University Hospitals of Leicester NHS
NHS Trust

The Deprivation of Liberty Safeguards Policy and Procedures

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

V1 (B15/2009 original approved by Policy and Guideline Committee)
V2 (B15/2009 revision approved by Policy and Guideline Committee May 2010)
V3 (B15/2009 revision approved by Policy and Guideline Committee November 2012)
V4 (B15/2009 revision approved by Policy and Guideline Committee September 2014)
V5 (B15/2009 revision approved by Policy and Guideline Committee September 2016)
V6 (B15/2009 revision approved by Policy and Guideline Committee September 2018)

Changes to the introductory section, to include reference to the Liberty Protection Safeguards.
Minor updates to UHL telephone extension numbers.

KEY WORDS

Deprivation of Liberty Safeguards

Deprivation of Liberty Safeguards Policy

Deprivation of Liberty Guidance Tool

DoLS

Deprivation of Liberty

Liberty Protection Safeguards

INTRODUCTION AND OVERVIEW

1.1 The Deprivation of Liberty Safeguards 2009 (DoLS) is an amendment to the Mental Capacity Act 2005. They provide a legal framework to protect people (over 18 years) who lack capacity to consent to the arrangements for their care or treatment, (for example by reason of Dementia, Delirium, significant Learning Disability, Brain Injury) and where the levels of restriction or restraint used in delivering care are so extensive that they potentially deprive the person of their liberty. The Safeguards apply where that person's care is being delivered in a hospital (or registered care home) and has not been authorised under the Mental Health Act 1983. For the purpose of DoLS, hospitals (and care homes) are referred to as the 'Managing Authority' and the Local Authorities are known as the 'Supervisory Body'. The Safeguards came into force on 1 April 2009 and from this point forward hospitals must identify those people who lack mental capacity to consent to being in hospital for care and treatment and are being or are at risk of being deprived of their liberty. They must then seek authorisation from the relevant Supervisory Body, (or in some cases the Court of Protection), in order to lawfully deprive a person of their liberty. The Safeguards prevent arbitrary decisions to deprive someone of their liberty and provide a robust and transparent framework to challenge deprivation of liberty authorisations. They therefore protect the rights of the most vulnerable people.

1.2 It is expected that in 2022, the Deprivation of Liberty Safeguards will be replaced by the Liberty Protection Safeguards (LPS). The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019. The LPS will provide protection for people aged **16** and above who are or who need to be deprived of their liberty in order to enable their care or treatment and lack the mental capacity to consent to their arrangements. The Liberty Protection Safeguards will deliver improved outcomes for people who are or who need to be deprived of their liberty. The Liberty Protection Safeguards have been designed to put the rights and wishes of those people at the centre of all decision-making on deprivation of liberty. In the meantime, the Deprivation of Liberty Safeguards remain the relevant legislation for depriving someone, who lacks capacity, of their liberty within an acute hospital setting.

1.3 This document provides a framework for the local application of the Deprivation of Liberty Safeguards 2009 within the University Hospitals of Leicester NHS Trust.

1.3 The document aims to set out the procedures that must be followed by clinical staff involved in identifying patients who may be being, or are at risk of being, deprived of their liberty, and also for those people within the Trust who are responsible for requesting, granting and reviewing Urgent and Standard Deprivation of Liberty Authorisations.

2 POLICY SCOPE

2.1 This policy is applicable to all Trust staff and Bank, Agency and Locum staff who are involved in the care of patients who meet all of the following criteria:

a) Where they are 18 years and over **and**:

b) Where they lack the capacity to consent to being in hospital for care and treatment **and;**

c) Where they are receiving care and treatment in circumstances where the levels of restriction and restraint are so high that they constitute a deprivation of liberty **and;**

d) Where detention is not already authorised under the Mental Health Act 1983

2.2 In line with case law (Court of Appeal in Ferreira (R (LF) v HM Senior Coroner for Inner South London & Ors [2017] EWCA Civ 31), patients in an acute hospital setting who are receiving 'immediately necessary life sustaining medical treatment' are not considered by the Courts to be deprived of their liberty provided that the treatment to be given to the patient, and the arrangements for the delivery of that treatment, is "normal" life-saving treatment with no unusual features. In these circumstances staff are not required to complete DoLS applications. If you unsure about a patient's specific circumstances please consult the Trust's Adult Safeguarding team at adultsafeguarding@uhl-tr.nhs.uk, or ext 17703, or Trust legal services on ext. 18960.

2.3 Case law (Cobb J in PL v Sutton CCG [2017] (EWCOP 22) also indicates that it is likely that deprivation of liberty will not be relevant for patients receiving palliative care, 'where they are no longer physically able to leave the place where they are receiving that care, and there are no unusual/coercive features about the arrangements made for them'. However, as the courts have not pronounced definitively upon the position of such patients staff are advised to seek Trust legal advice, on ext. 18960, if they are unsure about deprivation of liberty in the context of palliative care.

2.4 If you have concerns about **any** patient who you feel may be being deprived of their liberty, please discuss with your line manager initially. You can also contact the Trust's Safeguarding Adult team on ext. 17703 / email: adultsafeguarding@uhl-tr.nhs.uk.

2.5 If you have concerns about a child (under 18 years) who you feel may be being deprived of their liberty in hospital, please discuss with your line manager and the Trust's Safeguarding Children team on ext. 15770 / Head of Safeguarding on ext. 15446.

2.6 For **urgent** advice out of hours please contact your CMG onsite Matron, where available, or the Duty Manager who is available 24/7. For urgent out of hours legal advice, please contact the Head of Legal Services who can be contacted via switchboard.

3 DEFINITIONS

a) Beneficent Persuasion
For the purpose of this policy, this means persuading by means of effective communication and gentle guidance, which is in the best interests of the patient and is aimed at preventing harm. It is never coercive, threatening or forceful in nature.

b) Best Interests Assessor (BIA)
This refers to the assessor responsible for conducting a range of assessments to ascertain whether an authorisation for deprivation of liberty will be granted. The Best Interests Assessors work within (or on behalf of) the DoLS service.

c) Code of Practice
This refers to the deprivation of Liberty safeguards Code of Practice 2009 which supplements the main Mental Capacity Act 2005 Code of Practice.

d) Deprivation of Liberty (DoL)

This is a term used in the European Court of Human Rights (ECtHR) about circumstances when a person is deprived of their liberty and freedom. A distinction is drawn between deprivation of liberty of an individual (which is unlawful unless authorised) and restrictions on the liberty of movement of an individual. In March 2014 the Supreme Court (P v Cheshire West and Chester Council and P and Q v Surrey County Council) confirmed that **the 'acid test' of what may amount to a deprivation of liberty is whether:**

- **The person lacks capacity to consent to their care arrangements; and**
- The person is under **continuous supervision and control; and**
- The person is **not free to leave.**

e) DoLS Teams (see Appendix 10 for further details).
The DoLS teams are hosted by the Local Authorities. The DoLS teams undertake certain delegated functions associated with deprivation of liberty on behalf of the Supervisory Body. This includes responding to requests, conducting assessments, recommending timescales and conditions of authorisation and conducting reviews. They provide a single point of contact for DoLS queries for both Managing Authorities and Supervisory Bodies.

f) Independent Mental Capacity Advocate (IMCA)
This is someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one appropriate to support them. An IMCA is not the same as an ordinary advocate. The IMCA service was established by the Mental Capacity Act 2005.

g) Life-sustaining medical treatment
For the purpose of this policy this is defined as treatment without which the person would die immediately or within a short space of time, or as it was put by the Court of Appeal in Briggs; 'they are so unwell that they are at risk of dying anywhere other than in hospital. This could include both treatments provided in the critical care setting where a person has been brought in the immediate aftermath of a serious accident and also the provision of clinically assisted nutrition and hydration'.

h) Managing Authority
The hospital in which the patient is at risk of being deprived of their liberty (this can also be a registered care home).

i) Mental Capacity
Mental capacity is the ability to make a decision or take an action for yourself. A person who lacks capacity means 'a person who lacks the capacity to make a **particular decision** or **take a particular action for themselves** at the **time the decision** or **action needs to be taken'** (MCA Code of Practice, 2007, p. 3). Where the term 'lack of capacity' is used in this document it refers specifically to the person's lack of capacity to consent to being in hospital for care and treatment.

j) Relevant Person
The patient who is deprived of their liberty in a hospital or care home.

k) Restraint
The use, or threat, of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint under the Mental Capacity Act may only be used where it is necessary to protect the **person** from harm and is proportionate to the likelihood and seriousness of harm.

l) Signatory

The signatory is the relevant representative from the Supervisory Body who has overall responsibility for granting the Standard Authorisation, attaching any conditions recommended by the Best Interests Assessor and determining the period for which the authorisation will be lawfully in force.

m) Standard Authorisation
An authorisation given by the Supervisory Body, after completion of the statutory assessment process, which gives lawful authority to deprive a relevant person of their liberty in the hospital or care home.

n) Supervisory Body
The Local Authority that is responsible for considering a deprivation of liberty request, commissioning the assessments, and where all the assessments agree, for authorising the deprivation of liberty. This is determined by the ordinary residency (address) of the relevant person.

o) Urgent Authorisation
An authorisation given by a Managing Authority (hospital or care home), for a maximum of 7 days. The Urgent Authorisation gives the Managing Authority lawful authority to deprive a person of their liberty while the Standard Authorisation process is undertaken. This may be extended under certain circumstances by the Supervisory Body for a maximum of 7 days.

4 ROLES AND RESPONSIBILITIES

4.1 Responsibilities within the Organisation

a) The **Chief Executive and Board of Directors** have overall responsibility for Trust compliance with the Law and Trust Policies and Procedures.

b) The **Chief Nurse** is the Executive Director with lead responsibility for Safeguarding Adults and Children and is the Executive Lead for this policy.

c) The **Deputy Chief Nurse** is the Nominated Deputy for the Chief Nurse.

d) The **Head of Safeguarding** is the strategic lead for Safeguarding Adults and Children and will provide operational cover for the Adult Safeguarding Matron when required.

e) The **Matron for Safeguarding Adults** is the operational lead for Safeguarding Adults and is responsible for supporting UHL staff with the application of the MCA and DoLS, alongside the adult safeguarding specialist nurses.

f) **CMG Heads of Nursing** and **Clinical Directors** are the leads for disseminating the policy to clinical staff within their Clinical Management Groups

g) **Registered Clinical Staff / Nominated Deputies / Ward Sisters / Matrons** are responsible for complying with the procedures for identifying patients who are being deprived of their liberty or are at risk of being deprived of their liberty.

h) **Registered Clinical Staff / Nominated Deputies / Ward Sisters / Matrons** are responsible for assessing, requesting and reviewing Urgent and Standard Deprivation of Liberty Authorisations, as defined in the policy.

i) **Deputy Heads of Nursing and Heads of Nursing** are the nominated deputies when Ward Sisters / Matrons are not available.

j) **All clinical staff** are responsible for raising any concern about possible deprivation of liberty to the appropriate **Nurse in Charge** / **Ward Sister** / **Matron / Consultant** or their nominated deputies.

k) **All clinical staff** are responsible for:

- ✓ Delivering care in the least restrictive manner possible.
- ✓ Adapting care plans to ensure consideration is given to whether a person has capacity to consent to care and treatment.
- ✓ Ensuring that no person is deprived of their liberty except where:

  I. An Urgent Authorisation is in place; **AND/OR**
  II. A Standard Authorisation is in place **OR;**
  III. A Court Order is in place which authorises the deprivation of liberty **OR;**
  IV. Their liberty has been authorised by other legal means e.g. under the Mental Health Act 1983.

5 POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS

5.1 WHAT IS DEPRIVATION OF LIBERTY?

a) Many people in hospitals may have their liberty **restricted**, but not all will be **deprived** of their liberty. The difference between deprivation of liberty and restrictions on liberty of movement is merely one of degree or intensity, and not one of nature or substance (The Law Society, 2015). It may therefore be useful to envisage a scale, which moves from 'restraint' or 'restriction' to 'deprivation of liberty'.

b) In deciding whether someone has been deprived of their liberty, the European Court of Human Rights decided that the starting point must be the person's concrete situation, and account must be taken of a range of criteria such as the type, duration, effects and manner of implementation of the restrictive measure in question.

c) Whilst there is currently no statutory definition of a deprivation of liberty, in March 2014, the Supreme Court handed down judgment in two cases (P v Cheshire West and Chester Council and P and Q v Surrey County Council). That judgment, commonly known as Cheshire West, led to a considerable increase in the numbers of people in England and Wales who are considered to be deprived of their liberty for the purposes of receiving care and treatment.

d) The Supreme Court ruled that when an **individual lacking capacity** to consent to being in hospital for care and treatment (or a care home) is **under continuous supervision and control <u>and</u> is not free to leave, they are being deprived of their liberty**. This is now commonly called the 'a**cid test**'.

e) **What is 'Continuous supervision and control'?** The Supreme Court did not define "continuous supervision and control" but it is clear that they were concerned with whether staff / carers were effectively exercising complete control over every aspect of the person's life. 'Continuous supervision and control' is therefore likely to mean the person concerned:

  i. will need constant or frequent supervision to prevent harm / maintain safety

  ii. would not be left on their own even for a short period

  iii. is so disabled that staff are effectively deciding all or many aspects of their lives

  iv. will need support with all or many everyday tasks

  v. has a care plan or carers which effectively impose severe restrictions on their contact with family

vi. Staff being aware of the person's whereabouts at all times.

f) It may also be helpful to think in terms of the difference between support and supervision. Support is what happens when you help someone do the things **they want to do** i.e. empowerment of patients, facilitating choice, and working in the least restrictive manner. Twenty four hour care, by definition, means that people are supervised but is this more about staff being able to support the person as needed? What would be the intentions and actions of staff if the person concerned wanted to take certain decisions – would they facilitate this? If so this is more about support than control.

g) **What does 'Not free to leave' mean?** Again the Court did not precisely define this but it is likely to mean that the person concerned:

i. would not be allowed to return to live in the family home even though the family is happy to have them

ii. would not be allowed to live back in their old home, even if it was available to them

iii. all or much of the time would have to ask staff permission to go out

iv. all or much of the time would only be allowed out with an escort, and would be stopped if they tried to go out alone

v. doesn't show any interest in going out but would be stopped if they did

5.2 DETERMINING WHEN DOLS IS APPLICABLE

a) The MCA DoLS must be used for all patients in hospitals who, due to a mental disorder, lack capacity to consent to being there, but for whom receiving care or treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them from harm which appears to be in their best interests. A large number of these people will be those with dementia / delirium, other similar conditions and those with significant learning disabilities. It also includes those who have neurological conditions, for example as a result of a brain injury or stroke, and those with significant mental illness such as schizophrenia.

b) The Managing Authority (Hospital) must apply to the Supervisory Body for authorisation of deprivation of liberty if a person who lacks capacity is:

I. About to be admitted to hospital and staff believe that the person risks being deprived of their liberty (i.e. for planned care).
II. Already in hospital and is being cared for or treated in a way which deprives them of their liberty.

c) It is important to remember that depriving someone of their liberty in hospital is a serious issue and staff must always think about providing care or treatment in alternative ways which might avoid deprivation of liberty where possible.

d) The following fictitious scenario explains how DoLS will not always be needed.

Jean is known to have Dementia and is admitted from home following a fall. Her son says her level of confusion isn't normally too bad and she needs minimal help to support her at home. On the day of admission she is distressed and difficult to calm. The Ward Sisters wonders whether it is necessary to use the MCA DoLS to keep her safe.

Prior to completing the necessary DoLS forms the Ward Sisters assesses her care needs, including exploring Jean's interests and preferences with her son. It appears that Jean has a urinary tract infection and is more confused than usual. The Ward Doctor prescribes IV antibiotics which commence immediately. Jean's son and the meaningful activity facilitator spend time with her to help her settle and she is given meaningful activities to do which she enjoys. Jean is supported to make her own choices and decisions wherever possible. Over the next 24 hours Jean settles and improves. The Sister takes the view that a DOL authorisation is not currently necessary and the immediate care and treatment can be delivered under the Mental Capacity Act (sections 5-6).

e) The starting point for hospital staff is to consider:

   I. **Does the patient have capacity to consent to being on the ward / area for care and treatment?**

   II. **In considering the patient's best interests and looking at current care interventions, is there a less restrictive means of providing the care / treatment that would not constitute a deprivation of liberty?** (See Chapter 2, paragraphs 2.5 to 2.7 of the Deprivation of Liberty Code of Practice for further information).

f) If the answer to both the questions above is 'No', and you feel that the patient meets the DoLS threshold of 'not being free to leave the ward / area' and is 'under continuous supervision and control' then it is likely that the individual is being deprived of their liberty. In these instances, **you should complete DoLS Form 1 – 'Request for Urgent and Standard Authorisation'** (see section 5.4 for details).

g) Professionals must remember that authority to deprive someone of their liberty does not, itself, provide authority to provide care and treatment to them. If a person lacks capacity to consent to their care / treatment then it is necessary to consider the basis upon which those decisions are being taken by others, and their authority for doing so. For example, in many cases this will be routine care delivered under the provisions of the Mental Capacity Act (Sections 5-6). In a limited number of cases it may be on the basis of a court order, where the care and treatment goes beyond the routine. Or, in very few cases, it may be under the provisions of the Mental Health Act 1983, but only ever in relation to the provision of medical treatment related to the individual's mental disorder.

h) The test for considering whether to engage the DoLS process, (or in a few cases the MHA or the Court of Protection) is never whether the professional is **certain** that there is a deprivation of liberty, but rather there is a **risk** of a deprivation of liberty. If there is such a risk, that should trigger further assessment.

5.3 IDENTIFYING PATIENTS WHO MAY REQUIRE DEPRIVATION OF LIBERTY AUTHORISATION

a) Any member of staff within the ward or clinical area can raise a concern about possible deprivation of liberty if they are involved in looking after a patient who **lacks the capacity** to give consent to being there to receive care or treatment.

b) The initial concern should be raised and discussed with a Registered Clinical Professional (usually a ward Nurse or Doctor) or the Nurse in Charge / Consultant within 24 hours. If they are not available the concern should be raised with a nominated deputy / Matron / Deputy Head of Nursing / Head of Nursing.

c) The person receiving the initial concern (as above) from a staff member should refer to the **DoLS flowchart 1** (Appendix 9) and the **UHL Guidance Document** (Appendix 1) if they require further support. They should then ensure that all practicable and reasonable steps have been taken to avoid deprivation of liberty, where possible, through discussion with the clinical team.

d) If there are still concerns that the patient is at risk of being deprived of their liberty, then the Registered Professional must complete DoLS Form 1 '**Request for Urgent and Standard Authorisation'**. See Section 5.4 for details of how to Request an Urgent and Standard DoLS Authorisation. Staff can refer to the DoLS Code of Practice (CoP) and the MCA CoP to inform their decision if required (available on the safeguarding adults' webpages via the link: http://insite.xuhl-tr.nhs.uk/homepage/clinical/safeguarding-adults).

e) If DoLS authorisation is not deemed to be necessary the Registered Professional must document the reasons why in the patient's medical notes.

f) Where there is a question about whether or not UHL is authorised to deprive a person of their liberty, the deprivation will be lawful where it is necessary:

- For the purpose of giving the person life-sustaining treatment **OR**;
- To prevent a serious deterioration in their condition while a decision as respects any relevant issue is sought from the court of protection.

g) If further advice is required, contact the UHL Safeguarding Adults team via email adultsafeguarding@uhl-tr.nhs.uk or ext. 17703 / 15446.

5.4 REQUESTING AN URGENT AND STANDARD DOLS AUTHORISATION (FORM 1)

a) The **DoLS Form 1*** (**Request for Urgent and Standard Authorisation)** must be completed for any patient who is in hospital and is at risk of Deprivation of Liberty, which is deemed to be in their best interests and where there is no less restrictive alternative available. The Urgent Authorisation can be given for a maximum of 7 days**.**

*(*NB. the number given to each of the differing national DoLS form is allocated by the Department of Health and is for reference only).*

b) The Registered Professional or nominated deputies should refer to the DoLS Code of Practice for guidance governing the circumstances in which an Urgent Authorisation can and cannot be issued. Any care or treatment provided under an Urgent Authorisation must comply with Section 5-6 of the Mental Capacity Act 2005.

c) Before completing **DoLS Form 1 (Request for Urgent and Standard Authorisation)** the Registered Professional must identify whether the patient is a City resident or a County/Rutland resident, based on their usual address. This can be identified either on patient centre or by searching for the relevant local council using the local Government's

search facility, available at: https://www.gov.uk/find-local-council. If the person ordinarily lives outside of Leicester, Leicestershire/ Rutland, use an internet search engine to identify the relevant local authority DoLS details and follow their advice and instructions on how to request an Urgent and Standard Authorisation.

a) The Registered Professional or nominated deputy must then select the appropriate DoLS Form 1 via ICE selecting either the **City form or the County/Rutland form.** There is also a paper version of the DoLS Form 1 on INsite for those areas that do not have access to ICE, such as the Alliance.

b) If the DoLS Form 1 is completed via ICE it is automatically sent to the appropriate council's DoLS team (provided you select the correct form at outset) and the UHL adult safeguarding team.

c) If a paper version is completed in areas who cannot access ICE, then the form must be emailed **to the relevant DoLS team (see Appendix 11 for details)** and **to the UHL Safeguarding Adults via email at: adultsafeguarding@uhl-tr.nhs.uk.** At the same time as faxing Form 1, the person completing the authorisation must contact the relevant DoLS Team to inform them that a request is being sent (this procedure should be followed even during out of hours via answerphone as required).

d) The Registered Professional or nominated deputies may print and retain a copy of the completed Form 1 within the medical notes. Copies can also be provided to the relevant person and any IMCA instructed.

e) The Registered Professional or nominated deputies must inform the relevant person's family, friends and carers when completing a request for an Urgent and Standard Authorisation. A Trust DoLS Patient Information Leaflet should be provided (available on Your Health on INsite and via Print Rooms).

f) **The Registered Professional must record that they have completed a DoLS Form on Nerve Centre handover, on the date it is completed, and they must also record the date the urgent authorisation expires.** This is 7 days from, and including, the date of completion. For example, if you complete Form 1 on the 8th day of the month, it will expire on the 14th day of the month, based on a 24 hour clock (see Appendix 11 for further details).

5.5 MANAGING EXPIRED URGENT DOLS AUTHORISATIONS

Following the aforementioned Supreme Court ruling (March 2014), there has been a huge rise in the number of DoLS applications being submitted, nationwide. Additionally, resources have not kept up with demand, and consequently Local Authorities (acting as Supervisory Bodies) are not routinely seeing and assessing people within the statutory timeframes (i.e. within 7 days for an urgent application). This means that most UHL patients who have a DoLS submitted are at risk of being unlawfully deprived of their liberty once the urgent authorisation expires (i.e. on the 7th day). However, the Trust recognises that some patients will remain in hospital longer than 7 days, and that their circumstances may still amount to a deprivation of liberty, which is in their best interests. There are very limited options available to the Trust in this situation. However, it is essential that the Trust has a local process in place for the oversight and management of patients who are at risk of being unlawfully deprived of their liberty in hospital, until such a time that the Local Authorities can meet their statutory responsibilities, or the patient is no longer at risk of deprivation of liberty (i.e. on discharge).

5.5.1 PROCESS FOR MANAGING EXPIRED URGENT DOLS AUTHORISATIONS

a) On the date that the urgent DoLS expires, as recorded on Nerve Centre (see Section 5.4 and Appendix 11 for details) the Nurse in Charge / Ward Sister or Matron must:

- Check if the patient still lacks capacity to consent to being in hospital for care and treatment. (If the patient has regained capacity then seek consent for care / treatment and record in medical notes).
- If patient still lacks capacity, continue to act in the patient's best interests, in accordance with the Mental Capacity Act.
- Inform and Consult with the patient's representatives (family / carers and any IMCA involved).
- Raise any concerns about the potential deprivation of liberty to their CMG Matron or Deputy / Head of Nursing, and the Trust's Safeguarding Adults team at adultsafeguarding@uhl-tr.nhs.uk or ext. 17703.
- Inform the Trust's Safeguarding Adults team at adultsafeguarding@uhl-tr.nhs.uk or ext. 17703 if the patient or their representatives are raising any objections to the potential deprivation of liberty.
- Record the above in the patient's medical notes.
- Repeat the above steps every 7 days until the patient is discharged, or regains capacity, or is granted a standard DoLS Authorisation by the Local Authority DoLS team.

This policy is also supported by the following procedures found in the associated documents as detailed below, which must be used in conjunction with this policy:

Procedure	Appendix
Deprivation of Liberty Guidance Tool for Staff	1
Requesting a Standard Authorisation for a patient who is not yet admitted to UHL (i.e. planned admission)	2
Procedures following Granting / Refusal of a Standard Authorisation	3
Actions to be taken where liberty is being deprived but the requirement for authorisation are not met	4
Procedures for the Use of Forms 14, 15 & 19 – Suspending and Reviewing Standard Authorisation	5
Procedures for Terminating / Extending an Urgent Authorisation	6
Procedures for Terminating a Standard Authorisation	7
Procedure for Notifying the Coroner when a Patient dies whilst detained under DoLS	8

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 All new starters to the Trust must complete the Trust Induction programme which includes a basic awareness level Safeguarding Adults training session incorporating an introduction to the Mental Capacity Act.

6.2 All clinical staff who have direct clinical contact with patients must complete the Trust's e-learning modules relating to Consent, Mental Capacity Act and Deprivation of Liberty Safeguards which are available via your required training page on HELM.

7 PROCESS FOR MONITORING COMPLIANCE

7.1 Policy Monitoring Table

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements
Correct Completion of DoLS Form 1	UHL Safeguarding Adults team	Review completed DoLS forms	Annually	UHL Safeguarding Assurance Committee
All relevant staff attend MCA /DoLS training	CMG Management Team	HELM reports	Quarterly	CMG Board UHL Safeguarding Assurance Committee

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

a) MENTAL CAPACITY ACT 2005. London: The Stationery Office

b) DEPRIVATION OF LIBERTY SAFEGUARDS 2007. London: The Stationery Office

c) Deprivation of Liberty Safeguards Code of Practice 2008. London: The Stationery Office.

d) Mental Capacity Act Code of Practice 2007. London: The Stationery Office.

e) Deprivation of Liberty in a Hospital setting 2018. Essex Chambers. Available at: http://www.39essex.com/content/wp-content/uploads/2018/02/Deprivation-of-liberty-in-the-hospital-setting-February-2018-1.pdf

f) Deprivation of Liberty: A Practical Guide 2015. The Law Society. Available at: http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

Policies Available on INsite

a) UHL Mental Capacity Act Policy (Trust Ref: B23/2007)

b) UHL Policy for Assessment and Care Management of Patients at Risk of Wandering in the Acute Setting (Trust Ref: B25/2008)

c) UHL Management of Violence, Aggression and Disruptive behaviour Policy – Including Restraint Guidance (Trust Ref: B11/2005)

d) UHL Supervision and Management of Adult Patients with Agitated / Challenging Behaviour (Trust Ref: B6/2012)

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 The updated version of the Policy will be uploaded and available through INsite documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trust's PAGL system. It will also be available through the dedicated Safeguarding Adults Webpages.

10.2 This policy and procedures contained within it will be reviewed after 3 years by the Policy Author.

APPENDICES

Appendix 1 - Deprivation of Liberty Guidance Tool for Clinical Staff

This tool is designed to guide practitioners and will not necessarily determine whether or not deprivation of liberty is actually occurring; it seeks only to raise the possibility which must then be acted upon by staff. The following issues must be considered for each patient who lacks mental capacity to give informed consent to being on a ward / area to receive care and treatment.

PART A: Does the patient have the mental capacity to consent to being on the ward / area for care and treatment?
Please circle as appropriate: YES NO
If the answer is **YES** you do not need to continue; it is not appropriate to consider DoL if your patient has the mental capacity to decide about their care arrangements. Please document this in the medical notes.

PART B: If the patient lacks capacity to consent to being on the ward / area for care and treatment then you must consider the issues below.

1. Is the patient free to leave the hospital? The focus here is on what staff would do if the patient sought to leave the hospital and not on their ability to ask to leave, or on their ability to actually attempt to leave (see Section 5.1 (g) for further details)	Yes No
2. Do staff exercise continuous supervision and control over the patient's care and movement? (see Section 5.1(f) for further details)	Yes No
3. Is restraint being used to treat / nurse or manage the patient when they are resisting, other than in an emergency? (emergencies could include disturbed, threatening or self-harming behaviour)	Yes No
4. Is the patient being physically or chemically restrained to prevent them from leaving your area? Use of sedatives does not in itself mean that a person is deprived of liberty – it is only relevant if the purpose is solely to prevent them from leaving the ward / area	Yes No
5. Have relatives or carers asked for the patient to be discharged to their care and has this request been refused? (even if it's in the patient's best interests)	Yes No
6. Have relatives, carers or friends been refused access to the patient, or had severe restrictions put on their access? This would include preventing the patient from spending time with family/friends inside or outside the area. It would not include guiding the person away from people who appear to be abusing or exploiting the person, or placing reasonable restrictions on visiting times.	Yes No
If the responses to any of the issues is 'YES', then the patient is at risk of being deprived of their liberty and you will need to arrange for DoLS Form 1 'Request for Urgent and Standard Authorisation' to be completed.	

Appendix 2 - Requesting a Standard Authorisation (for patients who are not yet admitted)

1) If an Urgent Authorisation is not required but a Standard Authorisation is required, for example prior to a planned admission where there is a risk that the patient will be deprived of their liberty, the Registered Professional or nominated deputies must complete the **DoLS Form 1: Request for Urgent and Standard Authorisation,** leaving the Urgent section blank. This can be done **up to 28 days** in advance of the deprivation of liberty occurring.

2) The Registered Professional or nominated deputies should print and retain a copy of the Form 1 within the relevant person's medical records and keep clear written records of the reasons for the request. Where appropriate / practicable, the staff member should inform the family and carers of the relevant person that an application for a Standard Authorisation has been made.

3) Once a Standard Authorisation is requested the Supervisory body (SB) will arrange for the 6 necessary assessments to be completed within 21 calendar days from the date they receive the request from the hospital, where possible.

4) The SB will either grant or decline the requested Standard Authorisation once they have all of the required assessments. The SB will notify the hospital of their decision in writing, using their standard forms.

5) If the hospital receives a request from a third party (i.e. carer/family member) to apply for an authorisation, or to change the care regime, they must respond to this request within 24 hours.

6) Where the hospital has been unable to resolve the Third Party request, i.e. where they have not been able to satisfy the Third Party that no deprivation of liberty is occurring, they must submit an application to the Supervisory Body via the DoLS Team following the procedures outlined above.

7) Where the hospital has failed to make an application, the DoLS Team will accept a referral from the Third Party on behalf of the Supervisory Body. In such circumstances, the Care Quality Commission and the appropriate commissioning authority (if involved) will be notified.

Appendix 3 - Procedures following Granting of a Standard Authorisation by the Supervisory Body

1) Where all assessment requirements are met, the authorisation will be granted by the Supervisory Body (SB). The DoLS Teams' Administrators are responsible for ensuring that copies of the outcome forms are sent to the hospital, the patient, IMCA (if required), the patient's representative and any other persons consulted by the BIA. The DoLS team will also ensure that the relevant person and their representative have information regarding how to appeal against a decision and how to access the Court of Protection.

2) If the hospital receives an outcome form stating that the authorisation has been granted, it must take all practical and possible steps to ensure that the patient understands the effects of the authorisation, their rights, the complaints procedures and consider any specific communication needs. The hospital must also comply with any conditions attached to the authorisation. The outcome form must be included in the patient's records and be made known to all relevant staff.

3) The MCA DOLS permit the hospital to detain the person only in a specific hospital, it important to understand that an MCA DOLS authorisation does not, in itself, authorise care or treatment. Any care or treatment still needs to be carried out under the wider 'best interests' provisions of the MCA and follow the five key principles of the Act.

4) **Court of Protection**

4.1 The Mental Capacity Act 2005 enables anyone deprived of their liberty to make speedy application to the Court of Protection to review the lawfulness of their deprivation.

4.2 The Managing Authority and the Supervisory Body should endeavour to resolve any concerns through mediation or their own complaints procedures before the relevant person or their representative refer the matter to the Court.

4.3 The Managing Authority and Supervisory Body are required to comply with any conditions imposed by the Court following a hearing.

Appendix 4 - Actions to be taken where liberty is being deprived but the requirement for authorisation is not met

1) In cases where the deprivation of liberty is occurring, but authorisation for deprivation of liberty is refused because one of the requirements are not met the hospital (Managing Authority) and Supervisory Body will need to take appropriate alternative action (action will depend on which of the six requirements are not met).

2) In these cases, the relevant DoLS Team Manager will inform the hospital and the Supervisory Body who will arrange for a Planning meeting to take place **within 48 hours** of notifying the hospital of its decision. (The Supervisory Body has responsibility for calling the planning meeting).

3) The purpose of the Planning Meeting will be to review the care or treatment currently in place and agree a plan to ensure no unlawful deprivation of liberty continues, assessing any risks as a means of reducing restriction and safeguarding issues. The planning meeting can also consider any additional resource requirements of the Managing Authority resulting from the recommendations of the Best Interests Assessor to amend the care plan.

4) **Within 7 days** of the planning meeting taking place, an appropriate solution must have been affected and the care plan must have been amended to ensure an unlawful deprivation of liberty does not continue.

5) Visits by the Relevant Person's Representative (RPR) must be accommodated and details of visits are to be recorded in the relevant person's records. The hospital must inform the DoLS Team if the Relevant Person's Representative is not maintaining appropriate contact.

6) Two months after this Planning Meeting (where relevant), the individual responsible for the relevant person's care will review the care provided to ensure that the care regime has not reverted back into unlawful deprivation of liberty. This should be recorded and kept in the relevant person's records.

Appendix 5 - Procedures for the Use of Forms 2, 7 and 10 – Requesting a Further Standard Authorisation, and Suspending and Reviewing a Standard Authorisation

1) All of the above forms can be accessed via the relevant Local Government's webpage available at: **https://www.gov.uk/government/publications/deprivation-of-liberty-safeguards-forms-and-guidance.**

2) The Registered Professional or nominated deputies will complete Form 7 to notify the SB that a standard authorisation should be suspended because the eligibility requirement is no longer being met (i.e. because the person has been detained under the Mental Health Act). Seek advice from UHL Adult Safeguarding Team where required.

3) If the hospital decides that a DoL is no longer necessary then they must end it immediately by adjusting the care regime or implementing whatever other change is appropriate. The Registered Professional or nominated deputies should then complete Form 10 to request a review of a standard authorisation to the SB.

4) If a further standard authorisation is required (because a current standard authorisation is going to expire before the relevant person is discharged from the ward / unit) then the Registered Professional or nominated deputies must complete **Form 2 'Request for a Further Standard Authorisation'.** Advice can be sought from the UHL adult safeguarding team on ext. 17703 or email **adultsafeguarding@uhl-tr.nhs.uk.**

5) The Form 2 'Request for a Further Standard Authorisation' can be submitted up to 28 days in advance of the current standard authorisation expiry date. There is no statutory time limit on how far in advance the Managing Authority can request a renewal of an authorisation, however it will need to be far enough in advance for the renewal to take effect before the existing authorisation expires, but not so far in advance that the relevant person's needs could not be reasonably predicted

6) The DoLS Team will follow the same process for assessments as for an original Standard Authorisation as outlined above.

Appendix 6 - Procedures for Terminating / Extending an Urgent Authorisation

1) The Urgent Authorisation is terminated if the Standard Authorisation applied for is granted by the Supervisory Body, or if it is not granted as this would constitute an unlawful deprivation of liberty.

2) The DoLS Team Administrators will inform the relevant person and any IMCA instructed that the Urgent Authorisation has terminated (on behalf of the Supervisory Body). If possible, this notification should be combined with the notification of the outcome of the assessment process for the Standard Authorisation.

3) In circumstances where the Standard Authorisation cannot be dealt with within the period of the Urgent Authorisation, the Supervisory Body **may** ask the Managing Authority to extend the period of the Urgent Authorisation for a maximum of a **further 7 days, but only if the SB reasonably believes that it can complete the assessment within the extended timeframe**. The request for an extension can be made by completing the relevant section (page 8) of DoLS Form 1 which should be sent to the Supervisory Body via the DoLS Team. The Managing Authority must keep a written record of the reason for the request and any discussions held with the SB.

Appendix 7 - Procedures for Terminating a Standard Authorisation

1) When a Standard Authorisation ceases to be in force, the Supervisory Body will need to record this using the appropriate form.

2) A Standard Authorisation will cease to be in force in the following circumstances:

- Where the Managing Authority gave notice to the Supervisory Body via the DoLS Team that this person has ceased to meet the eligibility requirement and 28 days have elapsed since that notice was given without the suspension being lifted. This will include circumstances where capacity has been regained.

- The Standard Authorisation has expired.

- A review of the Standard Authorisation has been completed and the review concluded that the person no longer meets the requirements for being deprived of their liberty.

- Following a change in the place where the person is deprived of their liberty, the Standard Authorisation has been replaced with a new authorisation for the new place and therefore ceases to have effect.

- The Court of Protection or another court has made an order that the Standard Authorisation is invalid or that it shall no longer have effect.

- The person has died.

- When an authorisation expires, the hospital cannot lawfully continue to deprive the person of their liberty.

Appendix 8 – Procedure for Notifying the Coroner when a Patient dies whilst detained under DoLS

1) In April 2017 the Coroners and Justice Act 2009 was amended so that people subject to authorisations under the Deprivation of Liberty Safeguards (known as DoLS) are no longer considered to be 'otherwise in state detention' for the purposes of Section 1 of the Coroners and Justice Act 2009.

2) The effect of this is that for any death that occurs after 3 April 2017, where the deceased was subject to a DoLS authorisation, the coroner will no longer have a duty to conduct an inquest in **all** cases.

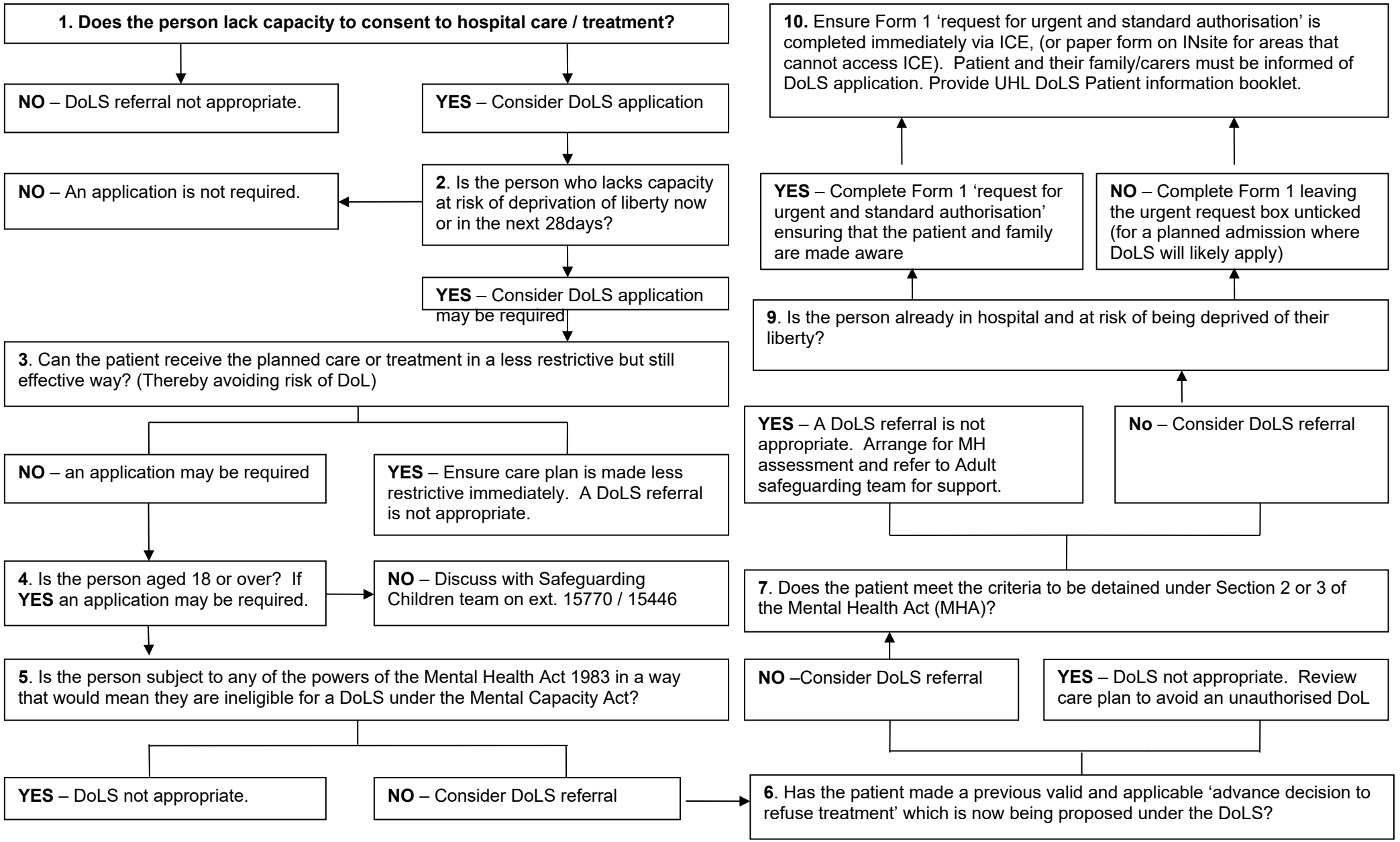
3) Locally, HM Coroner has advised the Trust that for any person with a **valid** DoLS authorisation at the time of death, this need only be reported (by Registered Medical Practitioners) to the coroner where the cause of death is unknown or where there are concerns that the cause of death was unnatural or violent, including where there is any concern about the care given having contributed to the person's death.

4) In this context, 'valid' means: **during** the 7 day urgent authorisation or while the patient is detained under a valid and in date standard authorisation period.

5) Deceased patients who were detained under a valid DoLS in UHL will fall under the jurisdiction of The Coroner for Leicester City and South Leicestershire (as UHL hospital sites fall within the City geographical boundaries).

6) Where required, Registered Medical Practitioners should refer to H.M Coroner using the Trust's accepted method, ensuring that specific reference is made to the deceased patient being detained under DoLS where this is relevant. H.M Coroner will expect to be informed of the date that the DoLS was authorised.

Appendix 9 – Determining if the Deprivation of Liberty Safeguards are applicable



Appendix 10 – Details of the Local Deprivation of Liberty Safeguards teams

1) The Leicester City and the Leicestershire and Rutland Deprivation of Liberty Safeguards teams respond to requests for Standard Authorisations from Managing Authorities. The core teams consist of Team Managers, a number of Best Interest Assessors and administration support. A number of "floating" Best Interest Assessors are contracted into the team as they are needed. Paid Personal Representatives, IMCAs and Mental Health Assessors are available to the DoLS service as required

2) The DoLS service are hosted and managed by both the Leicester City and the Leicestershire County Council.

3) **The contact details for the DoLS teams are as follows:**

LEICESTERSHIRE COUNTY AND RUTLAND DOLS TEAM

Telephone: 0116 305 7853
Safe Haven Fax: 0116 305 5555
Email: Dols.Team@leics.gov.uk

LEICESTER CITY DOLS TEAM

Telephone: 0116 454 6010
Safe Haven Fax: 0116 454 0703
Email: DoLS@leicester.gov.uk

Out of Area DoLS teams
If the person ordinarily lives outside of Leicester, Leicestershire/ Rutland, use an internet search engine to identify the relevant local authority DoLS details and follow their advice and instructions on how to request an Urgent and Standard Authorisation. You can also contact the UHL Safeguarding Adults team on ext. 17703 for advice on out of area DoLS teams.

4) **Receiving a request for assessment for Urgent / Standard Authorisation – this is a summary of the procedure for the DoLS Team to inform UHL staff in brief:**

4.1 Upon receipt of a request for an Urgent and / or Standard Authorisation, the DoLS Team Administrators and duty Best interests Assessor (BIA) will jointly consider whether the application is appropriate, complete or whether any additional information is required from the Managing Authority.

4.2 The DoLS Team Manager (or nominated deputy) will consider the case and allocate to an appropriate BIA who will then contact the applicant / ward / hospital and inform them of the date they intend to commence the assessment process. The BIA will be responsible for coordinating the assessment process.

4.3 The relevant person must have someone who can provide support to them throughout the assessment process, such as a family member, friend or carer; this person cannot be someone who provides care or treatment in a professional capacity or for remuneration.

4.4 If the relevant person does not have somebody available to support them, then the DoLS Team on behalf of the Supervisory Body will need to instruct an Independent Mental Capacity Advocate (IMCA).

4.5 Upon request from the BIA, the Managing Authority must provide any relevant assessments or care plans and enable access to and copies of any records held that assessors or IMCAs.

Appendix 11 – Table of Urgent DoLS Expiry Dates (per calendar month)

Date Urgent Authorisation completed and submitted (Form 1)	Date the Urgent DoLS Expires
1st	7th
2nd	8th
3rd	9th
4th	10th
5th	11th
6th	12th
7th	13th
8th	14th
9th	15th
10th	16th
11th	17th
12th	18th
13th	19th
14th	20th
15th	21st
16th	22nd
17th	23rd
18th	24th
19th	25th
20th	26th
21st	27th
22nd	28th
23rd	29th (amend for Feb if leap year)
24th	30th (amend for Feb if leap year)
25th	31st, or 1st if April, June, Sept or Nov (amend for Feb)
26th	1st, or 2nd if April, June, Sept or Nov (amend for Feb)
27th	2nd, or 3rd if April, June, Sept or Nov (amend for Feb)
28th	3rd, or 4th if April, June, Sept or Nov (amend for Feb)
29th	4th, or 5th if April, June, Sept or Nov (amend for Feb)
30th	5th, or 6th if April, June, Sept or Nov (amend for Feb)
31st	6th, or 7th if April, June, Sept or Nov (amend for Feb)