Adult Social Care and Health Directorate

Mental Capacity Act 2005
and
Deprivation of Liberty Safeguards
Policy and Practice Guidance

Document Information

Document title:	Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) Policy and Practice Guidance
Owner for KCC (Adults):	Sarah Denson, Assistant Director, Strategic Safeguarding, Policy, Practice and Quality Assurance Adult Social Care & Health Directorate, Invicta House, Maidstone, Kent, ME14 1XX
Owner for KCC (Strengthening Independence Service):	Sharon Howard, Assistant Director, Strengthening Independence Service – Disabled Children and Young People 0-25 Sessions House, County Hall, Maidstone Kent ME14 1XQ
Reviewed by:	Catriona Brodie, Policy and Quality Assurance Officer aschpolicyandqualityassuranceteam@kent.gov.uk
Status:	Final
Version no:	5
Replaces:	All previous versions called MCA & DoLS Policy and Practice Guidance
Next Review date:	**Please note that this document will be fully reviewed once the Liberty Protection Safeguards come into force and the new Code of Practice is published**
Master Location:	Strategic Safeguarding, Policy, Practice and Quality Assurance
Publication:	Kent ASC & Health Documents and Templates (trixonline.co.uk)
Authorised to vary:	Policy & Quality Assurance Team

Document Governance

Owner	Date	Sign Off
ASCH	18.06.2024	Senior Management Team
CYPE	06.06.2024	Countywide Services Director
CYPE	25.07.2023	Countywide Services Management Team
ASCH	18.04.2023	Senior Management Team
ASCH	11.10.2022	Senior Management Team
CSWS	17.10.2017	CSWS, Div MT
ASCH	07.09.2017 19.10.2017	DC, LD/MH Div MT OPPD Div MT

Version	Date	Issued by / Amended	Changes
V.1.0	May 2011	S. Smith	New policy
V.2.	Nov 2017	C. Brodie & L. Sheridan	Remove seconded staff Add concerns about coercion
v.3	Oct 2022	K. Dapaah C. Brodie	Appendix added - Guidance for virtual BIM
v.4	May 2023	C. Brodie, E. Parsons J. Cunningham R. Henn-Macrae	Process for Community DoL
v.5	May 2024	C. Brodie	Changes from Community DoL Task & Finish Group

Contents

Part 1 - Introduction

1. Glossary

ADASS	Association of Directors of Social Services
ASCH	Adult Social Care and Health Directorate
BIA	Best Interests Assessor
BICA	Background Information and Contact Assessment
COP	Court of Protection
DoLS	Deprivation of Liberty Safeguards
ECHR	European Convention of Human Rights
EPA	Enduring Power of Attorney
EWHC	High Court of England and Wales
FABO	Finance and Benefits Officer
GP	General Practitioner
ICB	Integrated Care Board
ICS	Integrated Children's Services
IMCA	Independent Mental Capacity Advocate
KCC	Kent County Council

KMPT	Kent & Medway NHS & Social Care Partnership Trust
LAS	LiquidLogic Adult Service
LIN	Kent & Medway Local Implementation Network
LSSA	Local Social Services Authority
LPA	Lasting Power of Attorney
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983 (Amended 2007)
NHS	National Health Service
OPG	Office of Public Guardian
RPR	Relevant Person's Representative
SA1	Adult Protection Form
SDS	Self Directed Support
SIS	Strengthening Independence Service

2. Definitions of Terms

2.1. Advance Decision to Refuse Treatment (ADRT)

An ADRT is a decision to refuse specific treatment made in advance by an individual who has capacity to do so. The decision will then apply at a future time when the person lacks capacity to consent to, or refuse the specified treatment.

Please note: *Specific rules apply to advance decisions to refuse life sustaining treatment.*

2.2. Best Interests (BI) Decision

A BI Decision is any decision made, or anything done for an individual who lacks capacity to make specific decisions. The decision must be in the individual's best interests. These are the requirements of the statutory best interests checklist *(For more information please see S.12, Best Interests page, 31),* which have to be met, including involving the individual and consulting all relevant others when working out what is in an individual's best interests such as, taking into account their views, their wishes, their lifestyle and beliefs.

Please note: *Any best interests decision made should be the least restrictive*

2.3. Best Interests Assessor (BIA)

An Approved Mental Health Professional (AMHP), social worker, nurse, occupational therapist or chartered psychologist. A BIA must have a 2 years post-qualification and have completed the approved training to be a BIA.

2.4. Capacity

The ability of an individual to make a decision regarding a particular matter at the time the decision needs to be made.

2.5. Children

Children are referred to in the MCA Code of Practice as being individuals aged **below 16**. This differs from the Children Act 2004 and other legislation where the term *"child"* is used to refer to individuals under the age of 18.

2.6. The Court of Protection (COP)

The COP has the same power as the High Court. The Mental Capacity Act 2005 (MCA) sets out the powers the COP has including:

- To make orders or give directions relating to an individual without capacity in their best interests

- To call for reports from the Office of Public Guardian (OPG, a COP Visitor, a Local Social Services Authority (LSSA) or a NHS body.

In complying with this requirement the OPG or COP Visitor may:

- Examine and take copies of health and social care records relating to an individual without capacity
- Interview the individual in private
- Carry out in private a medical, psychiatric or psychological examination of the individual's capacity and condition (Special Visitor only)

For additional guidance **when to make an application to the COP** please see the document by the Association of Directors of Adult Social Services (ADASS) **at:** https://www.adass.org.uk/media/5894/court-of-protection-guide-for-council-staff.pdf

2.7. Court of Protection (COP) Visitors

COP Visitors are appointed by the Court to investigate with the LSSA a case of suspected abuse or to check on the welfare of an individual who lacks capacity.

2.8. The Decision Maker

Under the MCA there are many different people who may be required to make a decision or act on behalf of an individual who lacks capacity to make decisions for themselves. The person making the decision is referred to throughout the MCA Code of Practice as *"the decision maker".* It is the responsibility of the decision maker to determine what would be in the best interests of the individual who lacks capacity.

2.9. Deprivation of Liberty Safeguards (DoLS)

DoLS is an additional legal framework that was introduced as an amendment to the MCA (2009) to strengthen the rights of individuals who lack capacity to decide about their care and treatment. They do not apply to individuals detained under the MHA. They were introduced to

prevent breaches of the European Convention of Human Rights (ECHR), as highlighted by the Bournewood case (HL v U.K, 2004)

For additional guidance please see **"Quick Guide to DoLS"** by ADASS **at:** https://www.adass.org.uk/media/5894/court-of-protection-guide-for-council-staff.pdf

2.10. Deputies

Deputies are appointed and directed by the COP to make decisions in the best interests of those who lack capacity in relation to their property/financial affairs and/or health and welfare. They are vetted under the Disclosure and Barring Scheme and will be supervised by the OPG. The COP defines their powers and limitations. They are required to submit reports and to keep records. They have a right to be consulted as appropriate, and their *"best interests"* view should be agreed or the matter will be brought to court.

2.11. A Donee

A Donee is a person named by the individual when they have capacity who will represent them at times when they lack capacity.

2.12. A Donor

A Donor is an individual who at the time has capacity to delegate decisions regarding their welfare and/or their property and finances to a nominated person known as a Lasting Power of Attorney (LPA).

2.13. Enduring Powers of Attorney (EPA)

An EPA is a legal process in which a person (the Donor) hands over to someone else (the Attorney) the power to decide what is done with their financial affairs and property. They were replaced in October 2007 by Property and Affairs LPAs. A registered EPA only covers decisions relating to a Donor's financial and property affairs, when they lose capacity.

2.14. The High Court of England and Wales (EWHC)

The EWHC (usually known simply as the High Court) is, together with the Crown Court and the Court of Appeal, one of the Senior Courts of England and Wales. It deals at first instance with all high value and high importance cases. It also has a supervisory jurisdiction over all subordinate courts including, the COP.

2.15. Ill Treatment

A person must either have deliberately ill treated the individual or be reckless in the way they were treating the individual such as to be likely to cause harm or damage the victim's health.

2.16. An Independent Mental Capacity Advocate (IMCA)

An IMCA provides an additional safeguard to an individual who:

- Lacks capacity to make a specific decision at the time it needs to be made

- Is facing a decision about a change of accommodation or about serious medical treatment

AND

- Has nobody else (other than paid staff) who is willing and able to represent them or be consulted in the process of working out their best interests (MCA Code of Practice, 10.1)

An IMCA may also be instructed to support an individual at their care review and if s/he is subject to a safeguarding investigation *(For more information please see Part 2: S.5. "The Role of the IMCA", page 18)*

The help IMCAs provide to individuals should include:

- Support for the individual
- Represent the individual in discussions
- Provide information to help work out the individual's best interests
- Raise questions or challenge decisions, which appear not to be in the individual's best interests (MCA Code of Practice, 10.4).

For additional guidance and an **Easy Read information leaflet about an IMCA** please see **Tri-x**

2.17. Lasting Powers of Attorney (LPA)

An LPA is a legal process in which a person (the Donor) chooses someone else (the Attorney) that they trust to make decisions on their behalf at a time in the future when they either lack the mental capacity or no longer wish to make those decisions themselves. The Attorney is **legally required** to have regard to the MCA Code of Practice when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves.

There are two types of LPA:

- Property and Affairs LPAs when the decisions could be about the Donor's property and financial affairs
- Personal Welfare LPAs when the decisions could be about the Donor's health and personal welfare.

Please note: *A Donor can have both.*

2.18. Managing Authority

A body, which *"manages"* a care home or a nursing home or a hospital

setting including acute and mental health. A managing authority must identify every individual who lacks capacity to consent to their care **and/or** treatment arrangements **and** who is at risk of being deprived of their liberty. In each case, the managing authority must apply to a *"Supervisory Body" (For more information please see, S.2.28. "Supervisory Body", page 10)* for a *"standard authorisation"* to deprive that individual of their liberty.

For additional guidance please see **the KCC website at:**
www.kent.gov.uk/mentalcapacityact **"DoLS"**

2.19. Mental Health Assessors

A doctor who is approved under S.12, MHA or a registered medical practitioner with at least 3 years post-registration experience in the diagnosis or treatment of mental disorder **and** completed the relevant training to be a DoLS Mental Health Assessor.

2.20. The Office of the Public Guardian (OPG)

The OPG supports and promotes decision making for those who lack capacity, within the framework of the MCA. Established in October 2007, the OPG supports the Public Guardian in registering and supervising EPAs and LPAs and supervising COP appointed Deputies.

For additional guidance please see **the OPG website at:**
https://www.gov.uk/government/organisations/office-of-the-public-guardian

2.21. Personal Welfare LPA

A Personal Welfare LPA allows the Donor to appoint an Attorney to make decisions on their behalf about their health and welfare. A registered Health and Welfare LPA can **only** be used in relation to the specific decisions for which the Donor has given authority when the Donor lacks the capacity to make these decisions for themselves.

Please note: *A Personal Welfare LPA* ***cannot*** *make any Property and Affairs decisions about the donor, unless they have been granted a Property and Affairs LPA.*

2.22. Powers of Attorney

People who lack mental capacity may require someone else to manage their financial, social and health affairs. The MCA made provision for people to choose someone to manage not only their finances and property should they lose capacity, but also to make health and welfare decisions on their behalf. They will be able to do this through a LPA. Property and Affairs LPAs replaced EPAs in 2007.

Please note: *that EPAs registered before 2007 are still valid dependent on restrictions contained within the document.*

2.23. Property and Affairs LPA

A Property and Affairs LPA allows the Donor to appoint an Attorney to manage their finances and property whilst they still have capacity to make decisions for themselves. For example, it may be easier for them to give someone the power to carry out tasks such as paying their bills or collecting their benefits or other income. So a registered Property and Affairs LPA could act on behalf of the Donor in this way if the Donor chooses before the Donor loses capacity. Alternatively, the Donor may include a restriction that the LPA can only be used at a time in the future when they lack the capacity to make decisions for themselves for example, due to the onset of dementia in later life or as a result of a brain injury.

Please note: *A Property and Affairs LPA* ***cannot*** *make any Health or Personal Welfare decisions about the donor, unless they have been granted a Personal Welfare LPA.*

2.24. A Receiver

A receiver is a person appointed by the former COP to manage the property and affairs of an individual lacking capacity to manage their own affairs. Existing receivers continue as Deputies with legal authority to deal with the individual's property and affairs

2.25. Relevant Person's Representative (RPR)

An RPR is a safeguard to ensure the rights of the individual being deprived of their liberty are protected. They are usually, the relevant person's friend or family member but where an individual is un-befriended **or** the friend/family member is unwilling **or** unable to fulfil this role a paid RPR will be appointed by the Supervisory Body. An RPR has certain responsibilities including, maintaining regular contact with the relevant person, representing him/her and supporting him/her.

2.26. Restraint

Restraint is the use of or threat of force to help do an act, which the individual resists. Alternatively, it is the restriction of the individual's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the individual from harm and is proportionate to the likelihood and seriousness of the harm.

2.27. A Rule 1.2 Representative

A Rule 1.2 Representative writes a statement to explain whether they think that it is in the person's best interests to have a package of care and support that would include depriving them of their liberty. The COP reads the statement to help them decide whether to authorise the deprivation of liberty.

2.28. Standard Authorisation

A Managing Authority must request a Standard Authorisation when it appears likely that, at some point in the next 28 days, an individual will be accommodated in its care home or hospital in circumstances that amount to a *"deprivation of liberty"* (Article 5, ECHR).

2.29. A Supervisory Body

A Supervisory Body is responsible for considering a DoLS application and commissioning the statutory independent assessments. In cases where all the assessments agree the Supervisory Body is responsible for issuing a DoLS authorisation.

For additional guidance please see **the KCC website at:**
www.kent.gov.uk/mentalcapacityact **"DoLS"**

2.30. Un-befriended

Un-befriended refers to an individual who has no friend, family, nominee or legal representative in effective contact with them. Alternatively, it applies to when any of the aforementioned is **not** willing **or** appropriate to represent the individual's best interests.

2.31. Urgent Authorisation

When a Managing Authority believes it is necessary to deprive someone of their liberty in their *"best interests"* **before** the Standard Authorisation process can be completed it **must** give itself an Urgent Authorisation **and** apply for a Standard Authorisation at the same time. An Urgent Authorisation can be issued by a Managing Authority for a maximum of 7 days but may be extended by the Supervisory Body for a further 7 days in exceptional circumstances.

2.32. Wilful Neglect

The meaning varies depending on the circumstances but usually refers to a failure to carry out an act the person knew they had a duty to undertake or complete.

2.33. Young People

The MCA refers to young people as being aged 16-17 years.

3. Purpose of this Policy and Practice Guidance

3.1. The MCA was passed in 2005 and came into effect in 2007. It provides how to determine and make decisions on behalf of individuals who lack capacity to make specific decisions themselves.

3.2. The DoLS were introduced into the MCA through the MHA and came into effect in 2007. Their main aim is to avoid deprivation of liberty, wherever possible **and** that where deprivation of liberty does need to occur, it has a lawful basis.

3.3. This policy and practice guidance aims to promote compliance with the legislation, for all those in KCC working with an individual who may, or does, lack capacity to make a particular decision at a particular time.

Please note: *This is to be viewed as a supplement to, and* ***not*** *a replacement for, the statutory MCA Code of Practice or any other national guidance and case law*

For additional guidance please see **the KCC website at:** www.kent.gov.uk/mentalcapacityact **"Guidance Notes"**

3.4. This policy and practice guidance **must** be read in conjunction with:

- Disability Discrimination Act 1995
- Human Rights Act 1998
- Data Protection Act 1998
- The Mental Health Act 1983 (Amended 2007) (MHA)
- The Care Act 2014
- The Mental Capacity Act 2005 (Amended 2009) (MCA)
- The MCA Code of Practice, in particular, S.1 (Guiding Principles)
- The Deprivation of Liberty Safeguards (DoLS) Code of Practice
- Kent and Medway NHS and Social Care Partnership Trust's (KMPT) CPA Policy
- Kent and Medway's Safeguarding Adult policies

3.5. The MCA **must** be considered with every decision and in relation to every policy and guidance but in particular:

- Needs Assessment
- Safeguarding
- Financial Assessment
- Care and Support Planning
- Direct Payments
- Outcome Focussed Reviews
- Risk Management
- Carers

3.6. Failure by a KCC practitioner to adhere to the principles of the MCA Code of Practice can result in disciplinary action and/or dismissal from their relevant registered body.

3.7. If a KCC practitioner is found guilty by the court of breaching the principles of the Code of Practice s/he could be fined and/or imprisoned up to 5 years.

3.8. The S.44, MCA introduced two criminal offences namely:

1. Ill treatment either deliberately or by recklessness and by doing so cause harm to the individual's health

2. Wilful neglect such as, a failure to carry out a statutory act

Please note: *These offences can be carried out by:*
the person responsible for the individual's care
or their LPA/EPA
or their Deputy

4. Five Statutory Principles

4.1. S.1, MCA and S.2, MCA Code of Practice sets out five statutory principles, which are designed **not only to protect** individuals who lack capacity **but also help** them take part, as much as possible, in the decisions that affect them.

1. Assumption of capacity:
"An individual **must** be assumed to have capacity unless, it is established that s/he lack capacity"

2. Assisted decision-making:
"An individual 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. Unwise decisions:
"An individual is **not** to be treated as unable to make a decision merely because s/he makes an unwise decision"

4. Best interests:
"An act done, or a decision made, under the MCA for or on behalf of an individual who lacks capacity must be done, or made in their 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 effectively achieved in a way that is less restrictive of the individual's rights and freedom of action

Please note:
*These principles underpin the legal requirements of the MCA and therefore, **must** be followed at all times.*

4.2. Case Example of an "unwise" decision:

5.

Mr Garvey is a 40-year old man with a history of mental health problems. He sees a Community Psychiatric Nurse (CPN) regularly. Mr Garvey decides to spend £2,000 of his savings on a camper van to travel round Scotland for six months. His CPN is concerned that it will be difficult to give Mr Garvey continuous support and treatment while travelling, and that his mental health might deteriorate as a result.

However, having talked it through with his CPN, it is clear that Mr Garvey is fully aware of those concerns and has the capacity to decide to have break and thinks this will be good for him.

Just because, in the CPN's opinion, continuity of care might be a wiser option, it should **not** be assumed that Mr Garvey lacks the capacity to make this decision for himself.

(S.2.10, MCA Code of Practice)

Scope

5.1. The MCA principles are applicable to anyone aged **16 years and above** who may lack capacity

5.2. The MCA DoLs are applicable to anyone aged **18 years and above**.

5.3. **All staff** working for or acting on behalf of KCC, regardless of their specific role, will at some point be involved with the care and support of an individual who may lack capacity.

Please note:

All staff *are* ***legally required*** *to:*
have "regard" to the MCA, the MCA Code of Practice and the DoLS Code of Practice
when acting or making a decision on behalf of an individual who lacks capacity to make the decision for themself

6. Children and Young People[1]

6.1. The MCA does not generally apply to children under the age of 16 but there are **2 exceptions**:

[1] ***"****Young people"* are defined as aged 16-17

- The COP can make decisions about a child's **property or finances** if the child lacks capacity to make such decisions and is still likely to lack capacity to make these decisions once they have reached the age of 18.

- Offences of **ill treatment and wilful neglect** of an individual who lacks capacity can also apply to a child younger than 16.

6.2. Most of the MCA applies to young people and therefore there may be an overlap with the Children Act 1989 but there are **3 exceptions**:

- Only an individual aged 18 can make an **LPA**

- Only an individual aged 18 can make an **Advance Decision**

- The COP can only make a **statutory will** for an individual aged 18 and over

Part 2 – Mental Capacity Act 2005

1. Decisions covered and NOT covered by the MCA

1.1. The MCA covers a wide range of decisions from day-to-day activities, such as what to wear (MCA, S.5) to significant life changing events, such as where to live.

Please note: *Different types of decisions need different levels of capacity depending on their complexity (For more information please see S.10* ***"Decision Making",*** *page 25).*

> ***Please note:***
>
> *For an* ***Easy Read guide to the MCA*** *please see* **Tri-x**

1.2. Some decisions can **NEVER** be made by someone else on behalf of the individual.

1. Family relationships:
e.g. giving consent to marriage, divorce or adoption
(MCA, S.27)

2. Medical treatment:
for an individual who lacks capacity **and**
is detained under the MHA
(MCA Code of Practice,13)

3. Voting (MCA, S.29)

4. Unlawful killing or assisting suicide
(MCA, S.62)

Please note:
*These decisions are deemed to be either **so personal** or are governed by **other legislation***

2. Kent MCA DoLS Service

2.1. Kent MCA DoLS Service supports KCC with the delivery of its statutory functions under the MCA and DoLS.

2.2. Kent MCA DoLS Service achieves compliance with these responsibilities in a number of different ways:

- Provides **guidance, advice and support** to a range of multi-agency partners on MCA/DoLS matters
- Supports KCC in its role as a Supervisory Body by **processing DoLS applications** from care homes and hospitals
- **Commissions and arranges** BIA's, Mental Health Assessors, DoLS IMCA's and RPRs
- Makes arrangements for lead professionals within KCC to **scrutinise applications** from Managing Authorities and quality assure assessments.

For more information please see **KCC website at:**
www.kent.gov.uk/mentalcapacityact **"DoLS", "Contact Us"**

Or email: dols@kent.gov.uk

3. Definition of mental capacity

3.1. Mental Capacity is defined as, ***"time and decision specific"*** and the starting point **must always** be:

The Presumption of Capacity:
An individual (over the age of 16 years) **has the capacity** to make:

a particular decision

at the time the decision needs to be made

unless it can be established that s/he lacks capacity

Please note:
No one can be regarded as lacking capacity simply on the basis of their diagnosis, age or behaviour

3.2. The MCA sets out a simple *"test"* to determine whether an individual is, by law, unable to make the decision *(For more information please see* ***S.8."How to assess an individual's capacity", page 23).***

4. How to support an individual to make decisions

4.1. Before deciding if an individual ***"lacks"*** **capacity** the KCC member of staff **must** give him/her:

- All the practical and individualised support necessary, in order to help him/her make the decision themself.

4.2. To assist with this process, the KCC practitioner **must consider** whether the individual has:

1. All the relevant information needed to make the decision, including the consequences of making or not making a decision

2. All the information on all the **alternatives,** if there is a choice

3. The information **explained or presented in a way** that is easier for them to understand
e.g. pictures, sign language or an interpreter

4. Particular times of the day when their understanding is better

5. A particular place where s/he feels more at ease and able to make a decision

6. **Enough time** to process the information as decision-making is often a process

7. Anyone else who can help or support the individual to understand information or make a choice
e.g. a relative, friend or IMCA?

4.3. When the KCC practitioner has **reason to believe** the individual **lacks capacity** to make the specific decision s/he **must also consider:**

1. Has **everything** been done to help and support the individual?

2. Has **more than one** attempt been made?

3. Does the decision need to be made **without delay**?

4. If **not,** is it **possible to wait** until the individual has the capacity to make the decision for themselves?

Please note:
It is essential that ***any external pressure or coercion*** *which may impact on the individual and their decision-making is minimized*

If you have any ***safeguarding concerns or concerns about possible coercion*** *please:*

contact the Safeguarding Team

and/or talk to your manager

and/or ensure you have consulted the ***multi-agency safeguarding adult policy, protocols and guidance on Tri-x***

5. The role of an IMCA

5.1. An IMCA provides an additional safeguard to an individual who:

> **1.** Has been assessed as **lacking capacity** to make a specific decision at the time it needs to be made
>
> **2.** Is facing a decision about a **long-term move** **or** about **serious medical treatment**
>
> **3. Has nobody else** (other than a paid carer) who is willing, able to represent them or be consulted in the process of working out their *"best interests"*
>
> (S.10.1, MCA Code of Practice)

5.2. The help IMCAs provide to individuals include:

> **1.** Find out their **feelings, wishes and belie**fs by communicating with them (as far as possible) as well as by talking to others involved in their life.
>
> **2. Represent** the individual in discussions
>
> **3. Provide information** to help work out the individual's best interests
>
> **4. Raise questions or challenge decisions,** which appear **not** to be in the individual's best interests
>
> (S.10.4, MCA Code of Practice)
>
> ***Please note:***
> *The IMCA **does not** test the mental capacity of the individual and **is not** the decision maker **at any time***

5.3. An NHS practitioner **must:**

- Refer an individual to an IMCA when the decision relates to:
  - Planning, providing, withdrawing or stopping serious medical treatment

  Or

  - Making arrangements for the individual to stay in hospital for 28 days or more

  Or

  - Making the arrangements to move the individual into

accommodation[2] for **8 weeks or longer**

Please note:
Although it is not a statutory requirement to refer an individual moving into accommodation for **8 weeks** it is still best practice to do so.

For more information please see
Appendix 5 -Hospital Discharge to Short Term Placement
in the ***Residential and Nursing Home Placement Guidance***
on ***Tri-x***

5.4. A KCC practitioner **must:**

- Refer an individual who lacks capacity to an IMCA **when** the decision relates to:

1. Moving into long-term accommodation for
8 weeks or longer
or about to change accommodation

Or

2. s117 MHA After-care

And

i. A capacity assessment has been completed and the individual **lacks capacity** to make the specific decision at that particular time

And

ii. There is a best interest decision in relation to the above

And

iii. The individual has **nobody** else (S.10.11, MCA Code of Practice)

Please note:
For the ***referral form to the advocacy provider***

and more information please see
s117 Policy and Practice Guidance *on*
Tri-x

[2] *"Accommodation"* may mean: a care home, a nursing home, ordinary and sheltered housing, housing association or other registered social housing or in private sector housing provided by the LSSA or in hostel accommodation (S.10.11, MCA Code of Practice).

5.5. The **decision maker can** (with the agreement of their manager):

- Refer an individual to an IMCA **when:**

1. There is an accommodation review that would lead to a **significant change** in the way the individual's care is provided

2. KCC or the NHS arranged the original accommodation

And
1. The individual has been assessed as **lacking capacity** in relation to this review
And
2. The individual has **nobody else**

5.6. An individual **can also** be referred to an IMCA **if:**

- There is an **open adult safeguarding alert**

And

- The individual may have family, friends or neighbour who are involved

Please note:
*The individual should **not** be referred simply because there is a family dispute*

*Each individual case **must** first of all be discussed with either the MCA & DoLS Manager or the KCC practitioner's line Manager*

*The final decision whether to provide a service will be at the **IMCA's discretion**.*

For more information please see
Adult Safeguarding polices on Tri-x

5.7. The IMCA **must:**

- **Have access** to any health or social care records that are relevant to the decision being made.

5.8. To ensure IMCAs are as **independent** as possible they are commissioned by KCC.

6.

*For more information and an **Easy Read information leaflet about an IMCA** please see **Tri-x***

When an individual's mental capacity should be assessed

6.1. The need for a decision specific mental capacity assessment may arise during the individual's contact with any service **at any point** for example:

1. Their **initial contact** or subsequent needs assessment

2. During their **Care Planning**

3. During their Care Planning or review **following a change** in their health or circumstances

6.2. An assessment could also be triggered **for a number of reasons** for example:

1. The way the individual is **behaving**

2. A change in their circumstances such as, the death of their carer

3. Concerns raised by someone else

7. Who assesses an individual's mental capacity and when

7.1. The MCA states that **anyone** can assess another person's mental capacity providing they do so within the statutory framework of the MCA.

7.2. The person who assesses an individual's capacity to make a decision **should** usually be:

The person who is **directly concerned** with the individual **at the time** the decision needs to be made (MCA Code of Practice, S.4.38)

Please note:
This means that different people will be involved in assessing the individual's capacity to make different decisions at different times

7.3. More complex and significant decisions are likely to need **more formal** assessments (S.4.42, MCA Code of Practice).

Where this is the case, the KCC practitioner **must**:

Involve a **qualified and professionally registered** practitioner

Please note: *This must be decided on a case-by-case basis*

8. How

to assess an individual's capacity

8.1. Prior to assessing the individual's capacity the practitioner **must:**

1. Understand the ***5 statutory principles*** of the MCA

2. Consider **all** the relevant circumstances of the case

Please note:
This may involve the individual's carer,
any family and/or friends (where appropriate),
as they may be able to provide valuable information

8.2. The starting point **must always** be:

The Presumption of Capacity:

An individual (over the age of 16 years) **has the capacity** to make:

a particular decision

at the time the decision needs to be made

unless it can be established that s/he lacks capacity

Please note:
No one *can be regarded as lacking capacity simply*
on the basis of their diagnosis, age or behaviour

8.3. The "Two-Stage Test" should be used by **anyone** assessing an individual's capacity to make a decision of the nature or the complexity of the decision.

8.4. Stage 1:

- Does the individual have:

1. An **impairment** of the mind or brain?
Or
2. Some sort of **disturbance**
affecting the way their mind or brain works?

Please note:
It doesn't matter whether the impairment or disturbance is
temporary or permanent*.*

8.5. Stage 2:

- If so, does that impairment or disturbance mean the individual is:

Unable to make **the decision** in question
at the time it needs to be made?

8.6. Whether an individual lacks capacity or not will also be determined by **if** s/he **cannot** do any **one or more** of the following:

1. Understand information relevant to the decision to be made

2. Retain that information in their mind for long enough to be able to

3. Use or weigh that information as part of the decision-making

4. Communicate their decision (by any means)

Please note:
The assessor must have a ***"reasonable belief"***
i.e. to be ***more sure than not*** *(on the balance of probability) the answers to these questions are* ***"no"***

8.7. Summary:

If an individual is assessed to be lacking in capacity in relation to a specific decision at a specific time the assessor must:

- Answer **"yes"** to **Stage 1**
- Answer **"no"** (more likely than not) to **Stage 2**

8.8. The assessor must:

Document a detailed record of **the steps** they have taken as evidence, should their assessment be challenged.

Please note:
For ***the Mental Capacity Assessment - less complex decisions form***
Or
the Mental Capacity Assessment - complex decisions form
please see ***Mosaic***

9. When the individual has Fluctuating Capacity

9.1. If an individual has been assessed as lacking capacity but it is also recognised that their capacity fluctuates the assessor **must:**

- Decide whether the decision **should** be made.

9.2. When this situation arises, the assessor **must consider:**

Can the decision **wait?**

1. If the individual is **unconscious or heavily medicated**

And/or

2. To allow the individual to be supported
to develop or **regain capacity over time**

Please note:
*If the assessor is **unsure** of the individual's current state*
*then s/he **must** make an assessment using*
*the **"Stage 2 Test"***

(For more information please see,
***S.8. "How to assess an individual's capacity"** above)*

10. Decision Making

10.1. If an individual is assessed as **having capacity** under the MCA they are entitled to:

- **make their own decision**

10.2. As capacity is decision specific the individual **may**:

- Be able to make **some** decisions but **not** others.

10.3. Prior to assessing the individual's capacity the assessor **must:**

- Be clear about **the nature** of the decision being made.

10.4. In general:

1. Less complex decisions are **day-to-day** routine decisions

2. More **complex decisions** are likely to need
a more formal assessment and therefore,
require a professionally registered practitioner
(S.4.42, MCA Code of Practice)

Please note:
*This decision should be made on a **case-by-case** basis*
And
*The decision maker can vary from **decision-to decision***

10.5. If a KCC practitioner is asking an individual to make a decision about any aspect of their social care provision **and** they believe s/he may lack capacity to make this particular decision then **they must:**

- Assess their capacity.

10.6. Examples of types of **complex** decisions an individual may be asked to make are:

- A **financial assessment** i.e. provide evidence of income, savings or available capital
- Decide what their **Support Planning needs** are
- An **admission to a Care/Nursing Home** following an assessment

10.7. The KCC practitioner **must:**

- **Gather wider information,** such as the individual's wishes and feelings, as well as details of their power of attorney or deputy if appropriate.

10.8. The KCC practitioner **must:**

- **Consider** whether there is **the need to re-assess** the individual's capacity **if:**

1. The individual **challenges** an assessment that s/he lacks capacity

2. The individual **expresses different views** to different people

3. There is disagreement about the individual's capacity from their family members, friend, carer and/or other professionals.

Please note:
Different decisions may also need to be ***reviewed over*** *the course of* ***time***

10.9. An individual (aged 18 years or over) **can:**

1. While s/he has capacity **make an advanced directive**
to refuse specified medical treatment
at a time in the future when s/he lacks the capacity

2. This has the **same authority**, as a decision made
by the individual with capacity
and
health care professionals **must** follow this decision

3. This can include **refusing life-sustaining treatment**

Please note:
*The Advanced Directive **must be valid***
i.e. in writing, dated, signed and witnessed

10.10. It is the **responsibility of the individual** who made the advance directive to:

- Ensure s/he **notify** healthcare professionals, including their General Practitioner (GP)
- **Provide** healthcare professionals with **a copy** to ensure it is recorded on their health records

Please note:
It may also be useful for the individual to share this information with their family, friends and/or carer

10.11. A healthcare professional will be **protected from liability if:**

- S/he **stops or withholds** treatment to an individual because s/he believes that an applicable and valid advance decision exists
- S/he **treats** an individual **after** having taken all the practical and appropriate steps to find out if the individual made an advance decision but still does not know or is not satisfied that one exists.

10.12. In **most cases**, applying the *"Statutory Principles"* of the MCA and following the processes laid out in S.5 & S.6, MCA Code of Practice will be sufficient.

10.13. Sometimes an **application to the COP** may be necessary when:

1. It is a particularly **difficult** decision

2. There is a **disagreement** that cannot be resolved in any other way

3. The situation requires **on-going** decisions to be made about the welfare of the individual who lacks capacity (S.8.3, MCA Code of Practice)

Please note:
For additional guidance please see
the OPG website at:
https://www.gov.uk/government/organisations/office-of-the-public-guardian

10.14. In specific cases the individual can be referred to the High Court.

11. Decision Makers

11.1. Where an individual has **not** made an advance decision or an advance statement of their wishes and feelings, it is **the decision maker's responsibility** to:

- Work out what would be in the **best interests** of the individual who lacks capacity, in relation to the specific decision to be made.

11.2. As capacity is decision specific there can be **a range of decision makers** involved with the individual who lacks capacity.

11.3. The range of decision makers can include:

1. An **EPA** (finances and property)

2. LPA (**finances and property**)

3. LPA (**welfare**)

4. A Court appointed **Deputy** with specific authority

5. Someone **authorised** by an Order from the COP

6. The **health or social care professional** (or group of professionals) proposing the specific care or treatment **if** there is **no** Designated Decision Maker

Please note:
*Someone who **only** has a finance and property LPA **cannot** make any decision regarding welfare **and** visa versa.*

11.4. If an individual's family member or friend considers themselves to have **Power of Attorney** for the individual then they **must** be asked:

- To provide the **original authorised** (stamped by the OPG) **registration document.**

Please note:
A copy of this document **must** be kept on the individual's KCC record

11.5. In some cases the individual's family member or friend may have arranged the EPA/LPA through a Solicitor. If this is the case s/he **must** be asked:

- To arrange with the solicitor **for a copy** of the document to be released.

Please note:
A copy of this document **must** be kept on the individual's KCC record and **not simply** the contact details of the solicitor

11.6. If the family member or friend is **unable** to produce any evidence the KCC staff member **can:**

- Request a ***"first-tier search"*** on the register by completing and submitting an ***"OPG100 form"***

Please note:
This service is **free of charge**

11.7. If the KCC staff member requires any additional information following this search s/he **can:**

- Request a ***"second-tier search"*** by writing to the OPG

Please note:
*This service is **free** of charge **only** to LSSAs*

For a copy of the **referral form**
And
any additional guidance please see the **OPG website at:**
https://www.gov.uk/government/organisations/office-of-the-public-guardian

11.8. If an individual's family member or friend considers themselves to have been awarded a **Deputyship** for the individual then s/he **must** be asked:

- To provide the **original authorised order**

> ***Please note:***
> *This may be **limited** to specific decisions and time limited*
>
> ***A copy** of this document **must** also be kept on the individual's KCC file*
>
> For additional guidance please see **the OPG website at:**
> https://www.gov.uk/become-deputy

11.9. Where an individual is assessed as lacking capacity **to sign:**

- Their tenancy **agreement**

And/or

- Their tenancy **termination notice**

it can only be signed on their behalf by someone who has the **legal authority** to do so *(For more information please see, **S.11.3 list of Decision Makers,** above).*

11.10. If the KCC staff member has any **concerns** about the actions of a Designated Decision Maker then they **must:**

> **Contact the Safeguarding Unit of the OPG,**
> please see **the OPG website at:**
> https://www.gov.uk/report-concern-about-attorney-deputy

12. Best Interests

12.1. Any decision made or action taken on behalf of an individual who lacks capacity by the KCC practitioner **must:**

1. Not be made on the basis of prejudicial assumptions, such as the individual's age, appearance, diagnosis or behaviour

2. Consider **all** the relevant circumstances

3. Consider whether the individual is likely to regain capacity. If so, **can the decision wait** until then?

4. Do whatever is possible to permit and encourage the **individual to take part** or to improve their ability to take part as fully as possible.

5. Not be motivated in any way by the desire to bring about the individual's death if the decision is concerning life sustaining treatment.

6. Try to find out **the views of the individual** including their past wishes and feelings, present wishes and feelings, beliefs and values and any other factors the individual would consider that would be likely to influence the decision.

7. Consult others (if practicable and appropriate) for their views and any information they have about the individual's wishes, feelings, beliefs and values.

8. Consider any other options that might be **less restrictive**

9. All of the above also apply in relation to any powers which are exercised by an **LPA or any other decision maker**

Please note:
***All** of the above **must** be weighed up*

***"Life-sustaining treatment"** means treatment which is considered **necessary to sustain life** by the person providing health care*

"Relevant circumstances"** are those which the decision maker is **aware of** **and** that would be reasonable to **regard as such

("Checklist", LIN: 2009)

*For more information please see, **S.5, MCA Code of Practice***

12.2. If the situation is **not urgent** the KCC practitioner **must:**

Before making the decision

Consult with the individual, their family members, friends, other relevant professionals and IMCA (where appropriate) and determine if the Best Interests meeting should be held virtually.

This must then be evidenced by recording the discussion and/or the minutes of a formal Best Interests meeting

Please note:
For further information about the IMCA please see ***s5 The Role of the IMCA, page 16***

For the ***referral form for the commissioned advocacy provider*** *and* ***an Easy Read information leaflet about an IMCA*** *please see* ***Tri-x***

For more information about holding ***a virtual BIM*** *please see* ***Appendix 1, page 53***

12.3. In cases **where there is disagreement** amongst the individual's family members and/ or other professionals and/or conflict of interest, the KCC practitioner **must:**

- Consider requesting **an independent Chair** who will have a separate role from the decision maker

12.4. The KCC practitioner **must:**

- Ensure **all** practical steps are taken and **clearly document**:

1. Any decision that is taken

2. Details of **those involved** in making the decision

3. Reasons why any specific family member, friend or relevant professional was **not consulted**

4. When the conversations took place

5. What information was provided by those who were consulted

6. **How** did the information gathered inform the decision so it is clear **why** it was made?

Please note:
For the ***Best Interests Meeting form*** *please see* ***Tri-x***

12.5. If the situation is **urgent** and there is no time to hold a Best Interests Meeting the KCC practitioner (decision maker) **must:**

1. Still undertake **formal consultation** with **all** the appropriate people (as above)

2. Have considered all of the factors in the **Best Interests Checklist** (as above)

3. Be able to **justify** that their actions were in the individual's **best interests**

12.6. A Case example of a Best Interests decision:

Pedro, a young man with a severe learning disability, lives in a care home. He has dental problems, which cause him a lot of pain, but refuses to open his mouth for his teeth to be cleaned.

The staff suggest that it would be a good idea to give Pedro an occasional general anaesthetic so that a dentist can clean his teeth and fill any cavities.

His mother is worried about the effects of an anaesthetic, but she hates to see him distressed and suggests instead that he should be given strong painkillers when needed.

While the views of Pedro's mother and carers are important in working out what course of action would be in his best interests, the decision must **not** be based on what would be less stressful for them. Instead, it must focus on Pedro's best interests.

Having talked to others, the dentist tries to find ways of involving Pedro in the decision, with the help of his key worker and an advocate, to try to find out the cause and location of the problem and to explain to him that they are trying to stop the pain.

The dentist tries to find out if any other forms of dental care would be better such as a mouth wash or dental gum.

The dentist concludes that it would be in Pedro's **best interests** for:

1. A proper investigation to be carried out under anaesthetic so that immediate treatment can be provided

2. Options for his future dental care to be reviewed by the care team, involving Pedro as far as possible.

(S.5. MCA Code of Practice)

13. Refusal of Services

13.1. Where an individual has capacity but makes a decision that appears to be **unwise** the KCC practitioner **must:**

- Respect the individual's right to *"private and family life"* (Article 8, European Convention of Human Rights (ECHR)).

13.2. An Individual has **the right** to refuse a service even if it seems contrary to their best interests.

13.3. Where an individual has capacity but makes a decision that appears to be **unwise and** there is reason to believe their decision will result in **harm** to themselves and/or a member of the community, the KCC practitioner **must:**

1. Explore all avenues for managing the potential/actual risk

2. Liaise with other professionals and/agencies

3. Engage the individual in all aspects of the multi-agency discussions

4. Be mindful of any barriers to communication and address these accordingly

5. Ensure the process is person-centred throughout

6. Record the individual's decision along with an assessment of their capacity

7. Communicate actions and outcomes to the individual in writing (where appropriate)

Please note:
For further information please see
"Positive Risk Management Policy and Good Practice Guidance" on Tri-x

13.4. Where an individual has capacity and refuses assistance from health and/or social care agencies but **significant self neglect** has been established, the KCC practitioner **must:**

1. Consider how the individual will be **monitored** in case of further deterioration

2. Consider whether a referral to the Approved Mental Health Professional (AMHP) Service is required in order that an **assessment under the MHA** is carried out

3. Consider whether a **safeguarding** referral is required

4. Consider the ***"Kent and Medway Multi-Agency Policy and Procedures to Support People who Self-Neglect"***

5. Seek professional supervision and support throughout this process

Please note:
For further information please see ***Adult Protection Policy, Protocols and Guidance*** *on* ***Tri-x***

14. Restraint

14.1. Someone is using restraint if they:

1. Use force or **threaten to use force** to make an individual do something that they are resisting

Or

2. Restrict an individual's **freedom of movement**, whether they are resisting or not

(S.6 (4), MCA

14.2. A KCC practitioner **must:**

- Take reasonable steps to determine the individual's **capacity**

And

- Reasonably believe s/he lacks capacity in relation to the **specific decision**

And

- Reasonably believe it is in their **best interests** for the decision to be undertaken (S.5(1), MCA).

14.3. A KCC practitioner **must:**

- Consider using a **less restrictive** option before using restraint

And

- Where possible, **ask** those involved with the individual's care what they think is necessary to protect the individual from harm (S.6.48, MCA Code of Practice).

14.4. On the occasions when the use of force may be **necessary**, a KCC practitioner **must:**

- Use the **minimum** amount of force for the **shortest** possible time (S.6.44, MCA Code of Practice).

14.5. Any action carried out by a KCC practitioner, which is intended to restrain an individual who lacks capacity **must** meet two conditions:

1. The person taking the action **must** reasonably believe that restraint is **necessary** to prevent **harm** to the individual who lacks capacity

And

2. The amount or type of restraint used and the amount of time it lasts **must** be a **proportionate response** to the likelihood and seriousness of harm
(S.6.41, MCA Code of Practice)

Please note:
"proportionate response" *means using the* ***least intrusive*** *type and* ***minimum amount*** *of restraint to achieve a specific outcome in the best interests of the individual who lacks capacity*
(S.6.47, MCA Code of Practice)

14.6. Although S.5, MCA permits the use of restraint where necessary (i.e. the above conditions have been met), S.6(5) MCA confirms that there is:

- **No protection from liability** for any action that results in the individual being deprived of their liberty (as defined by Article 5(1), ECHR) (S.49, MCA Code of Practice).

14.7. A KCC practitioner **must:**

- **Keep a record** (as evidence) of having gone through the necessary statutory tests (the *"quick summary",* below) before a decision is taken to use restraint

And

- **Every time** restraint is used in this situation.

14.8. A KCC practitioner **must consider:**

1. Is the action to be carried out in connection with
the **care or treatment** of the individual
who lacks capacity to give consent to that act?

2. Who is carrying out the action (i.e. the decision maker)?

3. Is it appropriate to carry out this action at the **relevant time**?
(i.e. can it wait?)

4. Have all possible steps been taken to try to
help the individual **make a decision** for themselves?

5. Has a mental **capacity assessment** been undertaken?

6. Is there reasonable belief that
the individual **lacks capacity** to give permission?

7. Has the ***"best interests checklist"*** been applied?

8. All relevant circumstances

9. Is there a **less restrictive** option available?

10. Is there reasonable belief that
the proposed act is in the individual's **best interests**?

11. If restraint is being considered,
is it **necessary** to prevent harm to the individual
and a **proportionate** response
to the likelihood of him/her suffering **harm**
and the **seriousness** of that harm?

12. Does the restraint amount to
depriving the individual of their **liberty**?

13. Does the action **conflict** with
a decision that has been made by an LPA/EPA or deputy?

(*"Quick Summary"* - S.6, MCA Code of Practice)

14.8. The **appropriate** use of restraint falls short of deprivation of liberty (S.2.9, DoLS CoP)

Please note:
For further advice and guidance please see,
"Policy for the Prevention and Management of Violence to Staff"
and in particular, ***Appendix H:***
"Physical Intervention Policy and Guidance" on Tri-x

15. Recording

15.1. It is mandatory that KCC members of staff maintain **clear and up-to-date records**, which include:

1. MCA assessment form for **less complex** decisions

2. MCA assessment form for **complex** decisions

3. Details of Best Interests meetings including,
BIA **Balance Checklist**
and
Best Interest Meeting form

4. Any **supporting documentation**,
which is a standard part of the assessment process

5. Up-to-date **contact sheets**

Please note:
In cases which involve a COP hearing,
accurate records act as ***vital evidence***

15.2. In cases where there is a COP hearing the KCC practitioner **must:**

1. Clearly set out the **events** that took place

2. The **reasoning** that supported each decision made

3. Clear evidence that **all decisions** made
were undertaken **in compliance** with
the requirements of the MCA

4. If decisions taken did **not** comply with the MCA,
then evidence the **reasons** why not

Please note:
The importance of maintaining clear records
should ***not*** *be underestimated*

For more information on ***COP*** *please see*
Part 1, S.2 "Definitions of Terms", page 5)

15.3. If the KCC practitioner **fails** to keep clear records evidencing compliance with the MCA then:

1. Any decision s/he has made could be **challenged** in any civil or criminal court proceedings

2. KCC could receive a **claim for damages**

3. S/he could receive **disciplinary action**

4. S/he could be **dismissed**

5. S/he could receive **sanctions** from their regulatory body

Part 3 – Deprivation of Liberty Safeguards (DoLS)

1. What are DoLS?

1.1. The **purpose** of DoLS is to extend the powers of *"restriction"* provided by S.5, MCA namely:

To allow for the lawful ***"deprivation of liberty"*** *of*

a vulnerable individual living in

a registered care home or nursing home or hospital setting

who **lacks capacity** to consent to

highly restrictive care plans that are

proportionate and necessary

in order to protect him/her **from harm**.

1.2. There are several **measures**, which could be **used to *"restrict"*** an individual's freedom, which involve more than *"restraint"* and therefore amount to a deprivation of liberty such as:

1. Close observation and supervision

2. Sedative medication

3. Distraction/persuasion to control their behaviour and freedom of movement

4. Preventing him/her from leaving the hospital/home/residence

5. Bringing him/her back to the hospital/home/residence if s/he tries to leave

6. The use of equipment e.g. bed rails, chairs, lap straps, etc.

7. Locked doors, coded keypads, etc.

8. Electronic devices e.g. tagging devices

9. Physical intervention techniques

10. Refusing requests for discharge

11. Restrictions on social activities or contacts with other people
(S.2.5, DoLS Code of Practice)

Please note:
*This list is **not** exhaustive*

*The difference between **"restriction"** and **"deprivation"** is one of **degree or intensity***
(S.2.3, DoLS Code of Practice)

1.3. The Supreme Court Judgement[3] clarified an ***"acid test"*** for what constitutes a *"deprivation of liberty"* for the purposes of Article 5 (ECHR) as:

1. Lack capacity to consent to their care/treatment arrangements

2. Under continuous supervision and control

3. Are not free to leave

Please note:
All 3 elements must be present

[3] P v Cheshire West and Chester Council and another and P and Q v Surrey County Council (2014)

1.4. Where this is the case, the deprivation of liberty **must be authorised** by:

- KCC as the Supervisory Body (for those aged 18 plus)

Or

- The COP (including for all 16- and 17-year-olds)

Or

- **The MHA** (where applicable)

1.5. Factors which are **not** relevant in determining whether an individual is deprived of their liberty are:

- The individual's **compliance/lack of objection** to the proposed care/treatment
- The **reason/purpose** behind the placement
- **Comparing** the individual to anyone else with a similar condition

1.6. It can occur **in:**

- **Community** and **domestic settings** where the State is responsible for such arrangements, including supported living placements or foster care placements for 16- and 17-year-olds.
- **Non-psychiatric hospital settings**[4]
- **Residential education settings**

2. How and when can a DoLS be applied for?

2.1. Given that depriving an individual of their liberty is a very serious matter it must be avoided at all costs and can **only** be done following an **independent** assessment.

2.2. A request for an independent assessment **must** be made by:

- The ***"Managing Authority"*** to the ***"Supervisory Body"***

Please note: *For additional information relating to each organisation's responsibilities please see,"Checklist": S.11, DoLS Code of Practice*

[4] NHS Trust & Ors v FG (2014) EWCOP 30

2.3. In the case of **an NHS hospital**, the *"Managing Authority"* is:

- The NHS body responsible for the running of the hospital in which the individual is or will be resident.

2.4. In the case of a **care home or nursing home or private hospital**, the *"Managing Authority"* is:

- The person registered under Part 2, Care Standards Act 2000.

2.5. Anyone with a concern, for example a family member, **can:**

- Apply to the Supervisory Body to trigger an assessment **if** they have already asked the Managing Authority to do so but it has **not** been done.

2.6. The independent assessments are undertaken by:

- ***"Mental Health Assessors"***

And

- ***"Best Interests Assessors"*** (BIA)

2.7. The DoLS application process involves **6** assessments and the ***"qualifying criteria"*** for each assessment **must be met** in order for the authorisation to be granted. These include:

1. Age assessment **- 18** years and over

2. No refusals assessment - a relevant ***"advance decision"*** has **not** been made
Or
An objection by a Done with LPA for health and welfare has been made

3. Mental capacity assessment - **lacks capacity** to give consent to the arrangements (public or private) made for their care or treatment

4. Mental health assessment – suffering from a ***"mental disorder"***

5. Eligibility assessment - **not detained** under the MHA
Or
Where it is considered the individual might be eligible to be detained under the MHA

6. Best Interests assessment - the proposed restrictions **must be:**

in the individual's **best interests,**
the **least restrictive** option,
necessary to prevent harm
and
a proportionate response to the likelihood of harm

Please note:
"mental disorder" *is, as defined by S.1, MHA*

2.8. Any DoLS for a **young person** (i.e. aged 16 or 17) **must:**

- Be authorised by the COP.

2.9. If a KCC practitioner thinks that an authorisation is needed they **must ensure:**

1. A **complex mental capacity assessment** of whether the individual lacks capacity to decide whether or not to accept the care or treatment proposed

2. Where practical and possible an **IMCA is involved if** the individual is un-befriended

3. That all decisions and the reasons for them are **recorded**

4. Before admitting an individual to a care home in circumstances which amount to a DoLS, consider whether their needs could be met in a **less restrictive** way

5. Any restrictions placed on the individual should be kept to a **minimum** and should be in place for the **shortest period of time**

6. Steps are taken to help the individual to **retain contact** with their family, carers and friends

7. The individual's care plan is reviewed on a regular basis

Please note:
*If there is concern that an individual **has already** been deprived of their liberty **without authorisation** please see S.9, DoLS Code of Practice*

2.10. A case example of a Standard Authorisation:

Mrs Jackson is 87 years old and lives by herself in an isolated bungalow in a rural area. Over the past few years, staff at her local health centre have become increasingly concerned about her wellbeing and ability to look after herself. Her appearance has become unkempt, she does not appear to be eating properly and her house is dirty.

The community mental health team (CMHT) have attempted to gain her trust, but she is unwilling to engage with them. She has refused care workers entry to her home and declined their help with personal hygiene and household chores.

Because it is believed that she is a potential risk to herself, she is admitted to hospital under the MHA.

She is assessed as potentially having mild dementia, most probably of the Alzheimer type, but because there is no obvious benefit from anti-dementia medication, further treatment for mental disorder is felt unnecessary.

Mrs Jackson insists that she wishes to return to her own home, but given past failed attempts to gain her acceptance of support at home and her likely future mental deterioration, transfer to a care home is believed to most appropriate.

A best interests meeting is held by the CMHT to consider her future care and placement. The meeting concludes that Mrs Jackson **does not have** sufficient mental capacity to make an informed decision on her stated wish to return home.

There is no advance decision in existence, no LPA or court deputy appointed and no practical way of contacting her immediate family.

An appropriate care home is identified. A care plan is developed to give Mrs Jackson as much choice and control over her daily living as possible. However, it is felt that **the restrictions still necessary** to ensure Mrs Jackson's wellbeing will be so intense and of such duration that a request for a standard deprivation of liberty authorisation should be made by the care home manager (the relevant managing authority).

The best interests assessor agrees that the proposed course of action is in Mrs Jackson's best interests and recommends **a standard authorisation** for six months in the first instance.

(S.4. DoLS Code of Practice)

2.11. When a **Managing Authority** believes that a deprivation of liberty is occurring in the individual's best interests they **must:**

1. Issue an ***"urgent authorisation" immediately and without delay***

2. It allows for the lawful authority to deprive
the individual of their liberty
in the relevant hospital/care home
for **up to a maximum of 7 days**

3. It can be extended by the **Supervisory Body**
in **exceptional** circumstances for
up to a maximum of a further 7 days

4. This allows time for the ***"standard"*** DoLS application
to be processed by the Supervisory Body

Please note:
Forms can be submitted ***outside of normal office hours***

For ***"standard and urgent request" (form 1)***
And
"further authorisation request" (form 2)

please see the ***KCC website at:***
www.kent.gov.uk/mentalcapacityact ***"DoLS"; Forms"***

2.12. When a **Supervisory Body** receives an urgent authorisation it **must:**

1. Arrange for an **independent** assessment
(for more information please see S.2.7, above)

2. Refer the (un-befriended) individual to
the **(DoLS) IMCA service**

3. If the statutory requirements are met it then issues
a ***"standard authorisation"***, which summarises
the purpose, duration and conditions

4. It allows for the lawful authority to deprive the individual
of their liberty in the relevant hospital/care home
for **up to a maximum of 12 months**

5. If the statutory requirements are **not** met it then issues
a ***"standard authorisation not granted"***

6. Send copies of the outcome to:

the allocated case manager
And
their line manager
And
the Relevant Person
And
the RPR
And
any Interested Persons
And
the Managing Authority

Please note:
*For "**standard authorisation granted" (form 5)***
And
"standard authorisation not granted" (form 6)

*For the **referral form to the IMCA service***
*And **the Easy Read IMCA information leaflet***
*please see **Tri-x***

3. When there is a Standard Authorisation in place

3.1. The **Managing Authority must:**

- Work with all professionals involved with the individual
- Follow the conditions attached to the Authorisation
- Work towards reducing the restrictions and avoiding deprivation of liberty of the individual
- Involve the RPR in any changes to the individual's care plan and restrictions in place
- Monitor that the RPR is fulfilling their role and advise the Supervisory Body of any concerns
- Request a review if it believes there are any changes in the six qualifying requirements for DoLS

3.2. The KCC practitioner **must:**

1. Ensure all DoLS paperwork is kept on the individual's file

2. Review the care plan to ensure the Managing Authority is following the **conditions** attached to the Authorisation

3. Discuss any concerns or changes of circumstances in supervision and with their line manager

4. Report any concerns or changes of circumstances to the MCA DoLS Service **as soon as possible**

5. Involve and consult with the RPR

Please note:
*For **MCA DoLS Service***
*please see the **KCC website** at:*
www.kent.gov.uk/mentalcapacityact ***"DoLS"; "Contact Us"***

3.3. The MCA DoLS Service will:

1. Appoint a RPR for the individual

2. Refer the individual to the **(DoLS) IMCA service** where there is **no** one available to act (temporarily) as their **RPR**

Or

3. Where **the individual** or their representative **requests** the support of an IMCA to ensure s/he understands their rights

Please note:
*A **RPR** can either be a family member, a friend or someone who is paid to carry out this role*

3.4. Where the MCA DoLS service have made a case management referral in exceptional circumstances (where there is a legal challenge) **and** where the individual is **self-funding** the KCC practitioner **must:**

- Treat this referral as a **priority,** consider the conditions of the Authorisation and review the care arrangements of the relevant individual.

3.5. The **RPR must:**

- Have regular face-to-face contact with the individual
- Monitor any conditions attached to the DoLS Authorisation
- Request a review if any of the six qualifying requirements are not met
- Support the Relevant Person (should s/he object) to make a challenge through the COP even if s/he feels it is not in the Relevant Person's best interests.

3.6. Where **the individual dies** the Managing Authority **must:**

- **Contact** the Supervisory Body, the RPR and any other relevant parties.

- **Inform** the **Care Quality Commission** by completing the relevant notification

4. When should a DoL in the community be applied for?

4.1. When the person is:

1. 16 years and above

2. Of unsound mind
(e.g., has a mental illness, acquired brain injury, and/or a learning disability)

3. Lacking capacity in relation to them making decision about their accommodation and/or care arrangements in the community

4. Not subject to any powers of the MHA that would conflict with a DoL authorisation

5. Does not have any valid decision-making authorities that would conflict with a DoL authorisation
(e.g. Advance decision, LPA, Court Appointed Deputy)

And
measures are in place to restrict the person's freedom and movement e.g.:

1. Close observation and supervision

2. Sedative medication

3. Distraction/persuasion to control behaviour and freedom of movement

4. Preventing the person from leaving the community setting or bringing them back if they try to leave

5. Equipment intended to restrict freedom of movement
(e.g., bed rails, chairs – tip-back, deep-seated or with fixed tables, lap straps, gloves, splints, bandaging and helmets)

6. Locked doors, coded keypads, 'baffle' handles

7.Electronic devices
(e.g., pressure mats and tagging devices)

8. Physical intervention techniques

9. Refusing requests from the person to leave the community setting

10. Restrictions on social activities or contacts with others

11. Restrictions on movement within the community setting

12. Restrictions on outings from the community setting

And
the severity and the impact of the restrictions is significant e.g.:

1. Restrictions are used frequently and/or for prolonged periods of time

2. Restrictions are severe and frequent –
impact significantly on the person's freedom of movement

3. Restrictions have a significant psychological impact on the person
(e.g. objecting, distressed)

4. Relatives/carers object or are concerned that the person is severely restricted

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

1. They are necessary to protect the person from harm

2. They are a proportionate response to the likelihood and severity of the potential harm

3. Consideration has been given to reducing or eliminating the restrictions – least restrictive

4.2. The KCC practitioner **must:**

- **Take any necessary action immediately** to reduce the restrictions so that the person is not deprived of their liberty **if it possible** to minimize the restrictions

4.3. The KCC practitioner **must:**

- Ensure that any remaining restrictions are monitored closely and kept under review

4.4. The KCC registered practitioner **must:**

- Make a COP application for a DOL authorisation **if** 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

Please note

*This includes when an individual is **not** currently receiving any services from KCC*

Please follow the process below

5. How to apply for a DoL in the community

5.1. The KCC practitioner **must:**

- Complete a MCA assessment

Please note:

It is important to record:

*There is **'no reason to doubt capacity'** when the person's capacity has not been formally assessed*

*The person **'has capacity'** when their mental capacity has been formally assessed*

(Norfolk Safeguarding Adult's board)

5.1. The KCC practitioner **must:**

- Apply the MCA/DoL screening tool every time they review the individual's care and support needs.

Please note:

*For a copy of the **Community DoL Screening tool** please see **Tri-x***

*For guidance on how to score please see **the MCA/DoL screening tool***

5.2. The KCC practitioner **must:**

- Identify an individual's circumstances as reaching a 'high priority' on the MCA/DoL screening tool and upload to the relevant social care case management system.

5.3. The KCC practitioner **must:**

- Email their Community Team Manager (ASCH) or Team Manager/DoL Lead (Strengthening Independence Service (SIS)) the Community DoL screening tool to confirm the 'high priority' threshold has been reached.

Please note:

Contact the Community Team Manager/DoL Lead to discuss if there is any uncertainty the threshold has been met

5.4. The Community Team Manager/Team Manager/DoL Lead **must:**

- Quality assure the MCA/DoL screening tool

- Upload the quality assurance form to the relevant social care case management system.
- Track all individuals who have reached the 'high priority' threshold.

Please note:

*For a copy of the **Community DoL Quality Assurance form** please see **Tri-x***

5.5. The KCC practitioner **must:**

- Continue to monitor the situation if the Community Team Manager/Team Manager/DoL Lead confirms that the individual's circumstances do not reach the 'high priority' threshold in case things change.
- Seek to reduce the restrictions where possible and end the deprivation.

Please note:

*KCC's involvement **cannot be ended** if a Community DOL has been identified even if the person is **not** currently receiving any services from KCC*

This includes when the individual and/or their family no longer want any involvement from KCC
(Re A and Re C [2010] EWHC 978 (Fam))

5.6. The KCC practitioner **must:**

- Send a letter to a medical practitioner or psychiatrist or psychologist who knows the person and seen them in the last year requesting they confirm the individual has a diagnosis that would deem them to be 'of unsound mind' or 'impairment of the mind' if there is not one already uploaded.
- Enclose a copy of the '7 Minute Briefing Community DoL' leaflet on Tri-x
- Upload the letter upload to the relevant social care case management system.
-

Please note:

***The letter must be sent asap** to ensure the process is not delayed*

*For a copy of **the template letter***
*and the **'7 Minute Briefing Community DoL' briefing***
*please see **Tri-x***

5.7. The KCC practitioner **must:**

- Escalate to the ICB safeguarding via the Community Team Manager/Team Manager/DoL Lead if the medical practitioner or psychiatrist or psychologist refuses to complete the letter or there is no response for 4 weeks.

5.8. The KCC registered practitioner **must:**

- Arrange for the individual's mental capacity to be assessed in relation to them making decisions about their accommodation and/or care arrangements in the community.
- Ensure the COP Assessment of capacity (COP3 form) is completed and upload to the relevant information management system.

Please note:

*As this is a **complex decision** the assessment must be carried out by **a registered practitioner***

*For a copy of the **COP Assessment of capacity (COP3 form)** please see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/958044/cop3-eng.pdf*

5.9. The KCC practitioner **must:**

- Identify a Rule 1.2. Representative for the application.

Please note:

*Primarily, the Rule 1.2. Representative **should b**e from P's family/friend network*

*For **A Quick guide to Community DoLs information leaflet***
and
*an **Easy Read information leaflet for Rule .1.2 Representatives***
*please see **Tri-x***

5.10. The KCC practitioner **must:**

- Ensure that the friend/family member is **willing and able** to carry out this role

5.11. The KCC practitioner **must:**

- Inform their budget holder of the need for a paid representative
- Obtain a purchase order number for the spot purchase form

Please note:

*For a copy of the **Spot Purchase Agreement** please see **Tri-x***

5.12. The KCC practitioner **must:**

- Make a referral to the commissioned advocacy provider if there is **no one appropriate** to take on the role of a Rule 1.2. Representative from the individual's family/friend network.
- Upload a copy of the referral form upload to the relevant social care case management system.

> ***Please note:***
>
> *For a copy of the **Community DoL /Rule 1.2. Representative referral form** to the advocacy service please see **Tri-x***

5.13. The KCC practitioner **must:**

- Include with the referral:
  - A copy of the individual's care and support plan
  - The individual's contact details
  - Notification of any risks to the representative

5.14. The KCC practitioner **must:**

- Arrange for a Best Interests Meeting

> ***Please note:***
>
> *For guidance on **Conducting Best Interests meeting via virtual communication platforms** please see **Appendix 1, page 66***
>
> *For further guidance on **how to conduct a Best Interests meeting** please see **the MCA Best Interests minutes template***
>
> *For a copy of the **MCA Best Interests meeting template** please see **Tri-x***

5.15. The KCC practitioner **must:**

- Consider making a request for legal advice **if**:
  - there are any objections or contentious issues
  - there is some indication that the application is not suitable to be made under the streamlined process and an oral hearing is required in the first instance

Please note:

For further information regarding ***the possible triggers*** *which may indicate that the application* ***is not suitable*** *to be made under the streamlined process please see* ***the COP Application to authorise a DoL (COPDoL11 form, page 31)***

For a copy of ***the COP Application to authorise a DoL (COPDoL11 form)*** *please see* copdol11-eng.pdf (publishing.service.gov.uk)

For a copy of ***Guidance for legal services access*** *and* ***Invicta Law request form*** *please see* ***Tri-x (Legal)***

5.16. The KCC practitioner **must:**

- Complete the COP Application to authorise a DoL (COPDoL11 form) within **14 days** of the Best Interests meeting.
- Upload the draft COPDoL11 form upload to the relevant social care case management system.

5.17. The KCC practitioner **must:**

- Send the COP Application to authorise a DoL (COPDoL11 form) to the Community Team Manager/Team Manager/DoL Lead to quality assure.
- Ensure there is a comprehensive care and support plan on the relevant social care case management system.

Please note:

The care and support plan ***must*** *detail:*

The care hours

All restrictions, controls and levels of supervision for the various care needs in all settings

the address (s) where the individual is deprived of their liberty

5.18. The Community Team Manager/Team Manager/DoL Lead **must:**

- Quality assure:
  - the Application to authorise a DoL (COPDoL11 form)
  - The COP Assessment of capacity (COP3 form)
  - The care and support plan
  - The Best Interests meeting minutes

- The medical practitioner or psychiatrist or psychologist psychologist letter

- Upload a copy of the quality assurance form to the relevant social care case management system.

5.19. The KCC practitioner **must:**

- Make a request for legal advice after the documentation has been approved and authorisation has been given from budget holder

> ***Please note:***
>
> *For **Guidance for legal services access** and **Invicta Law request form** please see **Tri-x (Legal)***

5.20. Invicta Law **will:**

- Allocate a solicitor

5.21. The KCC practitioner **must:**

- Send all documentation to nominated solicitor copying in the Community Team Manager/Team Manager/DoL Lead:
  - The COP Application to authorise a DoL (COPDoL11 form)
  - The COP Assessment of capacity (COP3 form)
  - The care and support plan
  - The Best Interests meeting minutes
  - The medical practitioner or psychiatrist or psychologist letter

5.22. The nominated solicitor **will:**

- Review all documents and advise on amendments/additions that need to be made
- Send back all documentation to the KCC practitioner after it has been approved

5.23. The KCC practitioner **must:**

- Upload all the documentation to the relevant social care case management system.

5.24. The KCC practitioner **must:**

- Send the Rule 1.2. Representative the template letter requesting them to complete and sign the COP witness statement (COP24 form) and **Annex C, page 23-26** of the COP Application to authorise a DoL (COPDoL11 form)
- Enclose copies of:

- The COP Application to authorise a DoL (COPDoL11 form)
- The COP Assessment of capacity (COP3 form)
- The COP witness statement (COP24 form)
- The care and support plan
- The risk assessment
- The Best Interests meeting minutes
- The medical practitioner or psychiatrist or psychologist letter.

Please note:

For a copy of ***the Rule 1.2. Representative template letter*** *please see* ***Tri-x***

For a copy of the ***COP witness statement (COP 24 form)***
please see:
COP24 - Witness statement (12.17) (publishing.service.gov.uk)

5.25. The Rule 1.2. Representative **must:**

- Complete and sign the COP witness statement (COP24 form)
- Complete **Annex C, page 23-26** of the COP Application to authorise a DoL (COPDoL11 form)
- Send these forms back to the KCC practitioner

5.26. The KCC practitioner **must:**

- Send the COP witness statement (COP24 form) and Annex C of the COP Application to authorise a DoL (COPDoL11 form) to the Community Team Manager/Team Manager/DoL Lead to quality assure.
- Upload the documents to the relevant social care case management system.

5.27. The Community Team Manager/Team Manager/DoL Lead **must:**

- Quality assure:
  - the COP witness statement (COP24 form)
  - Annex C of the COP Application to authorise a DoL (COPDoL11 form)
- Upload the quality assurance form to the relevant social care case management system.

5.28. The KCC practitioner **must:**

- Send the additional documents to the nominated solicitor copying in the Community Team Manager/Team Manager/DoL Lead once approved:
  - COP witness statement (COP24 form)
  - Annex C of the COP Application to authorise a DoL (COPDoL11 form)

5.29. The nominated solicitor **will:**

- File the application along with all the supporting documentation with the court.

5.30. If any significant changes occur prior to the final court order being issued, the KCC practitioner **must:**

- Complete a COP24 witness statement to explain the reasons for the changes and how the best interests process has been followed.
- Update the care and support plan to include the changes
- Upload the COP24 witness statement to the relevant social care case management system.
- Send the updated documents to the Community Team Manager/Team Manager/DoL Lead to quality assure.

Please note:

Significant changes include:

The individual has gained capacity to consent to their care and support needs

The individual has died

A decrease in the restrictive measures being used

The individual's address has changed

5.31. The Community Team Manager/Team Manager/DoL Lead **must:**

- Quality assure:
  - The updated COP24 witness statement
  - The updated care and support plan
- Upload the quality assurance form to the relevant social care case management system.

5.32. The KCC practitioner **must:**

- Send the Rule 1.2. Representative change of circumstances template letter requesting them to update the COP witness statement (COP24 form)
- Enclose copies of:
  - The updated care and support plan
  - The COP witness statement (COP24) completed by the KCC practitioner
  - A blank COP witness statement (COP24 form)

Please note:

*For a copy of the **Rule 1.2. Representative change of circumstances template letter** please see **Tri-x***

5.33. The Rule 1.2. Representative **must:**

- Update the COP witness statement (COP24 form)
- Send this form back to the KCC practitioner

5.34. The KCC practitioner **must:**

- Upload the documents to the relevant social care case management system.
- Send the updated documents to the nominated solicitor copying in the Community Team Manager/Team Manager/DoL Lead:
  - the COP witness statement (COP24 form) by the Rule 1.2. Representative
  - the COP witness statement (COP24 form) by the KCC practitioner
  - the updated care and support plan

5.35. The nominated solicitor **will:**

- File the updated documentation with the court.

5.36. The court **will:**

- Send the court order to the nominated solicitor and the Rule 1.2. Representative

5.37. The nominated solicitor **will:**

- Send the KCC practitioner the court order

5.38. The KCC practitioner **must:**

- Upload the court order to the relevant social care case management system.
- Change the legal status on the relevant social care case management system.
- Inform the Community Team Manager/Team Manager/DoL Lead

5.39. The KCC practitioner **must:**

- Apply the MCA/DoL screening tool every time they review the individual's care and support needs

5.40. If any significant changes occur the KCC practitioner **must:**

- Update the care and support plan to include the changes
- Inform the Community Team Manager/Team Manager/DoL Lead

- Inform the court that the order is no longer required
- Send the Rule 1.2. Representative the end of Community DoL order template letter (A - change of circumstances or B - death of service user)
- Change the legal status if the order is no longer required on the relevant social care case management system.
-

Please note:

Significant changes include

The individual has gained capacity to consent to their care and support needs

The individual has died

A decrease in the restrictive measures being used

For a copy of the ***Rule 1.2. Representative end of deprivation template letters*** *please see* ***Tri-x***

6. How to renew a DoL in the community

6.1. The KCC practitioner **must:**

- Seek to reduce the restrictions where possible and end the deprivation.

6.2. The KCC practitioner **must:**

- Follow the process **s5. How to apply for a DoL in the community**, **from s5.6.** on page 54 onwards

7. Moving an individual for care and/or treatment

7.1. Where an individual may have to move from their home (and/or hospital) but **lacks capacity** to consent to the move it is still lawful under S.5, MCA **if:**

1. The **MCA** ***"Statutory Principles"*** have been rigorously applied **and** the processes followed

2. The requirements for working out the individual's ***"Best Interests"*** have been followed
(S.6.11, MCA Code of Practice)

And
3. There is **no dispute**

And
4. The individual is **not objecting**

Please note:
For more information please see,
Part 1, S.3."Five Statutory Principles", page 13
And
Part 2, S.12 "Best Interests", page 31

7.2. Where this is case, the KCC practitioner **must:**

1. Assess the individual's mental capacity
for the specific decision

2. Ensure **evidence** is provided in the assessment
for the conclusion of lack of capacity

3. Explore **all** options for supporting the individual
at home in the **least restrictive** way
and
clearly **document** this in the Care and Support Plan

5. Consider the individual's **wishes and feelings**
and
clearly document these

6. Engage all relevant others in consultation

7. Make a referral for an **IMCA**
(if the Relevant Person is un-befriended
and
where appropriate **before** the move)

8. Identify any potential **dispute or objection**
at the earliest opportunity

9. Discuss the need with the receiving care home for
making an application for a **standard DoLS** authorisation
(before the move)

10. Alert the Kent MCA DoLS Service

Please note:
For more information please see ***KCC website at:***
www.kent.gov.uk/mentalcapacityact ***"DoLS", "Contact Us"***

Or email: *dols@kent.gov.uk*

7.3. In cases where there is **real doubt** or it is **clear** that the tests in S.5 and S.6, MCA (S.3.1. above) have **not** been met the KCC practitioner

must:

> **1. Avoid moving** the individual except in an absolute emergency
>
> **2. Discuss** the case **in supervision** or with a manager
>
> **3. Discuss** the case **with Invicta Law** where appropriate

7.4. The case of Re: AG (2015) Sir James Munby makes the following observation:

> *"…LSSAs **must** seek and obtain appropriate judicial authority before moving an incapacitous adult from their home into other accommodation. LSSAs do **not** themselves have power to do this…"*

- This could lead to the view that this type of case **must always** be the subject of an application to court for the COP to ratify an agreed best interests decision.
- If so, this would affect **every single** anticipated move for an individual who lacks capacity.

7.5. KCC has in consultation with the Legal team and the regional DoLS group concluded:

- An application to court does **not** have to be made **every time** because:
  - KCC is not aware of any case law that significantly changed the law in this respect
  - The judicial observation in AG can be read within the context of AG's move, which was disputed by his mother
  - The observation in AG is simply an opinion and not part of the final decision therefore, **not binding**

7.6. In cases where it is agreed an application to the court will be made the

KCC practitioner **must:**

1. Discuss and if possible **agree a plan** with other agencies **the way in which removal** of the individual is intended **prior to** the COP hearing

2. Provide the COP with **a care plan** outlining the various options for restraint and the circumstances in which they will be used

3. Provide the COP with any **information relating to** an **agreement** between the applicant and the police

4. Provide the COP with any **information relating to** the nature and extent of any **disagreement**
(Re: MP; LBH v GP (2009)

Please note:
*This **must** include, where applicable,*
the extent to which restraint and/or force might be used
and
*the nature of **any** restraint that might be used*

Appendix 1 Conducting Best Interests Meetings via Virtual Communication Platforms

This guidance should be read in conjunction with other practitioner guidance documents and policies such as KCC's MCA 2005 & DOLs policy and practice guidance.
It should also be used in conjunction with the Mental Capacity Assessment for Complex Decisions Form, when it has been assessed that the Person lacks the capacity to make the named decision(s).

1. Guidance for using technology

- When considering using a remote meeting determine what is best for the individual and/or their family members. Although virtual meetings can ensure that the meeting happens quickly the decision needs to be made in consultation with the individual and/or their family to clarify what the best way forward is.

- To participate in a remote meeting attendees will need to be able to access the chosen video platform by computer, tablet, or mobile phone.

- If attendees do not have access to one of these devices or aren't able to access the video platform application, the Chair of the meeting should be notified. Alternative arrangements can then be considered, e.g., joining the meeting by telephone.

- When determining the technology that people need to meet their needs, practitioners should focus on the strengths of individuals, groups and/or communities.

- Use the agreed platform to support the virtual meeting e.g., Skype, Microsoft Teams, Zoom, WhatsApp

- Consider how many people are on the camera at any one time during the meeting. Having more than one face on the screen may be confusing or too much of a distraction for the person ASCH/SIS is supporting.

- Make sure all phones and computer notifications are on silent if using a video conference call

- Be aware of the delay between practitioners speaking/ screen sharing and the other person receiving.

- Remember that this medium may not work for everyone. If it is not working, then it is ok to acknowledge this and stop.

2. Chair's Responsibilities

2.1. Before the meeting

- It is best practice for the Chair to arrange to speak, (with those previously mentioned) prior to the meeting to go through the agenda and how the meeting will run in order to support the individual, their family members and/or their representatives.

- This allows attendees to have an opportunity to meet via the chosen platform and express how they feel about using remote techniques, as well as any concerns or fears they may have about the process.

- If anyone feels uncomfortable participating in this way their views should be collected during a one-to-one conversation. Where possible also receive their views in writing e.g., email.

- The Chair should help the attendees to familiarise themselves with the video platform, e.g., where the chat function is, how to mute etc., explain the best interests decision making process, outline the meeting agenda, confirm who will be attending and allow people to settle before the other attendees arrive.

- The Chair should check with all attendees whether they have any accessibility needs regarding using the equipment for the meeting such as laptops or require any other reasonable adjustments.

- The Chair may create and share a contact list for all attendees in case of any technical difficulties.

- The Chair should send out the Best Interests Meeting Agenda prior to the meeting so that all those attending are clear about what the decision is that needs to be made and to ask everyone to bring along all relevant information they have which will assist in making the decision.

- The Chair will send out an electronic meeting request, via email, regarding the meeting date. KCC's preferred platform is MS Teams. The meeting request will include a web link to be able to join the meeting.

2.2. During the meeting

- The Chair should, at the start of the meeting, remind everyone of the confidentiality requirements.

- The Chair should ask practitioners and the other attendees participating in the meeting to confirm there is no-one else present with them and that all parties are in a confidential space.

- All technical devices that may record such as Alexa, Siri and Google Home devices should be switched off during the meeting.

- The Chair should inform the attendees of their responsibilities at the beginning of the meeting.

- The Chair should check at the beginning and periodically throughout the meeting to ensure that practitioners and the other people present at the meeting are able to hear and if any clarification is needed.

- The Chair will determine when breaks are taken (i.e.to confer privately, stretch, or change position).

3. Attendees' responsibilities

- Attendees should let the Chair know prior to the meeting if any adjustments need to be made.

- Practitioner's, agency representatives, along with everybody else at the meeting e.g., family members have a responsibility for saying at any point during the meeting if they are experiencing any difficulties with internet connections or having disruption with sound or video quality (see Chair's responsibilities above).

- The Chair will respond to determine if the meeting can continue e.g., by turning off cameras to improve network quality or if another form of video platform is required.

Please note:
Confidential meetings are not currently being recorded within ASCH.

Further information:
ETIQUETTE FOR MS TEAMS MEETINGS
psw-and-swe-best-practice-guide-for-video-call-and-virtual-home-visit-20200505.pdf (socialworkengland.org.uk)
Building rapport using technology in social work (scie.org.uk)

Delta Learning
Bitesize Learning for Microsoft Teams for Beginners
Intermediate Skills for MS Teams
Advance Skills for MS Teams
Advance Skills for MS Teams

Appendix 2 Process map for How to apply for a DoL in the community

KEY

- KCC practitioner
- Community Team Manager/DoL Lead
- Invicta Law
- The Court
- Rule 1.2 Representative

5.1. The KCC practitioner **must:**
- Apply the MCA/DoL screening tool every time they review the individual's care and support needs.

↓

5.2. The KCC practitioner **must:**
- Identify an individual's circumstances as reaching a 'high priority' on the MCA/DoL screening tool and upload to the relevant social care case management system.

↓

5.3. The KCC practitioner **must:**
- Email their Community Team Manager (ASCH) Team Manager or DoL Lead (Strengthening Independence Service (SIS) to confirm the 'high priority' threshold has been reached.

↓

5.4. The Community Team Manager/Team Manager/DoL Lead **must:**
- Quality assure the MCA/DoL screening tool
- Upload the quality assurance form to the relevant social care case management system.
- Track all individuals who have reached the 'high priority' threshold

↓

5.5. The KCC practitioner **must:**
- Continue to monitor the situation if the Community Team Manager/Team Manager/DoL Lead confirms that the individual's circumstances do not reach the 'high priority' threshold in case things change.
- Seek to reduce the restrictions where possible and end the deprivation.

↓

5.6. The KCC practitioner **must:**
- Send a letter to a medical practitioner or psychiatrist or psychologist who knows the person and seen them in the last year requesting they confirm the individual has a diagnosis that would deem them to be 'of unsound mind' or 'impairment of the mind' if there is not one already uploaded.
- Enclose a copy of the '7 Minute Briefing Community DoL' leaflet on Tri-x
- Upload the letter upload to the relevant social care case management system.

↓

5.7. The KCC practitioner **must:**
- Escalate to the ICB safeguarding via the Community Team Manager/Team Manager/ DoL Lead if the medical practitioner or psychiatrist or psychologist refuses to complete the letter or there is no response for 4 weeks.

↓

5.8. The KCC practitioner **must:**
- Arrange for the individual's mental capacity to be assessed in relation to them making decisions about their accommodation and/or care arrangements in the community.
- Ensure the COP3 form is completed (upload on the relevant social care case management system)

↓

5.9. The KCC practitioner **must:**
- Identify a Rule 1.2. Representative for the application.

↓

5.10. The KCC practitioner **must:**
- Ensure that the friend/family member is willing and able to carry out this role

↓

5.11. The KCC practitioner **must:**
- Inform their budget holder of the need for a paid representative
- Obtain a purchase order number for the spot purchase form

↓

5.12. The KCC practitioner **must:**
- Make a referral advocacy if there is no one appropriate to take on the role of a Rule 1.2. Representative from the individual's family/friend network.
- Upload a copy of the referral form (upload on the relevant social care case management system).

↓

5.13. The KCC practitioner **must:**
- Include with the referral:
  - A copy of the individual's care and support plan
  - The individual's contact details
  - Notification of any risks to the representative

↓

5.14. The KCC practitioner **must:**
- Arrange for a Best Interests Meeting

↓

5.15. The KCC practitioner **must:**
- Consider making a request for legal advice if there are any objections or application is not suitable for the streamlined process

↓

Continued on next page

5.16. The KCC practitioner **must:**

- Complete the COPDoL11 form within 14 days of the Best Interests meeting and upload on the relevant social care case management system

5.17. The KCC practitioner **must:**

- Community Team Manager/Team Manager/DoL Lead to quality assure.
- Ensure there is a comprehensive care and support plan on the relevant social care case management system.

5.18. The Community Team Manager/Team Manager/DoL Lead **must:**

- Quality assure the COPDoL11 and COP3 forms along with the care and support plan, the BIM minutes and the medical practitioner or psychologist letter.
- Upload a copy of the quality assurance form to the relevant social care case management system.

5.19. The KCC practitioner **must:**

- Make a request for legal advice having got authorisation.

5.20. Invicta Law **will:**

- Allocate a solicitor

5.21. The KCC practitioner **must:**

- Send all documentation to nominated solicitor copying in the Community Team Manager/Team Manager/DoL Lead.

5.22. The nominated solicitor **will:**

- Review and approve all documentation and send it back to the KCC practitioner.

5.23. The KCC practitioner **must:**

- Upload all the documentation to the relevant social care case management system.

5.24. The KCC practitioner **must:**

- Send the Rule 1.2. Representative the template letter requesting them to complete and sign the COP24 form and Annex C, (pages 23-26 of the COPDoL11 form)
- Enclose copies of:
  - The COP Application to authorise a DoL (COPDoL11 form)
  - The COP Assessment of capacity (COP3 form)
  - The COP witness statement (COP24 form)
  - The care and support plan
  - The Best Interests meeting minutes
  - The medical practitioner or psychiatrist or psychologist letter

5.25. The Rule 1.2. Representative **must:**

- Complete and sign the COP24 form and Annex C of the COPDoL11 form and send these back to the KCC practitioner

5.26. The KCC practitioner **must:**

- Send the COP24 form and Annex C of the COPDoL11 form to the Community Team Manager/Team Manager/DoL Lead to quality assure and upload the documents the relevant social care case management system.

5.27. The Community Team Manager/Team Manager/DoL Lead **must:**

- Quality assure the COP24 form and Annex C of the COPDoL11 form
- Upload the quality assurance form to the relevant social care case management system.

5.28. The KCC practitioner **must:**

- Send the COP24 form and Annex C of the COPDoL11 to the nominated solicitor copying in the Community Team Manager/Team Manager/DoL Lead once approved.

5.29. The nominated solicitor **will:**

- File the application along with all the supporting documentation with the court.

5.30. If any significant changes occur prior to the final court order being issued, the KCC practitioner **must:**

- Complete a COP24 witness statement to explain the reasons for the changes and how the best interests process has been followed and update the care and support plan.
- Upload the COP24 witness statement to the relevant social care case management system.
- Send the updated documents to the Community Team Manager/Team Manager/DoL Lead to quality assure.

Continued on next page

5.31. The Community Team Manager/Team Manager/DoL Lead **must:**

- Quality Assure the updated COP24 form and updated care and support plan.
- Upload the quality assurance form to the relevant social care case management system.

5.32. The KCC practitioner **must:**

- Send the Rule 1.2. Representative the template letter requesting them to update the COP24 form and enclose a copy of the updated care and support plan, the COP24 (completed by the KCC practitioner) and a blank COP24 form

5.33. The Rule 1.2. Representative **must:**

- Update the COP24 form and send this back to the KCC practitioner

5.34. The KCC practitioner **must:**

- Upload the documents (upload on the relevant social care case management system)
- Send the COP24 forms and the updated care and support plan to the nominated solicitor copying in the Community Team Manager/Team Manager/DoL Lead.

5.35. The nominated solicitor **will:**

- File the updated documentation with the court.

5.36. The court **will:**

- Send the court order to the nominated solicitor and the Rule 1.2. Representative

5.37. The nominated solicitor **will:**

- Send the KCC practitioner the court order.

5.38. The KCC practitioner **must:**

- Upload the court order to the relevant social care case management system.
- Change the legal status on the relevant social care case management system.
- Inform the Community Team Manager/Team Manager/DoL Lead

5.39. The KCC practitioner **must:**

- Apply the MCA/DoL screening tool every time they review the individual's care and support needs

5.40. If any significant changes occur the KCC practitioner **must:**

- Update the care and support plan to include the changes
- Inform the Community Team Manager/Team Manager/DoL Lead
- Inform the court that the order is no longer required
- Send the Rule 1.2. Representative the end of Community DoL order template letter
- Change the legal status if the order is no longer required on the relevant social care case management system.