The Deprivation of Liberty Safeguards

Key points

- Good practice in applying the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA) closely aligns with putting the person at the centre of care and focusing on human rights.
- Variation in how providers implement DoLS and the MCA continues to be an issue, as are delays in local authorities assessing and authorising DoLS applications. This increases the risk of people being unlawfully deprived of their liberty.
- Services that use overly restrictive practices often do so because they lack understanding of the MCA and DoLS legislation. Services can also find it challenging to balance safety and freedom with limited staff time and resources.
- Strong leadership and governance with a positive organisational culture are key factors underlying good DoLS and MCA practice. Together with partnership working, adequate staffing levels and embedded staff training, they foster positive risk-taking, and encourage greater autonomy for people.
- A dedicated MCA (including DoLS) lead and team in hospitals can be an important way to drive change and improvement in practice.
- It is important that system partners and providers continue to work together to improve and develop the delivery of the DoLS scheme in its current form, to protect people when they are deprived of their liberty, and to support their families and carers.

Elizabeth and Tessa's story

Elizabeth has experience of her mum, Tessa, having a DoLS in place. Tessa is in a care home and lives with severe dementia. Sometimes she can be violent and a risk to herself or others. Elizabeth can clearly see the positives of DoLS – that it helps keep her mum safe, while also protecting her liberty and human rights:

"The staff ask mum where she wants to go and take her to places like a dementia-friendly cinema. She is still making her own decisions in her own way – if she says that she doesn't want to do something then that is the decision and that is it."

"The home gives mum options to sit in the lounge, the garden, her room… Sometimes she is not allowed to sit in the dining room if she becomes violent. It is in her best interests to be moved from there and is a case of what needs to be done at the time. DoLS does not restrict mum's freedom, it just gives us peace of mind to know that she can be kept safe."

However, Elizabeth had a generally frustrating experience of the DoLS process and found it very confusing. She got very little information from the decision-making organisations and thought that it all took too long. She also felt that the various assessments and decisions took place without her fully understanding what was happening. For example, the local authority did a mental capacity assessment for Tessa but Elizabeth and her family were not notified in advance or properly involved. The care home also did not seem to understand much about the DoLS application process. She got most of her information from a charity organisation.

Introduction

Increasing numbers of people are living longer with multiple and complex health and care needs. One of the challenges is supporting people who may lack mental capacity to make a decision at the time it needs to be made, for example people living with dementia. The Alzheimer's Society has said that more than 850,000 people currently live with dementia in the UK and this is projected to increase to one million by 2025. Seventy per cent of people in care homes live with dementia or severe memory loss problems.[145]

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005 (MCA) and both work together to provide an empowering legal framework that balances safety and freedom through best interests decision-making, the right to representation, and advocacy arrangements.

DoLS make sure that people who lack capacity to make decisions and to consent to certain aspects of their care, have any significant restrictions on their liberty made in accordance with their human rights, and through a defined process including right of appeal.

The DoLS scheme has been the focus of strong criticism over recent years from the Law Commission, the House of Lords Select Committee[146] and organisations such as the Alzheimer's Society[147] and the Local Government Association (LGA),[148] with concerns that it is not working for people. They and others, including CQC, welcome change and reform if correctly designed, funded and implemented to a high quality.

One of the main issues in recent years resulted from the Supreme Court ruling (see 'DoLS and the MCA explained' box) that generated an increase in the number of applications and the build up of applications not completed. Over four years, applications for DoLS authorisations have risen from 13,715 in 2013/14 (before the ruling) to 227,400 in 2017/18. This has led to pressure on local authorities processing applications. The average length of time it took to complete an application in 2017/18 was 138 days, although this ranged from 68 days in London to 188 days in the South East. The number of incomplete applications that had been waiting for authorisation for more than a year was 48,555.[149] Providers must notify CQC of the outcome of a DoLS application to the local authority as soon as it is known, or if they have withdrawn it. Our data for 2017/18 suggest under-reporting of these notifications to us when compared with local authority authorisations.

The Deprivation of Liberty Safeguards and the Mental Capacity Act 2005 explained

People who are not able to make some or all of their own decisions at the time they need to be made due to a lack of mental capacity are protected and empowered by the Mental Capacity Act 2005 (MCA). The purpose of the Act is to promote and protect people's decision-making within a legal framework. The Act's principles are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make 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 their best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.[150]

The Deprivation of Liberty Safeguards (DoLS) are one part of the MCA and protect the rights of people who are deprived of their liberty in their own best interests. DoLS are used in hospitals, hospices and care homes. If a person needs to be deprived of their liberty in other settings they should be referred to the Court of Protection. Providers apply for a DoLS authorisation through a supervisory body (the local authority).[151]

A Supreme Court ruling in March 2014 ('Cheshire West') clarified the definition of deprivation of liberty and expanded the criteria used to identify when someone is being deprived of their liberty.[152] This 'acid test' can be described as applying:

- when a person is under continuous or complete supervision and control, and
- is not free to leave, and
- the person lacks capacity to consent to these arrangements.

In 2017, the Law Commission laid out reforms to DoLS following a review commissioned by the government.[153] The Mental Capacity (Amendment) Bill proposes a new scheme, the Liberty Protection Safeguards, to replace DoLS.[154] At the time of publishing, the Bill was under scrutiny in Parliament. The current DoLS scheme has put providers in a difficult position as they wait for an outcome of a DoLS application, leaving people without safeguards in place. The House of Commons and House of Lords Joint Human Rights Commission said in their report on DoLS in June 2018 that the current scheme has resulted in a situation where "those responsible for care and treatment are having to work out how best to break the law".[155]

Despite the issues and uncertainty over the legislation, it is important that system partners continue to work together with providers to improve the delivery of the DoLS scheme in its current form to protect people when they are deprived of their liberty, and to support their families and carers. Providers must follow the legislation as it currently stands until full implementation of any new legislation takes place, which is likely to be several years ahead.

Varied practice and the reasons for this

In 2017/18, we continued to observe variation in how care home and hospital providers use DoLS and the MCA. This variation can lead to poor practice and have a negative effect on people using services, for example unnecessary restrictive practices that can result in a loss of freedom. In some cases, these practices can breach people's human rights.[156] Our inspections found that although most care home providers comply with DoLS legislation, there remains variation in the quality of how the safeguards are applied in services.

Varied practice appears in different ways depending on the sector, but is commonly linked with a basic lack of understanding of DoLS and the wider MCA. This can then be reinforced by limited staffing levels and a lack of time to complete applications, as well as inadequate staff training. The general complexity of the DoLS legislation and a lack of local authority resources to deal with the number of DoLS applications also influence varied practice.

Understanding of legislation and practice

DoLS legislation is complex and providers can often misunderstand how to apply it – this can extend to a misunderstanding of the MCA. Providers can also be unclear as to when a restrictive practice amounts to a deprivation of liberty. This happens across different services but sometimes within services, particularly in hospitals where DoLS and MCA practice can vary from ward to ward.

In relation to the MCA, we sometimes find that mental capacity assessments and best interests decisions are not properly completed or recorded. In some cases capacity assessments are too general and do not look at the individual elements of capacity, for example which decisions the person can and cannot make for themselves or whether they can make a decision with the right support. In other instances, a best interests decision has been made, but a capacity assessment has not happened first to trigger the process as required by the legislation.

In some hospitals, we found a lack of understanding as to what a DoLS authorisation means in practice. Some services were quite clear about what they needed to do, whereas others had very limited knowledge and understanding.

Implementing DoLS effectively needs providers to carefully balance safety and freedom, and strong leadership and a positive organisational culture tended to enable this. On the other hand, we found that a risk-averse approach to care and treatment can contribute to breaches despite a well-meaning desire to keep people safe. Concerns about safety and failing to fully understand the principles of the legislation can mean providers are not upholding people's human rights.

For example, in some care homes, providers sometimes do not know when and in what circumstances to apply for DoLS authorisations, which can then result in a person being deprived of their liberty unlawfully. In other services, we see low staff awareness of when a restrictive practice may amount to a deprivation of liberty, with instances where safety gates, barriers, wheelchairs or tray tables have been used to restrict people without understanding how they might then impede a person's human rights. In relation to the MCA, we have concerns about the use of covert medication (medicines disguised in food and drink) without an understanding of whether it could be a restrictive practice, and sedatives to manage challenging behaviour. The DoLS Code of Practice sets out the distinction between a restriction or restraint, and if this is then a deprivation of liberty.[157]

The challenge is for services to manage health, social and environmental risk, while ensuring that people are empowered to make choices and maintain their independence. The LGA has published a useful tool for promoting less restrictive practices.[158] Additionally, our ongoing work with NHS England and other national system partners to improve restrictive practice data and develop training standards will support providers, and help commissioners and regulators to identify concerning practice.[159]

We found that tensions can arise between providers and families or carers where family members do not understand the DoLS scheme and how it relates to human rights. Similar to providers themselves, there can be a tendency for some families to be focused on the safety of their relative and to be less open to positive risk-taking. It can be difficult for providers to manage the involvement of families, friends and Independent Mental Capacity Advocates. Providers should take more of a role in helping families and friends understand best interests decision-making and the rights of the person being cared for.

Staff training

We found variation in the depth and frequency of the training provided. Online learning is very common, but perhaps less suitable for gaining a practical understanding of DoLS and the wider MCA. The way training is delivered, the quality of the content and the opportunities to embed, discuss and reflect on learning are fundamental to creating the conditions for good practice. Regular training is important as case law can frequently change the interpretation of the legislation.

Poor practice: Low staff levels leading to unnecessary restriction

In an adult social care service, one of the residents had a DoLS authorisation in place that lawfully deprived them of their liberty to freely leave the home. The system to manage this used keypad door codes known only to staff, including on doors that separated communal areas connected by corridors. This was partly a consequence of low staffing levels that impaired the service's ability to support the person's freedom of movement around the home. This had a negative effect on other residents who were not subject to DoLS. They were unable to move around the home without staff intervention and were therefore subject to blanket restrictions and unnecessary restraint. The MCA permits restrictions and restraint to be used, but only where they are in a person's best interests and where that person lacks capacity to make a decision themselves.

In response to CQC's inspection and regulatory action, the home has started to make some positive, person-centred improvements. The keypad doors are now unlocked during the day and the resident with the DoLS authorisation has one-to-one care to support her better. All residents can more easily access and enjoy the garden.

Staff numbers

Inadequate staffing levels can negatively affect DoLS and MCA practice. In acute hospitals, we found that when staff numbers are too low, person-centred care, which underpins good DoLS and MCA practice, is not always prioritised. Having a DoLS or MCA lead in a hospital helps to bridge this gap. We found examples of this working particularly well when the lead is part of a safeguarding team that supports frontline staff.

In adult social care services, we found that low staff levels can lead to the use of overly restrictive practices or 'blanket' restrictions (restrictions for one resident that then extend to others for practical but not necessarily lawful reasons). For example, residents are sometimes restricted to certain areas of their care home as staff do not have time to help them move around safely.

Applications not completed

There continue to be a large number of DoLS applications not completed, which varies by area. For example, across three regions of England approximately half of the applications that had not been completed at 1 April 2018 had already been waiting for more than a year (50% in the South East and 49% in both the South West and East of England). At the other end of the scale, only 8% of incomplete applications in London had been waiting that long.

These delays, including delays in sending out best interests assessors, can often undermine the importance and value that providers place on the legislation. There is often a mindset that DoLS are just an administrative burden. In acute hospitals, the context of high turnover of patients and short stays means staff can feel there is limited value, as a person can be discharged before their DoLS is authorised.

Good practice and improvement

We found good DoLS and MCA practice and providers that have improved despite the challenges. Common to these providers are:

- person-centred care that actively involves people who use the service and focuses on human rights
- proactive leadership with strong governance
- a supportive organisational culture
- good local joint working with system partners.

Person-centred care

A positive and supportive organisational culture is central to effective DoLS and MCA practice. Our evidence suggests that involving the person fully in their care and keeping them at the forefront of decision-making is closely related to good practice.

Services that are focused on the person are more likely to be working in line with the principles of DoLS and the MCA. We find that these services are more likely to make sure that people are supported in the least restrictive way and take account of people's needs and capacity changing over time or on a day-to-day basis. For example, in a care home rated as outstanding, the registered manager and staff had good knowledge of DoLS and the MCA, and of fluctuating capacity. The home had applied for several people to have their DoLS authorisations removed as their condition had improved and they had regained capacity to make relevant decisions. People had been very proud to be removed from a DoLS authorisation, and the home had even organised an afternoon tea for one resident to celebrate.

Our equality and human rights resource, *Equally outstanding*, highlighted that a focus on person-centred care will naturally lead to equality of access, experience and outcomes as the needs of the individual are met.[160] It also described how some human rights issues need to be addressed at a service level, rather than an individual level. This means having an overall purpose that supports human rights and that a provider's leaders can get behind. Staff can then be supported to provide care in ways that maximise people's rights.

Strong leadership and governance, and a positive organisational culture

We found that proactive leadership and strong governance are important for driving good practice in the use of DoLS and the MCA. They help to shape the general culture of a service, and reinforce a focus on person-centred care and human rights.

In adult social care services, both the provider and the manager play an important role in shaping DoLS practice. Similarly in hospitals, the leaders at organisational and ward levels can determine how staff view and implement DoLS and the wider MCA. Where leaders work collaboratively with staff so that people are at the heart of care and empowered to make decisions, it can lead to a cultural shift overall.

The role of governance is important, particularly the systems and processes that are set up to provide monitoring and oversight of DoLS practice. For example, in an acute trust rated as outstanding, there was a proactive safeguarding team that visited staff on the wards to talk about the MCA including DoLS. The team made sure that there was good consistency of processes and practices across all sites at the trust.

We found that leaders who respond proactively to CQC's inspection findings and other external feedback can improve DoLS and MCA practice. A CQC inspection report can act as a trigger to solve issues such as using overly restrictive practices.

At one specialist rehabilitation service, the leaders at the trust had been unaware of the extent of the poor DoLS practice until the inspection took place. DoLS applications and authorisations were not being monitored consistently; there were gaps in evidence for mental capacity assessments; and occasionally some people were being deprived of their liberty without a DoLS authorisation in place. After the inspection, senior leaders visited the service and supported a number of rapid improvements, including daily patient review meetings and a training programme for all staff in DoLS best practice.

Good practice: maximising rights through positive risk-taking

A residential care home for older people has a statement of purpose with dignity, privacy, respect for human rights and quality of life at its centre. The registered manager described creating:

"a homely, comfortable atmosphere – a place where people can do what they want, when they want and we work for them".

During an audit, the manager had found some staff were risk-averse. Staff had decided that a person living in the care home was not safe to leave the home on their own. The manager then assessed the person's capacity and addressed this with staff. It was then agreed that the person was able to come and go freely.

To embed this approach across the home, the manager developed business cards with each person's name and the home's address. Residents who were assessed as having the capacity to come and go without the need for restrictions on their liberty could carry the cards so they could give them to someone in the community if they became lost. This meant the care home could support each person's right to maintain their autonomy.

Good local networks with system partners

Providers that demonstrate good DoLS and MCA practice can be more likely to be open to collaboration with others in the health and care system, and to seek out external expertise. For example, we have seen providers proactively link up with their local authority or clinical commissioning group for support.

In an example of the external support for providers, a local authority with a large backlog of DoLS applications set up a team of best interests assessors (including an MCA lead) to address it. The team's role then extended to providing advice, support and training on MCA best practice to partners and providers.

Improved organisational culture leading to better practice

A home that provides care for older people living with dementia saw a turnaround in the quality of care, including its approach to DoLS and MCA practice. This helped the home's rating move from requires improvement to good.

In two previous inspections, we found that some applications had not been made for DoLS that should have been, and some best interests decisions had not been properly recorded.

We also found that two people's freedom of movement around the home had been inappropriately restricted without a proper assessment or best interests decision – specifically, a gate had been installed that restricted access to two bedrooms. The manager immediately removed the gate after inspection, but a wider cultural shift was needed.

With support from the local authority's quality assurance and improvement team, the manager worked together with staff to improve the organisational culture and develop an approach to care that focused on the person.

The manager was new to the home and her proactive leadership style was instrumental in encouraging a more open culture for people living there, for their families and friends, and for the staff. She encouraged staff to tailor care to individual needs and preferences, and moved away from a task-based approach. She explained,

> *"We [the staff] put on dressing gowns and walk around with them at bed-time. It orientates them. We go into their world; we don't drag them into our world. They all get treated as the individuals they are. If they want to go to bed at 10, they go at 10. It's their individual choice."*

Collaborating externally was also important for the improvement journey. The manager worked closely with the local authority to develop a service improvement plan. They supported her throughout and monitored progress.

Senior staff were also encouraged to develop their understanding of DoLS and MCA best practice by attending external workshops with system partners. A full training programme was then organised for staff with regular follow-up meetings to reflect on and embed learning.

The combined efforts of the manager, her team of staff, and the local health and care system, led to substantial improvements in DoLS and MCA practice at the home.