Riverside

Mental Capacity Procedure
(Including Deprivation of Liberty)

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1. Procedural Context

1.1 Riverside supports and respects the right that all individuals have to make their own decisions about their lives. A customer must be assumed to have capacity unless it is established that they lack capacity. Within our services we support and care for vulnerable people who may, in some cases, lack the capacity to make an informed decision in relation to some or all aspects of their care and support. This can result in increased vulnerabilities and risk of harm.

1.2 The Mental Capacity Act (2005) (MCA) is important legislation which governs the way in which decision making for those who may lack capacity should be approached. The purpose of this procedure is to set out Riverside's approach to ensuring that colleagues work in line with the MCA. It also provides guidance to colleagues in dealing with issues relating to deprivation of liberty in both care homes and domestic settings. This procedure is written in line with:

- Mental Capacity Act 2005,
- Mental Capacity Act Code of Practice 2005,
- Deprivation of Liberty Safeguards Code of Practice,
- CQC Fundamental Standards as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) and the Mental Capacity Act 2005.

2. Scope

2.1 This procedure applies across all Riverside Care and Support services, including One Housing Group. Specific areas covered within this procedure may apply to different types of service depending upon the legislation as detailed below:

- The Mental Capacity Act (MCA) 2005 – this applies to all people over the age of 16 who live in England and Wales and may lack the capacity to make all or some decisions for themselves. It is applicable to all of Riverside's care and support services. It applies to any possible loss of capacity whether temporary or permanent.
- Deprivation of Liberty Safeguards (DoLS) – DoLS was introduced in 2009 as an amendment to the Mental Capacity Act. DoLS ensures that people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS. They apply to individuals who are over the age of 18 and are being cared for in a hospital or a care home in circumstances which may amount to a deprivation of liberty. The Deprivation of Liberty Safeguards will only apply within Riverside registered care homes.
- Deprivation of Liberty Orders (community / domestic settings) – it is possible for a deprivation of liberty to occur in a community or domestic setting, for example, supported accommodation or in a person's own home. This type of deprivation of liberty is not covered under the Deprivation of Liberty Safeguards. In these cases, a Deprivation of Liberty Order can be authorised via the Court of Protection and can be applied for where a person over the age of 16 years, lacks capacity to consent to the arrangements made for their care and is being cared for in circumstances which amount to a deprivation of liberty.

Pending Legislation Changes

2.2 It is expected that the Deprivation of Liberty Safeguards will be replaced by Liberty Protection Safeguards (LPS). However, the Department of Health and Social Care (DHSC) has announced that that the implementation of the LPS will not go ahead within this parliament. Progress on the implementation of the LPS will be monitored and this procedure updated when required. A summary of key changes that will be brought about by the LPS can be found in ***'Appendix 1 – Pending Legislation changes'***.

3. Capacity and Consent

3.1 Mental capacity is a person's ability to understand information and make decisions. *"A person lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for themselves in relation to the matter because of an impairment of, or disturbance in the functioning of the mind and brain." (MCA Code of Practice)*

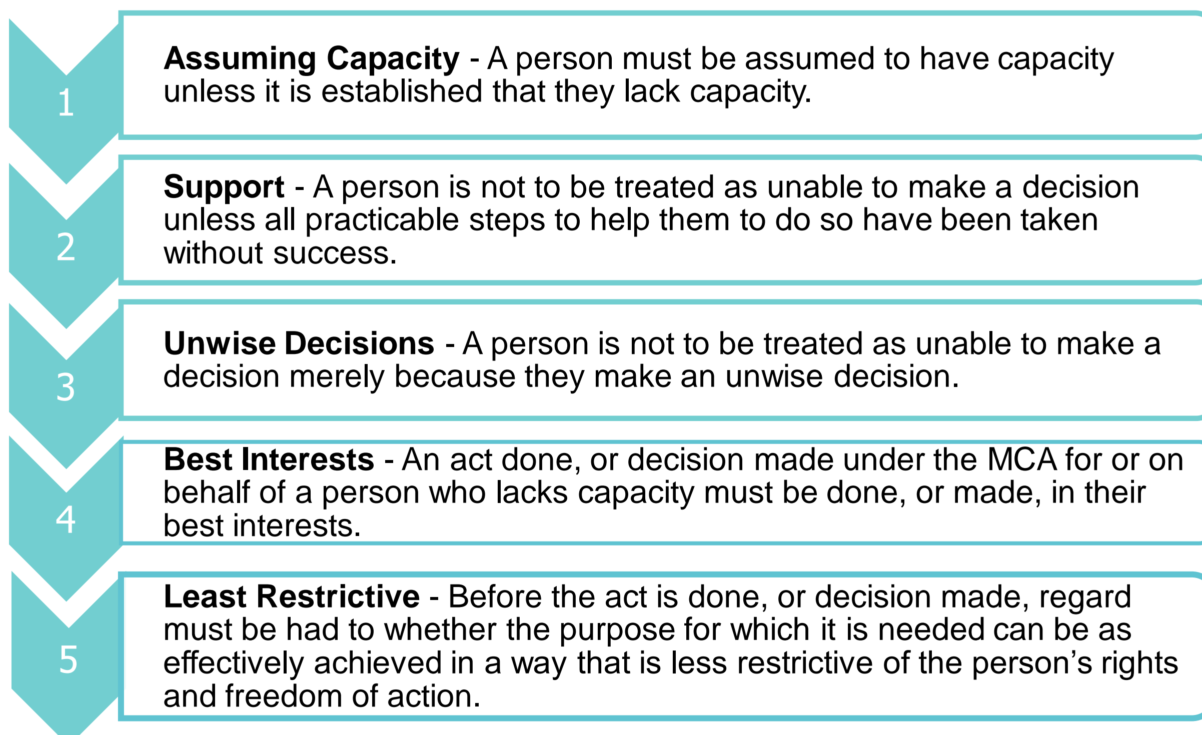
3.2 Consent is where a person gives permission for something to happen or agrees to do something. Consent must be:

- Voluntary – this means that a person must give consent freely and must not be pressured by others such as medical or care professionals, friends or family.
- Informed – this means that the person must be given all of the information that they need to make the decision e.g. risks, benefits, alternative options.

3.3 Where there is no reason to doubt a person's capacity, consent must be obtained where they are provided with care or support or where care and support interventions are put into place as part of their support plan.

4. MCA Statutory Principles

4.1 The MCA sets out five principles which must always be followed. These are:



4.2 It is expected that all Riverside colleagues will work with customers in line with these principles. In practice, this might include:

- Ensuring that customers are supported and encouraged to be involved in the planning and review of their care and support.
- Ensuring that assumptions are not made about a customer's ability to make a decision for themselves because of a disability or medical condition.
- Recognising that we all have our own individual preferences, beliefs, values and priorities and understanding that these things may affect the decisions that customers make.
- Ensuring that where they have concerns regarding a customer's ability to make a decision, this is discussed with the customer and other professionals to ensure that, where needed, assessments of capacity can be completed, and decisions made in line with the MCA.

4.3 For further information on each of the five principles please refer to '***Appendix 2 – Mental Capacity Act Principles'.***

5. Assessing Capacity

The Capacity Assessment

5.1 In order to decide whether an individual has the capacity to make a particular decision the MCA sets out a two-stage test:

- ***Stage 1*** *(this is the functional test) – Is the person unable to make a particular decision?* In order to answer this question the person carrying out the assessment must consider the following:
    - Can the person understand information given to them?
    - Can the person retain that information long enough to be able to make the decision?
    - Can the person weigh up the information available to make the decision?
    - Can the person communicate their decision?
- **Stage 2** (this is the diagnostic test) – Is the inability to make a decision caused by an impairment of, or disturbance in the functioning of, a person's mind or brain? Examples can include head injury, cognitive impairment, mental health condition, learning disability, substance misuse (drug or alcohol induced effects).

5.2 It is important to remember that capacity is:

- Decision specific – this means that capacity relates to a specific decision and not a general ability to make all decisions. A person may lack capacity to make some decisions but not others.
- Time specific – consideration needs to be given to whether the person can make a particular decision at a particular time.
- Can fluctuate - just because someone lacks capacity to make a decision at one point in time, does not mean that this will always be the case.
- Assessed on the balance of probabilities - is it more likely than not that the person lacks capacity?

Who Can Assess Capacity?

5.3 In determining which colleagues can assess a customer's mental capacity the current law states the following:
"The MCA does not lay down professional roles or require people hold certain qualifications to undertake assessments. The capacity assessment should be done by the person who is proposing to undertake an action or make a decision. This person is known as the 'decision-maker'."

5.4 In practice, the person responsible for assessing capacity will generally depend upon the decision that needs to be made:

- Day-to-day or routine decisions – this type of decision is one which would require a more informal capacity assessment. The responsibility for assessing capacity in these cases will generally lie with the person who is supporting the customer at the time that a decision needs to be made. As an example, where a decision relates to the provision of personal care, the assessment would be completed by the person who would need to provide the care or support needed with personal care at the time. Other examples of day-to-day decisions would be deciding what to wear, deciding what to have for dinner or deciding what to buy for the weekly shop.
- More complex decisions - this type of decision would require a more formal capacity assessment as this type of decision will usually be more sophisticated and have more serious consequences. This type of assessment would usually be carried out by a professional with particular expertise or who would usually be involved in supporting the person to make the decision. For example, if the decision related to medication, it would be the person who would be prescribing the medication who would carry out the assessment. Other examples of more complex decisions could include decisions relating to care moves, contact with family, serious medical treatment.

5.5 Riverside colleagues may be involved in the capacity assessment process in the following ways:

- Referring to the appropriate authorities/practitioners or appropriate Riverside employee if they have any concerns in relation to capacity, where a formal mental capacity assessment may need to take place.
- Ensuring that customers have as much help and support as possible to make decisions themselves;
- Completing informal capacity assessments relating to day-to day decisions and recording the outcome in a customer's care or support plan.
- Ensuring that care or support plans are reflective of any capacity assessments and subsequent best interests decisions that have been completed.
- In Riverside care and support services, in most cases, formal capacity assessments will be carried out by an external professional. However, in some CQC registered services, colleagues will need to complete and record a more formal capacity assessment.

5.6 The table below shows details of individuals who would generally carry out assessments for customers using Riverside Care and Support services:

Relevant Professional	Assessment / Decision relating to:
Support Worker / Care Assistant	Day-to-day decisions such as bathing, what to wear, what to have for lunch.

Social Care teams	Conflicts between involved parties or tenancy related issues.
A doctor or other health professional	Someone's capacity for the treatment they are prescribing, or initiating, a care pathway and decisions about life sustaining or significant medical treatment. *It should be noted that Riverside employees must never sign medical consent forms.*
Nurse	The treatment or care that they are delivering or administering.
Social Care professional / Social Worker	Commissioning an individual's package of care including accommodation. Decisions relating to moves into or out of care or support services.
Court of Protection	Significant financial or property issues (including tenancies). Serious decisions where parties do not agree on what is in the persons best interests.

6. Best Interests

6.1 If a customer has been assessed as lacking capacity, then any decision made on their behalf must be done in their best interests. In the case of best interests decisions, the decision maker will depend upon the decision that needs to be made. As with capacity, most routine or day-to-day decisions the decision maker will be a member of the care team who is directly involved with the customer at the time that the decision needs to be made. However, for more complex decisions, the decision maker will likely be an external professional e.g. medication related decisions – prescriber, move of care setting – Social Worker. Where a customer has a Power of Attorney (POA) or Court Appointed Deputy in place (see Section 8) and the decision falls within their specified authority then they will be the decision maker. Best interests decisions can be impacted where a customer has an advanced decision to refuse treatment in place.

6.2 Section 4 of the MCA sets out some key factors that must be considered when deciding what is in a person's best interests. These are set out below:

- A decision made on behalf of a person who lacks capacity must not be made purely based on a person's age, appearance, condition or behaviour.
- All practical steps must be taken to support and enable the person who lacks capacity to be involved in the decision-making process.
- All of the relevant circumstances must be considered when deciding what is in a person's best interests.
- Consideration must be given to whether the person will regain capacity and whether the decision can be reasonably delayed until the person regains capacity.
- Consultation must take place with others who are close to the person so that their views can be considered as part of the process.
- The person's past and present wishes, beliefs, feelings and values must be considered when making the decision.
- Decisions relating to life sustaining treatment must not be motivated by the desire to bring about a person's death.

6.3 Where a formal best interests decision is required then a best interests meeting will usually be held. These meetings should take place in a multidisciplinary context, with all individuals who have an interest in the customer and the decision being made being invited. In practice, Riverside colleagues are often not responsible for arranging best interests meetings but will be consulted as part of the best interest process and so must attend these meetings where required.

6.4 What is in a customer's best interests may well change overtime. This means that decisions made must be regularly reviewed as part of a multi-disciplinary team approach.

Independent Mental Capacity Advocate (IMCA)

6.5 An Independent Mental Capacity Advocate (IMCA) provides an independent safeguard for people who lack capacity to make important decisions where there are no other people, with the exception of paid colleagues, to represent them and be consulted about what is in their best interests. Where a decision pertains to serious medical treatment, a hospital admission of more than 28 days or care home move for more than 8 weeks, or a deprivation of liberty an IMCA will be involved. Local councils or NHS Trusts are responsible for contacting and arranging the involvement of an IMCA however, colleagues must be aware of what an IMCA is, when they should be involved and understand their duties and responsibilities so that they can assist them appropriately. IMCA's have the right to see all relevant care and support records for a customer and services must provide these to assist with being involved in best interests processed where needed.

The Court of Protection

6.6 The Court of Protection is a specialist Court for all issues which relate to people who lack capacity to make certain decisions. It has its own procedures and nominated judges. In cases where there are concerns or an agreement cannot be reached relating to capacity or best interests, the Court of Protection can be consulted to make a judgement.

6.7 The type of issues that may be referred to the Court are those involving serious or complex matters which, after considering all options available, there remains an irresolvable conflict or disagreement. These are likely to be issues including health and welfare and property and affairs. The Court should be seen as a provision of last resort. The Court can decide where there is a single issue or appoint a Deputy where there are a series of on-going decisions to be made. A court appointed deputy may have very limited authority or quite wide depending on the level of involvement the court decides is needed.

Court Appointed Deputy

6.8 A court appointed deputy is a person or organisation that has been appointed by the Court of Protection to make decisions on behalf of a person who lacks capacity. A court appointed deputy may be:

- A family member or friend (lay deputy),
- The Local Authority or Health body (public authority deputy),

- Someone chosen from the Office of the Public Guardian's list of approved panel deputies.

6.9 There are deputies for different types of decisions, personal welfare and property and financial affairs. Colleagues must ensure that where a customer has a deputy this is documented in the care or support plan, and they are contacted where decisions need to be made that fall within their remit. Riverside colleagues must not act as a deputy.

Appointee

6.10 An appointee is a person that has been appointed by the Department for Work and Pensions (DWP) to look after a person's benefits on their behalf, either because they lack capacity to do this, or because they struggle with certain elements of it e.g. online banking, paying bills. An appointee is put into place by the DWP, and the role is restricted to welfare benefits rather than managing personal assets or larger amounts of savings as a Court Appointed Deputy would.

6.11 An appointee can be a family member or friend but are also sometimes an organisation such as a solicitors or the Local Authority. Colleagues should ensure that where a customer has an appointee this is documented within their care or support plan. Riverside colleagues must not act as an appointee for customers.

7. Recording

Capacity Assessments and Best Interests Decisions

7.1 The way that a capacity assessment and subsequent best interests decision is recorded will depend upon the seriousness and complexity of the decision that needs to be made. Generally, it should be recorded in the following ways:

- Routine or informal decisions (decisions where an informal capacity assessment is required) – capacity assessments and best interests decisions for this type of decision can be recorded in a customer's care or support plan. This type of decision can usually be reviewed through the care or support plan review process.
- Serious or higher risk decisions (decisions where a formal capacity assessment was required) – this type of decision should be addressed through a best interests meeting and recorded formally and in much more detail. In most cases a professional who is external to Riverside will be responsible for this type of decision and they will usually have a standard template that they use to record best formal capacity assessments and best interests decisions to ensure that all necessary information is recorded appropriately. Riverside do have templates available should a Riverside colleague need to complete a formal capacity assessment or best interests decision. These are available here:
  - Mental Capacity Assessment Template (see Appendix 3)
  - Best Interests Decision Template (see Appendix 4).

7.2 Where a Riverside colleague completes an informal capacity assessment, they should record the following in the care plan:

- Detail of how capacity was assessed,
- Who was involved,

- How the customer was involved and supported to be part of the process,
- The decision that was made and why this is thought to be in the persons best interests.

7.3 Although this does not need to be done daily, the record should identify the decisions made and document that this will be reviewed regularly unless or until capacity is regained. Recording decisions in this way will help colleagues to demonstrate why they had a reasonable belief that the customer lacked the capacity to make the decision in question and why it was referred for assessment.

7.4 It is important that teams request copies of any formal capacity assessments and best interests decisions that have been completed by external professionals where they relate to the care or support being delivered within Riverside services. These should be stored with the customers Riverside care or support records and referenced within relevant areas of the care or support plan. Care / support plans must be written in line with any best interests decisions that have been made.

8. Lasting Power of Attorney (LPA)

8.1 An LPA allows a person (the donor) to give authorisation to make certain decisions in certain circumstances to another person. Only adults aged over 18 can make an LPA, and they can only be made where a person has capacity to do so. LPA's must be registered with the Office of the Public Guardian.

8.2 There are two types of LPA:

- **Property and affairs LPA** - only relates to financial matters and can be used when the customer still has capacity. This can be helpful where a person may still have capacity but has problems in getting out to the bank or using online banking for example.
- **Personal welfare LPA** - a person can nominate another person to make decisions on their behalf in relation to both health and personal welfare matters in the event that they lack capacity in the future. This can include areas such as medical care, care moves and life sustaining treatment. A personal welfare LPA may only be used when the customer who appointed them lacks capacity.

8.3 Where there is an LPA in place, Riverside colleagues should:

- Request a copy and ensure that this is kept with the customers care or support records,
- Ensure that details of the LPA and the areas which it covers are documented in the customers care or support plan. This should include any details of specific decisions that the LPA allows for or that it excludes.
- Involve the attorney in any areas where a decision needs to be made where the LPA authorised them to do this on the customers behalf.

9. Capacity and Tenancy Agreements

The law and signing and terminating tenancy agreements:

9.1 The MCA states that if a person lacks the mental capacity to sign a tenancy agreement, anyone intending to sign the agreement on the person's behalf can only

do so with the authorisation of the Court of Protection. Someone can only sign a tenancy agreement on the person's behalf if they are:

- An attorney under a registered lasting power of attorney (LPA) or enduring power of attorney (EPA)
- A deputy appointed by the Court of Protection, or
- Someone else authorised to sign by the Court of Protection.

9.2 If the person has a registered attorney under an EPA or LPA, or has a deputy appointed to make decisions on their behalf, then the deputy or attorney can terminate or enter into a tenancy agreement without further authorisation from the court.

9.3 Where a colleague has concerns that a customer may lack capacity to sign a tenancy agreement a capacity assessment should be completed. Colleagues should make contact with the referral source to agree how best to proceed in terms of the assessment.

10. Advance Decisions / Statements

Advance Decision

10.1 An advance decision enables an adult aged 18 or over to specify treatment that they want to refuse, if in the future, they lose capacity to consent to or refuse treatment. A valid advance decision is legally binding. Under the MCA, a valid and applicable advance decision has the same effect as a decision that is made at the time by a person who has capacity.

10.2 Advance decisions/directives can be used to refuse any medical treatment including life-sustaining treatment such as:

- Cardiopulmonary resuscitation (CPR) if their heart stops,
- Being put on a ventilator if the customer cannot breathe on their own,
- Being given food or fluids artificially, for example, through a drip or a tube through the nose or through a tube directly into the stomach,
- Antibiotics for a life-threatening infection.

10.3 Advance decisions to refuse life sustaining treatment have to meet specific criteria in order to be valid. They must:

- Be in writing,
- State clearly that the decision applies even if the person life is at risk,
- Be signed by the person making the decision and witnessed.

10.4 Even where an advance decision does not relate to life sustaining treatment it is recommended that colleagues encourage customers who wish to put an advance decision into place to do so in writing so that there is a formal record. A signature is also helpful as it makes it clear that it is the particular person's wishes that have been written down.

10.5 Where a customer wants to put an advanced decision to refuse treatment in place, they should be supported to contact an appropriate professional who can support them in doing this, usually a medical professional who can discuss the specific treatment options with them.

Advance Statement

10.6 An advance statement is a statement of preferences and wishes for the future that can be used by those caring for or supporting a person should they lose capacity in the future. An advance statement is different to an advance decision as it is much broader than a refusal of specific mental treatment and can cover all aspects of a person's views and wishes in relation to future care and quality of life. An advance statement is not legally binding but must be taken into account by anyone making best interest decisions in relation to a person who lacks capacity. In practice, a 'Preferred Priorities for Care Form' is often used to record a person's wishes in relation to care and support where they may be nearing the end of their life.

10.7 Examples of statements a person might make in an advance statement could include:

- I would want to stay in my own home as long as possible.
- I would like to continue to go to church for as long as possible.
- I would prefer to be supported by female carers.
- It is important to me that contact with my family is maintained.

Advance care and support planning can only be undertaken by a customer who has capacity. Therefore if someone is in the early stages of a deteriorating illness it is good practice for them to be encouraged to think about and to make plans for their future.

ReSPECT Process

10.8 The ReSPECT process and plan is used in some areas by health and social care organisations in England, and in some parts of Scotland, to support healthcare professionals and their patients in having conversations in advance about emergency care choices. This includes whether cardiopulmonary resuscitation (CPR) should be attempted in a future emergency. Although Riverside colleagues will not be responsible for putting a respect plan in place, they may be consulted as part of the process. Where colleagues are aware that a customer has a respect plan in place, they should ensure that a copy is kept with their care or support record and that the care or support plan reflects the agreements made in the plan.

10.9 Customers should be encouraged to keep original copies of any of the following in their room or property, in a visible place:

- ReSPECT Form or other documentation completed by professionals covering decisions made around treatment.
- Advanced decision to refuse treatment.
- Advance statement.

10.10 Making sure that these are readily available will ensure that any medical professionals / emergency services attending will have access to the information that they need to inform treatment decisions where a customer has lost capacity. Emergency services may not accept a photocopy or the word of an individual in an emergency situation.

11. Deprivation of Liberty

Human Rights

11.1 Human Rights Act[1] states that everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty unless in accordance with a procedure prescribed in law. There are two processes that may be used to authorise a deprivation of liberty within our services:

- Deprivation of Liberty Safeguards (DoLS) – this process will apply to care homes and includes where there are plans to move a person to a care home or hospital where they may be deprived of their liberty. The DoLS process applies in England and Wales and can be used where a person is aged 18 or over
- Court of Protection – where a person is deprived of their liberty in a setting outside of a care home or hospital, for example, a community setting such as extra care, intensive supported housing, or their own home this would need to be authorised via the Court of Protection. The authorisation is often referred to as a 'community DoL.' The Court of Protection can authorise a deprivation of liberty where a person is aged 16 or over.

What is a Deprivation of Liberty?

11.2 The Supreme Court[2] has agreed an 'acid test' that should be used to consider whether a person who is lacking capacity to consent to, or who refuse their care arrangements is deprived of their liberty. The two key questions to ask are:

- Is the person under continuous supervision and control? AND
- Are they free to leave?

11.3 If a person lacks capacity to consent to the arrangements made for their care and they are both subject to continuous supervision and control <u>and</u> are not free to leave then they will be deprived of their liberty.

11.4 Within Riverside, a deprivation of liberty would only occur in a CQC registered care service. Within Ofsted registered supported accommodation services for young people, support packages should not amount to a deprivation of liberty.

Free to Leave – what does this mean?

11.5 It is important to note that when considering whether a person is free to leave, they do not necessarily need to be expressing a wish or making attempts to leave. The key point to consider is whether, if the person asked to leave the service / discharge themselves, would colleagues allow this. If the answer is 'no' then it is likely that the person is not free to leave. The following points may be indicators that a person is not free to leave:

- The person's family members wish to remove them from the service and are not allowed to do this.
- The person is only allowed to leave the service with a colleague or a member of the wider care/support team.
- The person needs to ask permission to leave.

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[1] Human Rights Act, Article 5

[2] P v Cheshire West and Chester Council and Q v Surrey County Council (2014 UKSC 19)

- Doors are locked with the purpose of preventing a person from leaving.
- Lots of verbal or physical distraction techniques are used to dissuade a person from leaving the service.

11.6 It is important to remember that lots of services ask customers to sign out or let staff know when they leave the building for health and safety reasons. This is different from needing to ask permission to leave.

11.7 Locked doors – services may have locked doors with a key code or key fob entry system for security purposes / to prevent unauthorised access to a building. Again, this does not mean that customers are automatically classed as 'not free to leave.' Ensuring that customers who are able to leave freely are aware of and understand how to open exit doors e.g. they have been given codes or key fobs, will ensure that locked doors are not overly restrictive.

Continuous Supervision and Control – what does this mean?

11.8 The following may be indicators that a person is subject to continuous supervision and control:

Supervision	Control
• The person is supervised by colleagues for a large proportion of their day. • The person spends some time alone but only when colleagues feel that this is appropriate. • Alarm systems or door/movement sensors are used to alert colleagues / prompt checks when a person tries to leave their room or get out of bed. • Location devices are used to monitor where the person is.	• The care plan includes restraint whether verbal or physical. • Colleagues make decisions about many aspects of a person's life e.g. diet, when to get up, what to wear, when to engage in personal care etc. • There are restrictions in place around access to family or friends. • Medication is used that aims to manage certain behaviours. • Restricted access to finances. • Equipment that restricts movement is used e.g. bed rails, specialist chairs with lap belts, keypads on certain areas to prevent access. • Restricted access to methods of communication e.g. internet, telephone. • Restricted access to certain items to prevent harm.

11.9 These examples are not exhaustive lists. It is important to consider the individual circumstances of each case when deciding if a deprivation of liberty is occurring or likely to occur in the future. The type, duration, effect and degree and intensity of the restrictions put into place as part of a person's care plan should all be considered when deciding whether a DoL may be occurring.

11.10 In emergency situations, where actions are immediately necessary to prevent a person from coming to harm, one particular incident in itself may not amount to a deprivation

of liberty. Wherever restrictions are ongoing or frequent or where the cumulative effect of many ‘minor’ restrictions affects a person’s day to day life then consideration must always be given to whether authorisation for a deprivation of liberty should be sought. If a colleague is concerned that a deprivation of liberty may be occurring, they should always raise this with their line manager.

11.12 Before applying for a DoL to be authorised a capacity assessment and subsequent best interests decision should be recorded. Part of this process will involve looking at whether the restrictions in place:

- Are a proportionate response to the level of harm posed to the person.
- Are the least restrictive options available.

11.13 Best interests meetings and subsequent decisions must always be made as a multi-disciplinary team and done in conjunction with any relevant stakeholders, e.g. health and social care staff/professionals, family/friend/advocate.

Authorisation Process – Care Homes (Deprivation of Liberty Safeguards (DoLS))

11.14 Within the DoLS process the care home is the ‘Managing Authority.’ The Managing Authority is responsible for identifying people in the service who lack mental capacity to consent to the arrangements made for their care and / or treatment and may be deprived of their liberty. They are also responsible for making an application for authorisation using the appropriate form. All DoLS forms are available online here: Deprivation of liberty safeguards: resources - GOV.UK (www.gov.uk)

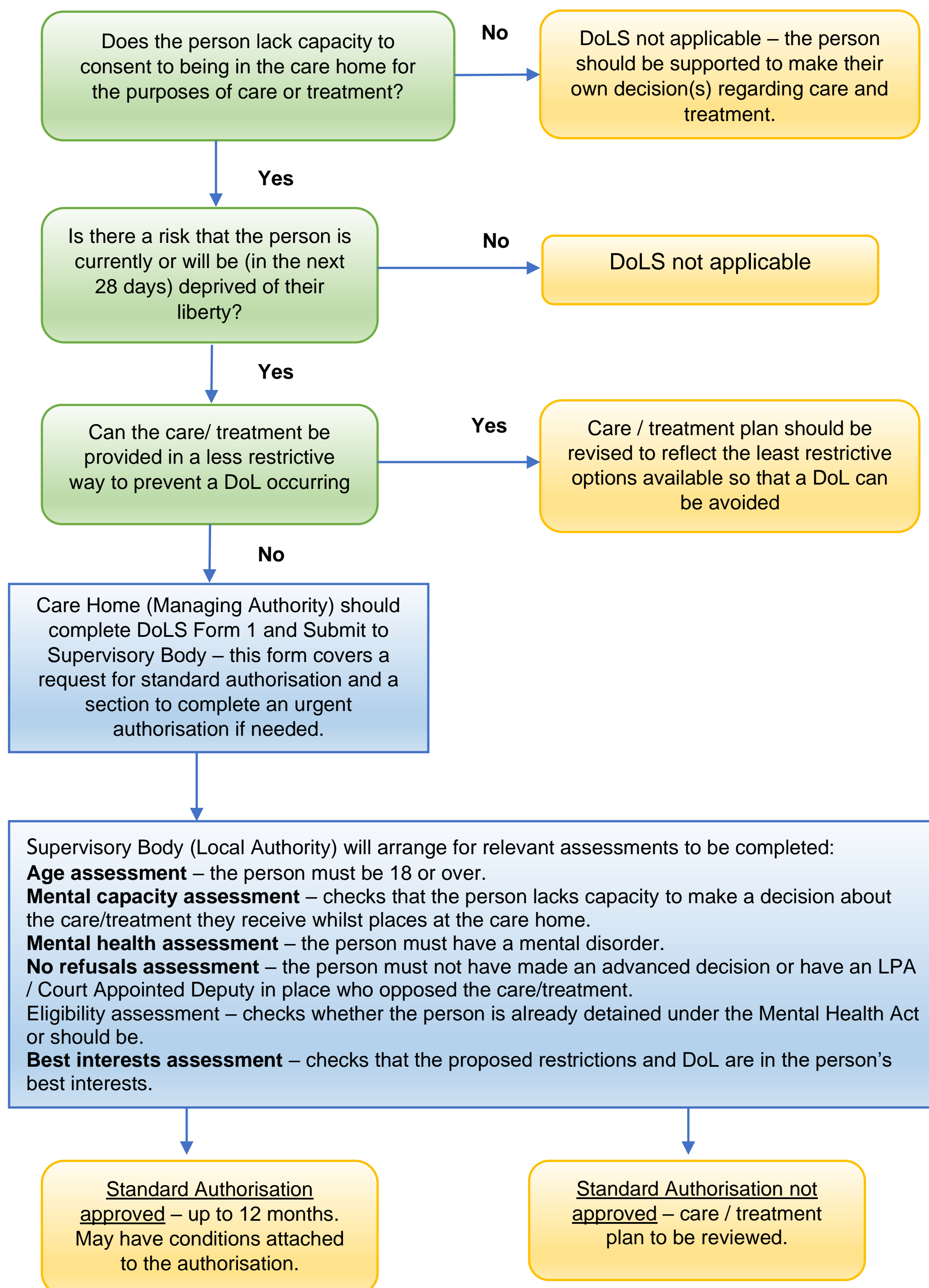
11.15 The Supervisory Body is responsible for arranging the assessments for standard authorisations and then authorising them. The authorisation process will involve the use of two professionals to carry out the relevant assessments for standard authorisations:

- Mental health assessor (doctor),
- DoLS best interests assessor (BIA) (a specially trained social worker, nurse, occupational therapist or psychologist).

11.16 There are two types of DoLS authorisations:

- Urgent Authorisation – this is authorised by the care home (Managing Authority) themselves and lasts for to 7 days. It can be extended to 14 days with permission from the Supervisory Body.
- Standard Authorisation – this is authorised by the Supervisory Body and can last for up to a year. It involves specialist professionals in carrying out the assessment process (see above). The views of the person concerned, as well as their family and friends are taken into account. The assessments also look at whether there are less restrictive options available.

11.17 DoLS Process Overview



Local Processes

11.18 Each Supervisory Body will usually have a DoLS team which will deal with applications for authorisation. These teams may have local approaches and processes that services are expected to follow when making an application for a DoLS authorisation. Service Managers should ensure that locally teams:

- Are aware of how to contact the DoLS team where they have any queries,
- Are aware of how they are expected to submit / request a DoLS authorisation to the DoLS team for the area in which they work.

Relevant Persons Representative / Independent Mental Capacity Advocate (IMCA)

11.19 Where a DoLS authorisation is granted, the Supervisory Body will appoint a Relevant Person’s Representative (RPR) to represent the persons interests. It is expected that the RPR will keep in contact with the person and represent and support them in everything relating to the DoL. The RPR is usually a relative or friend.

11.20 The Supervisory body must appoint an Independent Mental Capacity Advocate where there is nobody, other than those engaged in providing care or treatment to the person in a professional capacity, who it is appropriate to consult in the person’s best interests. An IMCA will usually also be appointed there the person requests on themselves or whether the RPR requests one.

Review / Requesting Further Authorisation

11.21 A standard authorisation can be reviewed at any time. Services should ensure that where an authorisation is in place, they keep the need for the DoL under regular review. They should contact the DoLS team and request a review wherever:
- The person’s situation has changed, and this may impact one of the conditions that are in place,
- There is significant change needed to the person’s care plan which means that the reason that the requirements for a DoL are met are different from the reasons when the authorisation was initially given.
- The DoL is no longer felt to be needed / the person no longer meets the eligibility requirements.

11.22 Services must ensure that they keep a record of when a person’s DoLS authorisation is due to end so that, prior to the end of the authorisation, a request can be made for further authorisation should this be required. Local procedures should be put into place to ensure that these ‘end dates’ are monitored and the request for further authorisation is made in a timely manner.

Assessment and Planning

11.23 Services must ensure that copies of any DoLS authorisations are kept with the customers care or support records and that risk assessments and care or support plans are reflective of the fact that an authorisation is in place and of any conditions that have been agreed.

Authorisation Process – Community Settings (Community DoL)

11.24 For people living in the community, in settings such as extra care, supported accommodation with care or at home, a deprivation of liberty will need to be authorised by the Court of Protection rather than by a Local Authority.

11.25 The duty to identify a community DoL generally lies with the authority funding the placement; within Riverside this is usually the Local Authority. Colleagues should be aware of the circumstances which may give rise to a deprivation of liberty (see 11.2 – 11.13) and contact the person's Social Worker where they feel that there may be a DoL occurring if this has not already been identified by the funding authority.

11.26 Local Authorities will sometimes have local referral processes or routes that services can use to flag up a possible community DoL; this may involve completion of notification forms or seeking verbal advice. Service Managers should ensure that teams are aware of what these local processes are so that they can be followed if needed.

11.27 To make an application to the Court of Protection for authorisation of a community DoL a form called a COPDOL11 needs to be completed. This will not be completed by Riverside colleagues; it is completed by the funding authority, often a person's Social Worker. Riverside colleagues may be asked to support in providing information or statements to enable the form to be completed.

11.28 If there are no objections to the proposed care arrangements that amount to a deprivation of liberty then the Court of Protection can review the case based on the papers only. This means that there is often no need for a formal hearing to take place to authorise a community DoL. More contentious cases, for example, where there is objection or disagreement on the most appropriate care plan, a formal hearing may be required.

11.29 The Local Authority have a duty to take a deprivation of liberty back to Court if the care arrangements become more restrictive and/or it is deemed that they no longer meet the person's needs. It is important that colleagues raise any concerns that they have regarding changes to a customer's needs that may impact upon the community DoL authorisation.

11.30 Copies of community DoLS authorisations should be kept with the customers care or support records and risk assessments and care or support plans must be reflective of the fact that an authorisation is in place and written in line with what has been agreed/authorised.

Review

11.31 The Local Authority must make an application to the Court no less than one month before the expiry of the review period set for the DoL authorisation. Colleagues within Riverside services should ensure that they have a record of the review period so that they can follow this up with the customers Social Worker if needed to check that the review process has been initiated.

12. References and Resources

Mental Capacity

Mental Capacity Act Code of Practice - GOV.UK (www.gov.uk)
Mental Capacity Act (MCA) and DoLS | SCIE

Deprivation of Liberty

Deprivation of liberty safeguards: resources - GOV.UK (www.gov.uk)
Deprivation of liberty safeguards: a practical guide | The Law Society
DoLS Resources | Edge Training

Liberty Protection Safeguards (LPS)
https://www.gov.uk/government/publications/mental-capacity-amendment-bill-easy-read
LPS Resources | Edge Training

13. Appendices

Appendix 1 – Pending Legislation Changes

MCA Appendix 1

Appendix 2 – MCA Principles (Further Information)

MCA Appendix 2

Appendix 3 – Mental Capacity Assessment Template

MCA Appendix 3

Appendix 4 – Best Interests Assessment Template

MCA Appendix 4

Appendix 5 – Tips for Assessing Capacity

Appendix 5