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<td>Relevant to</td>
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<tr>
<td>Policy lead</td>
<td>Pippa Dawson, Deputy Mental Health Law Manager/Mental Capacity Act Lead</td>
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<td>Contact details</td>
<td>Email: <a href="mailto:Philippa.dawson@Candi.nhs.uk">Philippa.dawson@Candi.nhs.uk</a></td>
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<td>Accountable director</td>
<td>Dean Howells, Nursing Director</td>
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DO NOT AMEND THIS DOCUMENT
Further copies of this document can be found on the Foundation Trust intranet.
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1. INTRODUCTION


1.2 The Deprivation of Liberty Safeguards (DoLS) were introduced into the Mental Capacity Act 2005, (which became effective in April 2009,) and provides a legal framework in circumstances where deprivation of liberty appears to be unavoidable and aims to prevent breaches of the European Convention on Human Rights.

1.3 DoLS apply to people in hospitals and care homes aged 18 years and over who lack capacity to consent to arrangements that amount to a deprivation of liberty as set out in the Acid test.

2. SCOPE OF THE POLICY

2.1 The MCA applies in conjunction with other legislation, under which health and social care staff have obligations relating to people who may lack capacity, including:

- Deprivation of Liberty Safeguards 2009
- Mental Health Act 1983 (as amended 2007)
- National Health Service and Community Care Act 1990
- Disability Discrimination Act 1995
- Data Protection Act 1998
- Human Rights Act 1998
- Care Standards Act 2000
- The Care Act 2015

2.2 This policy applies to all staff at Camden and Islington NHS Foundation Trust who are involved in the care, treatment or support of service users over 16 years of age who receive services from the Trust.

3. AIMS AND OBJECTIVES

3.1 The aims and objectives of this policy are to provide staff working for Camden and Islington NHS Foundation Trust with guidance about the Deprivation of Liberty Safeguards (DoLS) contained in the MCA 2005. It sets out the main provisions of the Deprivation of Liberty Safeguards, local procedures and roles and responsibilities of staff.

3.2 This policy is not a replacement for the MCA Code of Practice http://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf or the Deprivation of Liberty Safeguards http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476 or guidance from the recent Supreme Court ruling Cheshire West, which supplement the main MCA Code of Practice. These documents should be consulted in conjunction with this policy to provide guidance on good practice.

Please note if printing that the MCA Code of Practice is 297 pages in length and the DoLS document is 125 pages.
This provisions of the Mental Capacity Act in relation Test for Capacity and Best Interests are included in the Consent to Examination and Care Policy.

4. DUTIES AND RESPONSIBILITIES

4.1 Director of Nursing
Has executive responsibility for the development and monitoring of this policy.

4.2 Associate Divisional Directors
Have operational responsibility for the implementation of this policy within their areas of management accountability.

4.3 Clinical Staff
Are responsible for implementing the guidance and procedures within this policy and ensuring they are competent to do so.

5. DEFINITIONS

5.1 Lacks Capacity

5.1.1 A person lacks capacity in relation to a specific matter if at the material time they are ‘unable to make a decision’ for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

5.1.2 ‘Unable to make a decision’
The MCA states that a person is ‘unable to make a decision’ if they cannot do one or more of the following four things:

- Understand information given to them
- Retain that information sufficiently to be able to make the decision
- ‘Weigh up’ and evaluate the information available to make the decision
- Communicate their decision verbally or by using sign language or by muscular movement, for example, blinking or squeezing a hand

5.1.3 The MCA is specifically designed to cover situations where someone is unable to make a decision because their brain is affected by, illness or disability, or the effects of drugs or alcohol. A lack of mental capacity could be due to:

- A stroke or brain injury
- A mental health problem
- Dementia
- A learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- Substance misuse

Further guidance on how the CQC monitor substance misuse can be gained at:
http://www.cqc.org.uk/sites/default/files/substance_misuse_handbook_20150720.pdf and
5.2 Deprivation of Liberty

5.2.1 The Supreme Court (P v Cheshire West) has now confirmed that a person is being deprived of their liberty if all 3 of the below criteria are met:

1. The person is under continuous supervision and control
2. The person is not free to leave
3. The person lacks capacity to consent to these arrangements

The person may not be asking to go or showing by their actions that they want to but the issue is about how staff would react if the person did try to leave or if relatives/friends asked to remove them.

5.2.2 The following factors are no longer relevant to whether or not someone is deprived of their liberty:

- the person’s compliance or lack of objection;
- the suitability or relative normality of the placement (after comparing the person’s circumstances with another person of similar age and condition);
- the reason or purpose leading to a particular placement

6. POLICY CONTENT

6.1 Voluntary Admission

6.1.1 In accordance with paragraph 5.2 above a person who has capacity and consents to arrangement where they will be under continuous supervision and control and not free to leave are NOT being deprived of their liberty. That patient should they be admitted will be known as a voluntary patient.

6.1.2 All voluntary patients must have been given appropriate information in order to make their decision. This should be recorded by using Voluntary Admission form (See appendix 3) or recording consent to admission, including that relevant information has been given to the patient to aid their decision, in Assessments tab, Capacity and Consent form on Carenotes.

6.1.3 Any person who is unable to consent, because they lack capacity, to arrangements where they will be under continuous supervision and control and not free to leave can only be admitted to (or remain in) hospital using the Deprivation of Liberty Safeguards (DoLS). Unless it is deemed that the Mental Health Act is more appropriate.

6.2 Deprivation of Liberty Authorisation Procedures

6.2.1 There are some circumstances in which depriving a person, who lacks capacity to consent to the arrangements made for their care or treatment, of their liberty is necessary to protect them from harm, and is in their best interests. The managing authority has responsibility for applying for authorisation of deprivation of liberty for any person who may come within the scope of the safeguards.

6.2.2 When a person is about to be admitted (or is already in hospital) and is identified as lacking capacity and is, or is at risk of, being deprived of their liberty, the Trust as the managing authority must apply either to the London Borough of Camden or the London
Borough of Islington as the supervisory body for the deprivation of liberty authorisation. Before applying for authorisation of deprivation of liberty, the managing authority should consider:

- whether deprivation of liberty is or may be necessary in a particular case;
- what steps they should take to assess whether to seek authorisation;
- whether they have taken all practical and reasonable steps to avoid a deprivation of liberty;
- what action they should take if they do need to request an authorisation;
- how they should review cases where authorisation is or may be necessary, and;
- who should take the necessary action.

The procedure set out in the flowchart at Appendix 4 should be followed to help determine whether an application for authorisation is required.

6.2.3 Standard Authorisation

(i) The Trust, as the managing authority, must request a standard authorisation when it appears likely that, at some time during the next 28 days, a person will be accommodated in the hospital in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of ECHR. The request must be made to the supervisory body (see paragraph 7.2 above) in writing on the standard form.

(ii) The supervisory body will then decide if the application is appropriate and, if so, the supervisory body must obtain the following written assessments:

1. Age – applies to a person aged 18 years and over
2. Mental health – to determine presence of disorder of mind
3. Mental capacity – to confirm lack of capacity to decide on admission or to remain in hospital;
4. Eligibility – ineligible if the person is detained or subject to recall under the MHA
5. Best interests – must be in the person’s best interests, necessary to prevent harm to the person and a proportionate response, taking into account the person’s diversity
6. No refusals – the authorisation must not conflict with a valid decision by a third party with lasting power of attorney or a deputy appointed by the Court of Protection or conflict with a valid and applicable advanced decision.

Should the assessments conclude that these criteria are not met to authorise deprivation of liberty, the application will be refused and alternative ways will need to be found to provide the care and treatment required.

The supervisory body must give notice of its decision (to authorise or otherwise) in writing to specified people.

(iii) A standard authorisation comes into force when it is given, or at any time specified in the authorisation.

(iv) The duration of the deprivation of liberty will be assessed on a case by case basis. The maximum period for an authorisation is 12 months but should be for the shortest time necessary to ensure the person’s safety and for as long as the person is likely to meet the qualifying criteria. Authorisation must be in writing and include the purpose, time period, any conditions and the reasons that each of the 6 qualifying criteria is met.
A DoLS authorisation does not authorise care or treatment. This still needs to be carried out under the best interests provisions, and follow the 5 key principles of, the Mental Capacity Act.

**v**  The Trust, as the managing authority, is responsible for ensuring that any conditions attached to the authorisation are complied with and that they monitor whether the relevant person’s representative (appointed by the supervisory body) maintains regular contact with the person.

### 6.2.4 Reviewing a standard authorisation

(i) The person concerned, the person’s representative, attorney or deputy, can request a review of the authorisation by the supervisory body and also has the right to make an application to the Court of Protection.

(ii) The authorisation should be reviewed, and if appropriate revoked, before it expires if there has been a significant change in the person’s circumstances. To this end, the Trust as the managing authority, will be required to ensure that the continued deprivation of liberty of a person remains in that person’s best interests.

(iii) Before the current authorisation expires, the Trust may seek a fresh authorisation for up to another 12 months, provided it is established on the basis of further assessment, that the requirement continues to be met.

### 6.2.5 Urgent Authorisation

(i) Wherever possible, applications for deprivation of liberty authorisations should be made before the deprivation of liberty occurs. However, where this unavoidably needs to commence before a standard authorisation can be obtained, an urgent authorisation can be obtained. An urgent authorisation can be given which will make the deprivation of liberty lawful for a limited period of time.

(ii) The Trust as the managing authority must give an urgent authorisation where a standard authorisation has been requested but it is believed that the need to deprive the person of their liberty is so urgent that it needs to begin before the request is dealt with by the supervisory body, i.e.; London Borough of Camden or the London Borough of Islington.

(iii) An urgent authorisation may also be required when a request needs to be made for a standard authorisation but it is believed that the need to deprive the person of their liberty is so urgent that deprivation needs to begin before the request is made. In this case a request for standard authorisation must be made simultaneously with the urgent authorisation.

Before giving an urgent authorisation, Trust staff must have a reasonable expectation that the 6 qualifying criteria for a standard authorisation are likely to be met (see 6.2.3 (ii) above). Urgent authorisations should normally only be used in response to sudden unforeseen needs.

(iv) Trust staff must decide the period for which urgent authorisation is required which must not exceed 7 days. However, if there are exceptional reasons why the request for a standard authorisation cannot be dealt with within the original urgent authorisation, staff may request the London Borough of Camden or the London Borough of Islington as the supervisory bodies to extend the duration of the urgent authorisation for a maximum of a further 7 days.
6.2.6 Application process

(i) All applications must be made in writing on the standard forms provided. Completed forms must be sent to the appropriate local authority and copied to the Trust’s Mental Capacity Act Lead via MHL_Hub@Candi.nhs.uk. There are 2 standard forms that are for completion, as necessary, by Trust staff. These forms are available on C&I Trust Intranet.

<table>
<thead>
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<th>Form</th>
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<tr>
<td>1</td>
<td>Standard and Urgent Authorisation Request. This form should be used by staff when requesting a Standard authorisation from the appropriate local authority. It also allows staff (the managing authority) the power to grant themselves an Urgent Authorisation</td>
</tr>
<tr>
<td>2</td>
<td>‘Further Authorisation Request’. This form should be used to request a formal review of a standard authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005.</td>
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</table>

(ii) The Trust’s Mental Capacity Act Lead will:
- maintain a database for recording and monitoring the use of DoLS;
- retain files containing copies of all paperwork connected with the person and their deprivation of liberty;
- make mandatory notifications under the Health and Social Care Act 2008 to the CQC on the required form.

(iii) The DOLS assessor team will ensure that:
- Check that the standard forms are accurate and fully completed copies are made available for ward files;
- all correspondence and forms from the supervisory body are sent to the relevant clinicians and other appropriate staff;
- copies of the paperwork is sent to the Trust’s Mental Capacity Act Lead.

(iv) The person seeking authorisation must:
- ensure that all authorisations and re-applications for further standard authorisations are completed in a timely manner. It is therefore necessary for the dates these re-applications need to be made to be noted by the care team to ensure appropriate action is taken to prevent unlawful deprivations of liberty or the unnecessary use of repeated urgent authorisations.

(v) Ward staff must:
- ensure all correspondence, application forms and authorisations are uploaded to the patients Carenotes record
- ensure that all practical steps are taken to ensure that the person understands the effect of the authorisation and their rights. This includes their right to challenge the authorisation via the Court of Protection, their right to request a review and their right to and how to instruct an independent mental capacity advocate;
- ensure that the information is given to the relevant person both orally and in writing and this must be as soon as possible/practicable after the authorisation is given.
6.3 Criminal Offence of Ill Treatment

The MCA introduces two new criminal offences of ill treatment and wilful neglect of a patient who lacks capacity. There is no specified lower age limit. A member of staff who is found guilty of either offence may be liable to imprisonment for a term of up to five years.

6.4 Roles and Responsibilities

6.4.1 Health and Social Care Staff

6.4.1.1 All health and social care staff employed by, seconded to or working in partnership with Camden & Islington Foundation Trust must;

- adhere to the principles and framework of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards 2007;
- follow the Code of Practice in assessing capacity and acting in the patient’s best interests.

6.4.1.2 The deprivation of liberty safeguards have been added to the Mental Capacity Act 2005 to protect vulnerable people who require care and treatment that may deprive them of their liberty. Staff are required to:

- adhere to the provisions of the deprivation of liberty safeguards;
- follow the Code of Practice to identify when a person is, or is at risk of being deprived of their liberty and that where it does need to occur it has a lawful basis.

6.4.2 Decision Makers

A decision maker is a person who makes a best interests decision on behalf of a patient who lacks capacity for that particular decision. The decision maker is determined by the nature and complexity of the decision to be made. Day to day care decisions may be made by a paid or unpaid carer, support worker or nursing auxiliary appropriate to their role. Complex social care, finance and accommodation decisions may be made by health and social care professionals. Doctors are the decision makers for medical decisions.

6.4.3 Lasting Powers of Attorney (LPAs)

LPAs, once registered with the Public Guardian, grant a named attorney the power to make:

- health and welfare decisions (including giving/refusing consent to treatment);
- decisions relating to property and financial affairs for a patient who lacks capacity in relation to the decision. The solicitor or other legal representative acts as though they were the patient concerned.

6.4.4 Court of Protection Appointed Deputies

The Court of Protection has jurisdiction relating to the whole MCA and is the final arbiter for capacity matters. The MCA provides for a system of Court of Protection appointed deputies to replace the previous system of receivership. Deputies are able to take decisions on welfare, healthcare and financial matters as authorised by the Court (but not able to refuse
consent to life-sustaining treatment). They will only be appointed if the Court cannot make a one-off decision to resolve the issues.

6.4.5 Public Guardian

The Public Guardian and the Office of the Public Guardian (OPG) are the registering authority for LPAs and deputies. They maintain a register of LPAs and Enduring Powers of Attorney, supervise deputies appointed by the Court and provide information to help the Court make decisions. They also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating.

6.4.6 Independent Mental Capacity Act Advocate (IMCA)

6.4.6.1 An IMCA must be appointed to support a patient who lacks capacity and has no family or friends appropriate to consult and where one of the following are proposed:

- the patient needs serious medical treatment provided by the NHS
- the patient is moved into long term care of more than 28 days in hospital
- the patient is moved into long term care of more than 8 weeks in a care home
- the patient is to be moved (for more than 8 weeks) to different accommodation, such as a hospital or a care home

6.4.6.2 An IMCA should also be appointed in cases of safeguarding an adult and residential accommodation reviews. The IMCA will make representations about the patient’s wishes, feelings, beliefs and values, looking at all factors that are relevant to the decision. If necessary, the IMCA can obtain a further medical opinion and challenge the decision-maker on behalf of the patient lacking capacity.

6.4.6.3 If there is no-one appropriate to consult, other than people engaged in providing care or treatment for the relevant person in a professional capacity or for remuneration, the Trust as the managing authority must notify the supervisory body when submitting an application for deprivation of liberty authorisation.

6.4.6.4 It is the responsibility of the supervisory body to instruct an IMCA immediately to represent the person. It is particularly important that the IMCA is instructed quickly if an urgent authorisation has been given.

6.4.6.5 An IMCA may be instructed at any time where:

- the relevant person does not have a paid “professional representative”;
- The relevant person or their representative requests that an IMCA is instructed to help them;
- A supervisory body believes that instructing an IMCA will help to ensure that the person’s rights are protected.

6.5 Deciding Between MHA and DoLS when there is a Deprivation of Liberty of a Person Lacking Capacity to Consent to Admission who is not Objecting

6.5.1 The first step is to carefully scrutinise the care plan to see if this could be safely altered to reduce the restrictions so there is no longer a deprivation of liberty. If this is not possible then it is vital that legal authority is obtained to avoid breaching the patient’s Article 5 rights.
In these circumstances, you must decide between DoLS or the MHA as the most appropriate form of legal authority.

6.5.2 Some factors to consider

- There are certain circumstances when the person will be ineligible for DoLS and the only available legal authority will be the MHA (for example if they are objecting to admission / treatment).
- When an incapacitated patient is compliant (not objecting to admission or treatment), there may be a choice between the MHA and DoLS
- Is there any evidence of objection from the individual concerned? If there is subtle objection or the person is heavily sedated and is not in a position to voice objection or there is likely to be objection during the course of the care, then this would likely indicate that the patient will be ineligible for DoLS and the MHA will be the appropriate route.
- Both the MHA and MCA DoLS Codes of Practice acknowledge that objection must be assessed broadly, and is not limited to an individual making explicit statements that they want to leave. People who lack capacity to consent to their admission may not always be able to explicitly state their objection. In some cases, "doctors…will need to consider the patient’s behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained."
- In cases of fluctuating capacity, where the individual may regain capacity and there is evidence that they would object to treatment, again the patient is likely to be ineligible for DoLS and the MHA will be needed.
- Professionals should not assume one regime is “less restrictive” than the other. It is the care plan which imposes the restrictions not the procedural safeguards that are required if these restrictions amount to a Deprivation of Liberty.
- In deciding between the two options then the best interests of the patient must be carefully considered by taking into account a wide range of factors and taking into account the past and present views of the patient and those concerned with him or her (s4 MCA).
- Both the MHA and the DoLS provide procedural safeguards to ensure the rights of the individual are protected during a deprivation of liberty. However, the nature of the safeguards provided under the two regimes are different and decision-makers will wish to exercise their professional judgement in determining which is likely to be in the best interests of the individual. It is important to remember that Deprivation of Liberty Safeguards do not authorise treatment (which would be given under the MCA) nor do they provide specific safeguards about treatment, unlike the MHA. The MHA also provides a well understood and timely mechanism for appeal as well as a clear procedure allowing the nearest relative to seek discharge.
- Appendix 5 sets out a useful options grid summarising the availability of the MHA and of DoLS taken from Code of Practice to MHA (figure 5 – chapter 13). You may also find a useful case study on this subject in Code of Practice to MHA – chapter 13 page 111.

7. TRAINING

The Deputy Mental Health Law Manager/Mental Capacity Act Lead will be responsible for developing and arranging delivery of training to ensure that staff have the knowledge and skills to comply with the legal and ethical requirements of the MCA and DoLS and with the Trust’s policy.
8. DISSEMINATION AND IMPLEMENTATION ARRANGEMENTS

This policy will be promoted to all staff and awareness of the policy raised via the Trust’s intranet. Associate Divisional Directors will cascade the policy via email to their teams.

9. MONITORING AND AUDIT ARRANGEMENTS

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<td>Audit</td>
<td>Quarterly</td>
<td>MHL Monitoring Group</td>
<td>Quality Committee</td>
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<td>Mental Health Law Committee</td>
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### Equality Impact Assessment Tool

#### Appendix 1

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<tr>
<td>Culture</td>
<td>No</td>
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<td>Religion or belief</td>
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<tr>
<td>Age</td>
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<td>Disability - learning disabilities, physical disability, sensory impairment and mental health problems</td>
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<td><strong>2.</strong> Is there any evidence that some groups are affected differently?</td>
<td>No</td>
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<td><strong>3.</strong> If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?</td>
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<td><strong>4.</strong> Is the impact of the policy/guidance likely to be negative?</td>
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<td></td>
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<td><strong>5.</strong> If so can the impact be avoided?</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>6.</strong> What alternatives are there to achieving the policy/guidance without the impact?</td>
<td>N/A</td>
<td></td>
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<tr>
<td><strong>7.</strong> Can we reduce the impact by taking different action?</td>
<td>N/A</td>
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Appendix 2

**Admission to a Mental Health Unit for Mental Health Care and Treatment**

Assess patients Capacity and Consent in relation to Admission and whether they will comply with the elements of care being proposed concerning their admission to a Mental Health Unit.

- **They have capacity and they are not consenting.**
  - **Voluntary Admission**
  - **Staff Action:** Complete Voluntary admission form
  - **They later consent to admission**

- **They have capacity but are not consenting.**
  - **Only Mental Health Act can be applied**
  - **Staff Action: MHA assessment must be completed**
  - **Mental Health Act OR Deprivation of Liberty Safeguards can apply**
  - **Staff Action: MHA assessment must be completed OR DoLS Authorisation requested from Local Authority**
  - **They later regain Capacity BUT do not Consent**

- **They lack capacity but are compliant.**
  - **Mental Health Act OR Deprivation of Liberty Safeguards can apply**
  - **Staff Action: MHA assessment must be completed OR DoLS Authorisation requested from Court of Protection**

- **They lack capacity AND are not compliant.**
  - **Mental Health Act OR Deprivation of Liberty Safeguards can apply**
  - **Staff Action: MHA assessment must be completed OR DoLS Authorisation requested from Court of Protection**
Appendix 3

Record of Informed Consent for Voluntary Admission/Stay in Mental Health Units

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Description</th>
<th>Y/N</th>
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<tbody>
<tr>
<td>MANDATORY</td>
<td>Admission to a mental health ward (including conveyance) for care and treatment (including assessment) of a mental disorder</td>
<td></td>
</tr>
<tr>
<td>MANDATORY</td>
<td>This will include varying <strong>levels of observation</strong> (meaning staff will watch over you to make sure you are safe and well whilst on the ward and maybe whilst you are absent from the ward), depending on a risk assessment.</td>
<td></td>
</tr>
<tr>
<td>MANDATORY</td>
<td>As a voluntary patient you have a right to absent yourself from hospital temporarily if you wish, however you <strong>must make arrangements with the nursing staff before you leave the ward/hospital</strong>.</td>
<td></td>
</tr>
<tr>
<td>MANDATORY</td>
<td>If you go missing from the ward/hospital and/or don’t return from arranged absence and where there is a significant concern with regards to your safety or the safety of others, the <strong>hospital staff will take relevant steps to ensure your safe return</strong>. This may include contacting you, your family, police and, in certain cases, circulating your details to other mental health units.</td>
<td></td>
</tr>
<tr>
<td>MANDATORY</td>
<td>You may be asked to undergo searches of your person or personal property and if you refuse or are not prepared to undergo a search, discussion will take place with the senior clinician present and discharge may be considered.</td>
<td></td>
</tr>
<tr>
<td>MANDATORY</td>
<td>You have a right to discharge yourself from hospital and upon doing so you may be requested to see a doctor. If there are significant risks posed to you or others in relation to your mental disorder/physical condition, staff will have to consider using the power to detain under the Mental Health Act, or other legal authority. You will be informed of your rights if this were to occur.</td>
<td></td>
</tr>
<tr>
<td>OPTIONAL ³</td>
<td>The prescribing and administration of medication may at times involve an injection to control symptoms and behaviour. You will be given information about the medication and you will have a choice in the selection of the medication your consent will be sought before treatment is administered.</td>
<td>Y/N</td>
</tr>
<tr>
<td>OPTIONAL ³</td>
<td>Although it is very rare brief physical restraint may be used for the management of severely disturbed/aggressive behaviour. If the restraint is in relation to you wanting to leave the ward then this can only be done under the Mental Health Act and you will be informed of this.</td>
<td>Y/N</td>
</tr>
<tr>
<td>OPTIONAL ³</td>
<td>Blood tests and other relevant clinical investigations (for example ECG) will have to be carried out to ensure your physical health permits initiation of psychiatric medications and your consent will be sought at that time.</td>
<td>Y/N</td>
</tr>
<tr>
<td>OPTIONAL ³</td>
<td>All Camden &amp; Islington NHS Foundation Trust hospitals are non-smoking. You will therefore not be able to smoke whilst on the grounds of these premises.</td>
<td>Y/N</td>
</tr>
</tbody>
</table>
OTHER RELEVANT FACTORS: These are recorded in the patient’s EPR.

I can confirm the mandatory information above, along with any optional information indicated, was given to the patient and they have consented, without coercion, to be admitted (including conveyance) to a mental health ward for care and treatment (including assessment) for a mental disorder.

Delete either A or B:

A) This is an acknowledgement that there were no doubts about the patient’s capacity regarding this decision;

OR

B) This is acknowledgements that there were doubts about the patient’s capacity however after applying the two-stage capacity test (MCA 2005), it was found they did have capacity regarding this decision. This capacity assessment is recorded on EPR.

....................................................... Print Name:……………………………
Signature of Assessing Doctor/Nurse/AMHP (delete as appropriate)

NOTES & GUIDANCE ON COMPLETING THIS FORM

1 EPR – Electronic Patient Record

2 Appropriate member of staff:
- RC - If the patient is being regraded from MHA status to Voluntary
- Admitting doctor – If patient is transferred in from another Trust
- AMHP - When MHA assessment concludes with patient being admitted voluntarily
- CRT or Psych Liaison staff – If patient is admitted via these services

3 OPTIONAL - You must indicate whether you have (Y), or have not (N), explained one or more of these points to the patient. They must only be explained if they are relevant to circumstances of admission for that individual. Anything that is relevant and not covered on the list so far must be indicated (Y) in the OTHER RELEVANT FACTORS.

4 You must not rely solely on the patient’s compliance as evidence to support the presumption of capacity afforded by the Mental Capacity Act 2005.

5 This is a requirement of the Mental Health Act Code of Practice Para 13.22.
DOLS Flowchart

Evidence of lack of capacity to consent to care/treatment in a care home/hospital

Is there immediate risk of Dols or anticipated in the next 28 days

No

Have less restrictive options than DoLS been considered?

No

Is patient over 18 years of age?

Yes

Is patient under MHA 1983?

Yes

DoLS not applicable; use MHA 1983

No

Is there an existing AD, LPA/Deputy?

Yes

Follow existing arrangements

No

Apply for authorisation

Refer to MHA 1983/Children’s Act 1989
<table>
<thead>
<tr>
<th>MHA and MCA (DoLS) interface for adults: MHA Code of Practice 13.51</th>
<th>Individual <strong>objects</strong> to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder</th>
<th>Individual <strong>does not object</strong> to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment</strong></td>
<td>• Only the Mental Health Act is available</td>
<td>The Mental Health Act is available. Informal (Voluntary) admission might also be appropriate. Neither DoLS authorisation nor Court of Protection order available</td>
</tr>
<tr>
<td><strong>Individual lacks the capacity to consent to being accommodated in a hospital for care and/or treatment</strong></td>
<td>• Only the Mental Health Act is available</td>
<td>The Mental Health Act is available. DoLS authorisation is available, or potentially a Court of Protection order</td>
</tr>
</tbody>
</table>