

## Policy for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs)

### 2.1

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## Document History

### Title

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1		Merger of two separate policy for MCA and DoLs	EMC	05/2018

## Associated documents

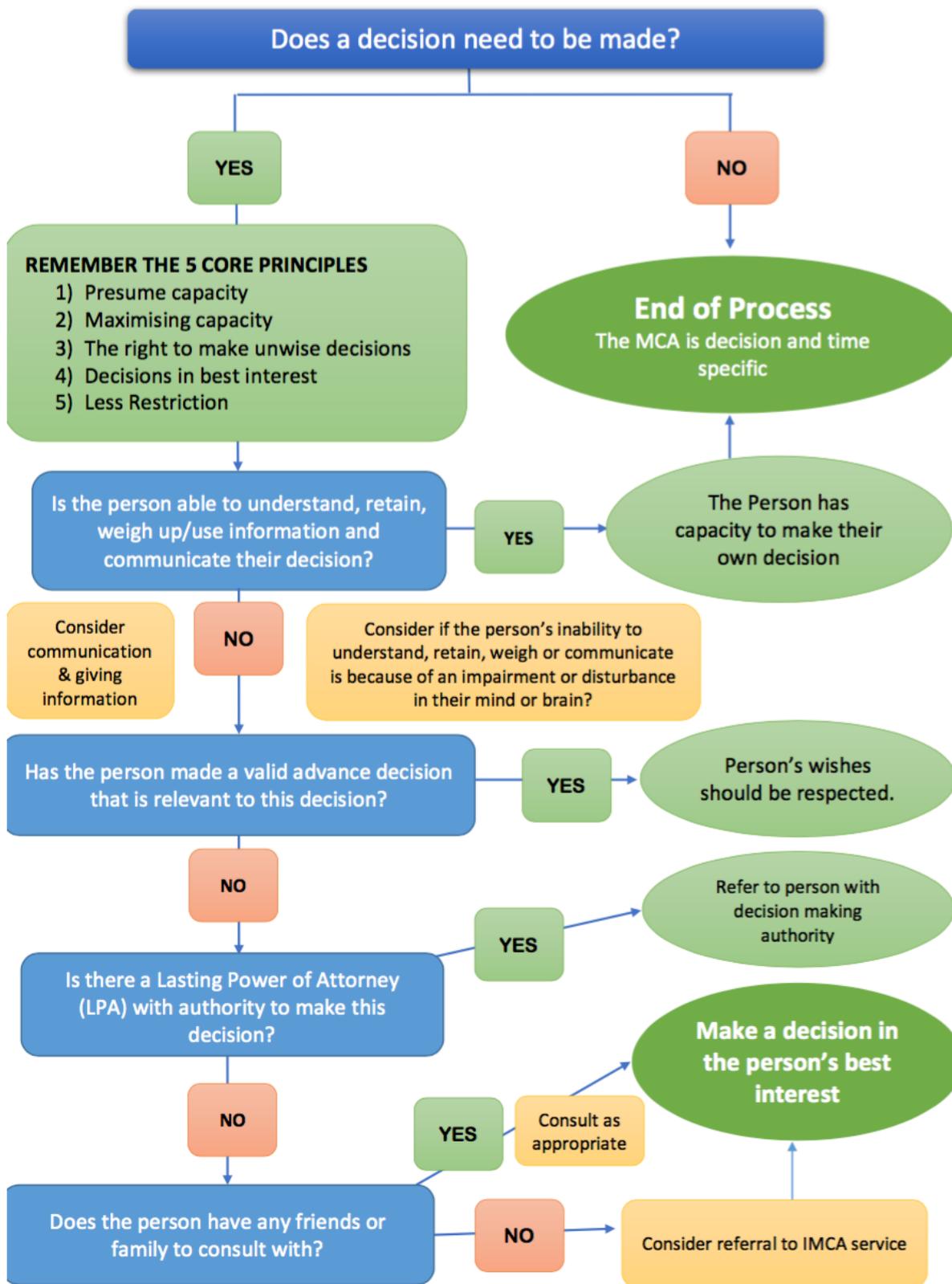
BHT Ref	Title	Location/Link
BHT POL 27	Clinical Record Keeping Policy	<a href="http://swanlive/sites/default/files/guideline_27.pdf">http://swanlive/sites/default/files/guideline_27.pdf</a>
BHT POL 93	Safeguarding Vulnerable Adults Policy and Procedures	<a href="http://swanlive/sites/default/files/safeguarding_adults_policy_bht_pol_093.pdf">http://swanlive/sites/default/files/safeguarding_adults_policy_bht_pol_093.pdf</a>
BHT POL 92	Raising Concerns Policy and Procedure	<a href="http://swanlive/sites/default/files/bht_pol_092_-_raising_concerns_policy_and_procedure_v3.0_rvw_07_2020.pdf">http://swanlive/sites/default/files/bht_pol_092_-_raising_concerns_policy_and_procedure_v3.0_rvw_07_2020.pdf</a>
	Mental Capacity Act 2005	<a href="http://www.legislation.gov.uk/ukpga/2005/9/contents">http://www.legislation.gov.uk/ukpga/2005/9/contents</a>
	Mental Health Act 1983	<a href="http://www.legislation.gov.uk/ukpga/1983/20/contents">http://www.legislation.gov.uk/ukpga/1983/20/contents</a>
	Mental Capacity Act: Code of Practice	<a href="https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice">https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice</a>
BHT POL 206	Professional and Personal Boundaries policy	<a href="http://swanlive/sites/default/files/bht_pol_206_-_personal_and_professional_boundary_policy_v1.1_rvw_03_2018.pdf">http://swanlive/sites/default/files/bht_pol_206_-_personal_and_professional_boundary_policy_v1.1_rvw_03_2018.pdf</a>

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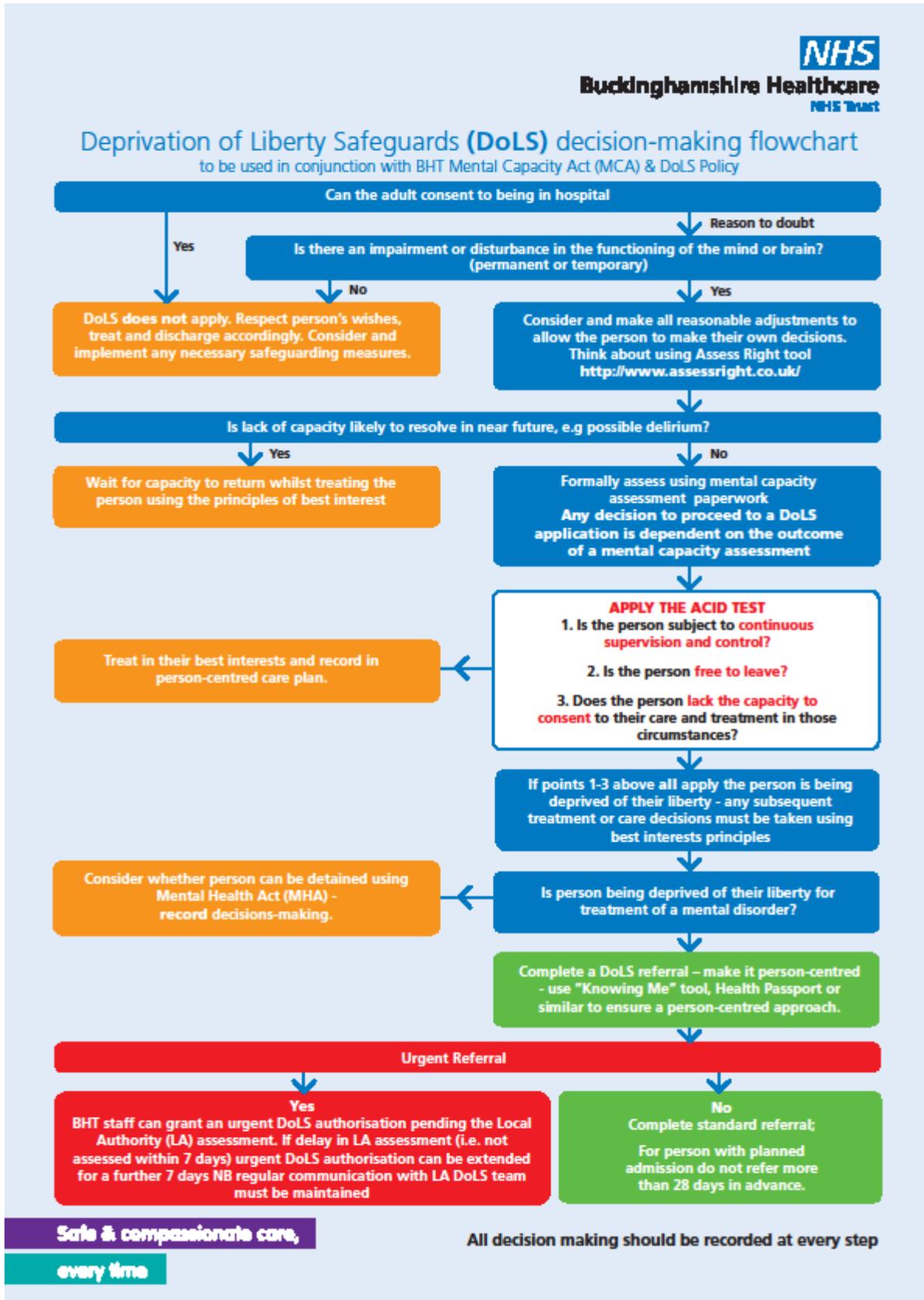
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**Section A: Mental Capacity Flow Chart**



Bogg et al (2016) **Mental Capacity Act 2005: Toolkit for GP's and Primary Care Practice**

**Section B: Deprivation of Liberty Safeguards (DoLS) decision making flow chart**



## **1. Introduction**

The Mental Capacity Act (MCA) (DoH 2005) applies to all people aged 16 years and over and provides a legal framework to empower and protect people who may lack capacity to make some decisions for themselves. The underlying philosophy of the MCA is to ensure that individuals who lack the ability to make specific decisions are the focus of any decisions made, or actions taken on their behalf.

The Deprivation of Liberty Safeguards (DoLS) are an addition to the MCA, introduced and published by the Ministry of Justice, establishing new statutory duties which came into effect on 1<sup>st</sup> April 2009. These safeguards provide positive protection for adults in hospitals or care homes in circumstances that amount to a deprivation of their liberty, but who lack capacity to the care or treatment they need.

## **2. Purpose**

The purpose of this policy is to provide staff working within Buckinghamshire Healthcare NHS Trust (BHT) with direction to enable the effective implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards. This will ensure patients' rights are upheld and that staff act in the patients' best interests at all times.

All staff including bank, agency and volunteers working with adults within BHT have a duty to be aware of its provisions and to act in compliance with the law.

This policy identifies who can make decisions, in which circumstances and what actions must be taken that allow a person to lawfully provide care and treatment to someone who lacks capacity.

This policy also sets out the actions to be taken if a patient presents with a valid Lasting Power of Attorney (LPA) or an Advance Decision Document. An Advance Decision document may also be known as an advance directive or living will.

## **3. Duties and Responsibilities**

Everyone acting in connection with the provision of care or treatment must understand the principles of the MCA as they have a responsibility and duty of care to assess capacity as part of their role.

All staff must make every effort to ensure patients are supported to make as many decisions as possible for themselves.

### **3.1 Key Responsibilities of the Trust in its role as Managing Authority**

To ensure that care is delivered in as least restrictive means as viable that is proportionate and necessary to prevent harm to any patient.

To ensure that consideration is given to the mental capacity of all patients and their ability to consent to services which are provided and whether care actions are likely to result in a deprivation of liberty.

To ensure staff are aware of MCA and DoLS framework.

To ensure that procedures for an application for an urgent and standard authorisations are followed.

To ensure a new authorisation is applied for prior to the expiry of the current one.

To maintain records and ensures that all relevant staff are made aware of whether an authorisation is granted or refused.

To maintain a system to keep copies of all DoLS forms they complete and receive.

**Inform the Care Quality Commission of a DOLs authorisation** - BHT must inform the Care Quality Commission (CQC) about the outcome of applications to deprive a person of their liberty.

**The Trust Board** - is "the managing Authority" but responsibility is delegated to Matron, Ward/Unit Manager level. It will ensure staff have an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards and have access to advice about Mental Capacity and the codes of practice.

**Chief Executive** - of the Trust has executive overall responsibility for the Trusts compliance with the Mental Capacity Act 2005 and the application of DoLS framework, the operational responsibility for the application of this policy and DoLS framework is devolved to the Director of Nursing and the Medical Director.

**Chief Nurse and Medical Director** - are jointly responsible for ensuring Trust compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Divisional Chief Nurses / SDU leads** - are responsible for ensuring that structures and processes are in place to enable staff to carry out their duties under the regulations. Along with all other managers and officers of the trust, they are responsible for ensuring they are familiar with the requirements of the regulations, are trained and competent to carry out their legal obligations when the need arises, and trained and competent to advise and instruct their staff. Each Division or Corporate Directorate is responsible for carrying out its own Training Needs Analysis and putting it into effect through the use of appraisal and personal development plans.

**Matron, Ward/Unit manager** – will take responsibility for confirming decisions re- potential requests to the DoLS team for Urgent Authorisations, and completing the documentation i.e. Form 1 and 4 for each request. They must also take responsibility for liaising, involving and communicating their decisions to the relevant family members or carers. They must document all their actions in the Patients health records and must inform the Consultant who's care the patient is under of the decisions made (the Trust complies with the Caldicott Principles and the Data Protection Act).

**All Clinical Staff** - with responsibilities for care and treatment should appraise themselves of the content of this policy and the requirement to assess restrictive practice should any patient be assessed as lacking mental capacity to consent to any aspect of their treatment or care.

## **4. Definitions**

The term 'patient' is used throughout to reflect the language of the MCA Code of Practice, but terms such as 'community patient' or 'service user' may be preferred locally.

For full glossary of terms and definitions please see appendix 1.

## **5. The Mental Capacity Act (MCA) and the Mental Health Act (MHA)**

A patient under the Mental Health Act 1983, cannot be given treatment for a physical illness without their consent. If the person is deemed to lack capacity to consent to make a decision about treatment for a physical illness then the MCA 2005 must be used.

If the person has capacity to make a decision then they can refuse treatment for a physical illness even if they need it, unless it can reasonably be said that the physical disorder is a symptom or underlying cause of a mental disorder.

## **6. Policy details**

### **6.1 What is Capacity**

Mental capacity is the ability to make a decision.

- This includes the ability to make a decision that affects daily life – such as when to get up, what to wear or whether to go to the doctor when feeling ill – as well as more serious or significant decisions (e.g. life changing events connected with medical treatment or decisions around discharge planning).
- It also refers to a person's ability to make a decision that may have legal consequences – for them or others. Examples include agreeing to, buying goods or making a will.

For every decision about provision of healthcare or treatment Buckinghamshire Healthcare Trust (BHT) staff must know that they are either acting with the person's informed consent or in their best interests (as defined in the MCA); therefore an assessment of capacity is an integral part of the process.

### **6.2 The Five Principles of the MCA**

Section 1 of the Mental Capacity Act 2005 sets out five principles designed to emphasise the fundamental concepts of the Act. All staff are required to work within the statutory duty to implement the Act by adhering to the five principles.

#### **Principle 1: A presumption of capacity**

Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.

This means it cannot be assumed that someone cannot make a decision for themselves just because they have a particular medical condition or disability.

### **Principle 2: Individuals being supported to make their own decisions**

A person must be given all practicable help before anyone treats them as not being able to make their own decisions.

This means that every effort must be made to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that the person is involved as far as possible in making decisions.

### **Principle 3: Unwise decisions**

People have the right to make decisions that others might regard as unwise or eccentric; a person must not be considered to lack capacity because of this.

Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

### **Principle 4: Best interests**

Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.

### **Principle 5: Less restrictive option**

Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention must be weighed up in the particular circumstances of the case.

When implementing the five principles in practice all staff must work in partnership with those identified below and ensure documentation reflects how the Act has been implemented:

- The person,
- Other agencies,
- Informal carers,
- Relevant others.

## **6.3 When to Assess Capacity**

The trigger for assessment of capacity is that a **decision has to be made** ( Section A)

The starting point must always be to assume that a person has the capacity to make a specific decision.

If there are doubts about the person's capacity then a capacity assessment must be carried out.

Assessment of capacity can be informal through daily conversation, but on occasions where there is concern about an individual's ability to understand health/treatment information, the assessment must be formalised and documented.

Doubts about capacity may arise because the person has a diagnosis of impairment in mind or brain function.

An assessment that a person lacks capacity to make a decision must never be based simply on:

- Age
- Appearance
- Assumptions about their condition, or
- Any aspect of their behaviour

It is accepted in law that in an emergency situation it would be inappropriate to lose valuable time formally assessing capacity (see section 9) and that emergency treatment must take precedence. Documentation of the event must always include any discussion had with the patient where this is possible and where the patient is deemed to have capacity. Any treatment provided must always be in the patient's best interests in accordance with the MCA 2005.

#### 6.4 Who Can Assess Capacity?

Anyone can assess capacity. The best person to assess capacity is dependent on the decision to be made. The Act requires a person to be named as the decision maker, and this person is responsible for ensuring the Act's requirements are followed and documented.

#### 6.5 The Decision Maker

The person with overall responsibility for assessing capacity is the Decision Maker as identified in the MCA Code of Practice, and is defined as:

"The person who is **most appropriate** to make a particular decision or has the **specific authority** to make the decision is usually the clinician taking responsibility for medical care and treatment at the time the treatment decision is required".

- For decisions relating to nursing care or therapy provisions then the person who is providing the care of therapy must be assessing capacity to consent to care.
- With regards to discharge planning decisions, the Social Care team are usually best placed to do their own capacity assessment in conjunction with the Hospital discharge Team.

- In cases of complex mental health or of team disputes about mental health concerns, an Approved Mental Health Practitioner (AMHP) may be asked to provide an assessment.

In some circumstances a specialist professional opinion on the person's capacity might be necessary. This could be, for example, from a psychiatrist, psychologist, a speech and language therapist, occupational therapist or social worker. But the final decision about a person's capacity must be made by **the person intending to make the decision or carry out the action** on behalf of the person who lacks capacity – not the professional, who is there to advise.

The name of the decision maker must be recorded. When proven an individual lacks the mental capacity to make the decision, then the process of arriving at a decision of 'best interests' (see section 9.) should commence and be led by the decision maker

It is the responsibility of the Decision Maker to consider and make all reasonable adjustments to allow the person to make their own decisions. (e.g. using an interpreter, Assess Right tool or using picture as appropriate). It is also the responsibility of the Decision Maker to ensure that the questions asked, decisions made and adjustments used are recorded in the clinical record.

## **7. Reasonable Belief**

In most circumstances, it is sufficient for the person assessing capacity to hold a reasonable belief that the person lacks capacity to make a specific decision. Absolute certainty is not required in law, however the assessor would need to be able to give objective reasons for this belief and evidence it through comprehensive record keeping.

The code of practice lays out the nature of decisions that can be made with only a reasonable belief of a lack of capacity. Significant decision, decisions relating to restrain as defined by the Act and decisions that have serious consequences must have a more considered and detailed assessment of capacity.

## **8. Enabling People to Make Decisions**

Staff will be flexible, person centred and responsive to each individual's communication needs. This can be achieved by:

- Providing all information relevant to the decision, including information about any choice or alternatives
- Communicating in a way that the person is most likely to understand.
- Providing information in a format that is likely to be understood by the person, not just relying on written or spoken word, E.G. the use of easy read guides, photographs, symbols, role play and social stories.

- Making the person feel at ease and considering what is likely to be the most conducive time and location for them to make the decision.
- Supporting the person and considering if others can help them to understand information, the risks and the benefits and therefore make an informed choice.

## 9. Formal Assessment of Capacity- (2-stage test of capacity)

BHT staff must carry out a formal two stage assessment using a standard pro forma (Appendix 2).

1. **Is there an impairment of or disturbance in the functioning of the person's mind or brain?**
2. **Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?**

**N.B** the Mini Mental State Examination (MMSE) is **not** a test of capacity but merely another tool that may indicate a disturbance in the functioning of the mind or brain.

**Reasons to consider doubt about a person's capacity could be due to:**

- a stroke or brain injury
- a mental health difficulty
- dementia
- a learning disability
- confusion, drowsiness or unconsciousness because of an illness or the treatment for it
- Substance misuse.

**An assessment of a person's capacity** must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. A person is considered unable to make a decision if they cannot do one or more of the following things:

- Understand the information given to them that is relevant to the decision.
- Retain that information long enough to be able to make the decision.
- Use or weigh up the information as part of the decision-making process.
- Communicate their decision – this could be by talking or using sign non-verbal communication methods and can include simple muscle movements such as blinking an eye or squeezing a hand.

In cases where the patient lacks capacity and requires serious medical treatment the Trust is under a duty to appoint an Independent Mental Capacity Advocate (IMCA). IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. The IMCA will be responsible for bringing to the attention of the professional any relevant information, feelings, beliefs and values of the patient who lacks capacity. The IMCA will be permitted to challenge any decision previously made in the best interests of the patient.

The depth of the capacity assessment will depend on the nature and impact of the decision being made. For significant decisions a more detailed assessment of capacity will be required. The opinion of others may assist in a finding of capacity but the decision as to whether someone has or lacks capacity must be taken by identified decision maker.

The minimum requirements for documenting an assessment of capacity are that the information relating to the stages of capacity are recorded within the clinical record. The record should evidence that the staff member has identified the impairment or disturbance in the functioning of the mind or brain and assessed the ability to understand, retain and weigh up the relevant information to the specific decision and if they have been able to communicate their decision by any means. (This may require additional support to be provided E.G. communication aids, interpreter etc.).

## **10. Best Interest Meeting and Checklists**

When a person is assessed as lacking capacity to consent or refuse care and/or treatment a best interest decision must be made by the decision maker (or an application to the Court of Protection for a court order/declaration).

As with assessments of capacity, each best interest decision must be decision specific and evidenced through care/support planning documentation.

- The Act identifies a clear best interest checklist that should be considered during the process of identifying a person's best interest.
- Will the person regain capacity in order to make the decision?
- If so, can the decision wait until a time the person has regained capacity?
- Has the person been supported and encouraged to participate in the decision making process?
- What are the person's known wishes, feelings, beliefs and values that may impact on the decision being considered?
- Are there any other factors the person would consider if they had capacity to make the decision?
- What are the views of those interested in the welfare of the person?
- Has the person identified anybody to be included in the process?
- Is there a registered LPA or Deputy of the Court who has authority to make the decision being considered?

A "Best Interests" meeting may be needed when a lack of capacity has been established and a serious decision or medical treatment is proposed. The Best Interests route allows all interested parties to have a view and help the decision maker choose whether or not to proceed with the particular course of action or treatment. It is good practice to use a Best Interests checklist, see example below.

The principle of best interests will not apply:

- When someone has previously made an advance decision to refuse medical treatment whilst they had capacity to do so (see section 13 of this policy).

## **11. Deprivation of Liberty Safeguards (DoLs) (Section 2)**

### **11.1 When someone can be deprived of their Liberty**

Depriving someone, who lacks the capacity to consent to the arrangements made for their care and treatment, of their liberty is a serious matter, and the decision to do so must not be taken lightly. The Deprivation of Liberty Safeguards makes it clear that a person may only be deprived of their liberty:

- In their own best interests to protect them from harm;
- If it is a proportionate response to the likelihood and seriousness of harm, and
- If there is no less restrictive alternative.

The European Court of Human Rights (ECtHR) and UK courts have determined a number of cases about deprivation of liberty. Their judgements indicate that the following factors can be relevant to identifying whether steps taken involve more restraint and amount to a deprivation of liberty:-

- Restraint is used, including sedation, to admit a person to an institution where the person is resisting admission.
- Restraint is used, including sedation to prevent a person from leaving an institution.
- Staffs exercise complete and effective control over care and movement of a person for a significant period.
- A decision has been taken by the institution that the person will not be released into care of others, or permitted to live elsewhere, unless the staff in the institution considers it appropriate.
- A request by carers for a person to be discharged to 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.

It is important to remember that this list is not exclusive; other factors may arise in the future in particular cases.

### **11.2 How to identify deprivation of liberty**

In determining whether deprivation of liberty has occurred, or is likely to occur, decision-makers need to consider the facts in each individual case. There is unlikely to be any simple definition that can be applied in every case, and it is probable that no single factor will, in itself determine whether the overall set of steps taken in relation to the relevant person amount to deprivation of liberty (Appendix 4).

The definition of a deprivation of liberty is determined by UK and European Courts and is known as the '**acid test**'.

Currently a person is considered deprived of their liberty if:

- The person is confined to a hospital or care home for any period of time, and
- They are subject to continuous supervision and control, and
- They are not free to leave, and
- They lack capacity to consent to their arrangements

**This means that if a person is subject both to continuous supervision and control and not free to leave they are deprived of their liberty.**

### **11.3 Procedure to be followed by Ward Staff – once a patient is identified as a being deprived of their liberty;**

- Involve Ward manager and Matron
- Inform clinical team overseeing persons care
- Numbers of DoL's on each area to be highlighted at Safety huddle each morning
- Ensure documentation of formal capacity assessment and DoLs form is recorded in the medical records and a care plan commenced indicating care while deprived

It is the responsibility of all inpatient areas where DoLs have been requested to monitor and record the following:

- Patient is lacking capacity;
- Date DoLs requested;
- Whether DoLs has been formally approved by the Supervisory Body, and if so when;
- Expiry date for any urgent DoLs requests or extension;
- Communication with the Supervisory body where a request has not yet been formally authorised but is urgently required.

Failure to adhere the above criteria may lead to a situation where a patient is being unlawfully detained or restricted.

### **11.4 The Trust as a Managing authority**

Under the terms of the DoLS Code of Practice, all care providers are classed as a Managing Authority. As Buckinghamshire Healthcare NHS Trust provides care and has management responsibility for the patient, the Trust is therefore regarded as a Managing Authority.

When a patient lacks capacity and is receiving care where levels of restriction and restraint are so high that they constitute a deprivation of liberty, the Trust must apply for a **Standard Authorisation** to the Supervisory Body (Buckinghamshire County Council) Where deprivation of liberty needs to commence before a Standard Authorisation can be obtained, the Trust is able to grant themselves **Urgent Authorisation** whilst applying for a Standard Authorisation.

## 11.5 Applying for a Deprivation of Liberty Safeguard (DoLS)

BHT uses a standard set of forms published by the Department of Health for applying for authorisation. (Appendix 3)

- Ensure all fields within the form are completed.
- Forms must be completed electronically and emailed via secure ward email to the appropriate DOLS team. The ward Matron, ward manager and the safeguarding team ([buc-tr.adultsafeguardsbht@nhs.net](mailto:buc-tr.adultsafeguardsbht@nhs.net)) must be included in the email.
- Inform patient's NOK / relevant others of decision to apply for authorisation and advise that they will be required to be involved in the process
- If an application for DoLS authorisation is not appropriate at the time of initial assessment, the assessment of restrictive practice will need to be repeated at frequent intervals to ensure that the DoLS status has not increased, thus requiring an authorisation.
- Staff will be notified by the Adults Safeguarding Office of all successful authorisations with dates of expiry recorded by the ward team. Copies of notification must be retained in the patient's medical notes.
- The DoLS record must remain open until the patient ceases to be deprived of their liberty under MCA or until the patient is discharged to another location.

## 12. Documenting and Recording Decisions

All professional staff involved must maintain documentation in line with Clinical Record Keeping Policy [http://swanlive/sites/default/files/guideline\\_27.pdf](http://swanlive/sites/default/files/guideline_27.pdf)

When documenting in relation to care or treatment of a person who may lack capacity the HCP must keep a record of long-term or significant decisions made about capacity in the place where details about a patient or service user are usually noted; care plan, file, Rio or clinical case notes. The record must show:

- What the decision was
- Why the decision was made
- How the decision was made – who was involved and what information was used

Documenting day-to-day assessments of capacity/best Interests decisions must be recorded in the patient's clinical records and the capacity assessment must always be included in the care planning/support plan and treatment process.

## 13. Advance Decisions to Refuse Treatment – ADRT – including life-sustaining treatment, and 'Consent to Treatment'.

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 that treatment. This used to be known as a "Living Will"

People can only make an advance decision under the MCA if they are 18 or over and have the capacity to make the decision. They must say what treatment they want to refuse, and they can cancel their decision – or part of it – at any time. It cannot be used to:

- Demand specific forms of treatment, as there is no right in law to do so
- Require a doctor to do anything unlawful e.g. assist suicide
- Replace a last will and testament
- Dispose of a property
- Appoint executors to a will
- Refer to an event after the person's death e.g. post-mortem

An advance decision to refuse treatment, which has been properly made and is not subject to legal exception (e.g. detention under the Mental Health Act) is a legal document with which the Trust and its employees and agents must comply.

An advance decision to refuse treatment must be valid and applicable to current circumstances; staff must have sight of the documents and make a copy for the clinical records. If a valid advance decision is in place, it has the same effect as a decision that is made by a person with capacity: the Trust and its employees must follow the decision.

#### **14. Lasting Power of Attorney (LPA)**

The Act introduced two new forms of Power of Attorney in October 2007, known as LPAs. These are a LPA for health and welfare, and LPA for property and finance. Where the existence of an LPA is declared, usually but not always by family members, BHT staff must see the original document to ensure that it is registered with the Office of the Public guardian (OPG) and to determine what powers it actually gives, and to whom. A photocopy of relevant pages e.g. treatments refused, names and contacts of donees or deputies etc. for the LPA must be obtained and placed in the clinical record.

#### **15. Court Appointed Deputies**

In some circumstances when a person lacks capacity to appoint a Lasting Power of Attorney, and on-going decisions are required, the Court of Protection may appoint a deputy to make specific decisions. Court appointed deputies make decisions that are as valid as those made by a person with capacity. The Court of Protection will stipulate what decisions can be made by the deputy.

In the majority of cases, the court appointed deputy is likely to be a family member or a person who knows the individual well, but in some cases the court can decide to appoint a deputy who is independent from the family.

As with LPA's, staff must check the powers of any court appointed deputy and when powers have been given associated to welfare decisions a copy of the court direction must be retained within the clinical record.

#### **16. Independent Mental Capacity Advocacy Service (IMCA)**

The IMCA service provides independent safeguards for people who lack capacity to make important decisions and, who are un-befriended (i.e. have no-one else other than paid staff to support or represent them or be consulted).

IMCA **must** be instructed, by the Local Authority or an NHS body, and then consulted, for people lacking capacity who are un-befriended 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
- They will stay in the care home for more than eight weeks

An IMCA may 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.

The IMCA's role is to support and represent the person who lacks capacity. Because of this, IMCAs have the right to access all relevant healthcare and social care records.

Any information or reports provided by an IMCA must be taken into account as part of the process of determining whether a proposed decision is in the person's best interests. A written copy of the final decision, and the decision maker's reasons for it, must be sent to the IMCA Service Manager as soon as possible after the decision is made.

It is vital that clear, accurate and timely identification of the need for an IMCA is made in all cases. Delay in identifying the need for an IMCA is likely to cause delays in medical treatment, discharge from hospital or placement in care homes.

Proceeding with the relevant interventions when the qualifying criteria for IMCA involvement are met, but without instructing an IMCA, will place the Health Trust or Local Authority at risk of legal action, such as Judicial Review.

Staff must consider issues of mental capacity at an early stage of every assessment, and whenever IMCA-qualifying interventions are indicated.

If there is any doubt about a person's capacity to make a decision, the assessment of their capacity must be recorded by the relevant agency to ensure clear decision-making, and timely instruction of an IMCA where necessary.

Contact information for the IMCA Service in Buckinghamshire is Pohwer.

[http://www.pohwer.net/our\\_services/independent.html](http://www.pohwer.net/our_services/independent.html)

For any other areas go to: <https://www.scie.org.uk/mca/imca/find>

Telephone: **0300 020 0092** Fax: **0300 456 2365** Minicom: **0300 456 2364**

Email: [pohwer@pohwer.net](mailto:pohwer@pohwer.net)

## **17. Mental Capacity Act and Young People**

Many aspects of the Mental Capacity Act apply to people aged 16 years and over who may lack capacity to make a specific decision. However the legislative framework for those aged under 18 will continue under the Children Act 1989 and 2004.

If a young person (aged 16 or 17 years) is required to consent to care and or treatment decisions and it is thought the individual may lack capacity, the capacity assessment contained within the Mental Capacity Act must be used to determine the outcome.

If it is deemed following assessment the individual lacks capacity, the decision maker must determine if parental consent is gained under the Children Act 1989 and 2004 or if treatment is delivered under the principles of the Act and a best interest decision is determined. Please note parental consent may only be sought if the decision falls under the zone of parental responsibility.

The zone of parental responsibility is determined following consideration of the specific decision, and if the parent would make that same decision for a 16 or 17 year old who has capacity.

When a young person aged 16 or 17 lacks capacity and is in hospital or in a permanent residential setting consideration must be given to the legal judgement of Birmingham City Council v D & Another [2016] EWCOP.

This judgement determined that once a young person reaches the age of 16, it is not enough to rely on parental consent when the individual lacks capacity to consent to the admission, is under constant supervision, and is not free to leave. Any such case will always need a referral to the Court of Protection for authorisation and at minimum annual review, until the time the individual falls within the scope of Deprivation of Liberty Safeguards (age 18).

The parent of a 16 or 17 year old may not consent to this type of admission and without valid consent of the young person the admission would amount to a deprivation of liberty.

Where staff can demonstrate they have acted in accordance with the Mental Capacity Act their actions will be protected from liability whether or not a person with parental responsibility consents. It is essential that a young person's views are sought on whether their parents should be consulted with during the best interest process.

If a decision is made in which treatment is given with parental consent, the decision maker must inform the parent(s)/ guardian that any decision must be in line with the Act in that decisions will be made in the young person's best interest.

Staff who work with young people who have a permanent impairment or disturbance in the functioning of the mind or brain, supporting families to become familiar with the powers and provisions within the Act is an essential part of the transition work. Families may choose to approach the Court to become a Court Appointed Deputy for welfare or finance, when they turn 18, and information should be provided to assist with this process.

## **18. Equality and Diversity Statement**

This policy has been assessed for its impact upon equality. The equality analysis can be seen in appendices.

Buckinghamshire Healthcare NHS Trust is committed to ensuring that the way we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group.

## 19. Consultation and Review Process

This policy was circulated for review to:

- Chief Nurse
- Medical Director
- Associate Medical Directors
- Divisional Chief Nurses, Divisional Chairs, Divisional Directors
- Head of Patient Safety and Litigation
- Matrons and Lead Nurses
- Information Governance Manager
- SDU Leads
- AHP Leads
- Safeguarding Team
- Safeguarding Committee
- BCC Joint Mental Capacity Act Coordinator and Deprivation of Liberty Safeguards Lead
- CCG lead
- Oxford Health

The policy will be reviewed 3 years from ratification or beforehand if there are any significant changes to national or local policy guidance.

## 20. Monitoring this policy

The Trust Safeguarding Committee and Adults Team will monitor this policy on behalf of the Trust to ensure the effectiveness of the organisation's duties and responsibilities.

Standard/process/issue	Monitoring and Audit			
	Method	By	Committee	Frequency
Training compliance	Safeguarding Dashboard	Safeguarding Adults Team	BHT Safeguarding Committee	Monthly
Quality of capacity assessments	Safeguarding Audit programme	Safeguarding Adult Team	BHT Safeguarding Committee	Annually
Monitoring of applications for authorisation of Deprivation of Liberty	Spreadsheet of applications	Local Teams	BHT Safeguarding Committee	Weekly

## 21. Staff Training

MCA and DoLs training is mandatory for all staff who have direct contact with patients. An employee's role will determine what level of training is required in

order to ensure that they are confident and competent to carry out their responsibilities in respect of the legislation. The Trust, supported by the Corporate Safeguarding Team, will ensure that a sufficient number of internal training events are provided and that access to e-learning and external training events is available to staff as appropriate.

Training is provided for all new staff as part of the monthly corporate induction programme. Regular monthly “pay day training” for MCA and DoLs is available to all staff groups. Bespoke training can be provided by the Safeguarding Team on request. Level three training is available to be booked via the Learning and Development Team.

It is the responsibility of individual staff members and their line managers to ensure that training is completed in line with their personal development plans and training Matrix. This will be monitored by the line manager as part of individual staff appraisal.

## **22. Support for Staff Involved in MCA and DoLs cases**

It is recognised that MCA and DoLs is a complex process to apply. Staff will gain support in the first instance from area managers and wherever necessary, from the Trust Safeguarding Team.

## Appendix 1: Definitions terms of reference

<b>Advance Decision</b>	An Advance Decision is a decision made by a person after s/he has reached the age of 18 and when s/he has the capacity to make such a decision. The effect of an Advance Decision is to enable the person to refuse specified medical treatment at a point in the future when that person has lost the capacity to give or refuse consent to that treatment
<b>Attorney</b>	Someone able to act for another in legal or business matters. An attorney is sometimes referred to as a <b>donee</b> (see LPA)
<b>Best Interests</b>	Acting in someone's best interests simply means trying to do what is best for them, what is most important to them, and what they would have wanted. In doing so, The Act says, the decision maker must, as far as it is reasonable and practicable to do so, take into account the previously expressed views and wishes of the person lacking capacity and the views of others, especially close family or friends.
<b>Court Appointed Deputy</b>	A person, or in some circumstances agency, appointed by the Court of Protection (see below) to act for or make decisions in relation to specified matters on behalf of a person lacking capacity. From October 2007 this replaces the previously existing system of receivership in relation to the property and financial affairs of a person lacking capacity. If there is a need for ongoing decision-making powers and there is no relevant EPA or LPA, the court may appoint a deputy to make future decisions. It can also approve applications from a person who wishes to act for the person without capacity, often next of kin, partner or carer can apply to the Court of Protection to be a Deputy. It will also state what decisions the deputy has the authority to make on the person's behalf. a) A deputy must be at least 18 years old b) The court cannot appoint a person to act as a deputy without his/her consent c) The court may appoint two or more deputies to act jointly, jointly and severally, jointly in respect of some matters and jointly and severally in respect of others d) The deputy is entitled to be reimbursed out of the person's property for his/her reasonable expenses in discharging the functions of a deputy. The court may confer on a deputy's powers to: a) Take possession of all or any specified part of a person's property b) Exercise all or any specified powers in respect of the property, including powers of investment determined by the court. <b>Restrictions On Deputy:</b> A deputy does not have power to make a decision on behalf of a person if he/she knows or has reasonable grounds for believing that the person has capacity in relation to the matter. (For further restrictions of the deputy's role see Chapter 9, Section 20 of the Mental Health Act)
<b>Court of Protection</b>	A specialised court established by the Act with a new

	jurisdiction to deal with decision-making for adults who lack capacity. From October 2007 the new court will take over the role and functions of the former Court of Protection in relation to the management of property and affairs of a person lacking capacity. It will also deal with serious decisions affecting healthcare and personal welfare matters that were previously dealt with by the High Court under its inherent jurisdiction
<b>Decision maker</b>	The decision maker is the person who is deciding whether to take action in connection with the care or treatment of the person who lacks capacity. This will normally be the carer responsible for the day-to-day care, or a professional such as a doctor, nurse, social worker or care manager where decisions about treatment, care arrangements or accommodation have to be made.
<b>Deprivation of Liberty safeguards (DoLS)</b>	Regulations came into force in April 2009 governing the authorisation, on an individual named-patient basis, for applying restraint. The trust is required to apply to its authorising body, which is usually the NHS Buckinghamshire, for any proposal for the restraint of an individual patient
<b>IMCA (Independent Mental Capacity Advocate)</b>	<p>The Independent Mental Capacity Advocate (IMCA) service is a specialised form of advocacy (cf independent advocacy, see below) established by the Mental Capacity Act. From April 2007 any NHS body and Local Authority has a duty to consult with an IMCA where they are making decisions about serious medical treatment and changes of residence for people who have no family or friends. The role of the IMCA is to meet, support and represent the person in the decision making process and ensure that the decision maker effectively follows the best interest process. The IMCA service in Buckinghamshire is commissioned jointly by Bucks County Council and Buckinghamshire PCT. All IMCAs have undergone specialist training in their role. Contact information for the IMCA Service in Buckinghamshire is</p> <p>Powher. Telephone: <b>0300 020 0092</b> Fax: <b>0300 456 2365</b></p> <p>Minicom: <b>0300 456 2364</b> Email: <b>pohwer@pohwer.net</b></p>
<b>Office of the Public Guardian</b>	The Office of the Public Guardian is responsible for the supervision of deputies appointed by the Court and for supporting Court Appointed deputies in their role. The Public Guardian will also be able to investigate any concerns or complaints against deputies or donee appointed under a Lasting Power of Attorney. The office will also keep a register of court appointed deputies and attorneys. All LPA (and EPA) must be registered with this Office.
<b>Power of Attorney (LPA and EPA)</b>	A power of attorney (PoA) is a legal document by which one person ( <b>the donor</b> ) gives another ( <b>the donee</b> ) power to act

and make decisions on their behalf. The Act introduced two kinds of Lasting Power of Attorney (LPA).

- A Property and Affairs LPA gives powers to a chosen Attorney(s) to make decisions about financial and property matters e.g. such as selling the person's house or managing their bank account.
- A Personal Welfare LPA gives powers to a chosen Attorney(s) to make decisions about the person's health and personal welfare, such as where a person must live, day-to-day care or having medical treatment.

The difference between the two types of LPA is that a Personal Welfare LPA only takes effect when the person is found to lack capacity to make decisions. With a Property and Affairs LPA the person can specify that the Attorney must only start managing their financial affairs after they lack capacity sometime in the future. If they do not specify this, the Attorney can start using the LPA after it is registered, but while the person still has capacity. Prior to the implementation of the Act a power of attorney could either be Ordinary PoA or Enduring PoA. Both of these related solely to management of the donor's property and financial affairs. An Ordinary PoA was automatically revoked once the donor lacked capacity. However, the Enduring PoA allowed the attorney (the donee) to continue to act on behalf of the donor even after the donor ceased to have capacity providing the donee had registered the EPOA. Unless it has been replaced by an LPA, an OPG registered EPA will still be valid. Separate applications are required for each LPA, obtainable from the OPG, guidance and a list of fees is included in the package.

The applicant must be over 18 and be able to understand what it means. To check this and to prevent fraud, they need to provide a „Certificate“, which is part of the LPA form. The Certificate must be signed by an independent person (not family or partners of donor or donees) stating that the applicant fully understands what is involved in making the LPA, what it means to have one in place and that no fraud or undue pressure is being used to create the LPA. After completing the form and the Certificate the LPA must be registered with the OPG before it can be used. The applicant can also choose who they want to be notified when the LPA is being registered. This does not have to be family; it is up to the applicant at the time. There is OPG guidance for the public available on the internet (link below) and by post - *Making decisions ...about your health, welfare or finances. Who decides when you can't?*

<http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/opg-601-0409.pdf>

*Also:*

<http://www.justice.gov.uk/downloads/forms/opg/lpa-guidance-health-and-welfare.pdf>

<http://www.justice.gov.uk/downloads/forms/opg/lpa-guidance-property-affairs.pdf>

<http://www.justice.gov.uk/downloads/forms/opg/lpa-guidance-registering-your-LPA.pdf>

## Appendix 2

### Two stage Mental Capacity Assessment

Page 1 of 2

Details of person being assessed:

Write details in space if no label available

Include MRN NHS number and DoB *See guidance note 2*

Affix patient label here

Capacity Assessment - Stage one

**See guidance note 3**

**Please give one or more examples of an impairment or disturbance in the functioning of the person's mind or brain:**

- |   |   |
|---|---|
| <input type="checkbox"/> Mental illness               | <input type="checkbox"/> Head Injury/Traumatic Brain Injury             |
| <input type="checkbox"/> Dementia                     | <input type="checkbox"/> Stroke/Acquired Brain Injury                   |
| <input type="checkbox"/> Learning Disability          | <input type="checkbox"/> Confusion, drowsiness or loss of consciousness |
| <input type="checkbox"/> Alcohol or drug intoxication | <input type="checkbox"/> Other medical condition                        |
| <input type="checkbox"/> Any other - please specify   |   |

**Please indicate whether the impairment or disturbance is**

- partial                       temporary or                       long-term

**Then go to Capacity Assessment Stage Two**

Capacity Assessment - Stage two

**See guidance note 4**

**Does the impairment or disturbance mean that the person is unable to make this decision within the timescale indicated below?**

**Ensure you have provided all practical / appropriate help and support to help the person to make the decision before moving to the next. Please detail here how you have done this:**

"Assessing ability to take the decision"- **please answer the next four questions**

**For a person to be able to make a decision they need to be able to do each of these four things. Please provide evidence of how you decided yes or no to each question. If you answer NO to ANY of these questions then the person lacks the capacity to take the decision.**

1	Does the person <b>understand</b> the relevant information about the decision?	Yes	No
2	Is the person able to <b>retain</b> the information/explanation long enough to make the decision?	Yes	No
3	Is the person able to <b>weigh</b> the information in the balance as part of the process of making the decision? (Note: this does not require that a person comes to the same conclusion as others, simply that they are considering consequences etc.)	Yes	No
4	Is the person able to <b>communicate</b> their decision either by speech, sign language or by any other means?	Yes	No

Affix patient label here

Two stage Mental Capacity Assessment  
**page 2 of 2**

Assessing ability to take the decision

**See guidance note 5**

<p><b>Reason for Assessment (decision to be made)</b></p> <p><i>See guidance note 6</i></p> <p><input type="checkbox"/> Proposed change of residence</p> <p><input type="checkbox"/> Medical treatment</p> <p><input type="checkbox"/> Safeguarding intervention</p> <p><input type="checkbox"/> Other-please indicate brief reason here or in clinical notes</p>	<p><b>Time scale for assessment:</b></p> <p><i>See guidance note 7</i></p> <p><input type="checkbox"/> Today</p> <p><input type="checkbox"/> One week</p> <p><input type="checkbox"/> One month</p> <p><input type="checkbox"/> Six months</p>
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**Sign here to confirm your belief about the person’s capacity to take the decision (delete a or b)**

- a. I believe the patient has capacity to take this decision \*
- b. I believe the patient does not have the capacity to take this decision\*

<p>Name and title of Assessor – the “Decision-maker”</p>  <p><b>PRINT</b></p>	<p>Signature</p>  
<p><b>Date of Assessment:</b></p>	<p><b>Place of Assessment:</b></p>

**If the 2-stage test for capacity has been completed and you have reasonable belief (as evidenced above) that the person lacks capacity to make the decision then a decision must be made in the person’s best interest, using the least restrictive option.**

The following information will help in this process. **See guidance notes 8, 9 & 10**

**Is there a family member or friend or other person who can act in the person’s best interests?**

**Check for any valid evidence of Advance Decision or Lasting Power of Attorney?**

**Write name and contact details here, tick nature of contact: - See guidance note 9**

Specify nature of contact

- Family member                       Friend                                       Other professional  
 Holder of EPA (see copy)       Holder of LPA (see copy)  
 Deputy, appointed by the Court of Protection

**If the person is unbefriended and no AD or LPA you may need to instruct an IMCA  
See Code of Practice Ch 10                      See guidance note 10 for contact details**

**Date of referral to IMCA service (currently Pohwer) \_\_\_\_\_  
\_\_\_\_\_**

Further specialist opinion **See guidance note 12**

<p><b>Do you wish to seek a further opinion about the nature of this person's capacity?</b></p> <p><b>If so, indicate: GP <input type="checkbox"/> Other doctor <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech Therapist <input type="checkbox"/> Psychiatrist <input type="checkbox"/></b></p> <p><b>Date of request:</b></p>
---

## **Mental Capacity Assessment Form Guidance Notes**

### **1. Rationale**

The Mental Capacity Act provides a statutory framework for people who lack the capacity to make decisions for themselves in connection with their care or treatment. The layout of this form ensures that if completed in full, capacity assessments will have been taken in accordance with the Mental Capacity Act (MCA) 2005. It is not necessary for this form to be completed every time a decision is taken for someone who lacks capacity, but it **must always be completed where a decision is being taken about serious medical treatment, a change in long-term residence or where an IMCA is instructed**. The following notes explain why certain information is requested.

### **2. Personal Details**

Either MRN and NHS number for health care situations or SWIFT number for social care situations must be given. Home address or usual residence must always be given. Place(s) where assessment has taken place must also be given.

### **3. Capacity Test-stage One**

If there **is** impairment then it is important to indicate whether the impairment is partial, temporary or long term, as the capacity to take a decision may fluctuate and you must not assume lack of capacity for all time, for any decision.

### **4. Capacity Test-Stage Two**

Chapter 3 of the Code of Practice discusses all that must be considered when helping a person to make a decision. The help a person needs will depend on the person themselves (their communication needs etc.), as well as the decision that needs to be made. Decision-makers must ensure to record how they have sought to help a person to make a decision as, must an assessment of capacity be challenged, this information will determine whether you have complied with the Act.

### **5. Assessing ability to take the decision**

If you answer NO to any one of these four questions, then the person lacks the capacity to take the decision in question.

### **6. Reason for Assessment**

MCA capacity decisions are always decision-specific, so it is important to show clearly what decision is being taken.

### **7. Time scale**

This recognises that some decisions must be taken without delay, especially where illness or serious medical treatment is required. Other decisions may require some time to elapse before a reasonable decision can be taken. This question prompts you to establish a reasonable decision-making time frame for the decision which has to be taken, including the time required to arrange for appropriate methods of communication, which could involve, for example, making a DVD, or arranging interpreting facilities.

## 8. Details of family, friends or others and IMCA instruction

You must always consult widely with family or friends, not just “next of kin”. Best interests decisions must be decided by a group of interested parties, not simply one individual. See Chapter 5 of the Code of Practice for guidance on how to meet achieve a best interests decision.

## 9. Power of Attorney

Where a family member or friend states that they hold power of attorney, they must be asked to produce a copy of the original document verifying this and a record of this must be made, either on SWIFT or in the medical notes. An enduring power of attorney (EPA) is still valid; as long as it has been registered with the Office of the Public Guardian BEFORE the person has lost capacity. If this has not happened, then it is invalid and application must be made to the Court of Protection to appoint a deputy. It is important to ensure that the person claiming the power is in fact entitled to do so. An EPA only provides for decisions to be taken on behalf of someone in respect of finance and property, **not** health and welfare. A lasting power of attorney (LPA) can be made in respect of property and finance decisions **or** health and welfare decisions, but they are two separate documents. More than one person may hold power of attorney. See Chapter 7 of the Code of Practice for more information about LPAs.

## 10. Advance Decision

An advance decision to refuse medical treatment reflects a general principle of law and medical practice that people have a right to consent to or refuse medical treatment. If an advance decision is thought to exist, its validity must be checked carefully. See Chapter 9 of the Code of Practice for full details of this.

## 11. IMCA Service

This service provides safeguards for people who lack capacity to make a specified decision at the time it needs to be made.

An IMCA *must* 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
- an NHS body or local authority is proposing to arrange accommodation (or a change in accommodation) in hospital (>28 days) or a care home (>8 weeks)

An IMCA *may* be appointed to support someone who lacks capacity to make decisions concerning:

- Care reviews where no-one else is available to be consulted
- Adult protection cases - even where family members or others are available to be consulted

Contact information for the IMCA Service in Buckinghamshire is Pohwer.

Telephone: 0300 020 0092

Fax: 0300 456 2365

Minicom: 0300 456 2364

Email: [pohwer@pohwer.net](mailto:pohwer@pohwer.net)

Bucks County Council MCA Policy: The policy is an internal BCC document, but a copy can also be obtained from the MCA lead at BCC.

Sarah Jane Pady, Joint Mental Capacity Act Co-ordinator and DoLS Lead,  
Supervisory Body and Safeguarding office, Room 111, Old County Offices, Walton Street

### Appendix 3: Guidance on Application Forms- DoLS

There are six main forms that the Trust may need to complete.

The forms are available on the Trust Intranet Site- Safeguarding Adults-Deprivation of Liberty Safeguards

Form	Purpose
<b>Form 1</b>	This form must be used if the Trust needs to give itself an <b>Urgent</b> authorisation to deprive a person of their liberty.  <b>Form 1 Urgent Authorisation-DoLS</b> <a href="http://swanlive/policies-guidelines/deprivation-liberty-safeguards-dols">http://swanlive/policies-guidelines/deprivation-liberty-safeguards-dols</a>
<b>Form 2</b>	This form must be used if there is a risk that an Urgent authorisation will expire before a standard authorisation can be given.
<b>Form 4</b>	This form must be used to request a <b>Standard</b> authorisation, including when an existing standard authorisation is coming to an end and the persons care or treatment still needs to be provided in circumstances that will amount to a deprivation of their liberty.  <a href="http://swanlive/policies-guidelines/deprivation-liberty-safeguards-dols">http://swanlive/policies-guidelines/deprivation-liberty-safeguards-dols</a>
<b>Form 14</b>	This form must be used if a standard authorisation is in force and the person then ceases to meet the deprivation of liberty safeguards eligibility qualifying requirement under the <b>Mental Capacity Act 2005</b> . For example because the person has been detained under the <b>Mental Health Act 1983</b> that conflicts with the terms of the standard authorisation.
<b>Form 15</b>	This form must be used to lift a previous suspension of a standard authorisation, for example, because a person who was detained under the Mental Health Act 1983 has now had their detention lifted.
<b>Form 19</b>	This Form must be used to request a formal review of a standard authorisation under <b>Part 8 of Schedule A1</b> to a Mental Capacity Act 2005

**The Supervisory Body for Buckinghamshire is Buckinghamshire County Council, County Hall, Walton Street, Aylesbury HP20 1YU**

**Advice phone line: 01296 382195**

**Fax no. for referrals: 01296 383338**

**Email: [DOLS@buckscc.gov.uk](mailto:DOLS@buckscc.gov.uk)**

**DoLS/MCA Best Interests Assessment Checklist** - see hyperlink to the; Buckinghamshire County Council, Deprivation of Liberty Safeguards Team DoLS/MCA Best Interests Assessment Checklist :

[http://swanlive/sites/default/files/mca\\_dols\\_best\\_interests\\_check\\_list.pdf](http://swanlive/sites/default/files/mca_dols_best_interests_check_list.pdf)

#### **Appendix 4: Deprivation of Liberty Safeguards (DoLS) Quick reference guide for Managing Authorities**

To request a standard authorisation or make an urgent authorisation, contact the Supervisory Body below, **you may also contact this office for advice and guidance**

**The Supervisory Body for Buckinghamshire is Buckinghamshire County Council, County Hall, Walton Street, Aylesbury HP20 1YU Advice phone line: 01296 382195 Fax no. for referrals: 01296 383338**

Email: [DOLS@buckscc.gov.uk](mailto:DOLS@buckscc.gov.uk)

All requests must be made only to this office.

If you wish to apply for a DoLS authorisation, please fax the relevant forms to our confidential fax number above. You will find the forms you require at:

[www.gov.uk/search?q=deprivation+of+liberty+safeguards#government-results](http://www.gov.uk/search?q=deprivation+of+liberty+safeguards#government-results)

Scroll down this web page to download documents without background colour (for scanning and faxing), in Rich Text format. A standard authorisation is Form 4 and an urgent authorisation is Form 1.