

DEPRIVATION OF LIBERTY SAFEGUARDS CASE STUDIES**CASE STUDY 1**Background

Mr S is an 85 year old gentleman who has been diagnosed with dementia: he lives alone in his own property. Mr S has smoked since he was 14 years old. Mr S's wife died many years ago and he has one daughter who provided support weekly with cleaning and laundry. Over the past few months it had been noticed by his daughter that her father's short term memory was poor and it had been brought to her attention by her father's neighbours that Mr S was knocking on their doors asking questions.

Mr S has not previously been in receipt of a commissioned support package, in part because of his private nature. Mr S accepts support, albeit reluctantly from his daughter. Mr S has a fixed routine at home, he enjoys going to the British Legion every Sunday and is collected by a gentleman and returned home.

Mr S was admitted to hospital following a fall whilst walking on uneven ground having sustained deep wounds to his finger and head. His daughter reported that her father was unsettled on the ward and repeatedly asked to leave. Due to the risks of Mr S either deliberately trying to leave the ward or inadvertently wandering off a security guard was appointed to monitor and restrict his movements.

Mr S was also prescribed Haloperidol; this is commonly prescribed to older adults displaying agitation. His daughter stated that she asked for the medication to be discontinued as she did not believe that sedative medication was necessary. His daughter stated that she believed her father was agitated for two main reasons, i.e. he was not allowed to go outside for a cigarette and he was desperate to go home. His daughter said on one occasion her father "begged me to take him home."

A mental capacity assessment undertaken whilst in hospital concluded that Mr S was unable to make an informed decision regarding his discharge destination. The hospital team was of the opinion that Mr S should not return home and that he required nursing care. His social worker and daughter thought Mr S should return home with a support package but said they were overruled by the hospital who felt it would be unsafe. A Section 5 was issued so a rehabilitation bed was commissioned and Mr S was discharged there the following month.

Mr S's capacity was discussed and his daughter, social worker and care team all believed that he was able to make an informed decision around his future care needs. The week prior to the meeting Mr S was deemed by his solicitor to have capacity in another primary area of his life, i.e. to appoint his daughter as his financial attorney. The meeting concluded that whilst Mr S had capacity to make his own decision re his discharge destination it was not in his best interest to return home as the risks identified were significant and compounded by the fact that in all

probability he would not engage with a commissioned support package. Mr S was subsequently admitted to a care home as a short term arrangement while his daughter attempted to identify a permanent placement near to her address.

A DoLS application was made by this care home as it was believed that Mr S was at risk of being deprived of his liberty as he had made it clear that he wanted to return home.

Determining Deprivation of Liberty

From his admission to hospital and the first residential care placement it appears that Mr S was certainly at risk of deprivation of his liberty if not actually deprived of his liberty. No application was made at either provision and there was no indication that DoLS had been considered. The second residential placement put in an application for a DoLS authorisation as they felt that Mr S was at risk. This was assessed as being the case.

Outcome

During the DoLS assessments Mr S became anxious and distressed and this impacted upon his ability to make his own decisions regarding accommodation, care and treatment. The Best Interest Assessor (BIA) concluded that currently Mr S lacked capacity, and that in the very short term he should reside in the care home. However the BIA was of the view that residential care was not the least restrictive option that could be explored or made available, as Mr S had his own home and a support package could be commissioned to minimise the risk of harm. A package was therefore commissioned and Mr S returned home.

Conclusion

It would appear that both the hospital and first residential home assumed that decision making around restrictions i.e. the fact that Mr S was prevented from leaving and subject to sedative restraint and residency could be made under Section 4 of the Mental Capacity Act and as a consequence the DoLS were not considered. Following referral by the second residential placement the DoLS team asked Mr S's care team to apply the principles of best interests as specified in the Mental Capacity Act and to balance the risks and benefits of both care/support options. As a consequence Mr S's human rights were safeguarded and he was able to return home.

CASE STUDY 2

Background

Mrs H was previously the main carer for her husband, who died eight years previously after suffering with Alzheimer's disease. Two years later Mrs H was diagnosed with multi infarct dementia.

Mrs H's mental health deteriorated and her family struggled to support her at home. She presented as being frequently restless, repetitive in her communications and disorientated in time and place. Mrs H was admitted to hospital with general deterioration. She was experiencing increased confusion and had reduced mobility. Tests were completed, including a CT brain scan, and the results of these supported

a diagnosis of Alzheimer's disease. She was subsequently assessed as meeting the eligibility criteria for 100% Continuing Health Care (CHC) funding and was discharged to a care placement.

Once there she was resistive to care on a daily basis, becoming extremely distressed when approached, and requiring two members of staff for all care interventions. Mrs H also required close and ongoing supervision due to her tendency to self harm. Sedative medication was prescribed twice daily to try and help manage the behaviours associated with her mental health.

During the day Mrs H was predominantly nursed on her bed and appeared distressed on numerous occasions throughout the day and night. She frequently moved herself by rolling and fidgeting, resulting in her falling from the bed. As a result of this her bed was surrounded by mattresses and crash mats but she still sustained regular injuries. Staff monitored and observed her every 15 minutes and calming techniques were used to try and reduce her agitation and distress. They reported that it was not possible to help her to leave her room when she was agitated and as a result she spent most of the time in her bedroom. Various professionals had been involved in her care and treatment but with no clear plan about how to improve the situation.

Determining Deprivation of Liberty

Due to concerns that the restrictive practices used amounted to a Deprivation of Liberty, the care home issued an Urgent Authorisation and requested an assessment for a standard authorisation from the DoLS team.

The BIA concluded that Mrs H was deprived of her liberty, and that residing in a care home to receive care and treatment was in her best interests. The BIA felt that there needed to be further discussion with regard to Mrs H's circumstances and quality of life, with a particular focus on those elements of the care plan that could be reviewed with a view to lessening the restrictions and enhancing her quality of life.

With this in mind the Standard Authorisation had conditions attached to ensure the care home (Managing Authority) took relevant action to address these issues.

- Request that the CHC team organise Occupational Therapy assessments to reassess the bed provided for Mrs H and possible seating options.
- Refer to and liaise with the Care Home Dementia In-Reach Team.
- Keep more detailed records in order to fully assess Mrs H's care needs.
- Attempt to identify previous pastimes and hobbies with a view to occupying Mrs H thereby reducing distress levels.

The Standard Authorisation was granted for 3 months in order to allow adequate time for these conditions to be addressed.

Outcome

Occupational therapy assessments were undertaken and there have been review meetings with relevant professionals and family members. As a result of more detailed record keeping evidence was produced detailing the benefits of Mrs H being

able to access a specialist chair, and the need for additional equipment, specialist flooring and 1:1 support to enable her to access other parts of the home.

Conclusion

As a consequence Mrs H was now able to spend 2 hours daily in an appropriate chair with staff support, with a reduced risk of falls. She also responded positively to increased staff interaction and an activity programme.

The DoLS team intervention had therefore reduced the restrictive practices in place, thereby enhancing her dignity and quality of life.