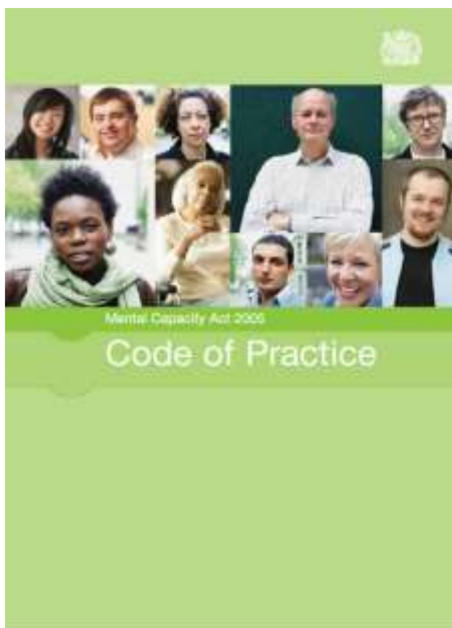
LGSS

The MCA & DoLS Provider Workshop

2019



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Workshop Objectives:

By the end of the workshop you will:

- Recognise what the Care Quality Commission expects from providers in relation to consent, the MCA and DoLS
- Be able to identify the duties and responsibilities under the Act and how this relates to your wider regulatory and contractual requirements
- Recognise your duties/responsibilities regarding consent and refusal of care
- Recognise how the MCA principles apply to day-to-day care and support, and how to evidence this in practice
- Understand what *'proof'* of lack of capacity and best interests decision making that the Mental Capacity Act requires and to how to record this
- Recognise what constitutes restraint/restriction, the documentation required to evidence this and CQC and contractual expectations
- Know how to evidence the legal arrangements that people have in place, including; LPA's, Advance Decisions, Deputies and Appointees
- Understand Deprivation of Liberty in the context of provider services and the expectations that this imposes on those delivering the care

Activity 1 : The CQC Temperature Check

Key lines of enquiry, prompts and ratings characteristics for adult social care services (November 2017)

CQC's inspection teams will use this updated framework to assess adult social care services, using the key lines of enquiry (KLOEs) and prompts where they are appropriate. This replaces the previous separate versions for different types of service, published in 2015, which duplicated many of the KLOEs and prompts.

Reaching Outstanding!!!

Is consent to care and treatment always sought in line with legislation and guidance?

- The service is skilled in how it obtains people's consent for care and treatment, involving them in related decisions and assessing capacity when needed, even where disability or other impairments make this very difficult.
- The service has a very flexible approach to any restrictions it imposes on people; keeping them under constant review, making them in a time-limited way, and only when absolutely necessary.
- Practices regarding consent and records are actively monitored and reviewed to improve how people are involved in making decisions about their care and treatment. Engagement with stakeholders, including people who use services and their family, friends and other carers, informs the development of tools and support to aid informed consent.
- The service has nominated champions for mental capacity, restraint and consent. They make sure that staff are fully educated and trained and have a comprehensive understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- Staff are confident about using the Mental Capacity Act 2005, and use innovative ways to make sure that people are involved in decisions about their care so that their human and legal rights are respected. Best interest decisions are always made in accordance with legislation and people's wishes.

E7: Is consent to care and treatment always sought in line with legislation and guidance?

Outstanding	Good	Requires improvement	Inadequate
The service is skilled in how it obtains people's consent for care and treatment, involving them in related decisions and assessing capacity when needed, even where disability or other impairments make this very difficult. The service has a very flexible approach to any restrictions it imposes on people; keeping them under constant review, making them in a time-limited way, and only when absolutely necessary. Practices regarding consent and records are actively monitored and reviewed to improve how people are involved in making decisions about their care and treatment. Engagement with stakeholders, including people who use services and their family, friends and other carers, informs the development of tools and support to aid informed consent. The service has nominated champions for mental capacity, restraint and consent. They make sure that staff are fully educated and trained and have a comprehensive understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff are confident about using the Mental Capacity Act 2005, and use innovative ways to make sure that people are involved in decisions about their care so that their human and legal rights are respected. Best interest decisions are always made in accordance with legislation and people's wishes.	Staff make sure that people are involved in decisions about their care so that their human and legal rights are upheld. Staff judge whether people have capacity to make particular decisions whenever this is necessary. They involve relevant people and professionals when needed, and record their actions and assessments whenever this is proportionate and appropriate. Managers gather information about consent-related activity in the service and use it to audit and improve how services are delivered, and to monitor appropriate use in line with national guidance. Staff know what they need to do to make sure decisions are taken in people's best interests and involve the right professionals. Where people do not have the capacity to make decisions they are given the information they need in an accessible format of their choice, and where appropriate, their family, friends and other carers, advocates are involved. Staff make sure people are referred for professional assessment at the earliest opportunity. Staff uphold people's rights to make sure they have maximum choice and control over their lives, and support them in the least restrictive way possible; the policies and systems in the service support this practice. Staff understand and demonstrate a good working knowledge of the Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005. They can demonstrate how they put these into practice effectively, and ensure that people's human and legal rights are respected.	The service does not make sure that staff fully understand the requirements about consent and they do not always seek people's consent to care and treatment. The service does not always assess people's mental capacity to make particular decisions, or it may do so in a way that does not meet legal requirements. Managers may gather information about consent and there may be related audit activity, but the information is not used to improve the service, or not used as effectively as it could be. People's family and friends are not always included or involved in such decisions. Where restraint is used it is not always recognised, or less restrictive options are not always used where possible. Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 may not be fully understood. People's human and legal rights are not always understood and respected. Some staff are unsure about what they should do to make sure that any decisions are made in people's best interests. People do not always receive information in a format they understand.	The service does not ensure that it obtains people's consent to care and treatment, and staff are unclear about the requirements relating to consent. Managers do not check or audit consent activity. The service does not ensure that people's capacity to make decisions is assessed when needed. Consent to care and treatment and best interest decisions have not been obtained in line with legislation and guidance, including the Mental Capacity Act 2005, the Children's Acts 1989 and 2004 or Deprivation of Liberty safeguards. Staff do not understand these requirements. Where restraint is used, it is not recognised, and no attempts are made to find less restrictive options to provide necessary care and treatment.

Discuss in your groups: On a scale of 0 – 10 (0 being not achieved (Inadequate) 10 being achieved (Outstanding) in all areas described) where are your services with regards to this standard? Discuss in your groups and you will be asked to share examples of:

The challenges in meeting this standard / Good practice in your services and / Areas that need to be improved.

Activity 2 : The MCA/DoL Knowledge Test

Question 1

What are the five principles of the Mental Capacity Act in the correct order?

Principle 1:

Principle 2:

Principle 3:

Principle 4:

Principle 5:

Supplementary – How do you embed an understanding of this with your frontline staff?

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____

Question 2 (Part 'a') – Fill in the blanks

There are 2 stages to the assessment of capacity highlighted in the MCA Code of Practice.

Stage 1 (diagnostic test): ____

Stage 2 (the functional test): ________________ **–** information relevant to the decision

________________ **-** information relevant to the decision

_______ & __________ **-** information relevant to the decision

________________ **-** the decision

Question 2 (Part 'b')

When is it your job to assess Mental Capacity?

____

____

<u>Supplementary</u> – How do you evidence this in your care plans?

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Question 3

Section 4 of the Mental Capacity Act and the MCA Code of Practice (Chapter 5) sets out some common factors that **MUST** always be considered when trying to work out someone's best interests. Write down these factors below:

- ____
- ____
- ____
- ____

Supplementary – How do you evidence this in your care plans and how do staff apply this in practice?

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Question 4 (Part 'a')

Part 1: Do you impose any restrictions on the people you support in your service? If you do, what documentation do you use to record and evidence this?

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____

Question 4 (Part 'b')

What examples of restraints, restrictions, supervision or controls may you find in care provider services?

- ____
- ____
- ____
- ____
- ____
- ____

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Question 5 (Part 'a')

What are the 3 elements that help us determine whether there is a Deprivation of Liberty?

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Question 5 (Part 'b')

Case Study

Part 1 – Ben is 22 has mild learning disabilities, Prader-Willi syndrome and behaviours that challenge others.

Prader Willi - *Prader-Willi syndrome (PWS) was first described in 1956 by Swiss doctors, Prof. A Prader, Dr A Labhart and Dr H Willi, who recognised the condition as having unique and clearly definable features.*

These features are, as medically described:

- *Hypotonia - weak muscle tone, and floppiness at birth.*
- *Hypogonadism - immature development of sexual organs and other sexual characteristics.*
- *Obesity - caused by excessive appetite and overeating (hyperphagia), and a decreased calorific requirement owing to low energy expenditure levels. (Obesity is not normally a feature of those whose food intake is strictly controlled.)*
- *Central nervous system and endocrine gland dysfunction - causing varying degrees of learning disability, short stature, hyperphagia, somnolence (excessive sleepiness), and poor emotional and social development.*

Due to a range of family issues and safeguarding issues during his childhood and early teen years Ben was a looked after child since the age of 14, and his family have made no attempt to maintain contact with Ben since. Since turning 18 he has lived in a Supported Living Service for people with learning disabilities and prader-willi syndrome.

There have always been concerns about Ben's health and weight because of his PWS but his weight has been increasing steadily since entering into residential care and this now stands at 142kg (22.4 stone). Staff in his residential home have tried to support Ben to limit what he eats and to make

healthy choices but with little effect. Both Ben's GP and his Social Worker believe steps should be taken to limit the food he eats and establish a diet / healthy eating plan for Ben that should be enforced by the Care Provider in his best interests?

Question: What are your thoughts at this time and what steps may now need to be taken?

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Part 2 – After a lot of joint work between Ben, the care provider, a dietician, his GP and social worker it is concluded and evidenced that, due to Ben's learning disability and the impulsivity associated with his PWS that he is unable to understand, retain or use or weigh the information relevant to the risks of severe or life threatening obesity if the diet is not controlled.

As such the following restrictions were agreed to be in his best interests:

- Access to the kitchen will be restricted to stop him going into the kitchen,
- Ben will always be supervised when out in order to stop him buying or stealing food,
- Access to his money will be restricted (agreed by his appointee), and he will only have a maximum of £10 a week to spend on non-food items and
- Ben's diet will be controlled by the care provider who will follow the healthy eating plan devised by the dietician.

Note:

- All of the above is supported by a completed risk assessment, capacity assessment and best interest decision.
- Whilst Ben does lack the capacity to consent to these arrangements and they have been agreed to be in his best interests, Ben is very clear that he is unhappy with these arrangements and doesn't believe that they are in his best interests.

Question: Is Ben deprived of his liberty? Whatever conclusion you come to you must explain your reasoning, but if you believe that Ben is deprived of his liberty what next steps would need to be taken as the care provider?

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Example Capacity Assessment & Best Interest Tool

Name of person:

Form completed by:

Name: **Role:**

Contact details:

Details of decision:

- **What is the decision that you are supporting the person to make?**

1.2 Describe how you supported the person to make the decision

1.3 Is the person able or unable to make the decision with all practicable support?	**YES**	**NO**
Is the person able to **understand** the relevant information? Record your evidence here:		
Is the person able to **retain** the relevant information long enough to make this decision? Record your evidence here:		
Is the person able to **use or weigh** the relevant information? Record your evidence here:		
Is the person able to **communicate** the decision? Record your evidence here:		

Conclusion

Why do you believe that this person lacks the capacity to make this decision?
Details:

Are you satisfied that the inability to make a decision is because of the impairment of the mind or brain?
Details:

How do you plan to support this person in their best interests **Best Interests decision**

NB: Where the decision is more complex or not 'day-to-day' you should use some of the additional best interest tools in Appendix 1.

Appendix 1: Best Interest record – For decisions that are not 'day-to-day'

Is there a person with legal authority for this decision?

- If **'YES'** record the **detail** of the best interest decision taken and the **Legal Authority they hold** (EPA/LPA/Deputy/Appointee) and **end your record here**.

Decision made:

- If **'NO' complete the rest of the record.**

Best Interests Checklist

Is it likely that the person will regain capacity in the future regarding the decision *(can the decision be delayed)*?

What attempts have been made to involve the person in the decision *(particularly when the person is close to 'borderline')*?

What is known of the person's past and present wishes and feelings – both current views and whether any relevant views have been expressed in the past, either verbally, in writing or through behaviour or habits.

What is known of the person's beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question?

Any other factors the person would be likely to consider if able to do so (this could include the impact of the decision on others).

What are the views of (if practicable and appropriate to consult):

- anyone previously named by the person as someone to be consulted on the decision in question or matters of a similar kind;
- anyone engaged in caring for the person, or close relatives, friends or others who take an interest in the person's welfare;
- anybody with legal authority over some decisions but who does not have the legal authority over this decision.

What options were considered for this Best Interest decision?	
OPTION 1:	
Advantages	**Disadvantages**
OPTION 2:	
Advantages	**Disadvantages**
OPTION 3:	
Advantages	**Disadvantages**

2.5 What decision was made in the persons best interests?
Decision Made: **Was this option less restrictive of the person's rights and freedoms?** ❖ If **'YES'** record the **detail** of why this option is **less restrictive** than other options considered. ❖ If **'NO'** record the evidence that justifies why this option is in the person's Best Interests.

What action can be taken to enhance the person's capacity in the future?

Signature of professional completing form:

Date:

Name of line manager:

Signature of line manager:

Date

Members of the Circles of Support Involved

Name of Person	Relationship to person

Example - Assessing & Managing Risk: Positive and proactive care planning Tool

PERSONS NAME	
AREA OF SUPPORT	
REVIEW DATE	
What is the identified risk?	
How did you enable the person to understand the risk?	
How do you plan to support the person to manage this risk?	
Does the person have the capacity to consent or refuse the support offered or does the person lack the capacity to consent and has a best interest decision been made (use capacity assessment and best interest tool where appropriate)? **Provide a summary and any additional actions.**	
Would the support be considered to be a potential restraint or restriction? **Yes / No** **Note: If the person consents to the intervention it should not be seen as a restraint or restriction, but a record of their consent should be evidenced in the support plan.**	
Contingency plan **(Detail any actions agreed if the above support does not meet needs)**	
COMPLETED BY / SIGNED / DATE	
REVIEWED BY / SIGNED / DATE	

Example - Risk Management & Deprivation of Liberty Checklist

Name of Individual:

Areas to consider	Conclusion
Does the person lack the capacity to consent to the placement in your service for the purpose of being given the proposed care and or treatment (Identified above)? **Note:** Even where the person is able to consent to certain aspects of their care it can still be the case that on the whole that they lack the capacity to consent to their care arrangements. Remember your conclusion only needs to be on the balance of probabilities. **Comment:**	Yes / No **Note:** *If the answer is no stop record here.*
Does the persons care plan indicate that the person is not free to leave? **Note:** Factors that may indicate that the person is not free to leave could be; locked doors, the person only being allowed in the community with support, the person will only be allowed into the community while being monitored (assistive tech, tracking devices), the person is only allowed out with permission from staff and steps would be taken to bring them back if they did not return. It is important to remember that these are only relevant where the person lacks the capacity to consent to these arrangements and these decisions are being made in their best interests. **Comment:**	Yes / No
Does the persons care plan indicate that the person is under continuous or complete supervision and control? **Note:** Factors that may indicate that the person is under continuous or complete supervision and control could include; the person has their medication controlled by staff, finances are managed by a deputy or appointee, supervision or monitoring arrangements in the home and / or in the community, plans designed to manage or control behaviour, locked cupboards and doors, controlled diets, covert medication, physical restraints, etc. It is important to remember that these are only relevant where the person lacks the capacity to consent to these arrangements and these decisions are being made in their best interests. **Comment:**	Yes / No

Where you have answered Yes to all of the above 3 options, have you: 1. **Residential Care:** Made a DoLS application using the DoLS Form 1? 2. **All other services:** Informed the commissioning body of the potential DoL?	Yes / No

There are certain circumstance in which you should consider escalating the issue and asking the Supervisory Body or Commissioning Body to consider the case as a priority.

This would include:

- There are objections from the person to staying at the service and/or requesting to go back home?
- There any objections from family member(s) to the person staying in the service?
- There are restrictions on family / friend contact?
- Medication is being administered covertly to the person?
- Physical restraint(s) are being used?
- The regular use of medication to control or manage behaviour.

Completed by:
Date

Reviewed by:
Date

NB: This summary should be updated as and when required and reviewed at least every 6 months.