Nurses need to understand Deprivation of Liberty Safeguards and ‘cannot be professionals without it’, says a leading expert in the field

The safety net with too many holes in it

Deprivation of Liberty Safeguards are supposed to protect patients at risk of having their liberty unlawfully deprived.

There is concern, however, that confusion about the safeguards, and a tendency to regard them as a bureaucratic hurdle, is letting patients down. 'This isn’t the way it was supposed to be,' says Jane Buswell, an independent nurse consultant and qualified Deprivation of Liberty Safeguards (DoLS) best interest assessor.

‘DoLS is about protecting some of the most vulnerable people in our society – it’s not just forms and assessments. It is perceived wrongly and negatively.’

Introduced in 2007 as an amendment to the Mental Capacity Act (MCA) 2005, and applicable to care homes and hospitals in England and Wales, the safeguards are designed to protect the rights of those whose liberty is deprived, so they can be given necessary care and treatment.

However, critics have consistently highlighted significant shortcomings in DoLS. A Lords select committee in 2014 described them as not fit for purpose, while a Commons health select committee report the previous year said people were ‘widely exposed to abuse because the controls which are supposed to protect them are woefully inadequate’.

In March 2014, a Supreme Court ruling defined when a deprivation of liberty takes place, in a case known as Cheshire West.

The ruling said an individual’s liberty is being deprived if she or he is:

- Under continuous supervision and control.
- Not free to leave.

- Lacks the capacity to consent to these arrangements.
- Age UK called the definition ‘extremely wide-ranging’.

In the ruling’s wake, there has been a surge of authorisation requests. In its sixth annual report on how the standards are being used, published in December 2015, the Care Quality Commission charted a tenfold increase in DoLS applications to local authorities, and an increasing backlog.

‘The CQC report is another telling us that we’re doing it wrong – but it’s the system at fault, not individuals,’ says Ms Buswell.

‘Local authorities are snowed under. The numbers have increased so much it’s become a process that’s not working.’

The legal framework

Care homes or hospitals must secure local authority permission to deprive a person of their liberty. Assessments need to take place before a ‘standard authorisation’ can be given. These include whether:

- The person has a mental disorder.
- He or she lacks capacity to decide about the proposed restrictions.
- The restrictions are in the person’s best interests.
- The person should be considered for detention under the Mental Health Act.

If any of the conditions are not met, deprivation of liberty cannot be authorised. This may mean the care home or hospital has to change its care plan, so that the person is supported in a less restrictive way.

Standard authorisations are made for up to a year, although they should stop when no longer needed. They cannot be extended, so if deemed necessary, a new request must be made. Conditions can also be set, which are binding on the care provider.

There is a code of practice for those involved in administering and delivering the safeguards, with information for those affected, including loved ones.

Mental Capacity Act 2005 code of practice: tinyurl.com/hauagoa

SUMMARY

Deprivation of Liberty Safeguards (DoLS) were introduced in 2007 to protect the rights of people in hospitals and care homes whose freedoms are restricted. In December 2015 the Care Quality Commission highlighted a tenfold increase in DoLS applications. Nurses need more training in this fundamental area of practice.

Author Lynne Pearce is a freelance journalist
shot up and it has created an enormous and unmanageable workload.’

Assessment is a key aspect of the authorisation process, with independent best interest assessors appointed to establish whether a deprivation of liberty is occurring or is likely to take place.

**Assessment**
The assessor is also required to decide whether deprivation of liberty is in the person’s best interests, necessary to keep them from harm, and a proportionate response to likelihood and seriousness of the potential harm.

Before she makes her recommendations, Ms Buswell will look at how the individual is being cared for, whether this reflects good or poor practice, and whether a less restrictive approach is possible.

Issues she examines might include whether the person is able to go outside, have their meals in a dining room and can easily interact with others, including whether there are any restrictions on visitors. ‘If we’re going to deprive someone of their liberty, we need to make sure we are demonstrating it’s in their best interests – and not those of the staff or the organisation,’ she says. ‘Safeguards is the vital word.’

Among the key safeguards is the appointment of someone with legal powers to represent them – usually a family member or a friend.

Other safeguards include rights to challenge authorisations in the Court of Protection, and access to the services of independent mental capacity advocates (IMCAs).

Alzheimer’s Society head of policy George McNamara emphasises that deprivation of liberty must be seen as a last resort. ‘Greater personalisation of care, rather than a standard approach, may reduce the need,’ he says.

‘Clear leadership and effective communication from someone at a senior level in the organisation, who understands the rationale for DoLS, can transform care for the better, decreasing the numbers of applications.’

One of the aspects often overlooked is the effect on a person’s loved ones when a DoLS authorisation is sought, says Mr McNamara. ‘It can cause a great deal of distress, with people unable to understand why it is happening,’ he says. ‘There needs to be more information.’

Considerable variation between care providers is another crucial issue highlighted in the CQC’s report. ‘We have a polarity of interpretations, with DoLS being used as a default in some places. This catch-all approach is deeply worrying,’ says Mr McNamara.

‘They are being thrown in as a safety net for organisations and institutions, rather than the individual. What is really needed is clarity.’

Ms Buswell shares the concern about lack of consistency. ‘There shouldn’t be the differences that we’re finding,’ she says.

‘Why are some organisations putting in so many applications while others so few?’ Both also agree there is a need for more training. ‘Those in the front line of delivering patient care need to feel confident what they’re doing is right,’ says Mr McNamara. ‘This means increasing the accessibility of training for nurses and other healthcare professionals.’

For Ms Buswell, training should encompass the whole of the MCA. ‘Outside the mental health world, nurses aren’t good at understanding how the act informs our daily practice,’ she says. ‘Its principles should be stamped on our foreheads.

‘Social workers tend to understand the implications of the MCA much more. We need much better training and education about it from pre-registration onwards – we cannot be professionals without it. It needs to be consistent and show why it’s so fundamental to nursing practice.’

The Law Commission is reviewing the legislation and guidance, with a final report and recommendations expected at the end of 2016.

‘I hope there will be some guidance about how to make this clumsy and bureaucratic system work better,’ says Ms Buswell.

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