will have access to a capacity assessment and Best Interest Decision record on this system and should record their assessments electronically there. Swindon Community employees can also refer to the documents recorded in Appendix C which can be found on the Trust intranet page under Mental Capacity Act tab http://gwh-intranet/trust-wide/mental-health,-mental-capacity-and-learning-disability/mental-capacity-and-deprivation-of-liberty-(dols)/dols/how-to-make-a-referral.aspx

## 3.8 How can Someone Challenge a Finding of Lack of Capacity?

There are likely to be occasions when someone may wish to challenge the results of an assessment of capacity. **The first step is to raise** **the matter with the person who carried out the assessment.** If the challenge comes from the individual who is said to lack capacity, they might need support from family, friends or an advocate. Ask the assessor to:

* **Give reasons why they believe the person lacks capacity to make the decision,**

**And**

* **Provide objective evidence to support that belief.**

The assessor must show clearly they have applied the principles of the MCA (2005) and, where applicable, that they have undertaken and documented the two stage test of capacity. To be protected by the MCA (2005) Attorneys, deputies and professionals will need to show that they have followed the guidance in Chapter 2 of The Code (Ref 2).

The Code also offers further guidance on how to resolve disagreements of assessments of capacity.

## 3.9 Independent Mental Capacity Advocate (IMCA)

An IMCA is an ‘Independent Mental Capacity Advocate’ and is someone appointed to support a person who lacks capacity and has no one to speak for them, such as family or friends. The IMCA makes representations about a person’s wishes, feelings, beliefs and values, and brings to the attention of the decision maker, all factors that are relevant to the decision.

* IMCAs are specific types of advocate who will help vulnerable people who lack the capacity to consent, who are facing important decisions about serious medical treatment or changes of accommodation.
* The IMCA will not be the decision maker, but the decision maker will have a duty to take into account the information provided by the IMCA.

An IMCA service is provided in each local area in England. The Trust’s service is provided by Swindon Advocacy Movement contact details: 01793 616562 and Wiltshire Rethink contact details: 01823 354879.

## 3.10 Restraint

Section 6 of the MCA (2005) states that someone is using restraint if they:

* Use 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 MCA (2005) stipulates that any action to restrain a person who lacks capacity will NOT attract protection from liability unless the following two conditions are met:

* The person taking action must reasonably believe that restraint is 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 a proportionate response to the likelihood and seriousness of harm.

Any physical intervention should be informed by and comply with professional and regulatory guidance. Any consideration of the use of restraint must have objective reasons to justify that restraint is necessary. It must be clearly documented that the person being cared for is likely to suffer harm unless proportionate restraint is used. Employees must not use restraint just so that they can perform a task more easily. If restraint is necessary to prevent harm to the person who lacks capacity, it must be the minimum amount of force for the shortest time possible.

Further guidance can be found in the Positive Behaviour Management (Physical Restraint) in Clinically Violent and Aggressive Adults in- Patients Policy (Ref 12)

## 3.11 Protection from Liability including the use of the MCA (2005) to Admit Someone to Hospital

Section 5 of the MCA (2005) allows actions to be taken to ensure a person who lacks capacity to consent receives necessary medical treatment. This could involve the person being taken to hospital for out-patient treatment or arranging for an admission to hospital. Section 5 provides protection from liability to a range of health and social care staff and also includes ambulance staff and police officers.

To receive protection from liability under section 5 all actions must be related to the care or treatment of the person who lacks capacity to consent. Before taking action there must be a reasonable belief that:

* The person lacks the capacity to make that particular decision at the time it needs to be made,

**and**

* The action is in the person’s best interests.

Wiltshire Police and South West Ambulance Service NHS Foundation Trust operate a locally agreed protocol that places the responsibility of the application of the MCA (2005) to take a person to hospital for medical assessment on the assessing Paramedic, wherever possible. The protocol is for the Police to offer a supporting role in case of any concerns regarding issues of safety. Wiltshire Police will apply the MCA (2005) to bring the person to the Great Western Hospital, Emergency Department in cases of urgent, immediate need for medical treatment and they are the only agency in attendance.

Police officers should where possible give advance notice of their intention to bring someone to hospital when they are acting under Section 5/Section 6 of the MCA (2005). When the person arrives and is received by Trust employees it becomes the responsibility of those emergency department employees to provide care and treatment for the person and to apply the MCA (2005) in relation to consent for this and any subsequent admission. Note that in a small number of cases negotiation might be necessary with the police officers as to how long they need to remain with the person whilst they are being admitted.

This care and treatment might include assessment of the person’s mental health and / or providing medical care. As part of these procedures it will be appropriate for Trust employees to carry out their own assessments of capacity re consent to care/ treatment and discharge and apply best interests as required.

It is important to stress that the person is not being ‘detained’ by Trust employees nor is the use of the MCA (2005) to be confused with Section 136 of the Mental Health Act 1983 (Ref 6). Receiving Trust employees should always ask the attending Police Officer to clarify whether they have used The Mental Health Act 1983 or The MCA (2005) which must be documented in the patient’s notes.

Unlike Mental Health Act 1983 sections there is no set period of time for which employees can keep someone in hospital under Section 5 of the MCA (2005). Employees will, instead, need to be able to justify:

a) why they believed that the person lacks capacity, and

b) why it was in their best interests to remain in hospital for treatment.

It will also be important to ensure that any restrictions placed on the person to provide safe care are reviewed and are in line with the principles of the MCA (2005) and where necessary appropriate authorised person is sought under the Deprivation of Liberty Safeguards (DOLS) (Ref 3).

Appropriate arrangements for the care and treatment of someone brought to hospital under Section 5/Section 6 of the MCA (2005) may involve assessment of the person’s mental health which may lead, as is the case for anyone else, to assessment for informal admission or for assessment under the Mental Health Act 1983.

# 3.12 Deprivation of Liberty Safeguards

DOLS ) is a legal provision which became law in April 2009. The safeguards are in addition to and part of the MCA (2005), they do not replace it.

These safeguards apply to people in hospitals and care homes registered under the Care Standards Act 2000(Ref 9) and apply to people in England and Wales.

The MCA (2005) Deprivation of Liberty Safeguards (2009) (MCA DOLS) exist to protect people who are not able to consent to decisions about their care and treatment when they need to be cared for in a particularly restrictive way. The Safeguards set out a standard process that hospitals and care homes should follow if they think it will be necessary to deprive a person of their liberty to deliver a particular care plan that is in the person’s best interests. By following the MCA DOLS, hospital and care home staff can ensure that people are deprived of liberty only when necessary and within the law.

The safeguards exist to provide a legal framework that upholds individuals’ rights under Article 5 of the Human Rights Act 1998 (Ref 8) and this affords individuals suitable protection in those circumstances where a deprivation of liberty appears to be unavoidable and is in their best interests.

The DOLS does this by providing:

* An authorisation and review process,
* A representative to act for the person and protect their interests,
* Rights of challenge to the Court of Protection against unlawful deprivation of liberty,
* Right to have the decision relating to the deprivation of liberty reviewed and monitored on a regular basis.

These safeguards do not apply to people detained under the Mental Health Act 1983.

On March 19th 2014 the Supreme Court handed down its judgement in the matter of P v Cheshire West and Chester Council and another and P and Q v Surrey County Council. Amongst the outcomes of this judgement was a revision of the test of what constitutes a deprivation of liberty, under the Deprivation of Liberty Safeguards (2009) to an “acid test”.

## 3.13 When Should a DOLS Application be considered?

The three acid test criteria for whether a deprivation of liberty is present are:

1. **The person lacks mental capacity to consent to be accommodated in the Trust’s care for the purpose of receiving care and treatment.**
2. **The person is subject to continuous supervision and control.**

**The following are potential indicators of Point 2 (continuous supervision and control) of the acid test:**

* How regularly does the person require support to meet their care needs i.e. throughout the day, throughout the night? (The higher the frequency the support is required to exercise the duty of care, the more they will be defined as receiving continuous supervision).
* How regularly does the person require supervision around their medical needs/treatment i.e. throughout the day, throughout the night? (The higher the frequency the support is required to exercise the duty of care, the more they will be defined as receiving continuous supervision).
* Consider what risk management plans are in place to maintain a safe environment for the person i.e. regular observations and supervisions from staff throughout the day and night to reduce risk of harm and maintain a safe environment (detail risks and level of restrictions)

Note: Continuous supervision could include – hourly checks, one to one (close support) support on a continuous or intermittent basis, the supervision of mobility/care tasks, the monitoring of falls. Further guidance on close support can be obtained via the Trust intranet (Ref 13).

1. **The person is not free to leave.**

This should not be assessed solely by whether a person may be actively seeking to leave or objecting to the stay but applies equally if the patient is fully compliant with care, treatment and restrictions. The test of whether to consider an application is to be based on the action the employees would need to take in order to prevent harm towards the patient should they try to leave. If this action would be to prevent them (in their best interests) from leaving to safeguard them from harm, an application should be made.

## What is a DOLS Authorisation?

* Where the acid test criteria are met a DOLS authorisation should be requested from the relevant supervisory body (Local Authority where the person resides).
* DOLS is a statutory process which involves a number of assessments carried out by the supervisory body to consider if a person has been deprived of their liberty.
* The managing authority (the Trust) makes the request for DOLS assessment to the supervisory body (Local Authority where the person resides).
* If the deprivation is already occurring, the managing authority can grant itself an urgent authorisation for a period of seven days, alongside an application for a standard authorisation which will commence the statutory process.
* If the supervisory body agrees that the person is being deprived in their best interests they will grant an authorisation to the hospital which legally allows the hospital to detain the person for a specified time.
* The Trust DOLS checklist (Acute and Community) can be found on the intranet for guidance on how to make a DOLS application and should be completed when making an application for DOLS and forwarded to the Safeguarding Adults Administrator and Safeguarding Adults Lead. Wiltshire Health and Care employees to refer to DOLS flowchart on Wiltshire Health and Care (WHC) intranet page.
* Completion of the Trust DOLS checklist is essential to ensure the Trust is compliant with the legal framework.

## 3.15 DOLS within Intensive Care

The Judgement Ferreira v Coroner of Inner South London (26.01.2017, ref14) relates to Intensive care settings and provides a positive approach to the issue around deprivation for people who require urgent or life sustaining treatment.

The Court of Appeal (in Ferreira v Coroner of Inner South London, 26 January 2017, per Lady Justice Arden) is clear that “…any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) of the Human Rights Act 1998 (ref 8) [the right to liberty] … so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose”. (Ref 14, para 89)

“The treatment must be given in good faith and is materially the same treatment as would be given to a person of sound mind with the same physical illness” (ref 14, para 93).

This means that the procedural safeguards of Article 5 are not triggered in those circumstances – in this case there is no need for a Deprivation of Liberty Safeguards referral.

In another context, the test for objective deprivation of liberty was set out as being “under continuous supervision and control and not free to leave” (the Supreme Court in Cheshire West). Arden LJ also said that the “not free to leave” element of the test requires that the patient themselves wants to leave but is being prevented by the state. This means that it is not met where the true reason for the patient not being able to leave is their underlying medical condition, or the essential treatment of it.

## 3.16 DOLS within a Domestic Setting

A deprivation of liberty may occur where the acid test criteria are met in a domestic setting such as supported living, adult placement/shared lives, domiciliary care and/or extensive informal or private care arrangements the deprivation of liberty safeguards cannot be used, so an application must be made to the Court of Protection.

If an employee becomes aware of a patient who meets the acid test requirements in a domestic setting they must contact the Safeguarding Adults Leads (Acute: 01793 607345, Wiltshire Health and Care: 07909 008 178) and/or Trust Legal Team (01793) 604928 for guidance.

## How do the MCA DOLS relate to the MCA (2005)?

The MCA DOLS do not replace other safeguards in the MCA (2005). Instead, any action taken under the MCA DOLS must be in line with the five key principles of the MCA (2005):

1. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he or she makes an unwise decision.
4. 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 his or her best interests.
5. Before the act is done, or the decision is made, regard must be made as 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.

The MCA DOLS permit the hospital or care home to detain the person only in a specific hospital or care home. It is important to understand that an MCA DOLS authorisation does not, in itself, authorise care or treatment. Any care or treatment still needs to be carried out under the wider ‘best interests’ provisions of the MCA (2005) and follow the five key principles of the MCA (2005).

More detailed information is available in the [Deprivation of Liberty Safeguards (DoLS and Mental Capacity Act) Policy](http://edrms/policiesandproceduraldocs/Policies/Deprivation%20of%20Liberty%20Safeguards%20(DoLS)%20Policy.docx) including the significant changes brought about by the Supreme Court Judgement 2014.

## 3.18 Trust Deprivation of Liberty Safeguards Process Checklist

A step-by-step process checklist must be completed and forwarded to the Mental Health Act and Safeguarding Adults at Risk Administrator by employees for each DOLS application made. The checklist can be found on the intranet and in Appendix E (Acute) Appendix F (Community) to this Policy. Wiltshire Health and Care Inpatient staff must follow the DoLS Flowchart and ensure that all authorisations requested are forwarded to the WHC Quality Team administrator.

## 3.19 Court of Protection

The Court of Protection works within agreed procedures and with nominated judges. The Court will make declarations, decisions and orders affecting people who lack capacity and will make decisions for or appoint deputies to make decisions on behalf of people lacking capacity. The Court will deal with decisions concerning serious medical treatment, property, affairs, health and welfare. The Court will participate in resolving complex or disputed cases. On occasions when a best interest decision required for a patient who lacks mental capacity cannot be reached by the application of the Best Interests Statutory Checklist, due either to the serious nature of the decision or the presence of objections or challenge (either from the patient or a party to the consultation), an application to the Court of Protection may be required to seek legal authority regarding the best interests decision. Employees should always seek guidance from the Trust’s Legal Team in these circumstances.

# 4 Protected Characteristics Provisions

The MCA is not limited to protected characteristics such as age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms possible, while still providing the required treatment and care.

The MCA allows people to express their preferences for care and treatment in case they lack capacity to make these decisions. It also allows them to appoint a trusted person to make a decision on their behalf should they lack capacity in the future.

# 5 Duties and Responsibilities of Individuals and Groups

## 5.1 The Trust Board

The compliance and Managing Authority (DOLS) responsibilities are held by the Trust Board and include assurance that systems and processes are in place and are effectively working to uphold the Trust’s legal and regulatory requirements. Wiltshire Health and Care arrangements are placed with Wiltshire Health and Care Board.

## The Chief Nurse

The Chief Nurse (as the designated Executive lead) has overall responsibility for the implementation of the MCA (2005). Wiltshire Health and Care overall responsibility is with the Head of Quality.

## Safeguarding Adults at Risk, MCA and DOLS Lead

The Acute Safeguarding Adults at Risk, MCA and DOLS Lead provides specialist support and advice on the day-to-day operations and strategic development of services and provides assurance to the Trust’s Mental Health Governance Committee on compliance with the MCA and DOLS, reporting any identified risks and makes recommendation on service improvement and redesign to the Deputy Director of Quality Governance and the Chief Nurse.

Wiltshire Health and Care’s Safeguarding Adults Lead provides specialist support and advice on the day-to day operations and strategic development of services and provides assurance to WHC Safeguarding Adults Board reporting any identified risks and makes recommendation on service improvement to the Head of Quality.

## Safeguarding Adults at Risk Administrator (including MCA (2005) and DOLS)

The Safeguarding Adults at Risk, MCA and DoLS Administrator receives the DoLS applications. The administrator will ensure that the number of applications and outcome of applications are recorded and presented to the Mental Health Governance Committee and external agencies (Care Quality Commission (CQC) and Clinical Commissioning Group (CCG)). The Mental Health Act and Safeguarding Adults at Risk Administrator also provides secondary support to the Safeguarding Adults at Risk Lead including MCA and DOLS. This function is undertaken by The Quality Team administrator in Wiltshire Health and Care. Data is reported through WHC’s Safeguarding Forum and Quality Assurance Committee.

## Divisional Directors of Nursing, Matrons, Ward Managers and Medical/Surgical Consultants

Ward Managers and Consultants should ensure that employees under their line management have received the Trust MCA DOLS training. Every registered Practitioner has a responsibility under their own professional codes to ensure their practice complies with the MCA (2005).

## On-Call Manager

To support employees in fulfilling their duties during out of working hours, weekend and bank holidays. To advise the Executive Director on-call of any cases that require referral to the Court of Protection. The Executive Director may wish to seek legal advice through the Trust’s Solicitors.

## Mental Health Governance Committee

The Mental Health Governance Committee is a sub-group of the Trust Board that provides assurance to the Board on compliance with its statutory and regulatory duties. This assurance function is provided by Safeguarding Forum and Quality Assurance Committee in Wiltshire Health and Care.

## Mental Health Governance Operational Group

To regularly review the Trust mental capacity systems and processes as well as delivery of service level agreement with mental health providers ensuring that the Mental Health Governance Committee are kept updated with progress and risk. This function is undertaken by Safeguarding Forum in Wiltshire Health and Care.

## Document Author and Document Implementation Lead

The document Author and the document Implementation Lead are responsible for identifying the need for a change in this document as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and resubmitting the document for approval and republication if changes are required.

## Target Audience – As indicated on the Cover Page of this Document

The target audience has the responsibility to ensure their compliance with this document by:

* Ensuring any training required is attended and kept up to date.
* Ensuring any competencies required are maintained.
* Co-operating with the development and implementation of policies as part of their normal duties and responsibilities.

# 6 Monitoring Compliance and Effectiveness of Implementation

The arrangements for monitoring compliance are outlined in the table below: -

| **Measurable policy objectives** | **Monitoring / audit method** | **Monitoring responsibility** (individual / group /committee) | **Frequency of monitoring** | **Reporting arrangements** (committee / group to which monitoring results are presented) | **What action will be taken if gaps are identified?** |
| --- | --- | --- | --- | --- | --- |
| All action taken in respect of patients subject to the MCA DOLS will be in accordance with the MCA (2005) and the procedures outlined in this policy. | Number of MCA DOLS applications.  Number applications granted or not granted.  Number of referrals to IMCA services  Number of complaints received in relation to application of the MCA DOLS | Safeguarding Adults at Risk Lead  Safeguarding Adults at Risk Lead  Safeguarding Adults at Risk Lead  Safeguarding Adults at Risk Lead | Bi-monthly  Quarterly | Mental Health Governance Committee Operational Group  Safeguarding Board in Wiltshire Health and Care  Mental Health Governance Committee  Quality Assurance Committee in Wiltshire Health and Care | If numbers are significantly lower than previous years a review of systems and processes may be required |
| Ensuring appropriate and sufficient training is available and promoted to give employees the knowledge and skills to comply with this policy. | Contents of training package adequate and up-to-date | Safeguarding Adults at Risk Lead  MH Governance Committee Operational Group  Safeguarding Board in Wiltshire Health and Care | Annual | Mental Health Governance Committee  Quality Assurance Committee in Wiltshire Health and Care | Action plan to achieve training compliance  Consider putting on the risk register |
| That the Trust mandatory training target of 80% compliance is reached | Training Tracker results | MH Governance Committee Operational Group  Safeguarding Board in Wiltshire Health and Care | Quarterly | MH Governance Committee Operational Group  Safeguarding Board in Wiltshire Health and Care | Add to the risk register. Advise Divisional Directors if they have any employees not up to date with training and the risks involved in lapsed training |
| External Reviews | Issues Identified by CQC and CCG Inspections and Quality Monitoring | MH Governance Committee Operational Group  Safeguarding Board in Wiltshire Health and Care | As required | Mental Health Governance Committee  Quality Assurance Committee in Wiltshire Health and Care | Action plan if required |

# 7 Review Date, Arrangements and Other Document Details

## 7.1 Review Date

This document will be reviewed every three years in accordance with the Trust’s agreed process for reviewing Trust wide documents.

## 7.2 Regulatory Position

Care Quality Commission.

## 7.3 References, Further Reading and Links to Other Policies

The following is a list of other policies, procedural documents or guidance documents (internal or external) which employees should refer to for further details:

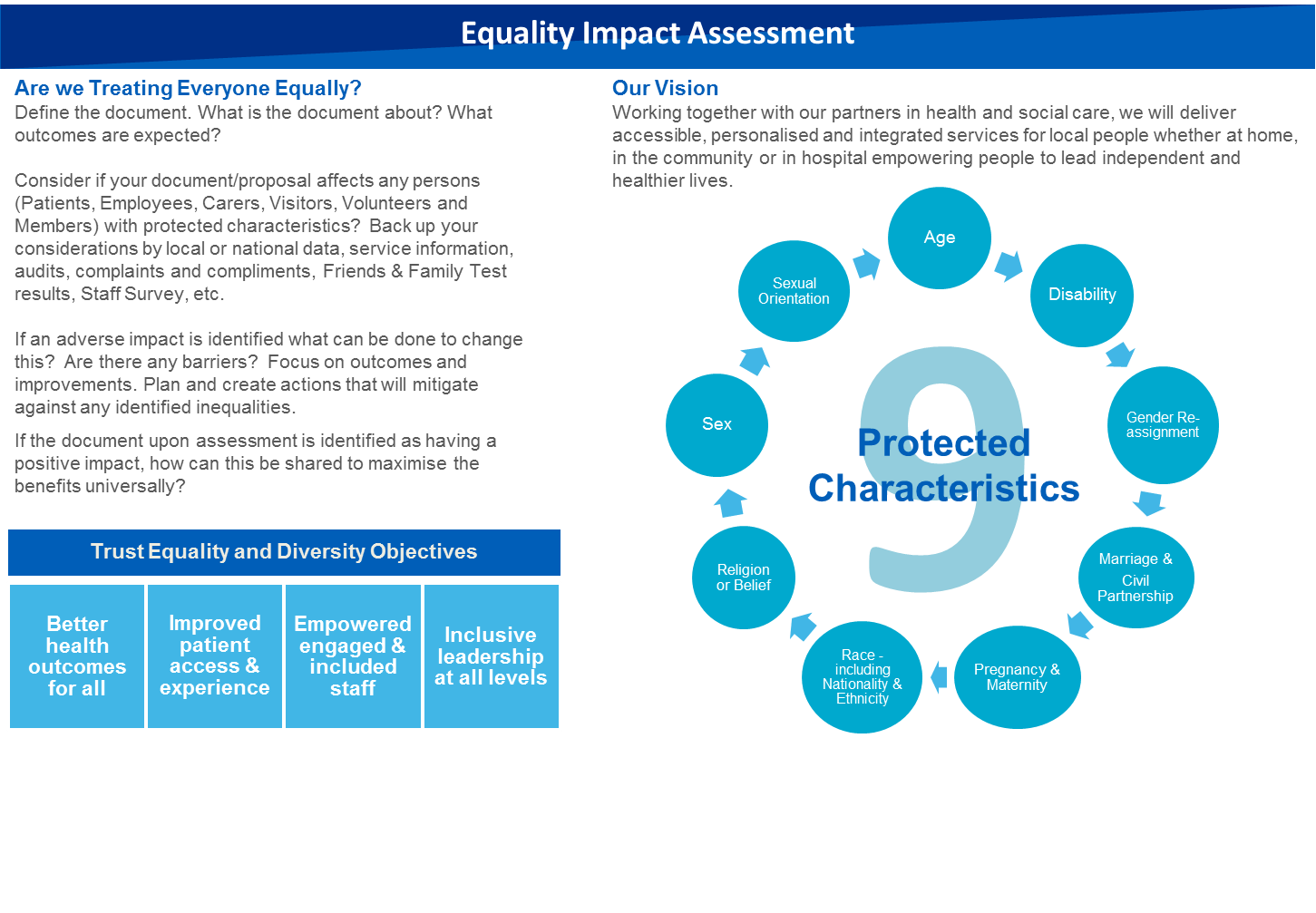
| **Ref. No.** | **Document Title** | **Document Location** |
| --- | --- | --- |
| 1 | Mental Capacity Act 2005 | [www.legislation.gov.uk](http://www.legislation.gov.uk) |
| 2 | Mental Capacity Act 2005 – Code of Practice | [www.gov.uk](http://www.gov.uk) |
| 3 | Mental Capacity Act 2005: Deprivation of liberty safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice | Now available online from the National Archives.  Hard copy available from the Mental Health Act Administrator |
| 4 | Additional Publications and Newsletters | [www.publicguardian.gov.uk](http://www.publicguardian.gov.uk) |
| 5 | Care Quality Commission | [www.cqc.org.uk](http://www.cqc.org.uk) |
| 6 | Section 136, Mental Health Act 1993 | [www.legislation.gov.uk](http://www.legislation.gov.uk) |
| 7 | [Deprivation of Liberty Safeguards (DoLS and Mental Capacity Act) Policy](http://edrms/policiesandproceduraldocs/Policies/Deprivation%20of%20Liberty%20Safeguards%20(DoLS)%20Policy.docx) | T:\Trust-wide Documents |
| 8 | Human Rights Act 1998 | [www.legislation.gov.uk](http://www.legislation.gov.uk) |
| 9 | Care Standards Act 2000 | [www.legislation.gov.uk](http://www.legislation.gov.uk) |
| 10 | Enduring Powers of Attorney Act, 1985 | [www.legislation.gov.uk](http://www.legislation.gov.uk) |
| 11 | Consent for Medical Treatment for All Patients at the Great Western Hospital Policy | T:\Trust-wide Documents |
| 12 | Positive Behaviour Management (Physical Restraint) in Clinically Violent and Aggressive Adults in- Patients Policy | T:\Trust-wide Documents |
| 13 | Close Support Standard Operational Procedure | <http://gwh-intranet/unscheduled-care/close-support.aspx> |
| 14 | R (Ferreira) v HM Senior Coroner for Inner South London and others | <http://www.39essex.com/cop_cases/r-ferreira-v-hm-senior-coroner-inner-south-london-others/> |

## 7.4 Consultation Process

The following is a list of consultees in formulating this document:

| **Job Title / Department** | **Date Consultee Agreed Document Contents** |
| --- | --- |
| Safeguarding Adults at Risk Lead, Wiltshire Health and Care Services | 22 May 2017 |
| Wiltshire Health and Care | 22 May 2017 |
| Independent Mental Capacity Advocate | 24 May 2017 |
| Mental Health Governance Committee Operational Group | 12 June 2017 |
| Sarah Canfield, Matron ICU | 17 July 2017 |

# Appendix A Equality Impact Assessment



# Appendix B - Quality Impact Assessment Tool

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Purpose -** To assess the impact of individual policies and procedural documents on the quality of care provided to patients by the Trust both in acute settings and in the community. | | | | | | |
| **Process -**The impact assessment is to be completed by the document author. In the case of clinical policies and documents, this should be in consultation with Clinical Leads and other relevant clinician representatives.  Risks identified from the quality impact assessment must be specified on this form and the reasons for acceptance of those risks or mitigation measures explained. | | | | | | |
| **Monitoring the Level of Risk -** The mitigating actions and level of risk should be monitored by the author of the policy or procedural document or such other specified person.  High Risks must be reported to the relevant Executive Lead. | | | | | | |
| **Impact Assessment**  Please explain or describe as applicable. | | | | | | |
| 1. | Consider the impact that your document will have on our ability to deliver high quality care. | The policy will facilitate Trust compliance with MCA (2005) and uphold patients rights under the MCA (2005). | | | | |
| 2. | The impact might be positive (an improvement) or negative (a risk to our ability to deliver high quality care). | Positive, empowering and safeguarding response to decision making. | | | | |
| 3. | Consider the overall service - for example: compromise in one area may be mitigated by higher standard of care overall. | | | | Must be applied Trustwide. | |
| 4. | Where you identify a risk, you must include identify the mitigating actions you will put in place. Specify who the lead for this risk is. | | | MCA (2005) Assurance Framework and Action Plan. Lead: MH Governance Committee. | | |
| **Impact on Clinical Effectiveness & Patient Safety** | | | | | | |
| 5. | Describe the impact of the document on clinical effectiveness. Consider issues such as our ability to deliver safe care; our ability to deliver effective care; and our ability to prevent avoidable harm. | | To facilitate the legal framework re decision making, which includes upholding patients rights to make capacitated unwise decisions. This may impact on the ability to deliver safe care or prevent avoidable harm. | | | |
| **Impact on Patient & Carer Experience** | | | | | | |
| 6. | Describe the impact of the policy or procedural document on patient / carer experience. Consider issues such as our ability to treat patients with dignity and respect; our ability to deliver an efficient service; our ability to deliver personalised care; and our ability to care for patients in an appropriate physical environment. | | | | | The Policy and Procedure facilitates person centred care. |
| **Impact on Inequalities** | | | | | | |
| 7. | Describe the impact of the document on inequalities in our community. Consider whether the document will have a differential impact on certain groups of patients (such as those with a hearing impairment or those where English is not their first language). | | | | | - |

# Appendix C – GWH Mental Capacity Assessment (Two Stage Test)



Addressograph

**Mental Capacity Act 2005**

This assessment is designed to record the process followed when assessing a person’s consent to (or refusal of) a proposed treatment or management plan and should be used to record the assessment of any specific decisions required.

**Patient name (please print)**……………………………………………**Unit Number**…………………….

**Ward**……………………………………………………………**Name of Assessor**…………………………

**Role/Title**…………………………………………………………………………………………………………

**What prompted this capacity assessment (brief summary of relevant history)**

**This patient being assessed may require close support due to the following issues (insert details below)**

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

What is the specific decision to be taken?

**There are 2 specific decisions being assessed**:

1. **Can the person consent to being accommodated at GWH for the purpose of receiving care and treatment**
2. **Can the Patient consent to the proposed Close Support Care Plan**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **STAGE ONE** |  | **YES** |  | **NO** |
| Is there an impairment of, or disturbance in the functioning of the person’s  mind or brain? |  |  |  |  |
| Is this of a nature or degree which might be sufficient to affect their capacity  for this decision? |  |  |  |  |

Please give details ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….……………………………………………………………………………………………………………………………………………………………………………………………

***NB: IF THERE IS A NO ANSWER DO NOT PROCEED TO STAGE 2, RECORD SUMMARY, SIGN, DATE AND PLACE ON PATIENT’S FILE.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **STAGE TWO** |  | **YES** |  | **NO** |
| Is the person able to understand the information relevant to the decision? |  |  |  |  |
| Is this of a nature or degree which might be sufficient to affect their capacity  for this decision? |  |  |  |  |

Please record details (Ensure you have provided the person with sufficient relevant information and that

this is included in your consideration of the person’s understanding. Ensure you have presented the

information in ways which can enhance the person’s likelihood of understanding)

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Decision 1- The Patient’s close support risk assessment outcome was discussed with them, including the level of observation and care plan required to meet this.** |  | **YES** |  | **NO** |
| The Patient demonstrated the ability to understand this information |  |  |  |  |
| The Patient did not understand this information |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Decision 2- The Patient’s current Treatment and Care Plan was discussed with them.** |  | **YES** |  | **NO** |
| The Patient demonstrated the ability to understand this information |  |  |  |  |
| The Patient did not understand this information |  |  |  |  |

**Please add any additional comments re the Patient’s understanding of the information about the decisions being assessed**

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….…………………………………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| Can the person retain the information for long enough to reach a decision? |  |  |  |  |

*(Ensure you have presented the information in ways which can enhance the person’s likelihood of retaining the information)*

Please record details

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….……

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Decision 1- The Patient’s close support risk assessment outcome was discussed with them, including the level of observation and care plan required to meet this.** |  | **YES** |  | **NO** |
| The patient demonstrated the ability to retain this information for a sufficient  period |  |  |  |  |
| The patient was not able to retain this information for a sufficient period |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Decision 2- The Patient’s current Treatment and Care Plan was discussed with them.** |  | **YES** |  | **NO** |
| The patient demonstrated the ability to retain this information for a sufficient  period |  |  |  |  |
| The patient was not able to retain this information for a sufficient period |  |  |  |  |

**Please add any additional comments re the Patient’s understanding of the information about the decisions being assessed**

Please record details

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| Can the person use or weigh the information as part of the process of  reaching a decision? |  |  |  |  |

Please record details

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….…………………………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Decision 1- The patient’s close support risk assessment outcome was discussed with them, including the level of observation and care plan**  **required to meet this. This should detail the advantages and**  **disadvantages of the required care** |  | **YES** |  | **NO** |
| The patient demonstrated the ability to use and weigh this information to enable  decision making |  |  |  |  |
| The patient was not able to use and weigh this information to enable decision making |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Decision 2- The patient’s current treatment and care plan was discussed**  **with them. This should detail the advantages and disadvantages**  **of the proposed care and treatment plan.** |  | **YES** |  | **NO** |
| The Patient demonstrated the ability to use and weigh this information to enable  decision making? |  |  |  |  |
| The Patient was not able to use and weigh this information to enable decision making? |  |  |  |  |

**Please add any additional comments re the Patient’s understanding of the information about the decisions being assessed**

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….………………………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| Can the person communicate their decision by any means? |  |  |  |  |

Please record details

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|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| The Patient was able to communicate their decision re decision 1 |  |  |  |  |
| The Patient was not able to communicate their decision re decision 1  by any means |  |  |  |  |
| The Patient was able to communicate their decision re decision 2 |  |  |  |  |
| The Patient was not able to communicate their decision re decision 2  by any means |  |  |  |  |

**Please add any additional comments re the Patient’s communication**

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….…

***NB IF THE PERSON IS ASSESSED AS ‘NO’ FOR ANY OF THE SECOND STAGE DOMAINS THEY WILL LACK CAPACITY FOR THE SPECIFIC DECISION AND THE BEST INTEREST DECISION RECORD SHOULD BE COMPLETED. IF ALL THE DOMAINS ARE ASSESSED AS YES THE PERSON IS CAPACITATED RE THE DECISION AND THE ASSESSOR SHOULD COMPLETE THE ASSESSMENT SUMMARY ONLY, SIGN AND DATE AND PLACE ON PATIENT’S FILE.***

**CAPACITY ASSESSMENT SUMMARY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| It is the reasonable belief of the assessor that the patient has capacity to consent to be accommodated at the Great Western Hospital for the purpose of receiving care and treatment including close support. |  |  |  |  |
| It is the reasonable belief of the assessor that the patient lacks the mental capacity to consent to be accommodated at the Great Western Hospital for the purpose of receiving care and treatment, including close support. |  |  |  |  |

**Please add any additional comments re the patient’s communication**

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….………………………………………………………………

**Name (Please print)**……………………………………………………………………………………………………

**Role/JobTitle**………………………………………………………………………**Date**……………………………..

**Signature** ……………………………………………………………………………………………………………….

*Please ensure copy is placed on patient’s file.*

# Appendix D– GWH Best Interest Decision Record



Addressograph

**BEST INTEREST DECISION RECORD**

In making a best interest decision you must not be influenced merely by the person’s age, appearance, any condition of the person or by any aspect of the person’s behaviour which might lead to unjustified assumptions about the person’s best interests.

**Patient name (please print)**…………………………………………………**Unit Number**……………….

**Ward**………………………………………………………………………………………………………………

**What is the specific decision to be made?**

**The specific decisions to be made** - *Should the patient be accommodated at Great Western Hospital for the purpose of receiving care and treatment, including Close Support Care?*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Query** | |  | **YES** |  | **NO** |
| Will the person regain the capacity to make this decision? | |  |  |  |  |
| If so when (approx. date) | Date: |  |  |  |  |
| Will this be soon enough to wait for their decision? | |  |  |  |  |
| Decision delayed as Capacity to be reassessed within 24 hours | |  |  |  |  |
| Decision delayed as Capacity to be reassessed within 48 hours | |  |  |  |  |
| Decision delayed as Capacity to be reassessed within 72 hours | |  |  |  |  |
| Decision not delayed | |  |  |  |  |
| Has everything “reasonably practicable” been done to encourage the person’s participation? | |  |  |  |  |
| Has everything “reasonably practicable” been done to improve his/her ability to participate as fully as possible? | |  |  |  |  |
| Do any of the elements of this decision relate to life sustaining treatment? | |  |  |  |  |
|  | |  |  |  |  |
| **So far as is reasonably practicable has consideration been given to:** | |  | **YES** |  | **NO** |
| * The person’s past and present wishes and feelings (including any written statement given by the person)? | |  |  |  |  |
| * The beliefs and values that would have influenced his/her decision if he/she had capacity? | |  |  |  |  |
| * Other factors that he/she would be likely to consider if able to do so? | |  |  |  |  |

**What is known to be the most important to the person regarding this decision?**

Record relevant details here -…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Have the views of the following, if it is practicable and appropriate to consult them, been taken into account as to what would be in the person’s best interests:** |  | **YES** |  | **NO** |
| Anyone named by the person as someone to be consulted on the matter in question or of that kind? |  |  |  |  |
| The beliefs and values that would have influenced his/her decision if he/she had capacity? |  |  |  |  |

Please record name, role and details of their views (if no document why)

**Name**…………………………………………………….**.Role**………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| Anyone engaged in caring for the person or interested in his welfare? |  |  |  |  |

Please record name, role and details of their views (if no document why)

**Name**…………………………………………………….**Role**………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| Does the patient have a Lasting Power of Attorney for Health and Welfare decisions |  |  |  |  |

Ensure this document has been seen and verified as being registered.

Please record name, role and details of their views (NB any registered Attorney will become the decision maker)

**Name**……………………………………………………..**Role**…………………………………………………………………………..………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| Any deputy appointed for the person by the Court of Protection? |  |  |  |  |

Ensure this document has been seen and verified as being registered

Please record name, role and details of their views NB any registered deputy will become the decision maker)

**Name**……………………………………………………..**Role**………………………………………………….

………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| Any Advocate/IMCA? |  |  |  |  |

Please record name and details of their views

**Name**………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| Any professionals involved or consulted |  |  |  |  |

Please records name/s, role/s and details of their views

**Name……………………………………………………..Role**…………………………………………………

……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………..

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Query** |  | **YES** |  | **NO** |
| Does an advance refusal of treatment exist |  |  |  |  |
| Is it relevant to this decision? |  |  |  |  |
| Can the care be done in a less restrictive way? |  |  |  |  |
| Have all other relevant circumstances been considered? |  |  |  |  |

Considering all relevant factors what is the Best Interest Decision reached by the Decision Maker

**I am the decision maker and have considered all the above relevant factors and conclude that the current care and treatment plan for this patient is of the least restrictive nature and it is in their Best Interests to be accommodated at Great Western Hospital in order to receive this.**

**Name (Please print)…………………………………………Job Title………………………………………**

**Date** ………………………………

**Signature of Decision Maker**……………………………………………………………………………….

*Please ensure copy is placed on patient’s file.*

# Appendix E - GWH DOLS Checklist

Great Western Hospitals NHS Foundation Trust

Mental Capacity Act 2005

**Application for Deprivation of Liberty Safeguards (DOLS)**

Check List -

**Guidance on criteria for application for DOLS can be found overleaf**

**Patient name (please print**)…………………………………. …..**Hospital Number**………………………

**Ward/Dept**…………………………………………………………………………………………………………

**Date of Application)**………………………………………**Time of Application**…………………………….

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **QUERY** |  | **YES** |  | **NO** |
| **Do you have the correct form for the Application:** |  |  |  |  |
| **First application: Form 1 Urgent and Standard Authorisation (7 days for urgent authorisation)** |  |  |  |  |
| **Exemplar A:** Not Medically Fit |  |  |  |  |
| **Exemplar B:** Delayed Discharge |  |  |  |  |
|  |  |  |  |  |
| **Have you completed a two stage Mental Capacity Assessment?** |  |  |  |  |
| **Have you completed a Best Interest Decision Record?**  If the patient is un-befriended consider referral to IMCA service. |  |  |  |  |
|  |  |  |  |  |
| **Have you discussed application and given information leaflets to:** |  |  |  |  |
| 1. Patient |  |  |  |  |
| 1. Patients family |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Have you signed and dated application form? NAME MUST BE IN SIGNATURE AND PRINT NAME - if not completed urgent authorisation will not be legal and standard application will not be accepted.** | |  |  |  |  | |
| **Have you printed out care plan and relevant background information** | |  |  |  |  | |
| **Have you contacted the relevant Supervisory Body to inform them you areEmailing/faxing application papers and care plan/information?**  **(email preferred)** | |  |  |  |  | |
| **Have you logged application in Medway clinical note on the electronic whiteboard. Enter date and time of application. Remember to update i.e. extension date.** | |  |  |  |  | |
| **Which Supervisory Body to contact?** Check the address of the patient and contact the following service:   |  |  |  |  | | --- | --- | --- | --- | | **Deprivation of Liberty Safeguards in South West SERVICE DETAILS** | | | | | **AREA** | **TELEPHONE** | **EMAIL** | **FAX** | | SWINDON  **GWH secure email to swindon.gov.uk** | Tel: 01793 463239 | [dols@swindon.gov.uk](mailto:dols@swindon.gov.uk) | **(email preferred)**  Fax: 01793 465866 | | WILTSHIRE  **GWH secure email to wiltshire.gov.uk** | Tel: 01225 756598 | [DOLS@wiltshire.gov.uk](mailto:DOLS@wiltshire.gov.uk) | **(email preferred)**  Fax: 01225 718274 | | WEST BERKSHIRE | Tel: 01635 519056 |  | Fax: 01635 519939 | | BATH & NE SOMERSET | Tel: 01225 396187 |  | Fax: 01225 831326 | | GLOUCESTERSHIRE | Tel: 01452 426005 |  | Fax: 01452 427359 | | OXFORDSHIRE | Tel: 01865 328064 |  | Fax: 0845 641 6416 | | | | | | | | | | |
|  | | **Please indicate the Supervisory Body you have faxed/emailed the application to:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Swindon** |  | **Wiltshire** |  | **Other- please specify** |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **QUERY** |  | **YES** |  | **NO** | | **Has the Supervisory Body confirmed receipt of application papers?**  ***YOU WILL RECEIVE WRITTEN ACKNOWLEDGEMENT FROM THE***  ***SUPERVISORY BODY*** |  |  |  |  | | **Have you emailed the application papers to the Mental Health Act and Safeguarding Adults Team email:** [safeguardingadultsteam@gwh.nhs.uk](mailto:safeguardingadultsteam@gwh.nhs.uk) (displays as Safeguarding.AdultsTeam on internal recipients)  **Fax: 01793 605197** **Tel: 01793 607345 / 604538** |  |  |  |  | | **Have you emailed your Safeguarding Lead to inform them of the application?** |  |  |  |  | | **Have you contacted the Site Manager to inform them of the application?** |  |  |  |  | |  |  |  |  |  | | **QUERY** |  | **DATE** | | | | **The Urgent Authorisation will expire at the end of the day on:**  *7 days from the date of the application (include the date of the application as day 1)* ***Inform the Supervisory Body by Day 7 the urgent is due to expire*.** |  |  | | | | **EXTENSION TO URGENT AUTHORISATION::** |  |  | | | | **Date Extension to Urgent Authorisation made to Supervisory Body** |  |  | | | | **The Extension to the Urgent Authorisation will expire at the end of day on:***7 days from the date when the urgent extension application was made (include day 7)* ***Inform the Supervisory Body by Day 14 the urgent extension is due to expire*** |  |  | | | | | | | |  | |  |

**LAPSE OF EXTENSION TO URGENT AUTHORISATION:** the patient continues to be potentially deprived of their liberty in their best interests but the statutory assessment process for the standard authorisation has not taken place.

* Ensure that the least restrictive option for patient is in place.
* Ensure an update to 2 stage mental capacity assessment is in place.
* Ensure an update to best interest record is in place.
* Ensure the patient’s care plan has been updated accordingly.

If the patient’s condition changes, please contact the Supervisory Body to address priority of patient assessment.

**If you have answered NO to any of the questions please state the reason why.**

**Signed** ………………………………………………………..**date**……………………….**time**…………………………

**Print Name**………………………………………………………………………………………………………………

**When completed, this form MUST be emailed with the DOLS application papers to the Safeguarding Adults Team (**[safeguardingadultsteam@gwh.nhs.uk](mailto:safeguardingadultsteam@gwh.nhs.uk)**)**

**Fax Number: 01793 605197 Tel: 01793 607345 / 604538**

|  |  |
| --- | --- |
| **Guidance on criteria for application for Deprivation of Liberty Safeguards (DOLS)**  **The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS)** introduced in 2009 a legal framework to prevent unlawful deprivation of liberty by protecting people aged 18 and over who lack capacity to make decisions about staying in hospital for care and treatment when they may need to be cared for in a particularly restrictive way. This may apply for example, when a patient experiences dementia, a stroke, a learning disability or delirium that affects their ability to make particular decisions. The Deprivation of Liberty Safeguards set out a standard process that hospitals and care homes should follow if they think it will be necessary to deprive a person of their liberty for the purpose of giving care or treatment.  **The legal thresholds for considering if a patient who is not capacitated re their care and treatment may be being deprived of their liberty is now as follows:** | |
| **Is the patient subject to continuous supervision and control?**  *This has not been clearly defined by the Supreme Court and could be as low as the care and support required to meet the needs of the patient and keep them safe whilst in our care. This could include hourly checks, 1:1 support on a continuous or intermittent basis and the supervision of mobility/care tasks* | **Is the patient free to leave?**  *This should not be assessed solely by whether a patient maybe actively seeking to leave or objecting to the stay but applies equally if the patient is fully compliant with care, treatment and restrictions. The test of whether an application be considered is to* *be based on the action the staff would need to take in order to prevent harm towards the patient should they try to leave. If this action would be to prevent them (in their best interests) from leaving to safeguard them from harm an application should be made.* |
| **All care plans developed for patients who lack capacity re their care and treatment should be written following a best interest process and be of the least restrictive nature to a patient’s autonomy and freedoms.** | |

# Appendix F - Wiltshire Health and Care Mental Capacity Assessment

**Mental Capacity Act 2005**

**MENTAL CAPACITY ASSESSMENT (TWO STAGE TEST)**



Addressograph

This assessment is designed to record the process followed to ensure compliance with the Mental Capacity Act (2005) when there is the potential eligibility for the Patient to be detained under the Deprivation of Liberty Safeguards

|  |
| --- |
| Patient Name:  Ward and Community Hospital:  Name of Assessor: Role/Title: |

What prompted this capacity assessment (Brief summary of relevant history)

|  |
| --- |
|  |

What is the specific decision to be taken?

|  |
| --- |
| **Below is the decision you are assessing on:**  **Can the patient make an informed decision about being accommodated at the above hospital for the purpose of receiving care and treatment.** |

**STAGE ONE**

Is there an impairment of, or disturbance in the functioning of the person’s mind or brain? Yes No

Is this of a nature or degree which might be sufficient to affect their capacity for this decision? Yes No

Please give details

|  |
| --- |
| Please record evidence here of the type and effect of the Patient’s impairment of the mind or brain. Include information about how this might disrupt the Patient’s decision making. |

**NB: IF THERE IS A NO ANSWER DO NOT PROCESS TO STAGE 2, RECORD SUMMARY, SIGN, DATE AND PLACE ON PATIENTS FILE**



Addressograph

**STAGE TWO**

Is the person able to understand the information relevant to the decision? Yes No

Please record details (Ensure you have provided the person with sufficient relevant information and that this is included in your consideration of the person understanding. Ensure you have presented the information in ways which can enhance the person’s likelihood of understanding)

|  |
| --- |
| **The Patient’s current Treatment and Care Plans were discussed with them.**  The Patient demonstrated the ability to understand this information  The Patient did not understand this information  **You must provide evidence here as the assessor of how you came to this outcome**   1. **Details of the relevant care, treatment and support plans** 2. **Consequences and risks of objecting or not giving consent to care and treatment plans.** |

Can the person retain the information for long enough to reach a decision? Yes No

(Ensure you have presented the information in ways which can enhance the person’s

likelihood of retaining the information)



Addressograph

Please record details

|  |
| --- |
| **The Patient’s current Treatment and Care Plans as tested above was assessed in relation to the Patient’s ability to retain the salient points to enable decision making.**  The Patient demonstrated the ability to retain this information for a sufficient period  The Patient was not able to retain this information for a sufficient period  **You must provide evidence here as the assessor of how you came to this outcome** |

Can the person use or weigh the information as part of the process of reaching   
a decision? Yes No

Please record details

|  |
| --- |
| **The Patient’s current Treatment and Care Plans tested above was assessed in relation to the Patient’s ability to use and weigh this information to inform and enable decision making**  The Patient demonstrated the ability to use and weigh this information to enable decision making  The Patient was not able to use and weigh this information to enable decision making  **You must provide evidence here as the assessor of how you came to this outcome** |

Addressograph

Can the person communicate their decision by any means? Yes No

lease record details

|  |
| --- |
| **The Patient was able to communicate their decision**  **The Patient was not able to communicate their decision**  **You must provide evidence here as the assessor of how you came to this outcome** |

***NB IF THE PERSON IS ASSESSED AS ‘NO’ FOR ANY OF THE SECOND STAGE DOMAINS THEY WILL LACK CAPACITY FOR THE SPECIFIC DECISION AND THE BEST INTEREST DECISION RECORD SHOULD BE COMPLETED. IF ALL THE DOMAINS ARE ASSESSED AS YES THE PERSON IS CAPACITATED RE THE DECISION AND THE ASSESSOR SHOULD COMPLETE THE ASSESSMENT SUMMARY ONLY, SIGN AND DATE AND PLACE ON PATIENT’S FILE.***



Addressograph

Capacity assessment summary (Please tick the below

Applicable assessment summary as documented below)

|  |
| --- |
| 1. **It is the reasonable belief of the assessor that the Patient is able to make an informed decision about the care and treatment they receive.** 2. **It is the reasonable belief of the assessor that the Patient is not able to make an informed decision about the care and treatment they receive.**   **If summary 1 has been selected the Patient’s decision should be recorded below;**  **If summary 2 has been selected a Best Interest Decision Record must now been completed to record a Best Interest Decision for this Patient.** |

|  |
| --- |
| Signature: ....................................................................... Date: ..............................................  Name: (Please print).......................................................  Role/Title: (please print).................................................... |

# Appendix G - Wiltshire Health Care Best Interest Decision Record

**Mental Capacity Act 2005**

Addressograph

This Best Interest Decision Record should be completed following the assessment of a lack of capacity (2 stage Capacity assessment) in relation to informed decisions about admission and inpatient stay and informed decisions about care and treatment being received whilst an inpatient.

This record should be completed to evidence compliance with the Mental Capacity Act (2005) in relation to any potential application made under the Deprivation of Liberty Safeguards.

In making a best interest decision you **must not** be influenced **merely** by the person’s age, appearance, any condition of the person or by any aspect of the person’s behaviour which might lead to unjustified assumptions about the person’s best interests.

|  |
| --- |
| Patient Name:  Ward and Community Hospital |

What is the specific decision to be made?

|  |
| --- |
| **The specific decisions to be made are:**  **Is it in the Patient’s best interest to be accommodated on the above named ward at the above named hospital for the purposes of receiving care, treatment and support?**  **Is it in the best interests of the Patient to receive the care, treatment and support plans assessed as appropriate to meet the Patient’s needs?** |

Will the person regain the capacity to make these decisions themself?

|  |
| --- |
| Yes the Patient may regain capacity to make these decisions themself  **You must provide evidence of how you have arrived at this outcome**  No the Patient is not likely to regain capacity to make these decisions themself  **You must provide evidence of how you have arrived at this outcome** |



Addressograph

|  |
| --- |
| **Outcome**  Decision delayed as Capacity to be reassessed within 24 hours…  Decision delayed as Capacity to be reassessed within 48 hours  Decision delayed as Capacity to be reassessed within 72 hours  Decision not delayed |

What is known to be the most important to the person regarding this decision?

Record relevant Details here:

|  |
| --- |
| **In accordance with the Best Interest Statutory checklist it is important to encourage the participation of a Patient who has been assessed as lacking capacity in all aspects of decision making. Please record here any stated views made by the Patient.** |

Does the Patient have a Lasting Power of Attorney or Deputyship Order for Health and Welfare decisions (“registered powers”)?

|  |
| --- |
| Yes  No  If no proceed to next section  **Ensure this document has been seen and verified as being registered.**  **Record here the decision made by the Attorney or Deputy;**   1. **The registered Decision Maker has decided that it is in the Patient’s best interests to be accommodated on the ward stated above in the Community Hospital stated above for the purpose of receiving care, treatment and support.** |



Addressograph

**The Decision Maker has decided on review of the relevant care, treatment and support plans that these are in the Patient’s best interests to promote healing, recovery and safety.** 

**2. The registered Decision Maker has decided that it is not in the Patient’s best interests to be accommodated on the ward stated above in the Community Hospital stated above for the purpose of receiving care, treatment and support. The Decision Maker has decided on review of the relevant care, treatment and support plans that these are not in the Patient’s best interests to promote healing, recovery and safety.** 

|  |
| --- |
| **Please record any relevant information here re how the registered power has arrived at this decision.**  **If summary 2 is selected discharge planning processes should be convened as soon as possible. If there are any concerns that there is not clear rationale in accordance with the Mental Capacity Act (2005) Code of practice as to how the decision maker has arrived at the best interest decision contact Safeguarding Adults Lead for guidance.** |

***Have the views of the following, if it is practicable and appropriate to consult them, been taken into account as to what would be in the person’s best interests re these decisions:***

|  |
| --- |
| **Please record any relevant information here re how the registered power has arrived at this decision.**  **If summary 2 is selected discharge planning processes should be convened as soon as possible. If there are any concerns that there is not clear rationale in accordance with the Mental Capacity Act (2005) Code of practice as to how the decision maker has arrived at the best interest decision contact Safeguarding Adults Lead for guidance.** |



Addressograph

***Have the views of the following, if it is practicable and appropriate to consult them, been taken into account as to what would be in the person’s best interests re these decisions:***

Anyone named by the person as someone to be consulted on the matter in question  
or of that kind? Yes No

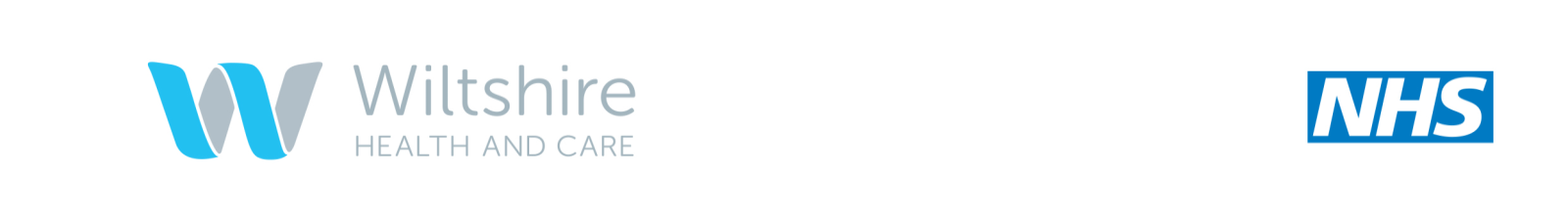
Please record name, role and details of their views *(if ‘No’ document why)*

|  |
| --- |
|  |

Anyone engaged in caring for the person or interested in his welfare? Yes No

Please record name, role and details of their views *(if ‘No’ document why)*

|  |
| --- |
|  |



Addressograph

Any Advocate/IMCA? Yes No

Please record name and details of their views

|  |
| --- |
|  |

Any professionals involved or consulted? Yes No

Please records name/s, role/s and details of their views

|  |
| --- |
|  |



Addressograph

|  |
| --- |
| Does an advance refusal of treatment exist?  Yes  No    If yes has it been seen and verified and is it relevant to this decision record details. If you are not sure of validity seek guidance from Safeguarding Lead/the organisations Legal team. |

|  |
| --- |
| Can the care be done in a less restrictive way? Record details here:  Have all relevant circumstances been considered? Record details here: |

Addressograph



Record the Best Interest Decision reached below

Considering all relevant factors what is the Best Interest Decision reached by the Decision Maker

|  |
| --- |
| **Summary 1. I am the decision maker and have considered all the ascertainable relevant factors and conclude that it is my reasonable belief that it is in the Patient’s best interests to** **be accommodated on the ward stated above in the Community Hospital stated above for the purpose of receiving care, treatment and support. I am the Decision maker and on review of the relevant care, treatment and support plans consider these are in the Patient’s best interests to provide care, promote healing, recovery and safety. These decisions will be reviewed during the duration of the Patient’s inpatient stay in line with Principle 4 and 5 of the Mental Capacity Act (2005)**    **Summary 2. I am the decision maker and have considered all the ascertainable relevant factors and conclude that it is my reasonable belief that it is not in the Patient’s best interests to be accommodated on the ward stated above in the Community Hospital stated above for the purpose of receiving care, treatment and support. I am the Decision maker and on review of the relevant care, treatment and support plans consider these are not in the Patient’s best interests to provide care, promote healing, recovery and safety.** |

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| **If summary 1 is selected an urgent and standard DoLS application (combined form 1 and 4) now needs to be made. Follow the DoLS flowchart for guidance.**  **If summary 2 has been selected the Patient’s capacity re discharge arrangements will now need to be assessed and a Best Interest meeting/discharge planning meeting should be convened asap to ascertain discharge planning.** |

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| Signature of Decision Maker  Date  Name (Please print)  Job Title |

Please ensure copy is placed on patient’s medical notes.

# Appendix H Wiltshire Health Care DoLS Flowchart

**DEPRIVATION OF LIBERTY SAFEGUARDS FLOWCHART**

**Contact supervisory body/WHC Safeguarding Lead if patient distressed or actively trying to leave to ensure priority for authorisation**

Complete a best interest decision record about inpatient stay

Complete two stage mental capacity assessment on the decision can the patient consent to be accommodated for care and treatment

**IS THE PATIENT SUBJECT TO CONTINUOUS SUPERVISION AND CONTROL?**

Ward to notify PSQ team if patient deceased/discharged/transferred after standard process

Ward to notify PSQ team if patient deceased/discharged/transferred prior to statutory process

Do not apply for further extension - *the supervisory body no longer process these applications*

Ward to Complete IR1 and record in patient’s notes to evidence that no statutory process completed within 7 days. Patient to continue to be treated under MCA. Ward should be notified by supervisory body of date that statutory commences - ward to notify PSQ of this date and outcome of the standard authorisation

PSQ team to notify CQC

PSQ team to monitor application and inform the supervisory body by day 5 that the urgent is due to expire; c.c. wards

Contact the relevant supervisory body to inform them you are emailing application papers and care plan/information

[dols@wiltshire.gov.uk](mailto:dols@wiltshire.gov.uk)

Ensure that you email the application papers to the PSQ team?

*Only electronic forms to be completed, no paper based or faxed referrals. Ensure that Kat Hitch, Trish Kidley and Kayleigh Gullis are copied in*

Has the supervisory body confirmed receipt of application papers? *Always obtain a read receipt on your e-mail to maintain audit trail*

Ensure the papers signed and dated

Print out care plan and relevant background information

Ensure you discuss the application and give information leaflets to the patient and/or the patient’s family/significant other

Complete the correct forms for the application

*Form 1 urgent and form 4 standard authorisation (7 days for urgent authorisation)*

The care and support required to meet the needs of the patient and keep them safe whilst in our care. This could include hourly checks; 1:1 support on a continuous or intermittent basis; use of sedation to ease agitation and the supervision of mobility/care tasks.

**IS THE PATIENT FREE TO LEAVE?**

This should not be assessed solely by whether a patient may be actively seeking to leave or objecting to the stay, but applies equally if the patient is fully compliant with care, treatment and restrictions. The test of whether an application should be considered is to be based on the action the staff would need to take in order to prevent harm towards that patient should they try to leave. If this action would be to prevent them (in their best interests) from leaving to safeguard them from harm an application should be made.

An urgent (Form 1) is an authorisation given by a managing authority (the Trust) for a maximum of 7 days. This gives the managing authority lawful authority to deprive a person of their liberty in hospital while the statutory assessment process is undertaken to authorise the standard (FORM 4) – is the application for a Standard Authorisation. Please note Forms 1 and 4 are now combined

Before considering if a Patient is being deprived of their liberty in the Trust’s care it is essential that the Patient is established to be lacking in capacity to make informed decisions about being accommodated for the purpose of receiving care and treatment and that this inpatient stay and the care and treatment that they are receiving is in their Best Interests. When making an application for DoLS, Forms 1 and 4 need to be completed.

**EXPIRATION OF URGENT AUTHORISATION**

The patient continues to be potentially deprived of their liberty in their best interests but the statutory assessment process for the standard authorisation has not taken place

* Complete an IR1 complete MCA/DoLS button
* Suggested wording for IR1 Patient lacks capacity to consent to being accommodated for the purpose of receiving care and treatment and meets the Acid test. An Urgent authorisation was in place this expired on *insert date* and no statutory process has taken place to authorise the Standard application by the Supervisory Body. The SB have been contacted to advise of the expired Urgent Authorisation but currently has no date for when the statutory process will be carried out by the Supervisory Body. Patient continues as an inpatient and ward are managing under the wider provisions of the MCA (Principle 4 and 5). However, the Patient continues to meet the criteria of the Acid Test as set out in the Supreme Court Judgement (March 2014) and is potentially being deprived of their liberty without the legal safeguards in place potentially interfering with their Article 5 Human Rights.
* Ensure least restrictive option for patient is in place
* Ensure an up to date 2 stage mental capacity assessment is in place
* Ensure an up to date best interest record is in place
* Ensure the patient’s care plan has been updated accordingly

If the patient’s condition changes, they are distressed in the ward’s care and/or are actively objecting or trying to leave, please contact the supervisory body/ICHD Safeguarding Lead to address priority of patient assessment.

**DEATH UNDER A DoLS** (if a patient dies whilst under an urgent authorisation or a standard authorisation)

From April 3rd 2017 there is no requirement to make a referral to the Coroner when a Patient dies whilst under a DoLS Authorisation UNLESS there are any concerns about the cause of death.