CQC Guidance GPs and the Mental Capacity Act 2005/Deprivation of Liberty Safeguards

The Mental Capacity Act (2005) is a crucial safeguard for the human rights of people who might (or might be assumed to) lack mental capacity to make decisions, in particular about consenting to proposed care and treatment.

We will be asking questions on our inspections to take account of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards.

GPs and their staff (and all providers of health and social care) should have a good understanding of the MCA 2005.

An awareness of Deprivation of Liberty Safeguards (DoLS) and when they may be used will be particularly important for GPs going into care homes – given that in certain circumstances it may be an alternative approach to the Mental Health Act.
Even for GPs that do not visit care homes, it is necessary for them to know about MCA and DOLS to ensure that they can act in a patient's best interest.

For example, a patient's condition may develop to a point where DOLS may need to be applied. Cognitive impairment in a patient with dementia will increase with time to the point that it may be in their best interest to enter a care home. At this point the GP would need to be able to advise on the best course of action and to be assured that the appropriate processes have taken place. This may include ensuring that an assessment for MCA or DOLS and a comprehensive assessment of the patients' needs are carried out prior to the application of DOLS.

Principles of the Mental Capacity Act
The principles of the MCA and Deprivation of Liberty Safeguards and the key areas affecting GPs are outlined below.

- Individuals are presumed to have capacity.
- All practical steps must be taken to support someone in decision-making.
- A person is not to be treated as lacking capacity merely through making an unwise decision.
- An action taken on behalf of a person must be in their best interests.
- Regard must be had as to whether an act or decision is the least restrictive of a person's rights and freedoms.

The MCA prohibits blanket decision-making on behalf of people with capacity issues and introduces a functional test of capacity that is time and decision specific.

It requires everyone who cares for or treats people with capacity issues to respect their individual rights and to act in their best interests when making decisions on their behalf.

For example, if a patient suffers from early stage dementia, and needs to make a decision on whether to have the flu jab, the GP should make every effort to communicate the pros and cons of having the treatment when the patient is most alert. This is so that the patient can make a decision.

A GP becomes the decision-maker only if the patient lacks the capacity to make that decision for themselves and has not made a Lasting Power of Attorney (LPA) granting the donee the power to make decisions about medical treatment GPs must make the decision

for the patient in their best interests. Consequently, GPs need to know when they can and cannot disclose confidential information.

Other key areas of the Act affecting GPs are:

- Independent mental capacity advocates (IMCAs).
- The ability for adult patients to make a lasting power of attorney (LPA).
- The establishment of a new Court of Protection.
- Court-appointed deputies. GPs need to be aware of people appointed to these roles and when to involve them in decision-making about patients who lack capacity.

Appointing an Independent Mental Capacity Advocate
The Independent Mental Capacity Advocate (IMCA) role became operational in 2007. It is relevant for a person who lacks capacity and has no family or friends whom it would be appropriate to consult, nor do they have an appointed attorney under a lasting power of attorney.

For these people, in certain situations (such as when there is a decision to be made about an NHS body providing serious medical treatment - the relevant NHS body is required to instruct and consult an IMCA. GPs need to be aware of the duty to appoint an IMCA or to consult with an existing IMCA when it is appropriate.

Lasting powers of attorney
Lasting powers of attorney replaced enduring powers of attorney. There are two types of last power of attorney (LPA). A property and affairs LPA allows an attorney to make decisions about financial matters and, unlike a personal welfare LPA, they can be used when the person still has capacity, unless otherwise specified. A personal welfare LPA allows an attorney to make decisions about both health and personal welfare. This personal welfare attorney, however, cannot consent to or refuse treatment when the person has capacity to make the decision themselves.
The patient can also add restrictions or conditions on areas where they do not wish the attorney to act.

Even if an LPA includes all healthcare decisions, the attorney has no decision-making power to refuse or authorise treatment in certain situations, such as if the patient has made an advance directive to refuse treatment proposed after making the LPA.

In addition, the attorney cannot insist on treatment that a doctor does not believe is in the patient’s best interest.

GPs who are aware that a patient has made an LPA will need to check whether it covers financial or personal welfare matters and that it applies to the situation in question.

The LPA will not be effective if the patient has capacity in relation to the welfare issue in question
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Therefore, if an attorney requests disclosure of a patient's records, the GP must check that a personal welfare LPA is in force, the detail of its provisions and confirm that the patient lacks capacity before complying. It may not be necessary to release the entire record but just the relevant parts to the attorney.

To understand the extent of the attorney's power fully, GPs should read the LPA, which will be registered at the Office of the Public Guardian. Only those over 18 can appoint someone to act as a LPA.

Court of Protection
The court has the power to make a declaration about whether an adult (or a child in some cases) has or lacks capacity, and to appoint a deputy to make a decision on behalf of a person lacking capacity.

Disputes over a person's capacity, or what treatment is in their best interest can be referred here.

GP members with concerns about treating patients who lack capacity are advised to contact the Medical Defence Union for advice.

Deprivation of Liberty Safeguards
The DoLS are part of the Mental Capacity Act 2005.

They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home or hospital only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. GPs should be a position to judge whether the safeguards are being met.

The safeguards apply to vulnerable people aged 18 or over who have a mental health condition (this includes dementia), who are in hospitals and care homes, and who do not have the mental capacity (ability) to make decisions about their care or treatment.

GPs who are involved in planning care should always consider all options, which may or may not involve restricting the person's freedom, and should provide care in the least restrictive way possible.

However, if all alternatives have been explored and the hospital or care home believes it is necessary to deprive a person of their liberty in order to care for them safely, then they must get permission to do this by following strict processes. These processes are the DoLS, and they have been designed to ensure that a person's loss of liberty is lawful and that they are protected.

The key elements of the safeguards are:

- To provide the person with a representative
- To give the person (or their representative) the right to challenge a deprivation of liberty through the Court of Protection (see 'Useful organisations')
- To provide a mechanism for deprivation of liberty to be reviewed and monitored regularly.
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What is deprivation of liberty?
There is no single legal definition of 'deprivation of liberty', so it can sometimes be difficult to establish whether it is taking place. It can be helpful to think of restrictions of a person's activity as being on a scale, from minimum restrictions at one end to the more extreme restrictions – deprivations of liberty – at the other end. One large restriction could in itself be a deprivation of liberty (such as sedating a person for non-medical reasons) or many small restrictions could combine to create a deprivation of liberty. It is the amount of control that the care home or hospital has over the person that determines whether the person is being deprived of their liberty.

There have been several test cases in the European Court of Human Rights and in the UK that have clarified which situations may constitute a deprivation of liberty, some of which may apply to GPs:

- A patient being restrained in order to admit them to hospital
- Medication being given against a person's will
- Staff having complete control over a patient's care or movements for a long period
- Staff making all decisions about a patient, including choices about assessments, treatment and visitors
- Staff deciding whether a patient can be released into the care of others or to live elsewhere
- Staff refusing to discharge a person into the care of others