Manchester Safeguarding Adults Board

Mental Capacity Act Policy and Procedures

Revised Date: June 2012

Stephen James
Head of Safeguarding and Governance

This policy and procedure must be read in conjunction with the Mental Capacity Act 2005 and its related Codes of Practice. Practitioners are required to have regard for these Codes as the statutory guidance on all MCA and DOLS matters.

Contents

Definition of terms

Capacity:
Capacity is the ability to make a specific decision at the time the decision needs to be made. Ability to make a decision is informed by, for example, a person's ability to understand the decision and why it needs to be made. See the MCC Capacity Assessment tool (Appendix 1) and the MCA code of practice for further information.

The Court of Protection:
The Court of Protection makes decisions for people who are unable to do so for themselves (those who lack capacity). It can also appoint someone (called a deputy) to act for people who are unable to make their own decisions. These decisions are for issues involving the person's property, financial affairs, health and personal welfare.

Best Interests:
Section 4 of the Act provides a statutory checklist of factors that decision-makers must work through in deciding what is in a person's best interests. This is laid out in Manchester's Best Interests tool (Appendix 2).

Acts in connection with care or treatment:
Section 5 clarifies that, where a person is providing care or treatment for someone who lacks capacity, and then the person can provide the care without incurring legal **liability**. The key will be proper assessment of capacity and best interests. This will cover actions that would otherwise result in a civil wrong or crime if someone has to interfere with the person's body or property in the ordinary course of caring. For example, by giving an injection or by using the person's money to buy items for them.

Restrictions, Restraint and Deprivation of Liberty:
Section 6 of the MCA defines restraint as the use or threat of force where an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person or others, and if the restraint used is proportionate to the likelihood and seriousness of the harm.

There is no single definition of a deprivation of liberty. The starting point must be the specific situation of the individual concerned and account must be taken of a whole range of factors such as the type, duration, effect, and the manner of implementation of the restriction and / or restraint measures in question.

There is a scale which moves from no restriction, through varying degrees of restriction, to deprivation of liberty; where an individual is on that scale may change over time. The code of practice gives practitioners a full explanation, and examples of, restriction and deprivation and when it may be appropriate to use either one.

Advance decisions to refuse treatment:
Adults with capacity may make a decision in advance to refuse treatment if they should lose capacity in the future. An advance decision will have no application to any treatment which a doctor considers necessary to sustain life unless strict formalities have been complied with. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands "even if life is at risk".

Independent Mental Capacity Advocate (IMCA):

The statutory Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack capacity, make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about these decisions.

Decision Maker(s):

This is the person who has undertake, or persons who have undertaken, a best interests process to arrive at a decision on behalf of a person who lacks capacity in relation to the 'decision in question', and they either make the best interests decision individually or collectively. See the 'CABIP' tool procedure.

Lasting Power of Attorney (LPA:

The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. The attorney must be registered with the office of the public guardian before they can legally act for the person in regards to decisions in connection with their Property & Affairs and / or decisions as to their Personal Welfare, in their best interests.

Donee:

This is the person who makes an LPA, for either Property & Affairs and / or Personal Welfare.

Deputy of the Court of Protection:

Court of protection deputies are appointed individuals given the power to make decisions about either personal welfare and/or financial matters.

Public Guardian:

The Public Guardian is the registering and monitoring authority for LPA's and deputies.

Managing Authority:

The care home or hospital provider such as acute or foundation trust.

Supervisory Body:

Manchester City Council or NHS Manchester.

Relevant Person:

The customer or patient, as appropriate.

Relevant Person's Representative:

The person appointed by the Supervisory Body to represent the 'relevant person' subject to a DOLS Authorisation.

Best Interests Assessor:

The professional appointed by the Supervisory Body to undertake certain assessments of the six qualifying requirements upon which the DOLS legislation is founded.

Mental Health Assessor:

The professional appointed by the Supervisory Body to undertake certain assessments of the six qualifying requirement s upon which the DOLS legislation is founded.

Standard Authorisation:
A Managing Authority must request a Standard Authorisation when it appears likely that, at some time during the next 28 days, someone will be accommodated in its care home or hospital in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights.

Urgent Authorisation:
Where it is not possible, and the Managing Authority believes it is necessary to deprive someone of their liberty in their "best interests" before the standard authorisation process can be completed, the Managing Authority must itself give an Urgent Authorisation and then obtain a Standard Authorisation within seven calendar days. An urgent authorisation can be for a maximum of seven days but may be extended by the Supervisory Body for up to a further seven days in exceptional circumstances.

1. Introduction

1.1 Purpose and scope of document

This document gives detailed guidance through this policy and the following procedures, for professionals to implement the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DOLS) in Manchester.

1.2 Governance / Structure

Role	Responsibility
Directorate for Adults, Health and Wellbeing	Through MSAB maintain governance and oversight of the implementation of this policy & procedures
MCA & DOLS Lead	• To advise MSAB on any changes or updates relating to the Mental Capacity Act and related regulations • To disseminate information as appropriate
Deprivation of Liberty Safeguards Team	• To act as co-ordinator for all DOLS requests on behalf of both Supervisory Bodies
DOLS Supervisory Body	• To review request for DOLS and grant authorisation if all qualifying requirements are met

1.3 MCA Policy

Manchester Safeguarding Adult Board (MSAB) is committed to ensuring that people who use Manchester services and who may lack capacity to make decisions are provided with high quality care from a knowledgeable and competent workforce.

This policy and the following procedures, alongside the implementation of the related Codes of Practice, aim to ensure that staffs are aware of the requirements of the MCA and are able to comply with their legal duties. The following statutory principles also underpin this policy and its procedures.

1.3.1 Statutory Principles of the Mental Capacity Act 2005

The Act establishes five "statutory principles" which underpin the legislation and which must be applied in all circumstances. These are laid out in section 1 of the MCA (2005), as follows:

1 **Assumption of capacity:** "a person must be assumed to have capacity unless it is established that he lacks capacity."

2 **Assisted decision-making:** "a person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success."

3 **Unwise decisions:** "a person is not to be treated as unable to make a decision merely because he makes an unwise decision."

4 **Best interests:** "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 best interests."

5 **Least restrictive alternative:** "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."

1.3.2 Context of the MCA (and DOLS legislation)

- The **Mental Capacity Act (MCA) 2005** provides the legal framework for acting and making decisions on behalf of individuals of 16 years and over who lack the mental capacity to make particular decisions for themselves. These can be decisions about day to day matters like what to wear, or life changing events such as whether the person should move into a care home or undergo a major surgical operation.

- Everyone working with and/or caring for an adult, who may lack capacity to make specific decisions for them, needs to be aware of and behave in accordance with the Act.

- The MCA also brought into effect, under Section 44, the creation of a new criminal offence of wilful neglect or ill-treatment, and the statutory provision of Independent Mental Capacity Advocates (IMCA's).

- The Act provided for reform of the previous statutory schemes of Enduring Powers of Attorney and of Court of Protection Receivers and created the Office of the Public Guardian (OPG). It created a new legal framework for Powers of Attorney and for Deputies of the Court of Protection, in regard to wider decisions around both Property & Affairs and Personal Welfare. The Act further established the legal status of Advance Decisions, and the lesser role of written statements.

- The **Deprivation of Liberty Safeguards** came into force on 1st April 2009. The Safeguards provide for the lawful deprivation of liberty of people who lack capacity to consent to arrangements for their care or treatment in either hospitals or care homes, but who need to be deprived of liberty in their best interests, to protect them from harm.

- The Safeguards apply to people in England and Wales who are 18 years or older. A large number of such individuals will be those suffering significant learning disabilities, or people with dementias, but may also include people with neurological conditions, for example, as the result of a brain injury, and where the criteria for detention under the Mental Health Act 1983 are not met at the time the care and treatment is proposed

- The Safeguards and accompanying Regulations assign specific statutory responsibilities to local authorities, primary care trusts, hospitals and care homes. Local authorities and primary care trusts are designated as 'Supervisory Bodies' whilst hospitals and care homes are designated as 'Managing Authorities'. The

Safeguards apply to people in hospitals and care homes which are registered under the Care Standards Act 2000, whether they have been placed there by a primary care trust, a local authority or through private arrangements.

- Manchester City Council and Manchester Primary Care Trust, are 'Supervisory Bodies' under the legislation, and have put in place a Collaborative Agreement, which allows for joint arrangements in Manchester for managing DOLS Applications, the Assessments, and where required, the issue and review of DOLS Standard Authorisations.

1.3.3 Training

In accordance with Department of Health directives, staffs across Manchester have access to a range of free MCA related training – both classroom based and e-learning.

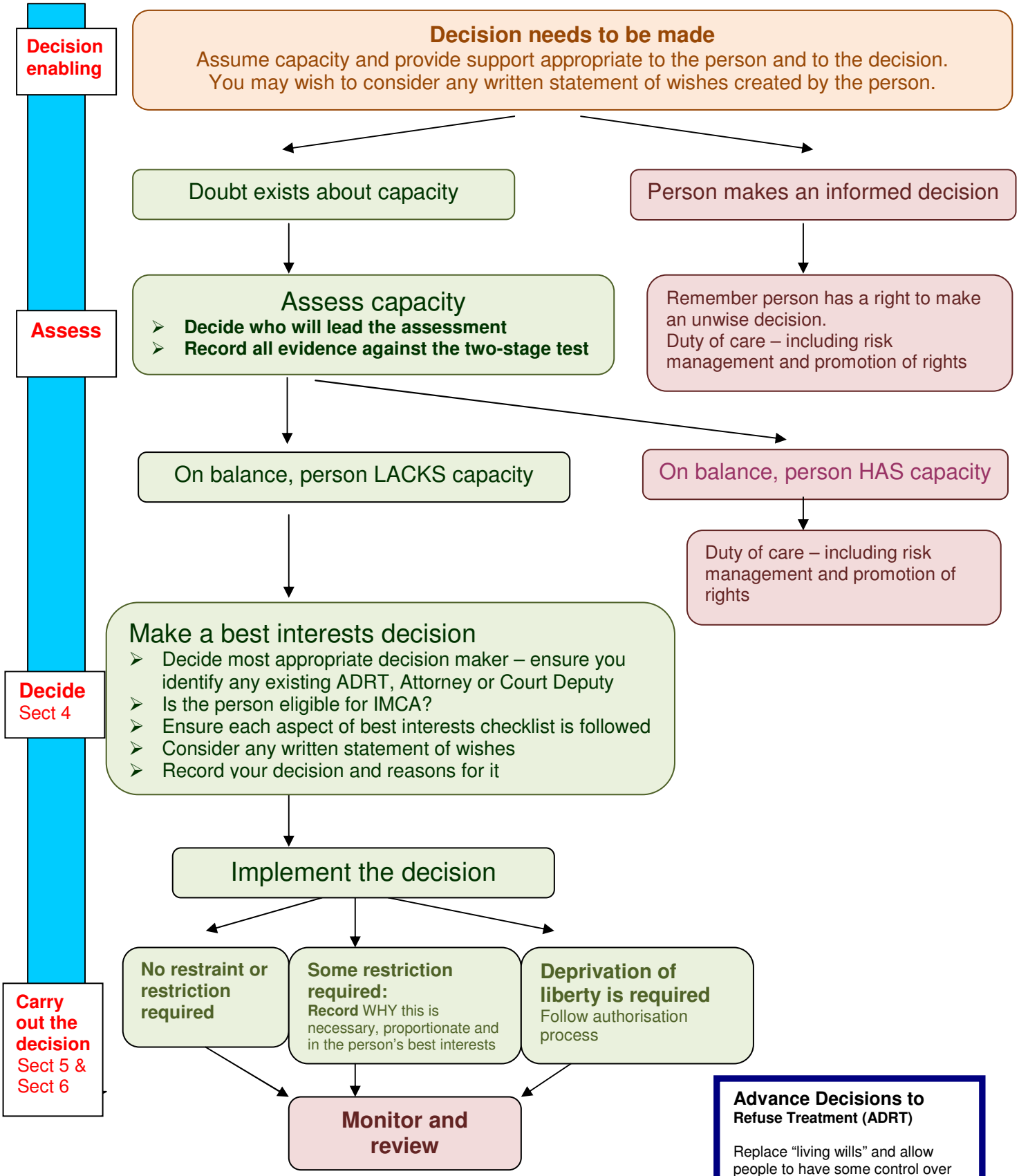
To access free multi-agency training or to discuss your requirements you should contact the Manchester City Council Learning and Events Team on learningandevents@manchester.gov.uk or email the course leader, Emma Fowler on emma.fowler@manchester.gov.uk.

1.3.4 Multi-Agency Scope

This policy and procedures are for adoption, information and application by all signatory agencies staff in respect of all adults at risk receiving care and treatment within or provided by their respective organisations.

Mental Capacity Act Flowchart

This flowchart supports the MCA procedures for all staff



Advance Decisions to Refuse Treatment (ADRT)

Replace "living wills" and allow people to have some control over their medical treatment should they lose capacity in the future.

See Code of Practice for further guidance.

2. MCA Procedures for ALL staff

The following procedures apply to all staff as defined in the above scope who are working with adults who may lack the capacity to consent to their care or treatment, including in circumstances that might be considered a deprivation of liberty.

The Mental Capacity Act outlines the process of enabling vulnerable people to make decisions for themselves and the process of formally assessing capacity where doubt exists about the person's ability to make a **specific decision**. Where a person is deemed to lack capacity the Act describes how we should approach the process of making a best interests decision. Whilst the process is fairly straight forward implementation of it in practice can be complex for example in situations where a person fluctuates in their ability to make decisions. Additional guidance, support and best practice principles are contained within these procedures in order to overcome the common queries professionals may have.

2.1 Support to make a decision

The process of decision making should be based on the five principles of the act and should, first and foremost, involve the person being given all 'practicable' and individualised support to make a decision for themselves. The Code of Practice provides guidance as to how this could be achieved and the information below is intended to complement that. Where possible:

- Delay the decision where the person's capacity may improve and the decision itself is not urgent.
- Provide support at a time when the person is at their highest level of functioning.
- Provide information in an appropriate format and address communication barriers e.g. sensory impairments.
- Use memory aids where helpful.
- Hold the discussion in an environment familiar to the person.
- Give the person enough time to process the information – decision making is often a process.
- Minimise external pressure or coercion that may impact on the individual.

2.2 Assessing Capacity

When assessing capacity, the following points from the Code of Practice should inform practice:

When do I assess capacity?	• When there is doubt about the person's ability to make a specific decision • At the time the decision needs to be made If there is more than one decision to be made then a capacity assessment should be done for each decision
Who conducts the capacity assessment?	The code of practice is not prescriptive about who should assess capacity but the following points may be of help. • For most routine decisions the person who assesses capacity will be the person directly concerned with the individual at that time. • More complex or sophisticated decisions may require a particular professional to lead the assessment. This may be: o The professional proposing the decision o The person who would be the decision maker if they lack capacity o A specific named professional, e.g., a solicitor in relation to legal transactions
How sure does an assessor need to be?	• Capacity is decided on the balance of probability, this is called the 'reasonable belief test' in other words you should be more sure than not.
Where should an assessment be recorded?	However assessments are recorded, the most important thing is to ensure they are evidence based. • Routine assessments can be recorded in any appropriate documentation for example medical notes or care plans. • Specialist or more complex assessments should be recorded on the capacity assessment tool in appendix 1.

To help you determine the difference between a routine or more specialist assessment refer to the diagram below:

Mental Capacity Act: Routine or Specialist Capacity Assessments

To be undertaken where there is a reasonable doubt as to the
Patient / service user's capacity to address the 'decision in question'

Routine Capacity Assessments:

Diagnostic examinations and tests (to identify an illness, condition or other problem).

Professional medical, dental and similar treatment.

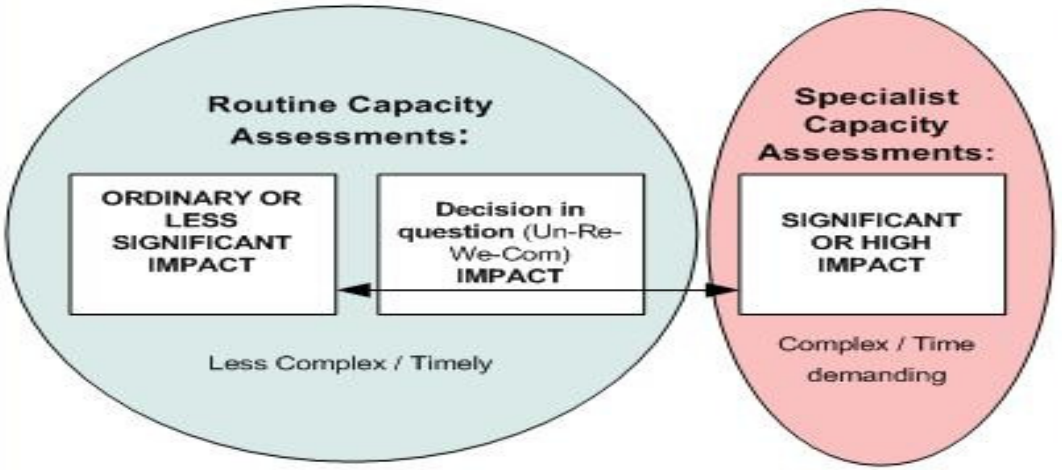
Giving medication

Taking someone to hospital for assessment or treatment

Providing nursing care (whether in hospital or in the community).

Providing necessary medical procedures (for example, taking a blood sample)
or therapies (for example, Physiotherapy or chiropody).

Providing everyday care, for example to assist with: washing, dressing, eating and drinking, mobility and communication, small purchases and bill payments.



A Capacity Assessment is undertaken by a worker with the competence to do so, based upon their knowledge and skills relevant to the needs of the patient or service user, and mindful of the key principles. The assessor may not necessarily be the 'decision maker'. A 'best interest decision' may need to be made where the patient / service user is assessed as lacking capacity.

Specialist Capacity Assessments:

Serious Medical Treatments and Therapeutic Interventions (physical & psychological)

Relevant hospital or care accommodation moves

Adult protection matters

Care Plan Reviews proposing changes of residence or other major quality of life matters

Financial matters involving large purchases, wills, trusts and savings.

Valid & Applicable ADRMT & ADR(LS)MT

All Court of Protection matters, and some Attorney & Deputy of the CoP matters,
as appropriate.

*** Un Re We Com stands for Understand, retain, use and weigh and communicate.**

2.3 Best Interests decision making

When should a best interests decision be made?	• When the person is assessed as lacking capacity.
Who can be a decision maker?	• A range of different decision makers may be involved with a person who lacks capacity to make different decisions. • For most day to day decisions the decision maker will usually be the person caring for or supporting the person on a day to day basis. • Lasting powers of attorney or court deputies will always act as a decision maker within the scope of their legal powers. • Sometimes the decision maker should be the person implementing the decision, e.g. hospital or social care professionals. • A joint decision may be most appropriate for example when creating a care plan.
What should guide the decision maker?	• Decision makers should always follow the statutory best interests checklist which can be found in the MCA code of practice and outlined in the best interests tool (appendix 2) • Give full consideration about whether it would be appropriate to delay the decision. • Always consider whether the person meets the criteria for an Independent Mental Capacity Advocate (IMCA) and appoint one where the criteria's are met. The eligibility criteria are: o The person must lack capacity about a specific decision o The person must be un-befriended (no friends or family who are appropriate/available to consult) o The decision must be about serious medical treatment or a significant change in accommodation (longer than 28 days in hospital or more than 8 weeks in any other setting). • Identify if there is any Lasting Power of Attorney or Court Deputy that should make the decision. • Consider how you will consult others. It is not a requirement to hold a best interests meeting but it may be good practice in some circumstances. • Consider applying a 'balance sheet' approach to assessing the risks and benefits of each alternative. See appendix 3. • Once a decision has been made consider if you need to review it at a later date. • In controversial and complex circumstances, decisions about best interests should be referred to the Courts. This should be discussed with your legal team, engaged in the first instance through your line manager and with the approval of your service.
How should decisions be recorded?	• Routine decisions can be recorded in any appropriate documentation for example medical notes or care plans. • Specialist or more complex decisions should be recorded on the best interest tool in appendix 2.

2.4 Implementing a best interests decision

Once a best interests decision has been made the decision maker will need to consider how the decision will be implemented. They must give thought to how the person's dignity and human rights can be maintained and how any restrictions that may be needed can be minimised.

Section 5 of the MCA provides protection for anyone carrying out actions in connection with care or treatment for people who lack capacity. Any actions taken must always be in the best interests of the person and fully recorded.

In some instances it may not be possible to act on behalf of a person who lacks capacity without using some form of restriction or restraint. Section 6 of the MCA permits the use of restraint in circumstances where it is:

- proportionate to the risk of harm
- absolutely necessary at the time
- in the person's best interests

A restriction could include anything from an instruction to physical or chemical restraint. The code of practice outlines the types of restraint that may be used under section 6.

Section 6 does not sanction restrictions or restraints that are so intense that the person's right to liberty under article 5 of the European Convention of Human Rights is breached. If a person needs to be deprived of their liberty in order to receive care or treatment deemed to be in their best interest authorisation must be sought.

If the person is over 18, they lack capacity, have a mental disorder and are residing either in a hospital or a registered care home, a deprivation of liberty authorisation must be sought from the appropriate supervisory body (See Deprivation of Liberty Safeguards guidance below). Deprivation of liberty in any other setting must be sought via court order. In these circumstances speak to your line manager or legal team. Advice could also be sought from the DOLS team.

There are a range of tools and templates that have been developed by MCC and other organisations that are designed to support practice and achieve the best possible outcome for the individual. The most relevant of these documents have been included as appendices.

3. Deprivation of Liberty Safeguards (DOLS)

Manchester Local Authority and Manchester PCT operate a Collaborative Agreement to undertake the statutory DOLS duties on behalf of both organisations, through joint funding of the DOLS team and ongoing service costs (for example: MHA assessor payments for contracted casework), and management of the workloads and professional activities of Best Interests Assessors, Mental Health Assessors, Paid Relevant Person's Representatives, IMCA's and other activities.

Whilst the bulk of the statutory duties under the DOLS lie with the Managing Authority and the Supervisory Body all professionals are responsible for upholding the human rights of service users- this includes being alert to potential unlawful deprivations of liberty. The commissioners of care are responsible for ensuring that any care package is commissioned in compliance with the Code of Practice for the Mental Capacity Act 2005, and doesn't include an inappropriate deprivation of liberty

Anyone with a concern, for example, a family member, can apply to the Supervisory Body to trigger an assessment to determine whether a person is deprived of liberty, if they have asked the care home or hospital to apply for authorisation but it has not been done. This would lead to the full assessment process if the initial finding is that the person is deprived of their liberty. Deprivation of a person's liberty is a serious matter and should be avoided wherever possible. One important way of avoiding deprivation of liberty is to reduce the amount and intensity of restrictions being applied however possible.

3.1 DOLS Procedures for Managing Authorities (registered homes / hospitals)

The flowcharts on the following pages provide guidance to managing authorities about to identify a potential deprivation of liberty and how to apply for authorisation when a person is being deprived of liberty.

The third flowchart explains the managing authority's responsibilities following an application.

Deprivation of Liberty Safeguards: Flowchart A
Deciding if an authorisation may be needed

The person

- Is over 18 years
- Has a mental disorder (e.g. mental illness, acquired brain injury, learning disability)
- Lacks capacity to consent to the admission
- Is not subject to any powers of the Mental Health Act that would conflict with a DoLS authorisation
- Does not have any other valid decision-making authorities (advance decision, Lasting Power of Attorney, Court Appointed Deputy) that would conflict with a DoLS authorisation

AND

Measures are in place to restrict the person's freedom of movement, for example.

- Close observation and supervision, 1:1 nursing
- Sedative medication
- Distraction/persuasion to control behaviour and freedom of movement
- Preventing them from leaving the unit of bringing them back if they try to leave
- Equipment intended to restrict freedom of movement, e.g. bed rails, chairs (tip-back, deep-seated, with fixed tables), lap straps, gloves, splints, bandaging, helmets
- Locked doors, coded keypads, 'baffle' handles
- Electronics devices – pressure mats, tagging devices
- Physical intervention techniques
- Refusing requests for discharge
- Restrictions on social activities or contacts with other people
- Restrictions on movement within the unit
- Restrictions on outings from the unit

AND

Severity and impact of the restrictions is significant, for example:

- Restrictions are used for frequently and/or for prolonged periods of time
- Restrictions are severe/intense – impact significantly on the person's freedom of movement
- Restrictions have a significant psychological impact on the person, e.g. objecting, distressed
- Relatives/carers object or are concerned that the individual is severely restricted

AND

The restrictions are considered to be in the person's best interests because:

- They are necessary to protect the person from harm
- They are a proportionate response to the likelihood and severity of the potential harm
- Consideration has been given to reducing or eliminating the restrictions

It is possible to minimise the restrictions to a level at which the person will not be deprived of their liberty

- **Immediately take any necessary action to reduce the restrictions so that the person is not deprived of their liberty**
- **Ensure that any remaining restrictions are monitored closely and kept under review**

- The person does appear to be deprived of their liberty **AND**
- It is not considered to be in their best interests to reduce the restrictions further

An application for DoLS authorisation MUST be made (see Flowchart B)

Deprivation of Liberty Safeguards: Flowchart B
The Application Process

PREPARATION: Information required

- The person's age (must be over 18 years)
- Why the authorisation is needed
- Any relevant medical information
- Any diagnosis of mental disorder and if the person is subject to the Mental Health Act
- Your assessment that the person lacks capacity to consent to the admission
- The person's communication style/language
- What restrictions are being used, any less restrictive alternatives considered
- Why deprivation of liberty is required – harm likely if not deprived of liberty
- Relevant assessments and care plans
- Who there is to consult with – whether an IMCA will be required
- Whether there is an advance decision to refuse treatment, a Lasting Power of Attorney or Court Appointed Deputy

↓

IDENTIFY (AND IF POSSIBLE ALERT) THE RELEVANT SUPERVISORY BODY

↓

Planned situation: application needed in advance of admission

↓

Complete Form 4 (application for a Standard Authorisation) and submit to Supervisory Body <u>together with any relevant assessments and care care plans</u>

Unplanned situation: the person is already deprived of liberty

↓

Complete Form 1 (Urgent Authorisation)

- Provide copies to the relevant person and any IMCA involved
- Take steps to help the person understand the effect of the authorisation and their right to appeal (oral and written information should be provided)

AT THE SAME TIME complete Form (application for a Standard Authorisation) and submit to Supervisory Body <u>together with any relevant assessments and care care plans</u>

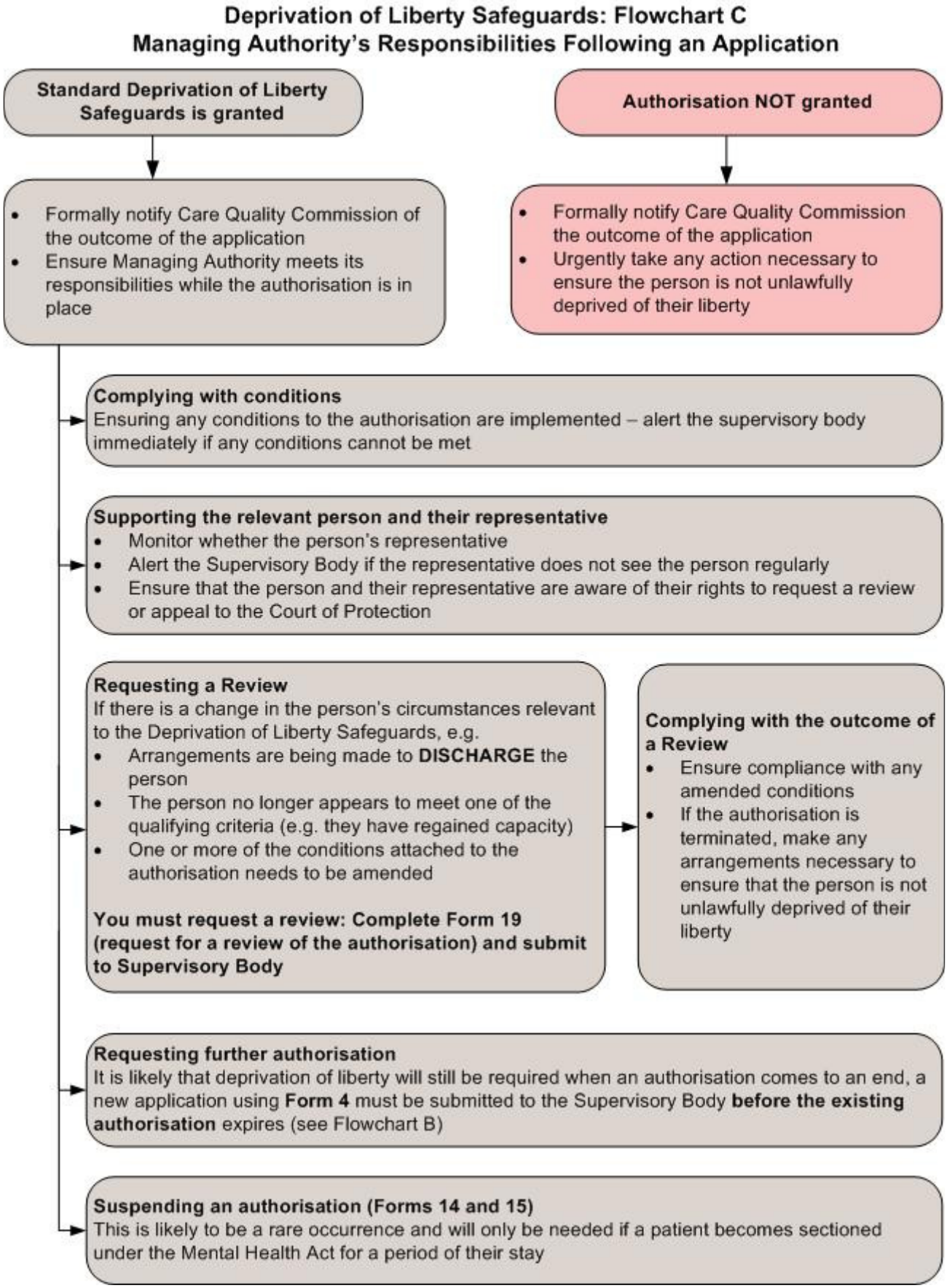
↓

- **Inform the relevant person and any other relevant parties,** including relatives, carers and any IMCA already involved (provide copies of DH leaflets if appropriate)
- **Facilitate the assessment process** by providing assessors with prompt access to:
  - The relevant person, who will need to be interviewed in private
  - Relevant clinical records
  - Staff involved in caring for the person
- **Formally notify Care Quality Commission of the application**

↓

Take appropriate action depending on the outcome of the application (see Flowchart C)

IF, In exceptional circumstances, an extension is required for an urgent authorisation, request this by submitting Form 2 to the supervisory body



To assist Managing Authorities, they can also refer to the **DOLS Individual Scale Tool** which is in appendix 6 and is available at www.manchester.gov.uk to help determine whether a deprivation of liberty is occurring or is at risk of occurring within the next 28 days.

3.2 DOLS Procedures for Supervisory Bodies

It is the role of the supervisory body to ensure a clear application pathway exists. On receipt of an application it is their statutory duty to commission two independent assessors (a DOLS Best Interests Assessor and a DOLS Mental Health Assessor) to complete six assessments within the given timescales. These assessments are:

1. Age assessment
2. Capacity assessment
3. Mental health assessment
4. Eligibility assessment (should the Mental Health Act or MCA apply)
5. No refusals assessment (Are there any legally valid objections?)
6. Best interests assessment

Within Manchester DOLS notifications and applications are received through Contact Manchester. Applications are processed by the DOLS team on behalf of the supervisory body.

If the Best Interests Assessor concluded that the person was not in fact being, or going to be, deprived of liberty, no action is likely to be necessary. They must inform the supervisory body

Where all assessments meet the criteria for an authorisation:

In cases where the independent assessors conclude that the relevant person meets the criteria for an authorisation the supervisory body must:

- Grant the authorisation in writing and include the purpose of the deprivation of liberty, the time period, any conditions attached and the reasons that each of the qualifying conditions is met.
- Consider attaching any appropriate restrictions / conditions to the authorisation, and reducing the time period of a standard authorisation but must not exceed the length of time recommended by the Best Interests Assessor.
- Send a copy of the authorisation to the Managing Authority, the relevant person, any IMCA instructed and all interested persons consulted by the best interests assessor.
- Appoint a representative. If there is no one available among friends or family, then the Supervisory Body will appoint a person, who may be paid, to act as the representative for the duration of the authorisation.
- Consider whether:
    - the intensity of restrictions
    - number of applications
    - accompanying safeguarding issues
    - any disagreement between professionals / family

  Warrant referral to the Court of Protection.

Review of an authorisation:

The Supervisory Body, IMCA, relevant person's representative, relevant person or Managing Authority can request a review of an authorisation at any time but as standard procedure the DOLS team will undertake a review within two weeks of an authorisation being due to cease. At any point during a long authorisation, for example six months or more, a person's circumstances may change so it is important that everyone concerned monitor the progress of the authorisation at timely intervals.

Where one or more assessment is not met but the person is deprived of their liberty:
Where the Best Interests Assessor comes to the conclusion that the best interests requirement is not met, but if it appears to the Best Interests Assessor that the relevant person is already being deprived of their liberty, the Best Interests Assessor must inform the Authorised Signatory for the supervisory body and explain in their assessment why they have reached that conclusion. The supervisory body must:

- Stop the assessment process immediately and inform anyone still engaged in carrying out an assessment that they are not required to complete it
- Inform the Managing Authority, the Relevant Person, any IMCA instructed and all persons consulted by the Best Interests Assessor of the decision and the reasons for it.
- Should the supervisory body have continuing doubts about the matter, it should alert the Care Quality Commission (CQC)

4. Recording

The Code of Practice states that "where assessments of capacity relate to day-to-day decisions and caring actions, no formal assessment procedures or recorded documentation will be required." As the gravity of the decision increases, the need for clear documentation grows.

However, "where professionals are involved, it is a matter of good practice that a proper assessment of capacity is made and the findings of that assessment are recorded in the relevant professional records."

The record of an assessment of capacity should include:

- Documentation of attempts to help the person make the decision themselves;
- Evidence of how the person is able to/unable to understand the information relating to the decision in question;
- Whether the person is able to retain the information, and if their retention is limited, whether they are able to hold the information long enough to make a decision;
- How well the person is able to weigh the decision in the balance (weigh up the pros and cons) in order to come to a decision;
- Where communication is problematic, the ability of the person to communicate the decision.

Full recording of mental capacity will not be needed for all decisions and actions. The Code of Practice gives guidance when professionals should be involved and by implication there is a need for a clearly documented assessment, where:

- a decision has major consequences, (e.g. decision to move accommodation, decision to accept or decline support at home, decision whether to report a criminal or abusive act);
- there may be a dispute with the person, their family 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 capacity (e.g. as a result of a claim for personal injury);
- the person is making decisions that putting him or herself or others at risk or that result in preventable suffering or damage.

These examples are not exhaustive, and each circumstance needs to be judged on its merit, using professional judgment, and support from manager or the care team as appropriate.

4.1 Recording in care plans

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 to help them make decisions. In addition, it is important to clarify where capacity is likely to be lacking, and whether this situation is chronic or fluctuating.

4.2 Recording in the running record

It should be a matter of professional judgment as to the threshold for recording assessments of capacity in the running record.

5. Safeguarding

People who may lack the capacity to make certain decisions may also be less able to protect themselves from abuse or exploitation and therefore be considered an adult at risk.

If you have any concerns that an adult at risk may be experiencing abuse, follow the safeguarding procedures.

By submitting an application in accordance with the DOLS, The relevant person would not usually meet the criteria for an Adult Safeguarding referral and whilst the managing authority co-operates with the process then this would remain the case.

However, there are circumstances where the use of a safeguarding referral should be considered if:

- it is suspected that the managing authority has knowingly not referred a resident or patient in accordance with the DOLS, in order to further deprive them of their liberty ;
- a managing authority refuses to co-operate with an assessor in order to facilitate the assessment process;
- a managing authority fails to adhere to the recommendations of the best interests assessment and the authorisation by the supervisory body.

In the event that a safeguarding referral is submitted during the DOLS process, the DOLS process can not continue until the safeguarding investigation has been concluded.

6. Research

The Mental Capacity Act also sets out clear parameters for Research

Research involving, or in relation to, a person lacking capacity may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees that the research is safe, relates to the person's condition and cannot be done as effectively using people who have mental capacity. The research must produce a benefit to the person that outweighs any risk or burden. Alternatively, if it is to derive new scientific knowledge it must be of minimal risk to the person and be carried out with minimal intrusion or interference with their rights.

Carers or nominated third parties must be consulted and agree that the person would want to join an approved research project. If the person shows any signs of resistance or indicates in any way that he or she does not wish to take part, the person must be withdrawn from the project immediately.

7. Information and Advice

Service	Role	Contact Details
Contact Manchester	All safeguarding referrals are received and processed by Contact Manchester	0161 234 5001 mcsreply@manchester.gov.uk
DOLS team	Execute some of the functions of the supervisory body for example commissioning independent assessors. They also provide help and support for any persons who have queries in relation to the DOLS legislation.	0161 219 2199 peter.drummond@manchester.gov.uk
Adult Safeguarding Team	Ensure that the Adult Safeguarding policies are appropriately and consistently implemented. Provide safeguarding advice and support to any professional.	0161 219 6830 adultsafeguarding@manchester.gov.uk
IMCA (Independent Mental Capacity Advocate).	IMCA is a new type of statutory advocacy introduced by the MCA. The Act gives some people who lack capacity a right to receive support from an IMCA.	For people living in Manchester : Kath Locke Centre 123 Moss Lane East Hulme M15 5DD Phone: 0161 226 3377 Fax: 0161 226 3356 For people living in other areas please contact their local IMCA service.

More information is available on: http://www.manchester.gov.uk

APPENDIX 1: Capacity assessment tool
MANDATORY for **professionals** undertaking sophisticated decisions
(this document has been incorporated into Micare for MCC staff)

MANCHESTER CITY COUNCIL

Manchester NHS Primary Care Trust

ASSESSMENT OF MENTAL CAPACITY

This capacity assessment tool should be used by individuals and multidisciplinary teams when assessing the mental capacity of a person aged 16 years or over to make a decision or take a particular course of action, and if a best interests decision has to be made. The assessor/s should follow the principles and guidance outlined in the Mental Capacity Act 2005 (MCA) and the MCA Code of Practice when undertaking the assessment. A separate form (form 2) is available for a best interests process should this be required.

Name of Service User: .....

Date of Birth .....

MiCare or NHS N°: .....

Address: .....

.....

.....

Postcode: .....

Person/s assessing: .....

Job Title/s: .....

Date/s of assessment: .....

Location of assessment: .....

What is the decision that has to be made (the 'Decision in Question')? Please be as specific as possible.

(Please note: The MCA Code of Practice makes it clear that this should be a particular and time specific decision. If a range of decisions need to be taken then the capacity of the individual should be assessed in relation to each of the individual decisions and documented separately).

Process of completing the assessment *

Duties under the Mental Capacity Act 2005 (MCA) *

* "The MCA 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 this Act 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." (MCA Code of Practice).

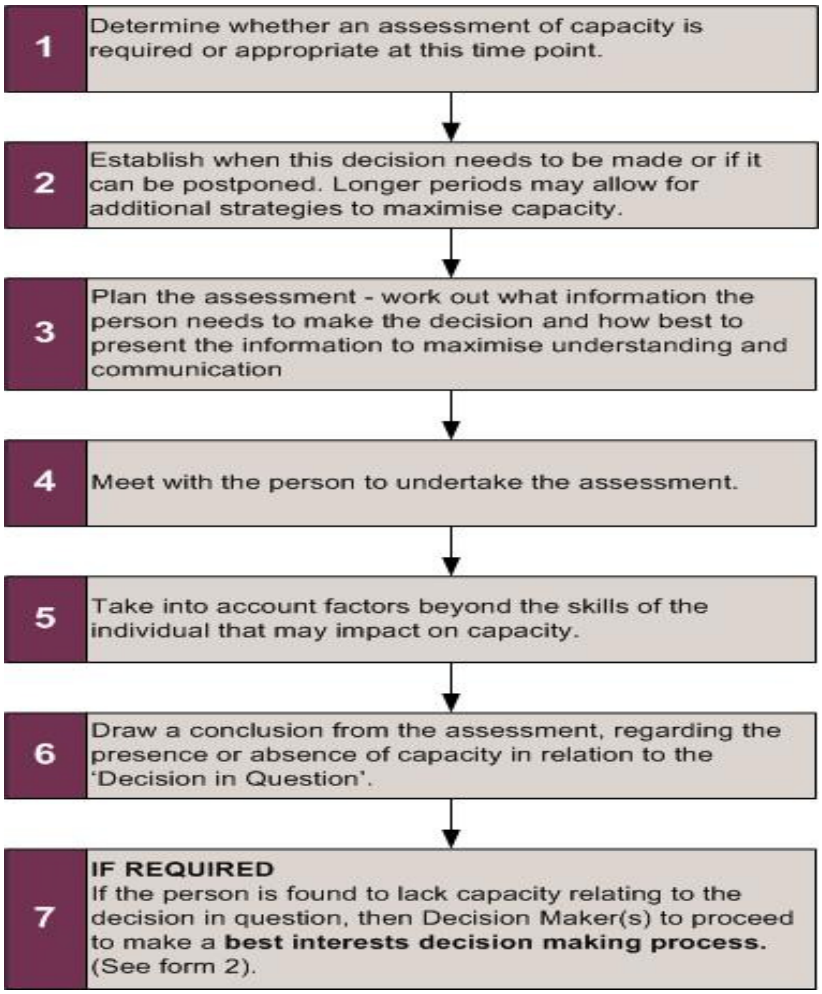
The MCA sets out the five 'statutory principles' – these are the values that underpin the legal requirements in the Act and are founded in the Human Rights Act. These principles should be adhered to when undertaking any assessment of capacity.

The **five statutory 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 him/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/she makes an unwise decision.
4. An act done or a decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his/her best interests.
5. Before 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.

The MCA also introduces a new **criminal offence** of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to a fine and/or imprisonment for a term of up to five years. For further information and guidance please refer to the MCA Code of Practice.

The form that follows is designed to help you establish an individual's decision-making capacity, and takes you through the following steps:



STEP 1: Determine whether an assessment of capacity is required or appropriate at this point in time.

Part 1. Does the person have an impairment of, or a disturbance in the functioning of the mind or brain?	Please provide details	Outcome	
		Yes	☐
		No	☐

If you have answered **NO** to part 1 you should assume that the person has capacity to make the decision. Please proceed to the conclusion to record this outcome.

Part 2. Is the impairment temporary, fluctuating or permanent? If the impairment is temporary or fluctuating can the decision be delayed until the individual's decision making ability has improved?	Please provide details

If you have answered **YES** to part 1 and you are not able to delay the decision to allow for the recovery of capacity then you should proceed to Step 2 below.

STEP 2: Determine the time frame in which you need to undertake this assessment.

Please specify a date or time frame within which this decision needs to be made.*

*It is important to establish this as it informs you how long you have to gather the relevant information necessary for the person to be to make a decision, as well as the requirement to maximise capacity where possible. The Mental Capacity Act Code of Practice (s2.7) states that the level of support depends on personal circumstances, the kind of decision that has to be made and the time available to make the decision. If a decision can be delayed to allow for additional support then the appropriateness of doing this should be considered.

STEP 3: Planning and Preparation Stage*

1.	Please provide details
What information is required for the person to make an informed decision? Is there a choice or are there alternatives?	

2.	Please provide details
How do you plan to present the information to the person (e.g. verbal, written, diaries , visual etc) How are you going to manage any sensory or cognitive difficulties that may be present?	

3.	Please provide details
Are there particular times of the day when the person's understanding or concentration is better? Are there particular locations where the person may feel more at ease?	

4.	Please provide details
Who can help at the preparation stage e.g. gathering relevant information relating to the decision? Can anyone assist to help the person make a decision or express their view (e.g. advocate, carer, interpreter)?	

*In order for an accurate assessment to be undertaken it is important that the individual is presented with adequate information about the decision, including choices and alternatives in a way that is understandable, and in an environment that maximises understanding and communication. This section helps you to think about how to do this before meeting with the person.

STEP 4: The 4-part statutory Mental Capacity Test*

1. **Does the person have an understanding of the relevant information relating to the decision?** This includes why they have to make the decision, options available, consequences of deciding one way or another or making no decision at all?	**Please provide evidence supporting the outcome, including person's responses and quotations where appropriate.**	**Outcome**	
		Yes	☐
		No	☐

2. **Is the person able to hold the information in their mind long enough to use it to make an effective decision?**	**Please provide evidence supporting the outcome, including person's responses and quotations where appropriate.**	**Outcome**	
		Yes	☐
		No	☐

3. **Is the person able to weigh up the information and use it to arrive at a decision?**	**Please provide evidence supporting the outcome, including person's responses and quotations where appropriate.**	**Outcome**	
		Yes	☐
		No	☐

4. **Can the person communicate his / her decision (e.g. talking, sign language, other form of communication)?**	**Please provide evidence supporting the outcome, including person's responses and quotations where appropriate.**	**Outcome**	
		Yes	☐
		No	☐

*The statutory test from the Mental Capacity Act (2005) is designed to establish whether the impairment or disturbance is sufficient enough that the individual lacks capacity to make that particular decision at the time it needs to be made. All four parts must be assessed. Guidance on addressing these areas can be found in the MCA 2005 Code of Practice s4.14 to s4.25.

STEP 5: Take into account additional factors beyond the skills of the individual

Are there additional factors beyond the cognitive and communication skills of the individual which you believe is affecting the person's ability to make a free and balanced decision? This may include external influences such as coercion or threats from others.

Please provide details	**Has this resulted in your opinion in impairment in the person's capacity to make this decision?**	
	Yes	☐
	No	☐

STEP 6: Conclusion*

☐ **Having taken 'reasonable' steps to establish capacity, I consider on the balance of probabilities, that the person DOES have capacity to make this decision**

☐ This decision should be reached if you have answered 'No' to Step 1 P 1 or if proceeding to Step 4 you have answered 'Yes' to all four parts. The influence, if any, of additional factors as outlined in Step 5 above should also be considered.

☐ **Having taken 'reasonable' steps to establish capacity, I consider on the balance of probabilities, that the person DOES NOT have capacity to make this decision**

☐ This decision should be reached if you have answered 'Yes' to Step 1 part 1, and if you have answered 'No' to one or more of the four parts in Step 4.

☐ **I consider that this person has temporary/fluctuating capacity and that the decision can be reasonably and safely DELAYED until such time that capacity can be re-assessed.**

* The MCA 2005 Code of Practice (s 4.10) refers to the level of proof required for claiming that a person lacks capacity. An assessor must be able to show, "on the balance of probabilities, that the individual lacks capacity to make a particular decision, at the time it needs to be made (section 2(4)). This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question."

Signature of person/s assessing: ----------

Post Title of person/s assessing: ----------

Date: ----------

If the person has been assessed as lacking capacity and the decision is not to be deferred then it will be necessary to make a Best Interests Decision on behalf of that individual. In this instance, please proceed to planning and undertaking the best interests decision making process using Form 2: 'Best Interests Decision' template.

APPENDIX 2: Best interests decision template
MANDATORY for **professionals** undertaking sophisticated decisions
(this document has been incorporated into Micare)

MANCHESTER CITY COUNCIL

Manchester NHS Primary Care Trust

BEST INTERESTS DECISION

Note: complete this form if the person has been assessed as lacking capacity in relation to the 'decision in question' and this has been recorded on Form 1 'Assessment of Capacity'.

If the person is found to lack capacity then it may be necessary to make a decision on their behalf. The MCA makes clear that an act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his or her **BEST INTERESTS*,** and adhere to the five principles of the Act.

- **Requirement to take into account all relevant circumstances -** Given that each case is different the law has not specified all factors that need to be taken into account in working out someone's best interests. Decision maker(s) is however advised to take into account all relevant circumstances and the MCA Code of Practice provides a Checklist, which this document provides the key area for consideration. For more detailed guidance please refer to the MCA Code of Practice.

- **Acts in connection with care or treatment** – Section 5 of the MCA clarifies that, where a person is providing care or treatment for someone who lacks capacity, and then the person can provide the care without incurring legal **liability**. The key will be proper assessment of capacity and best interests. This covers actions that would otherwise result in a civil wrong or crime if someone has to interfere with the person's body or property in the course of caring, for example, by giving an injection or by using the person's money to buy items for them. The more significant the best interests decision to address the 'decision in question', the more there is a requirement placed upon the health or social care practitioner to record evidence of not only the capacity assessment of the person in relation to the decision in question, but also the best interests decision process.

- **Court of Protection** - In some specific instances decisions are regarded as so serious that they will have to be deferred to the Court of Protection. Cases involving any of the following decisions should therefore be brought before a court:
    - decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)
    - cases involving organ or bone marrow donation by a person who lacks capacity to consent
    - cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
    - all other cases where there is a doubt or dispute about whether a particular treatment will be in a person's best interests and that this cannot be resolved in any other way (see section 15 MCA Code of Practice).

- **Decisions not covered by the best interests principles -** The following decisions cannot be made in a person's best interests as they are covered by other legal processes and require the person to have capacity, and / or court proceedings, to address:
    - to vote,
    - to marry or divorce (including civil partnerships),
    - to consent to sexual relations,
    - to consent to fertility treatment,
    - or make a decision to place a child up for adoption.

Name of Service User:	
Date of Birth	
MiCare or NHS N^{o}:	
Address:	
Postcode:	
Person/s assessing:	
Job Title/s:	
Date/s of assessment:	
Location of assessment:	

In making a best interests decision please record the following information:

PLANNING AND PREPARATION STAGE

Please specify who the best interests decision maker will be * and the reasons for this choice. If this is to be done jointly please specify all the people involved:

* The decision maker is the person who has the responsibility to work out what would be in the best interests of the person who lacks capacity. The MCA Code of practice makes it clear that the decision maker can be an individual or a group responsible for the care or treatment of the individual or a group of people involved in the care, treatment or support of an individual. It is also important to establish whether the person has a registered **Lasting Power of Attorney (LPA)** or a valid **Enduring Power of Attorney (EPA**), or a **Court of Protection appointed Deputy**. If this is the case then the Attorney or Deputy **may** be able to make decisions on behalf of the person for whom the decision relates **providing it falls within the remit of their legal responsibilities as indicated by the Court of Protection ruling**.

Have any advance decisions been made? If so, are they valid and applicable to the current situation*?

*An advance decision enables someone **aged 18 and over**, while still capable, to refuse specified **medical treatment** for a time in the future when they may lack the capacity to consent to or refuse treatment. Please refer to the MCA Code of Practice for more detailed guidelines around advance decisions. If relevant please record details of the advance decision.

If a valid and applicable advance decision has not been made, or if it is not valid and applicable to the decision in question, then it will be necessary for the decision maker to consider all the decision making options available and to make a best interests decision. Please continue below.

How do you <u>plan</u> to involve the person in the decision making process? This includes finding out the person's values, beliefs and wishes in relation to the decision*

*A person can put his/her wishes and feelings into a written statement or other form of communication if they so wish, which the person making the determination of best interests must consider.

Is a formal Best Interests Decision meeting required?
This may be required if a number of people are involved in the care and support of the individual and a joint decision would be preferable*

Yes ☐ No ☐

*A 'meeting' as such is often the most efficient means of undertaking a best interests decision-making process to arrive at a decision in consultation with relevant parties, however it is not required by the Act to hold a meeting as such - the key requirement is consultation by whichever means this can be effectively achieved to take all views into consideration.

Is it appropriate to involve an Independent Mental Capacity Advocate (IMCA)*, or any other advocate, in the best interests process?

Yes	☐	No	☐

* An IMCA **<u>must</u>** be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), whenever:

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

An IMCA **<u>may</u>** be instructed to support someone who lacks capacity to make decisions concerning:

- Care reviews, where no-one else is available to be consulted
- Adult protection cases, whether or not family, friends or others are involved.

Who do you <u>plan</u> to consult as part of the best interests' process or invite formally to attend a best interest decision meeting*? This will help ascertain the person's values, beliefs and wishes in relation to the decision. Please list individuals and their role.

Name	Job Title or Relation to Person

*Carers and family members have a right to be consulted under the MCA. This would also include anyone else engaged in caring for the person or who is interested in their welfare as well as anyone named by the person as someone who is to be consulted in decisions such as the decision in question. The MCA five principles apply to all those involved in the best interests decision making process, putting the welfare of the person first.

Is there anybody that you intend not to consult as part of this process*? If so, please indicate why.

Name	Job Title or Relation to Person

Please state why:

* The right to be consulted is not absolute, but there must be reasonable / justifiable grounds for not consulting.

BEST INTEREST ASSESSMENT AND CONSULTATION

Who was consulted* as part of the best interests process?

Name	Job Title or Relation to Person

* Consultation may have been done through varying forms of communication such as direct meeting, telephone conversation, or in writing.

If a formal best interests meeting was held who was present at the meeting?

Name	Job Title or Relation to Person

From consultation with others and/or a best interests meeting what opinions regarding the 'decision in question' have been expressed? Please be as specific as possible, recording down any differences in opinion that may have been expressed.

From meeting with the person, what is the person's past and present wishes and feelings in respect of this or similar decisions? If the person has an 'expressed wish' please record down what this is and how it was communicated.

Does the person hold any values or beliefs that would likely influence the decision if he/she had capacity?

THE DECISION

What are the decision-making options?

WHAT IS THE DECISION OR ACTION TAKEN OR PROPOSED ON BEHALF OF THE PERSON?

What were the reasons for reaching/proposing this decision as opposed to other options?

What are the costs (including risks) and benefits of making this particular decision/action?

Is the best interests decision/action the least restrictive option (as required by one of the five statutory principles of the Act)?

REVIEW

Under what circumstances will this decision need to be reviewed?

Is the person likely to gain capacity in the future? If so, will the current best interests decision/action need to be reviewed?

Date of review (if required):	

NAME AND SIGNATURES OF DECISION MAKER/S

Name	Job title or relation to the person	Signature
Date:		

APPENDIX 3: Capacity Assessment Audit tool

Recommended for **all professionals** undertaking sophisticated decisions – the questions relate directly to the MCC capacity assessment tool but could be adapted to suit alternative templates

Capacity Assessment Audit tool

Case details (E.g. MiCare / NHS record):

Name of professional involved:

Auditor:

*This audit tool is intended to accompany the "Capacity Assessment and Best Interests Process forms adopted for use by MCC and NHS Manchester.**

Its purpose is to systematically review assessments against explicit criteria in order to support reflective practice and ensure continuous improvement.

This tool can be used within a supervision context, by individual professionals who want to audit their own work or as part of peer group support arrangements.

*steps referred to in brackets relate to the corresponding steps in the capacity form

1. CAPACITY ASSESSMENT FORM

Planning and preparation	For each section the auditor should indicate: **1. Has this area been *met*, *partly met* or *not met*?** **2. Evidence or reasons for this decision**
Have all appropriate personal details for the person been completed?	
Have all relevant details of assessor been completed?	
Is the decision described in the documentation specific and accurate?	
Step one **Diagnostic test** Does the documentation indicate (in sufficient detail) whether the person has an impairment or disturbance in the functioning of their mind or brain?	
Has consideration been given to whether the decision can be delayed?	

Step two Has a timeframe for the assessment been documented?	
Step three (Information required to make an informed decision) Has the assessor documented exactly what they expect the person to understand, and to what level, in order to demonstrate capacity? *(e.g. the tasks the person would need to complete to be considered to have capacity)*	
Has the assessor presented evidence to show how they plan to present information to the person? *(e.g. providing the info beforehand, consideration of cognitive / sensory/ communication difficulties that may present – and evidence of how they tried to compensate)*	
Has evidence been recorded in relation to times of day when understanding or concentration may be better or in relation to environments where the person may feel more at ease?	
Has evidence been recorded about who could help at the preparation stage? *People / records that would provide relevant information to the decision (e.g. previous assessments, reports, case notes, members of an MDT or family members)*	
Has evidence been recorded about who could help the person to make their decision or help them to express their view? *(e.g. advocates, specialists or interpreters)*	

Functional assessment of capacity (6 steps)	For each section the auditor should indicate: **1. Has this area been *met*, *partly met* or *not met*?** **2. Evidence or reasons for this decision**
Step four Has evidence been recorded in relation to the person's ability to understand the decision in question?	
Has evidence been recorded in relation to the person's ability to retain information long enough to make a meaningful decision?	
Has evidence been recorded in relation to the person's ability to weigh up relevant information and use this information as part of the decision making process? *(the assessor should have made explicit the benefits and risks that the person was being asked to use and weigh as part of the decision)*	
Has evidence been recorded in relation to the person's capacity to communicate their decision?	
Step five Have any additional factors that may effect capacity– and any attempts to compensate for them - been documented appropriately? (e.g. fear or coercion from others)	
Step six Has the conclusion section been fully completed?	
Has the assessor indicated (here or elsewhere) that the person might regain capacity but not before the decision needs to be made? *(This would be a key consideration at the best interest stage if they are deemed to lack capacity)*	
On balance, are you satisfied that the assessment is adequate and meets the reasonable belief test outlined in the legislation?	**(Yes or no only for this question)**

APPENDIX 4: Best interests decision balance sheet template

Recommended for **all professionals** undertaking sophisticated decisions, particularly where the benefits are finely balanced or in instances where there may be disagreement

Best interests decision balance sheet template

How to use this form:

1. Consider using this form for complex decisions. Copy additional sheets where necessary. It should support adherence to the best interest checklist
2. Avoid drawing any conclusions or engaging in debate about the final decision until all the options have been identified and explored
3. Consider "how likely is it that this benefit / risk will be realised?" as part of the decision making process

Option:

Benefits to the customer	Risks posed to the customer

Option:

Benefits to the customer	Risks posed to the customer

MCA & DOLS Workforce Competency Framework

This competency framework provides a template to support the ongoing delivery of an MCA and DOLS Workforce Training and Development strategy, and to maintain a framework of multi-agency staff knowledge, skills and competence in practice in Manchester.

1. Unqualified social care and health care staff, and volunteers (1 – 4)

	Competence	Suggested evidence
1.1	Understanding of what mental capacity is	• Show understanding that a person does not lack capacity to make decisions solely due to an illness, diagnosis, age or disability • Recognise that a person may lack capacity to make one decision while having capacity to make others. • Demonstrate knowledge of their organisation's policies and procedures relevant to MCA
1.2	Recognising the need to assist a person to make their own decision	• Demonstrate ability to help people make their own decisions wherever possible • Demonstrate ability to communicate with people at an appropriate level to help them in their decision-making
1.3	Understanding the process of assessing a person's mental capacity in day-to-day situations (e.g. washing, dressing, eating)	• Show ability to recognise possible risks of making a particular decision and informing more senior member of staff as appropriate • Show ability to recognise the need to refer to a more senior member of staff where more complex decisions are involved
1.4	Understanding the process of making a best interests determination in day-to-day situations	• Demonstrate the need to act on someone's behalf when a person lacks capacity to make the decision themselves (day-to-day decisions) • Show understanding of the need to continue to involve the person in the decision-making process even when they lack capacity to make the decision

2. Qualified health and social care staff and managers (1-10)

	Competence	Suggested evidence
2.1	Understanding the need to assist someone in making their own decision	• Demonstrate ability to recognise when an impairment may be impacting on someone's ability to make a particular decision and implement appropriate support • Demonstrate effective communication with the person to ensure they understand the information relevant to the decision in question • Demonstrate ability to work with "unwise decisions" and ensure ongoing support to the person while protecting their autonomy
2.2	Ability to use the two-stage test of capacity	• Demonstrate ability to recognise – or seek advice about - impairments / disturbances in the mind or brain

	Competence	Suggested evidence
		• Demonstrate ability to assess an individual's ability to understand, retain, use or weigh up, and communicate their decision • Demonstrate ability to identify risks and benefits related to a decision, to clarify the person's ability to weigh the relevant factors in the balance when coming to a decision
2.3	Understanding of the process of making best interests determinations / decisions	• Demonstrate ability to follow the best interests checklist • Demonstrate able to use a "balance sheet approach" to determine best interests • Demonstrate ability to involve families and carers in best interests decision-making and being clear about the limits of their powers. • Demonstrate ability to analyse different views from a variety of people to come to a decision • Demonstrate ability to explain the reasoning for coming to a decision where there are conflicting views
2.4	Understanding who else can make decisions	• Demonstrate ability to identify Lasting Power of Attorney, Deputy, Advance Decision to Refuse Treatment (ADRT), and how to test the validity of each.
2.5	Understanding the relevance of European Convention of Human Rights Article 8 "right to private and family life"	• Demonstrate ability to weigh competing interests to justify 'interference' in a person's life. • Recognising the need to balance a person's wishes and feelings with other • factors when considering the need to make interventions in a person's life.
2.6	Understanding the concept of restraint and restrictions within the MCA	• Demonstrate ability to identify lack of capacity and risk when considering the need for restraint and/ or restrictions. • Demonstrate ability to analyse the likelihood and seriousness of risks in relation to a person lacking capacity. • Demonstrate ability to understand the concept of proportionality where restraint and / or restrictions are involved.
2.7	Understanding the Deprivation of Liberty Safeguards (DOLS)	• Demonstrate ability to understand the concept of deprivation of liberty, and the continuum between restraint, restriction and deprivation of liberty. • Demonstrate ability to advise hospital and care home staff of the legislation and their own statutory duties in relation to DOLS.
2.8	Understanding the role of an Independent Mental Capacity Advocate (IMCA) - 'Standard' IMCA - 'DOLS' IMCA: 39A 39C 39D Relevant Person's Representative: (RPR) ('paid'	• Demonstrate knowledge of the statutory eligibility criteria for instruction of an IMCA • Demonstrate ability to consider whether a person will benefit from an IMCA where there are discretionary criteria (adult safeguarding, care reviews). • Demonstrate ability to communicate effectively with IMCA to ensure the person is adequately supported during the decision-making process. • Demonstrate ability to distinguish the roles of DOLS IMCA (39: A, C & D) and 'RPR' in the DOLS Assessment and Authorisation process.

	Competence	Suggested evidence
	or unpaid))	• Demonstrate awareness of the RPR role, whether 'paid' or 'unpaid', for the person.
2.9	Maintaining accurate, complete and up-to-date records	• Demonstrate ability to record assessments of capacity and best interests within statutory requirements (CABIP tool). • Demonstrate ability to critique case notes created by self and others.
2.10	Supervision and teaching	• Demonstrate ability to teach a professional in training (e.g. student nurse, social worker) how capacity is assessed and supported in this setting. • Demonstrate ability to supervise staff and/or students in mental capacity work to ensure effective practice.

3. Lead and strategic managers in health and social care organisations (1- 3)

	Competence	Suggested evidence
3.1	Protecting the organisation from claims of negligence or malpractice	• Demonstrate ability to provide reports to the Board about the workings of the MCA and DOLS in this organisation.
3.2	Ensuring continuing staff competence	• Show evidence of MCA and DOLS coverage in the regular audit programme and work of the quality/performance teams. • Ongoing delivery of a Workforce Training and Development strategy to support and maintain a framework of multi-agency staff MCA and DOLS knowledge, skills and competence in practice.
3.3	Supporting effective implementation of the MCA & DOLS in local communities of practice	• Show knowledge of transfer protocols between social and health care, acute care and mental health, mental health and primary care. Mutual accountability for shared patients/customers – i.e.: the 'relevant person' as identified in the MCA & DOLS legislation.

APPENDIX 6: **Individual scale tool for DOLS**

Recommended for **all Managing Authorities in Manchester (registered homes and hospitals)**

Individual Scale Tool for DOLS

Use this tool if you are a **Managing Authority** providing care and treatment under the **Mental Capacity Act (MCA) 2005**, to assist you to determine the **scale of restriction or restraints applied** to the care of the relevant person.

Warning: This guide does not apply to individuals **detained** under the Mental Health Act 1983 (MHA), as amended by the MHA 2007**.** However DOLS may be used in parallel with the MHA in some individual cases – see Codes of Practice.

Person / Patient's Name		Care Home / Ward	
Date of uptake of residence, admission, or date of current review		Date of current assessment	

Current Mental Capacity Assessment: Have regard to the 5 Principles of the MCA 2005

Test of Capacity (refer to Mental Capacity Act Section 2 & 3, and the Code of Practice Chapter 4)

Part One - Does the patient / person have a mental impairment of, or a disturbance in the functioning of mind or brain?			Yes / No
Part Two - Does this impairment prevent the relevant person from: Deciding to remain resident / be admitted to hospital for care and /or treatment? Note: This may require time-specific capacity assessments of each 'decision in question' in relation to specific aspects of the care and / or treatment regime and what this involves for the person. The 4 elements of the functional Mental Capacity Test must be addressed below - does the person:			
1) Understand the information relevant to the decision?	Yes / No	2) Retain the information long enough to come to a decision?	Yes / No
3) Weigh the information in order to come to a decision?	Yes / No	4) Communicate their decision?	Yes / No
Outcome of the Capacity Assessment: Does the relevant person / patient have the capacity to consent to remain resident at the home / be admitted to hospital for care and / or treatment?	**YES:** the relevant person **has capacity** If the answer to **all** of the questions above is "Yes" the person has the capacity to decide to remain a resident / be admitted to hospital, for care and, or treatment. The following DOLS Scale Tool need not be applied. **No:** the relevant person **lacks capacity** If the answer to **any** of the questions above is "No" the person lacks the capacity to decide to remain a resident / be admitted to hospital, for care and, or treatment. Please continue with the Individual Scale Tool below.		

If the service user / patient **lacks the capacity to consent** to admission to a hospital, or uptake of residence at the care home for care and / or treatment:

Have alternatives to admission been considered?	Yes / No
Have all parties, relatives and carers been informed of when care plans will be reviewed?	Yes / No
Are there any documented reasons why it is not in the patient's best interests to involve family / carers? Is there anyone suitable to consult with?	Yes / No
Are carers / relatives aware of how they can challenge decisions? (Complaints procedure, Advocacy Service, etc)	Yes / No
Has the patient been offered the support of an Advocate? (Relative / Friend **Not** IMCA – see below)	Yes / No
If there is no suitable person to consult with, i.e. relatives / friend has an IMCA referral been made? (if admission is arranged by the LA and is for more than 8 weeks - see IMCA referral procedure). Engage an IMCA if person is being assessed for DOL	Yes: Please provide date of referral:

Note: To determine whether an individual has been deprived of their liberty, legally defined factors need to be considered such as the type, duration, effects and manner of implementation of the measures in question. The difference between deprivation of and restriction upon liberty is one of degree or intensity; it is useful to envisage a scale which moves from 'restraint' or 'restriction' to 'deprivation of liberty'. See below.

DOLS Matrix – matters to consider for the Individual Scale Tool for DOLS.

This DOLS matrix below enables you to gauge the impact on an individual; using points based within 2 main areas; **likelihood** of they arising, and the **impact** on the individual.

Likelihood

- Restraint is used (including sedation) to admit a person to an institution where that person is resisting admission
- Staff exercise complete and effective control over the care and movement of a person for a significant period
- Staff exercise control over assessments, treatment, contacts and residence
- A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate
- A request from family, friends or carer for a person to be discharged into their care is refused
- The person is unable to maintain social contacts because of restrictions placed on their access to other people
- The person loses autonomy because they are under continuous supervision and control

Impact

- Consider **all** the circumstances of each and every case
- What measures are being taken in relation to the individual, when are they required, for what period, what are the effects, why are they necessary and what is the aim of the steps?
- What are the views of the relevant person, their family or carers?
- Do any constraints on the individual's personal freedom go beyond 'restraint' or 'restriction' to the extent that they constitute a DOL?
- Are there any less restrictive options for delivering care or treatment that avoid DOL?
- Does **the cumulative effect** of all the restrictions imposed upon the person amount to a DOL?

Warning
This is an indicative tool only; full analysis of the individual's circumstances, care and treatment should be considered prior to applying for a DOL. If in doubt, submit an Application for assessment by the DOLS Team.

Use the **Likelihood** and **Impact** points listed to check against the person's care plan. If applicable these factors are to be scored accordingly on the DOLS Individual Screening Tool using the matrix below. The greater the elements of restriction identified in 'impact', coupled with the 'likelihood', then the higher the scoring.

The higher the score, the more likely the need will be for the restrictions to be assessed for a DOL authorisation.

Note: Consider that 'the cumulative effects of all restrictions imposed on a person may also amount to a deprivation of liberty even if individually they would not' (Code of Practice, 26th August 2008).

Likelihood of Restriction factors - Consider the type; Nature / substance manner and their occurrence	**Impact**: Degree or intensity of restriction of liberty. Consider the Duration and Effects				
	Insignificant	**Minor**	**Moderate**	**Major**	**Fundamental**
Certain	5	10	15	**20**	**25**
Likely	4	8	12	16	**20**
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5

Note: A combination of the 2 dimensions of Likelihood and Impact produces 5 ascending risk bands ranging from Insignificant to Fundamental impositions, which may amount to a Deprivation of Liberty. Any restriction or restraint measure which, when scaled, lies within the Orange / Red (Higher numbered) shaded area on the matrix above, should be an indicator to review the measures with a view to compliance with the five principles of the MCA 2005 – in particular 'the least restrictive intervention… of their basic rights and freedoms'.

Please apply the scores obtained from the DOLS **Matrix** above to each of the 7 boxes below:

Restraint is used, including sedation, to admit the person to an institution where that person is resisting admission	Yes – score: No
Staff exercise complete and effective control over the care and movement of the person for a significant period	Yes – score: No
Staff exercise control over assessments, treatment, contacts and residence	Yes – score: No
The person loses autonomy because they are under continuous supervision and control	Yes – score: No
The person is unable to maintain social contacts because of restrictions placed on their access to other people	Yes – score: No
A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere unless, the staff in the institution consider it appropriate	Yes – score: No
A request by family, friends or carers for a person to be discharged to their care is refused	Yes – score: No

Under the MCA DOLS legislation, it is the responsibility of the 'managing authority' of the registered care home or hospital to identify those at risk of deprivation of liberty and to submit an Application to the Supervisory Body for Assessment. Where appropriate, a DOLS Authorisation may then be issued.

Score: 1- 4 points – Green = Insignificant > Minor
Score: 5 -10 points – Yellow = Minor > Moderate
Score: 12 - 16 points – Orange = Moderate > Major
Score: 20 - 25 points – Red = Major > Fundamental

A **red** outcome for any screened area of a person's care and / or treatment regime would indicate a Major to Fundamental restriction or restraint, requiring appropriate safeguards immediately. In this instance, an Urgent Authorisation may be issued by the Managing Authority (care home or hospital.)

Signed:	*Dated:*
Position/job role:	*Location:*