Level 2 Adult Safeguarding

Restraint, Deprivation of Living Safeguards (DoLS)

Workbook

This workbook forms part of the Trust Adult Safeguarding Level 3 training package, prior to undertaking this Workbook you should complete the Mental Capacity Act (2005) and Best Interests Workbook and E assessment.

To achieve compliance, you are also required to complete the Mandatory Training Clinical Staff: E Assessments Level 3 Restraint, Deprivation of Living Safeguards (DoLS).

In this Workbook, we will look at:

- What restraint and a deprivation of liberty are and some of the confusions and challenges for staff
- The law and restraint and when it might be necessary to use restraint
- When the restrictions reach a threshold that they deprive a patient of their liberty
- The legal processes to authorise a deprivation of liberty.

All the set questions that form part of the E-Assessment are discussed throughout the work book.

Contents

Introduction

The term restraint understandably has negative connotations. When asked about restraint it is not unusual for staff to say they never use restraint. This in part reflects the emotive nature of the word but also a lack of understanding of the meaning of the term.

As the Mental Capacity Act 2005 (MCA) makes clear, anyone who lacks the capacity to consent must be cared for in accordance with the best interests and least restrictive principles (see Block 5 and 6). There may be some occasions where it will be in someone's best interests to be restrained or deprived of their liberty for a period of time to enable care and treatment to take place.

The Trust policy on *Therapeutic Restraint Policy (Restrictive Interventions) of Adults under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and Procedure for DoLS Authorisation. Link below*

download.cfm (lewishamandgreenwich.nhs.uk)

This clinical policy provides guidance to staff on the safe use of restraint under the MCA and if a patient needs to be deprived of the liberty. It has been written to ensure all staff work within the law and in the best interests of the patients they are providing treatment and care for. The policy sets out a framework for staff to follow which staff should familiarise themselves with and refer to this document.

RESTRAINT

Definition and legal requirements

In some cases, patients will have capacity and are able to consent to the use of restrictive equipment e.g. lap belts to make them feel secure whilst using a wheelchair but for the majority of cases restraint is necessary for people who cannot consent to the intervention because they lack the capacity to do so. For these individuals making a decision to restrain them is a serious one, and because of this, it is important for staff to have a basic awareness of the legal position.

The Mental Capacity Act (MCA) explains clearly what 'restraint' means, and when it is legal. Someone is using restraint if they:

- ‘use force – or threaten to use force – to make someone do something they are resisting, or
- Restrict a person’s freedom of movement, whether they are resisting or not’. Section 6(4) MCA 2005.

It’s important that you understand what restraint is, so that the care provided is lawful and if challenged you have documented clearly the reasons why you believed the restraint was necessary, proportionate and the least restrictive approach.

When restraining people who are not able to consent staff need to ensure that a mental capacity assessment is completed, and a decision in the patient’s best interests is made. There are also two extra conditions that must be met for restraint to be lawful and for staff to have protection from liability. These extra conditions are:

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

Types of restraint

One of the reasons why staff sometime believe that they never restrain their patients is because of confusion of what constitutes restraint.

TASK: Make a note in the drop-down box of as many forms of restraint that you can think of

Learning Points

There are various ways to describe the different types of restraint, so your list may differ. The key is to understand the range of restrictions that come under the heading of restraint so that any such interventions are undertaken within the law.

❖ **Physical restraint** involves one or more persons holding a person down or blocking movement. This type of intervention can involve the use of physical force to ensure the person does not move around freely, for example using physical pressure to keep an

individual seated or holding the person down on the floor. Such restraint should always involve the least restrictive practice and **only be carried out by those trained in the restraint technique being employed,** and be in accordance with the restraint procedure.

Physical restraint should be proportionate to the situation. If possible, physical restraint should be pre-planned through a multidisciplinary care and planning process. However it is recognised that emergency physical restraint is sometimes necessary to prevent harm to the individual or others. If this is the case and it is likely that the patient may need to be restrained again. It is recommended that as soon as possible a multi-disciplinary meeting is convened to discuss the approach to the behaviour, and a plan is developed to be used in the event of any further incidents that may necessitate restraint again.

Any physical intervention must not intentionally inflict pain. Particular attention must be paid to ensure a person's airway is not obstructed, and there is no compression on the person's chest that could compromise breathing if the person is to be restrained on the floor.

Please consult the Trust Restraint Policy for more information: Arrangements for Restraint/Physical Intervention.

Face Down / Prone Restraint

Wherever possible, restraining a person on the floor should be avoided. If, however, the person 'takes' the restraining staff to the floor or where there is no other option in the circumstances, the floor should only be for the shortest period of time and only for the purpose of gaining reasonable control. It is imperative that the person in charge of the restraint ensures the person's airway is not restricted, no pressure is placed on the chest and a member of the Nursing / Medical staff take responsibility for monitoring the person's airway, breathing and physical health. For further information:

Information on restraining children and young people restraint policy. Follow this link;

Use of Restraint Policy (lewishamandgreenwich.nhs.uk)

- **Mechanical** involves the use of equipment e.g. using a heavy table, bed rails or belt to stop the person doing something e.g. getting out of their bed or chair.

  Mechanical restraint includes specially designed **mittens** (also known as **restraint gloves** in intensive care) to stop patients removing nasogastric tubes or catheters. The use of restraint gloves is only permitted if the person responsible for the decision reasonably believes this is necessary to prevent harm to the person who lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of the harm. Hand restraint gloves may only be used in situations where the patient has

been formally assessed as lacking capacity and a capacity assessment form has been completed. BOTH of the following must apply:

The patient is behaving in ways which result in immediate risk AND the use of the gloves represents the least intrusive means of ensuring that care and/or treatment which is necessary to protect the interests of the patient is provided safely.

A DoLS must also be applied for. This does not apply to ICU patients who have hand restraints imposed. Consult the Adult Safeguarding Team if hand restraints are to be used in an ICU setting. For more information go to: The Trust policy on *Therapeutic Restraint Policy (Restrictive Interventions) of Adults under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and Procedure for DoLS Authorisation*.

- **Chemical** restraint refers to the administration of medication to restrain patients. The administration of a medication is considered a chemical restraint when used to sedate an agitated patient and not for direct therapeutic reasons.
- **Administration of Covert Medication –** the term 'covert' is used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them.

It is essential that any covert medication is done in the least restrictive way possible and that safeguards are in place, for example, regular reviews of the decision to covertly medicate and whether it remains in the patients best interests and is the least restrictive option in that particular patient's case. For further information see the and the Trust Safety Alert which was issued following the Court of Protection case*: AG v BMBC & Anor* (2016) EWCOP 37 (District Judge Bellamy) that provides guidance on the use of covert medication and Trust policy. Box 1 includes an extract form the Trust Safety Alert. Further information is also available in *Therapeutic Restraint Policy (Restrictive Interventions) of Adults under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and Procedure for DoLS Authorisation Accessed via the Truts intranet under clinical policies and guidance.*

Box 1
Extract form Safety Signals
Covert Medication and Deprivation of Liberty Safeguards (DOLS): August 2016

1. If the patient lacks capacity, is refusing to take the mediation and is unable to
2. understand the risks to their health by failing to take the medication, then, in exceptional circumstances, covert medication can be considered
3. Prior to medication being administered covertly, a best interests meeting should be held with the relevant healthcare professionals, RPR (if appointed) and the patient's family members
4. If there is no agreement, there should be an immediate application to Court
5. If it is agreed by everyone that covert administration of medication is in the patient's best interests, then this must be recorded and placed in P's medical records
6. The existence of the covert medication must be clearly identified within the best interests assessment and DOLS authorisation
7. An agreed management plan should specify the timeframes (possibly monthly, where the standard authorisation is longer than six months) and circumstances (such as change of medication or treatment regime) which would trigger review
8. These reviews should involve the relevant healthcare professionals, RPR (if appointed) and the patient's family members
9. All of this information must be easily accessible when reviewing any of the patient's records

- **Technological** developments have resulted in more sophisticated forms of restraint such as alarms, keypads that people can't use or designed to baffle them etc. This may increase safety and reduce the need for physical restraint but can limit a person's freedom, as well as others.

- **Psychological/ emotional restraint** such as telling patients that they are not allowed to do something or taking away aids necessary for them to do what they want, for example spectacles or walking aids. Psychological restraint can also include inappropriate threats to scare someone e.g. threats to call the police, if a person does not comply with an instruction

Note

Restraint used for clinical or professional convenience (rather than in the patient's best interests) is unlawful. This is clearly stated in the MCA:

'A carer or professional must not use restraint just so that they can do something more easily'. MCA s6.

The Least Restrictive option

In line with the law the Trust policy on therapeutic restraint recognises that people are entitled to be cared for in the least restrictive way and care planning should always consider if there are other, least restrictive options available.

Principle 5 of the MCA requires that when making a best interests decision about a person's treatment or care plan, staff must consider all of the options and then choose the one that meets the need and is the least restrictive of the person's rights and freedoms. Staff should always challenge themselves if they believe it is necessary to restrict, restrain or deprive someone of their liberty that their actions are the least restrictive option and be able to demonstrate that action has been taken to minimise the use of restraint.

Case example

Mr. T is an 80-year man with dementia, who was admitted with a chest infection three days ago. When he was first admitted he was calm but yesterday he showed signs of confusion and agitation in the afternoon when he proceeded to persistently tell the other patients in his bay that it was time for them to go home. He became frustrated and upset when they would not leave. After a short period of time he settled and slept but today the same thing happened at approximately

the same time (3:30). Mr T seems to think that he: '*needs to lock up the school'*. He makes no attempt to leave the ward, as he says, *'it's his job to stay'*.

Staff on the unit are concerned as Mr. T has a history of falls and is unsteady on his feet. His agitation also appears to be increasing and whilst they hope it will settle as he recovers it may also be harder to manage.

TASK: What advice do you give?

Make a note in the drop down box below

Now compare your notes with the Learning points below

Learning points

Situations like this can be difficult to manage on a busy ward but if left may also escalate. Trying to identify why Mr. T behaves in this way might assist the ward staff to proactively manage the situation and follow the least restrictive approach. Some prompts to consider are:

- What might the behaviour mean? (Could there be explanation from his past? Could it be triggered by a physical problem, such as pain or the need to go to the toilet?)
- What risks are associated with the behaviour? In this case, Mr. T is at risk of falls
- Who is it risky for? The patient or others?
- Who could help and /or advise? People who know him well. For example, family or staff who usually provide care and support. The Dementia Lead Nurses?

This case is a good example of the benefits of being proactive and trying to manage and understand why a situation occurs before it escalates further. This scenario has been drawn from a real case. The patient had been a residential school caretaker for

many years and when he was admitted to hospital his increased confusion triggered the behaviour. Discussions with family members revealed that this was also triggered at home if the man was restless and noticed the time. His family ensured that the man was 'busy' at that time to stop the behaviour being triggered. In hospital the family timed their visits to make sure that there was always someone with him to distract him and help him focus on other things that he enjoyed.

Duty of care

It is recognised that in exercising a professional's 'duty of care' in ensuring the safety of individuals within the Trust, decisions on the use of restraint methods may need to be applied to patients in urgent and emergency situations. Sometimes these decisions may have to be made quickly and without consultation with colleagues and relatives. Staff must ensure detailed documentation of actions and reasons for the restraint are recorded in the patient's records.

If restraint is used in an emergency, it should be recorded as a clinical incident and must be reported to the multi-disciplinary team and matron with a clear plan for future occurrences where possible.

Quick Quiz

1. Is it always wrong to use restraint?

YES or NO

Learning points

No, in some situations, it is necessary to restrain a patient to protect them from harm, but you must be able to demonstrate that the person's capacity has been assessed and that any restraint used is proportionate to the situation and the less restrictive option.

2. Read the following statement:

'If I am to restrain a patient because it's the right thing to do for them, it doesn't count as restraint'.

Is this

TRUE or FALSE

Learning point

The reason behind an act does not dictate whether the act is restraint. Staff sometimes incorrectly assume that because they are doing the act in someone's best interests it is not restraint. This is incorrect, the act maybe in the patient's best interests but it is still restraint. It is important for staff to recognise this and document the restraint and the measures taken to assess capacity and follow the principles of the MCA.

3. **Following treatment in hospital for a cardiac problem, a patient develops dangerously high blood pressure levels and is transferred to critical care. As part of her treatment she is heavily sedated. Is this restraint?**

   YES or
   NO

Learning point

This does not fit the definition of restraint, as the sedation is being given to treat the patient's illness, not to control her behaviour. The correct answer is NO

4. **Following admission to hospital with a heart condition, a man who also has a diagnosis of dementia is unable to settle at night and constantly wanders around the ward. After two nights with little rest, his legs have become very oedematous, and there is a concern that his constant movement is exacerbating his heart condition. Staff have tried different strategies to reassure him but nothing has worked. On the third night sedation is prescribed at night. Is this restraint?**

   YES or
   NO

Learning point

This would fit the definition of restraint, as the sedation is directed at controlling the man's behaviour. However, providing staff follow the requirements of the MCA, this is likely to be justified if challenged. The prescribing doctor needs to be able to

demonstrate that the man lacks capacity and that the chemical restraint is in his best interests and the least restrictive approach.

Film Clip

In this short film two scenarios are used to explore the practical application of restraint.

Note: example one refers to a man in a care home setting which also has relevance for Trust staff.

https://www.scie.org.uk/socialcaretv/video-player.asp?v=practical-approaches-to-minimising-restraintw

Deprivation of Liberty Safeguards (DOLS)

Background

The Deprivation of Liberty Safeguards (DoLS), were introduced in 2017 following a high-profile European Court of Human Rights case: HL v UK ('Bournewood' judgement) case in 2004 which found that a hospital in Surrey had illegally deprived an autistic man of his liberty. https://www.equalityhumanrights.com/en/what-are-human-rights/human-rights-stories/bournewood-case. The legislation was due to be replaced with a new system called the Liberty Protection Safeguards (LPS). See Box 2 for more information.

This means that the current procedures to deprive an individual of their liberty will remain the law until 2022. Box 3 outlines some key features of the safeguards.

Box 2
Liberty Protection Safeguards (LPS)

The Mental Capacity (Amendment) Act 2019 received the Royal Assent on the 16th May 2019. The bill, when implemented will replace the Deprivation of Liberty Safeguards (DoLS) with a new system called the Liberty Protection Safeguards (LPS). The introduction of this legislation had been planned for 2020 but in July 2020 due to the Covid 19 pandemic the Government announced on 16th July 2020 that the original implementation date for the LPS (1st October 2020) would be postponed until April 2022 which means the current Deprivation of Liberty Safeguards will remain in place until then.

Box 3
Key features

- The Deprivation of Liberty Safeguards is an amendment to the Mental Capacity Act 2005 – so the five-key principle of the MCA equally apply to DoLS.
- In addition, extra safeguards are needed if the arrangements for care and treatment deprive a person of their liberty.
- In hospitals and care homes these procedures are called the Deprivation of Liberty Safeguards (DoLS). The DoLS procedures are administered by the local authority (adult social care), who in this role are also known as the Supervisory Body. To comply with these procedures and the law, the Trust must complete and send a FORM 1 for standard and urgent applications to the Supervisory Body where the patient is a resident
- Specialist assessors; a mental health assessor and a Best Interest Assessor (BIA) determine whether the deprivation of liberty is lawful, proportionate and in the patient's best interests.
- The Deprivation of Liberty Safeguards (coordinated by the local authority) can only be used if the person is being deprived of their liberty in a hospital or care home. The Court of Protection authorises a deprivation of liberty for all other settings e.g. supported housing, young people (16-17 years), in people's own homes, adult foster placements etc.
- The Court of Protection can authorise a community deprivation of liberty two ways:
    - A streamlined approach, which involves a paper review of documentation using a COPDOL11 form
    - A judicial hearing
- The Court of Protection will also consider and authorise complex cases in hospital and care homes
- If a standard authorisation is given, one key safeguard is that the person has someone appointed with legal powers to represent them. This is called the Relevant Person's Representative (RPR) and will usually be a family member or friend.
- Other safeguards include rights to challenge authorisations in the Court of Protection, and access to Independent Mental Capacity Advocates (IMCAs).

As we have just considered earlier best interests and use of restraint. The MCA provides the legal authority to act in a person's best interests, including the necessary and proportionate use of restraint if certain conditions are met. However, these sections of the Act do not permit restraint or control to a degree which amounts to detention or what is defined under Article 5(1) of the European Convention on Human Rights as a deprivation of liberty. Box 4 shows the different legal authority used to authorise different interventions.

Box 4: Restraint to deprivation of liberty

Legal authority

Restraint or restrictive intervention	Deprivations of liberty
• To comply with the MCA document what restraints and /or restrictions are in place for example: • Bed rails • Chemical restraint • NB These elements may also be componets of a deprivation of liberty. • Legal authority comes from Section 5 AND Section 6 of the MCA	• DOES THE ACID TEST APPLY? • Is the person subject to continuous supervision and control? *AND* • Is the person free to leave? • To comply with Article 5(1) of the European Convention on Human Rights ('ECHR') an authorisation must be obtained via the DOLS procedures or the Court of Protection

The MCA principles must be applied for both interventions , which means the patient must lack capacity to consent to the intervention and it be in their best interests, as well as the specific requirements for both processes

It can be confusing for staff because of the overlap between an intervention that on its own may constitute restraint under the Section 5 and 6 of the MCA for example bed rails used as a short term intervention (without any other restrictions) and the use of bed rails which may also be one element of a restrictive care plan, which when put together with other restrictions constitutes a deprivation of their liberty.

Consideration of alternatives

Before applying for an authorisation to deprive an individual of their liberty the Trust must demonstrate that alternatives have been considered to provide the care or treatment in other ways and avoid the need to deprive the patient their liberty.

How is a deprivation of liberty determined?
The Acid Test

In 2014 two significant Supreme Court judgements (known as Cheshire West) clarified what constitutes a deprivation of liberty. Box 5 provides more information on the case.

Box 5
Supreme Court Judgement/ Cheshire West 2014

Cheshire West is the collective name given to two cases:

- P v Cheshire West and
- P and Q v Surrey CC (2014).

The judgements involved three adults living in community settings which had previously been considered as unlikely to deprive an individual of their liberty because of their domestic nature. The judgement was hugely significant for health and social care because the introduction of the 'acid test' meant that many more people in hospitals and living in the community had care arrangements in place that were now considered a deprivation of liberty. This led to an enormous increase in applications for authorisation to both the DoLS and the Court of Protection. For further information on the judgment CLICK https://www.39essex.com/cop_cases/1-p-v-cheshire-west-and-chester-council-and-another-2-p-and-q-v-surrey-county-council/

In this judgement the threshold for engaging Article 5(1) or a deprivation of liberty was clarified with the so called 'acid test', which is that a person is deprived of liberty if they are:

- not free to leave **and**
- they are subject to continuous supervision and control**.**

When staff believe that a patient's care arrangements maybe so restrictive that they amount to a deprivation of liberty staff must:

- Check if there is current DoLS in place and it is applicable. Many patients are admitted from Nursing Homes and they may have a DoLS in place at the nursing home. **If the patient is admitted the DoLS does not carry through.** The Trust must apply for an urgent and standard DoLS authorisation. This process will change Liberty Protection Safeguards replace DoLS in April 2022.

- Assess the patient's capacity using the Trust mental capacity assessment form within iCare.

- Review the **whole care and/or treatment package** and check that it is the **best interests** of the patient and they are the **least restrictive approach** to meet their needs AND that

- those **arrangements meet the 'acid test'** and amount to a deprivation of liberty

If you believe these conditions are in place, complete a ADASS FORM1 application if it falls within your role or get advice from either your ward or line manager, Clinical Site Practitioner (CSP) or the Adult Safeguarding Advisors.

The Medical Team or the Nurse in Charge may complete an ADASS DoLS Form 1.

All the DoLS Forms are available on the Adult Safeguarding Intranet Page and on the Trust intranet or contact the adult safeguarding team. LH.adultsafeguarding@nhs.net .

Note: Lady Hale who delivered the lead judgement in this case indicated that the requirements for vulnerable persons to have access to legal safeguards are so important that professionals should *'err on the side of caution'* when determining whether a deprivation is occurring.

Non relevant factors

The Supreme Court judgement also ruled that the following factors *are no longer* relevant to whether or not someone is deprived of their liberty:

1. The person's compliance or lack of objection;
2. The suitability or relative normality of the placement (after comparing the person's circumstances with another person of similar age and condition); *AND*

3. The reason or purpose leading to a particular placement

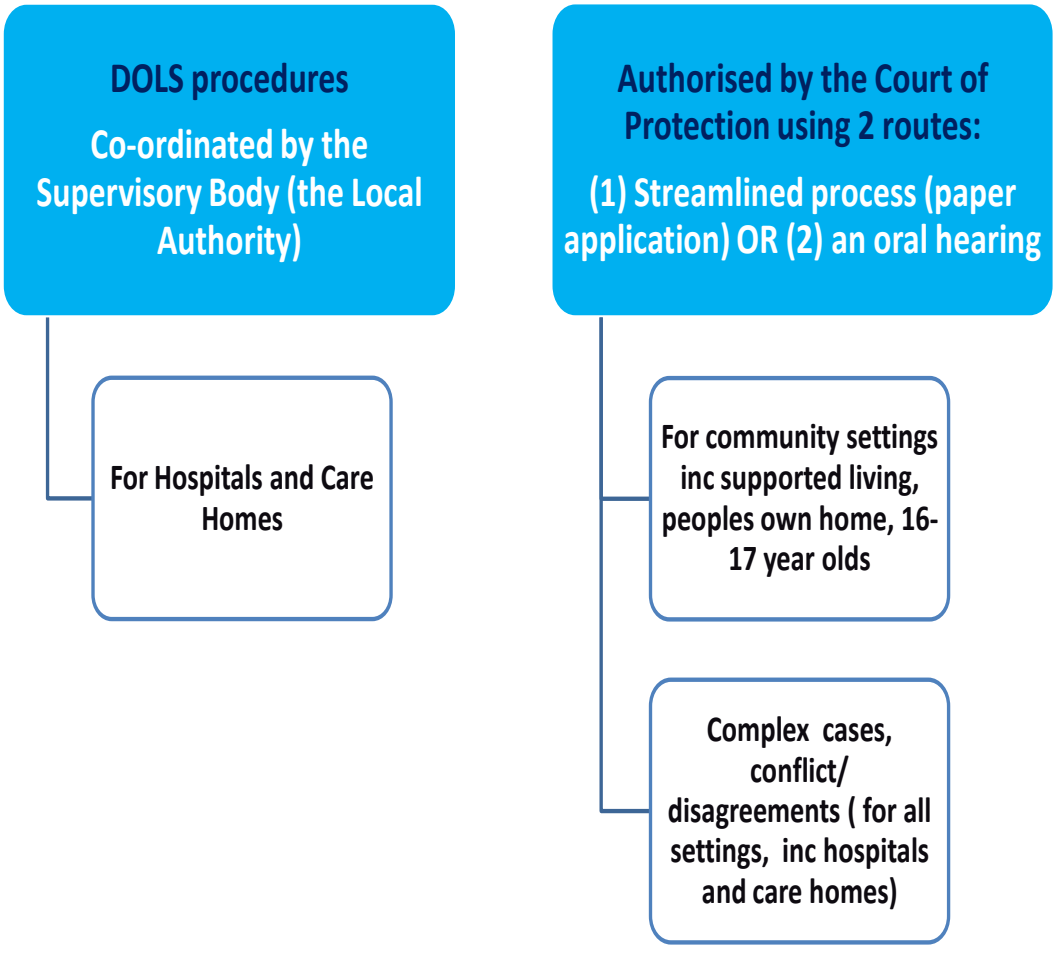
   These factors may still be relevant to whether or not the situation is in the person's best interests but they are not relevant when determining a deprivation of their liberty.

Authorisation process

There are a number of ways to authorise a deprivation of liberty. The DoLS safeguards are managed by the local authority at present. The local authority authorises the majority of hospital cases, as well as care homes. Complex hospital cases or where there is a disagreement that cannot be resolved are referred to the Court of Protection.

Where a person lives in other settings, such as their own home, or a supported tenancy or if they are 16-17, they must be authorised by the Court of Protection. For straightforward cases this can be done via a streamlined process, which involves a paper review of all the documentation. This is sometimes known as the Re X procedure. Complex community cases are referred for a full oral hearing. Box 6 illustrates these processes.

Box 6
Authorisation processes



Standard and Urgent Applications

The Trust must apply to the Supervisory Body (the Local Authority) for a Standard Authorisation using the FORM 1. Resources are attached to the E-Learning Package on how to complete a DoLS Form 1.

The completed forms should then be sent to: LH.adultsafeguarding@nhs.net
The adult safeguarding team will check the form, amend if necessary, send to the appropriate local authority and update the patient's notes.

Family or Friends that are supporting the patient must be alerted to the DoLS application. There is a check to inform the Supervisory Body that this has been done on page 6 of the application.

I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION (Please sign to confirm)

There is an information leaflet on the adult safeguarding intranet page that can be printed out and given to interested persons.

The Trust can authorise an Urgent Deprivation of Liberty Safeguard for up 14 days until a Standard Authorisation has been agreed by the Supervisory Body (Local Authority). This must be done if the deprivation of liberty has already commenced. In these circumstances a Standard Authorisation application must also be completed at the same time and sent to the relevant Local Authority.

In 2017 a case brought by the Coroner involving a woman with Down's syndrome and learning disabilities who died in an intensive care unit (ICU) had a significant impact on how deprivation of liberty is viewed in ICU. Box 8 outlines the implications of the case and provides a link to further information.

DOLS and Intensive Care Units (ICU)

Box 8
Ferreira v Coroner of Inner South London (Jan 2017)

This landmark judgment on deprivation of liberty in intensive care considered whether the 'Acid test' introduced following the March 2013 Supreme Court judgement should be applied in intensive care.The Court of Appeal ruled that DoLS applications do not usually need to be made for ICU patients, even if they have a pre-existing mental disorder affecting their capacity.

Lady Justice Arden said: ***"lifesaving treatment: in general - no deprivation of liberty"***
For further information on this case CLICK HERE: https://www.39essex.com/cop_cases/r-ferreira-v-hm-senior-coroner-inner-south-london-others/

If an individual is being deprived of his/her liberty legal safeguards exist to protect an them by providing them with:

- A representative to act for the individual and protect their interests
- The rights to challenge an unlawful deprivation of liberty in the Court of Protection
- The rights to have their deprivation of liberty reviewed and monitored on a regular basis.

CQC notification

The Care Quality Commission must be notified of all DoLS applications. This notification is completed by the Trust Adult Safeguarding Manager on behalf of the organisation.

Further resources

For staff who require more details on the law and the application of DOLS in hospital settings CLICK HERE: https://www.39essex.com/wp-content/uploads/2018/02/Deprivation-of-liberty-in-the-hospital-setting-February-2018-1.pdf

Quiz

5. **Peter is 85 and has early stage dementia. Peter was admitted to hospital for a routine surgical procedure which he was able to consent to pre-operatively. Post-operatively he develops delirium and he declares he wants to leave the hospital stating that he is being taken prisoner and he needs to leave to go to work. Peter packs his belongings. Peter is not medically fit to be discharged. Enhanced care is put in place which involves continuous supervision and control.**

What other actions will you take? Please tick all that apply.

a) Complete a Mental Capacity Assessment
b) If the MCA concluded that Peter does not have capacity to consent to his care and treatment, complete Form 1 Urgent and Standard DoLs request and send to the adult safeguarding team.
c) Inform Peter's relative
d) Continue to care and treat Peter in his best interests until the DoLS has been authorised by the local authority.
e) All of the above

Learning points

The key here is to identify whether Peter's care arrangements meet the threshold for the 'acid test'. In this case Peter is continuously supervised and controlled and is not free to leave.

6. **Who is <u>not</u> responsible for completing a DoLS form one (request for an urgent and standard authorisation of DoLS)?**

a) A member of the patient's medical team including physician associate
b) A professionally qualified member of the patient's Nursing Team who is managing the Ward.
c) The Ward Clerk

7. **What are the possible consequences of failing to request a DoLS authorisation where a patient is under continuous supervision and control and not free to leave? Tick all that may apply:**

a) An unlawful deprivation of liberty would be in progress, the patient's human rights would have been breached and the Trust could be sued
b) Possible disciplinary action against staff members responsible and escalation to professional bodies could take place.
c) An allegation of neglect against the Trust under Section 42 of the Care Act 2014

d) All of the above - are the right answer

8. **If a patient lacks mental capacity to consent to their care and treatment in hospital and they are under continuous supervision and control AND are not free to leave an application for a DoLS is required. Consider the following cases. Which of the following cases <u>does not</u> requires a DoLS request?**

NB In all cases the patient has been assessed as lacking mental capacity to consent to their care and treatment in hospital).

a) Dot has been admitted from home following a fall. She has advanced dementia. She requires enhanced care on a cohort bay due in particular to her risk of falls. She has not attempted to leave the ward but would not be allowed to as she is not safe to discharge.
b) Abdul has been admitted from home due to concerns of gross self- neglect. He is highly confused, the cause of this has not been diagnosed. He is constantly wandering about the ward and attempting to leave. Abdul is being persuaded and distracted from leaving the ward.
c) Rita has suffered a stroke. She requires maximum support in all activities of living. Due to swallowing difficulties she requires a naso gastric tube. She has pulled this out once and requires mittens to ensure the NG tube remains in place. There is no discharge plan in place and whilst she has made no attempt to leave the ward, she would be prevented from doing so.

d) Tony has been detained in mental health hospital due to an acute psychotic illness causing difficulties with managing his physical health. He is admitted to A&E while detained under the Mental Health Act (MHA).

Learning point

At first glance you may think that Dot and Rita (a and c) are not attempting to leave so they do not meet the 'acid test' but the Cheshire West Supreme Court judgement made it clear that intentions were not relevant to whether an individual was deprived of their liberty. It is therefore important not to confuse *"freedom to leave"* with *"ability to leave"* or *"attempts to leave."* In the Supreme Court judgement, it was made clear that all three adults involved had never attempted to leave of their own accord but all of them were still found to be deprived of their liberty.

Tony has already been detained under the MHA, so even if he did meet the 'acid test' it would not be necessary to also apply a DoLS, as arrangements are already in place via the MHA to deprive Tony of his liberty.

Learning Point: The Mental Health Act will always 'Trump' the Mental Capacity Act. A patient can only be detained on one or the other not both. The mental health section has to be rescinded before a patient is detained under a DoLS.

9. A patient has been admitted from a care home where there is currently a DoLS authorisation in place. The patients has had his capacity assessed and the team feel that the arrangements for his care in hospital also meet the threshold for a deprivation of liberty whilst he is in hospital. Tick all that may apply

a) Complete an Urgent DoLs request and a standard DoLS and send to the adult safeguarding team.
b) Inform his relatives
c) Do nothing as the care home have already made the DoLS application and the authorisation has been given
d) Continue to care and treat in his best interests until the DoLS has been authorised by the local authority

Learning points

The DoLS arrangements are setting specific so under the current arrangements a new DoLS application would need to be made. In the future, under the Liberty Protection

Safeguards (LPS) depriving someone of their liberty will be on the basis of the arrangements in the care and treatment plan and will not be based on where the care is being provided, which will mean that one authorisation can be used across settings but this will not be the law until 2022.

Additional Support

1. If these sessions leave any outstanding questions or issues for you, please email the Adult Safeguarding team with your questions and they will contact you either by email or phone.

2. If you have any suggestions for supervision or reflection sessions please also contact the Adult Safeguarding Team

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