*Innovation in Applied Nursing Informatics*
*G. Strudwick et al. (Eds.)*

*doi:10.3233/SHTI240192*

# Using Technology to Improve the Mental Capacity Assessment and Deprivation of Liberty Safeguards Process

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**Abstract.** The process of mental capacity act (MCA) assessment and depravation of liberty safeguarding (DoLS) was identified as an area for improvement. The project aimed to ensure that patients admitted to hospital for care and treatment were appropriately assessed if there is doubt about their mental capacity and that the subsequent legal process of DoLS is followed as needed. The project group sought to address this issue using clinical informatics through the electronic health record and data reports to re-design the process. User involvement was key to ensure the process and key pieces of documentation were designed to be easy for staff to use with responsibilities clearly defined. The importance of operational staff having good visibility of the end-to-end process was key to allow staff to identify and address any gaps in the process in real time without the need for escalation by the safeguarding team. A robust data report further supports the safeguarding team to effectively manage this group of vulnerable patients. The project has significantly increased appropriately the number of MCA assessments undertaken and subsequent DoLS applications submitted to local authority partners.

**Keywords.** Mental Capacity Act, Deprivation of Liberty Safeguarding

## 1. Introduction

This case study demonstrates innovative work undertaken at South Tyneside and Sunderland NHS Foundation Trust (STSFT) to utilise their electronic Health record (EHR) to improve processes in the way mental capacity is assessed and following assessment if required a depravation of liberty safeguarding is applied for. The work has taken a multi-professional, cross organisation approach, and has been transformative in nature.

The Mental Capacity Act [1] and Deprivation of Liberty Safeguards [2] commonly referred to as DoLS were introduced in England and Wales in 2005 and 2009. Where patients lack the mental capacity to consent to their admission and treatment, there is a legal process to follow to ensure any restrictions in their care are in the patient's best interests. DoLS is this legal process through which such restrictions are legally authorised. DoLS allows the hospital to authorise itself, to legally deprive the patient of their liberty in the short-term until a longer-term authorisation is sought from the relevant local authority.

Research has estimated that as many as 34% of patients may lack the mental capacity to consent to their hospital admission and treatment. [3] In 2014, The House of Lords

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Select Committee praised the MCA but was critical of DoLS legislation as it was felt to be complex, bureaucratic and not well embedded in practice. [4]

## 2. Case Study Description and Relevance

In 2022, the Care Quality Commission [CQC] carried out a thematic inspection at STSFT, including its policies and procedures for DoLS, the Mental Capacity Act [MCA] and Safeguarding services. Though generally, CQC's findings were positive, there were some improvements needed in relation our understanding and practice around MCA and DoLS.

Following the inspection, the Trust placed a heavy focus on ensuring patients were appropriately assessed if there was reason to doubt their mental capacity and that DoLS was authorised where appropriate. The overall project aim was to improve the MCA and DoLS documentation process for patients admitted to STSFT for treatment and care. To achieve this the following steps were taken.

- a project group was formed including clinical staff, safeguarding representatives and Information technology staff.
- Agreement was sought that the process needed to be integrated within the trusts EHR, Meditech, making it easy for all staff involved to undertake the right assessments during the admission process.
- A review of current documentation was undertaken to identify where improvements could be made to ensure documentation encouraged staff to complete these critical assessments as part of their routine processes.
- Assessments were re-designed to be more user-friendly, with prompts added within the system to encourage staff to think about best interest decisions that should be taken for patients lacking capacity.
- Updated clinical documentation was launched using existing trust comms.
- DoLS applications provided to local authority to be generated directly from the EHR.
- Ward manager status boards were updated detailing specific data to provide real time visibility of key steps in the process to ensure good compliance with the MCA / DoLS process.
- A daily data report was developed to provide the safeguarding team better visibility of patients who lacked capacity and allowed a clear escalation strategy should compliance not be achieved within a determined timescale.
- Data was reviewed and analysed by the working group and further refinement work undertaken.

## 3. Project Design

A working group was formed to look at current documentation, to understand challenges in completing required assessments and identify simple solutions to create a clear process to support the multi-disciplinary team to effectively contribute to the MCA/DoLS process.

The working group observed that a key complexity in the process is the lack of understanding as to how many patients should have MCA 1&2 completed this being due to the mental capacity act indicating that Mental capacity of patients should be assumed

and the process to assess mental capacity instigated only if there is reasonable doubt that the patient lacks capacity. Without a quantifiable number the extent of the issue is unknown and progress against target is impossible to determine. It was therefore proposed to ask a simple question in the initial medical assessment 'Is there reason to doubt that the patient lacks mental capacity?' a yes/no response to this mandatory question ensured visibility of all patients who may be lacking capacity and providing a key target for performance.

A review of MCA 1&2 assessments was undertaken, staff felt the lay-out of these assessments was not user-friendly, questions were not clear, had duplications and were difficult to complete. Where DoLS application is required there was no visibility in the process that this was a requirement or which professional was being tasked with completing this. The MCA1&2 assessment was re-drafted based upon staff feedback, this indicated when DoLS documentation should be completion and whether medical staff or nursing staff would complete. Where nursing staff were selected to complete this application, a notification was sent to the nursing worklist.

A review of nursing documentation further identified that where patients lacked capacity further detail should be provided for nurses to document the care delivered and encourage least restrictive, best interest decisions based around patients standards of care. A separate evaluation for patients who lack mental capacity was developed to detail this care delivery.

## 4. Execution

Changes to the documentation occurred on an incremental basis as steps in the process were refined. Changes were communicated via the trust's communication channels.

A useful element to the project was introducing two specific tools to ensure that all appropriate patients were identified through the MCA / DoLS process and appropriately escalate where the standard was not achieved.

- A daily data report was developed for use by the Safeguarding team of patients with MCA 2 completed cross referencing whether a DoLS had also been completed. Whilst this provided opportunity to intervene and request appropriate documentation the ownership of the process needed to be within operational teams.
- To provide operational oversight additional columns were added to the ward managers' assurance status board, the ward manager or nurse in charge regularly uses this board to ensure that key risk assessments are completed for all patients within their care. Columns displayed the response to the 'is there reason to doubt mental capacity' question and where Yes is indicated the second column indicates the date of completion of MCA1&2 and a third column indicates which professional is responsible for completing DoLS and the date completed. Having all of these key details together is a visual check of any gaps in the process that the ward manager can effect immediate change to rectify.

Following implementation of the new process the safeguarding team further reviewed medical documentation to consider the improvement work. Discrepancies were seen on case review as to the response to the initial question "is there any reason the doubt the patient has capacity to consent" with staff initially indicating mental capacity was not in doubt yet progressing to complete MCA1&2 or conversely indicating that this assessment was needed but failing to complete this. Clinical staff using the document

were approached for their further feedback, they highlighted that the initial question being posed at the start of the medical assessment posed two problems. Firstly, the opinion regarding the patients mental capacity may change during the assessment in response to the conversations being had and secondly indicating at the start of a document that an MCA1&2 would later be completed often resulted in staff overlooking this assessment after a lengthy consultation. The working group agreed to move the initial capacity question to the end of the medical documentation which resulted in a significant

As a consequence of the work to ensure prompt assessment of mental capacity, the number of completed MCA and DoLS rose significantly. This sudden increase greatly increased the workload for our safeguarding administration team and the relevant local authorities. Many of these applications did not progress as the patient subsequently regained capacity, was discharged, died or transferred before the local authority could complete the assessments. The process for DoLS applications to the local authority were prepared by the safeguarding team as a word document in an agreed template as required by the local authority, with details being sought from the EHR. This process was time consuming for the safeguarding team. Discussions with the local authority sought agreement that a document pulled directly from the Meditech EHR could be sent directly to local authority following safeguarding review, reducing the burden to the safeguarding team of the anticipated additional DoLS applications.

The Launchpad Daily Report was further amended to record the date the DoLS Form was completed and establish a count for how long the application was awaiting assessment. This data was then used to work with local authority partners to identify which patients were awaiting assessment, including their average waiting time and those who were waiting who were medically fit for discharge. This helped prioritise assessments with the aim of also protecting the rights of those patients and reducing the risk liability of the Trust. It is hoped this data can also help drive work to speed up the discharge planning processes for those patients who do not need medical treatment and are awaiting an appropriate package of care to facilitate discharge. This also includes those patients who will be moving from their own home into a residential or nursing facility, who may need DoLS in their move on accommodation.

## 5. Impact and lessons learned

Prior to our CQC Inspection in 2022, South Tyneside and Sunderland NHS Foundation Trust were making approximately 140 Depravation of Liberty applications per month (approximately 1700 per year). Following initial work to better identify those patients who may need a DoLS, that number, increased to around 400 per month (approximately 4,800 per year). Following refinement work to our DoLS process, now around 330 applications per month are progressed to the local authority. Approximately 70 inappropriate applications per month do not progress to the local authority, saving administration time and significant local authority resources.

The improved data also gives greater visibility of the number of medically fit patients awaiting discharge who lack the mental capacity to consent to their ongoing admission. This is on average, 70 patients per day, and represents around 6 or 7% of beds. The average length of stay for this cohort is 32 days. Further work with local authorities can support reducing this number.

The impact of the improvement project for patients is that they are now far more likely to have their mental capacity to consent to treatment and admission assessed at point of entry or within 48 hours of admission. This greatly increases their chances of having any potential deprivation legally authorised, which ensures their right to have advocacy and to challenge their depravation of liberty.

For the organisation the impact of the refined process is that we now make less inappropriate applications for DoLS to the local authority. This increases the chances that those who need this vital legal protection are more likely to receive them within the lifespan of their admission. This saves significant administration time and resources that can now be direct elsewhere in the safeguarding arena within the Trust. As a Trust, we are now able to provide real-time data to our local authority partners, allowing for more accurate discussions around prioritisation and as a result, reducing the risk of litigation against the Trust for unlawful deprivation of liberty. The organisation can now provide further assurance to the CQC around our MCA and DoLS processes in partnership with our local authority colleagues. A recent Audit One inspection recorded that our new processes demonstrate good practice.

There has been a positive impact on our staff who are now better informed of their legal responsibilities and feel better supported to meet those responsibilities in a timely fashion.

As an organisation we are aware of our responsibility to this cohort of patients that we have identified to be deprived of their liberty during their admission to hospital. This responsibility carries an automatic right to compensation if not legally authorised, specifically the group of patients who are medically fit but remain in hospital whilst awaiting a safe discharge. A secondary aim of the project has been to gather data from the patient journey as to which patients had become medically fit for discharge and identify how long they had been waiting for an assessment. This data could then be used to work collaboratively with the local authority to ensure this cohort of patients are given greater priority to facilitate a quicker discharge and better utilising hospital resources.

The impact of the project for our local authority partners is that they now receive less inappropriate referrals, with an improved level of urgency that allows them to better plan and utilise their resources to target their assessments to those who are at greatest risk of having their legal rights left unprotected.

## References

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