Acacium Group

Mental Capacity Act 2005 (MCA) & Deprivation of Liberty Safeguarding Policy

Policy Reference | ORG 41

Version | V3.1

Policy Name	Mental Capacity Act 2005 (MCA)& Deprivation of Liberty Safeguarding Policy
Purpose of Document	This policy sets out how Accium Group will fulfil its duties and responsibilities effectively in relation to the Mental Capacity Act (MCA 2005) and to the Deprivation of Liberty Safeguards (DoLS 2009) and show how Acacium Group demonstrate understanding and compliance with this legislation.
Target Audience	Acacium Group Employees
Version	V3.1
Author	Anna Meakin
Date of Approval	November 2021
Published Date	November 2021
Lead Director	Karen Matthews Shard
Review Frequency	Annually
Last Reviewed	December 2023
Next Review Date	December 2024
Risk and Resource Implications	Training Resource Incompliance with legislation and statutory requirements.
Associated Strategies and SOPs	CLIN 06 Consent Policy CORP 10 Policy on Policies CLIN 08 Safeguarding and Protecting Children , England Wales, and NI CLIN 09 Safeguarding Adults at Risk Safeguarding Adults and Children – CHS Policy
Equality Impact Assessment (EIA) Form	Acacium Group is committed to Equality, Diversity and Inclusion and in line with our values, we strive to ensure that everyone that is part of the Acacium community is not disadvantaged or discriminated against given their individual need or characteristics. To support this, an Equality Impact Assessment has been undertaken on this policy/procedure. This information is held centrally and can be requested from the Clinical Governance Team.
About Acacium Group	Details of all Acacium Group trading companies that this policy applies to are detailed within Appendix A
Legislation	Legislation and Guidance pertinent to this policy can be found within Appendix B

Document History			
Version	**Date**	**Changes made/comments**	**By whom**
V1	Nov 2021	New Document	AM
V2	Nov 2022	Review and updated	Clinical Advisory Group
V3	Dec 2023	Review and updated	Clinical Advisory Group
V3.1	Jan 2024	Rebrand	Clinical Advisory Group

Table of Contents

1. Introduction

1.1 The Mental Capacity Act 2005 (the Act) came into force in 2007 and provides a legal framework for the care, treatment and support of people aged 16 years and over, in England and Wales, who are unable to make some or all decisions for themselves. Anyone supporting people who lack capacity must have regard to the Mental Capacity Act.

1.2 The Act is accompanied by a statutory Code of Practice which explains how the act will work on a day to day basis and provides guidance to all those working with, or caring for, people who lack capacity. As the code has statutory force, all staff who are employed in health and social care are legally required to 'have regard' to the MCA Code of Practice.

1.3 This policy should be read in conjunction with the Mental Capacity Act Code of Practice which can be accessed via the following link: https://www.gov.uk/government/publications/mentalcapacity-act-code-of-practice

1.4 An updated Code of Practice is expected however timescales for publication are unknown. It is important to note case law [A Local Authority v JB [2021] UKSC 52] which highlights an error in the current Code of Practice which guides people to start with the so-called 'diagnostic' element of the two stage functional test. The judge Lord Stephens was clear that the practitioner should first consider the person's functional ability – can the person make the decision with support? This re-ordering of the functional test has been reflected in a revised Court of Protection COP3 form.

2. Scope of Policy

2.1 The purpose of this policy is to outline the responsibilities of Acacium Group in applying the principles of the Mental Capacity Act across the services the Group provide and how this is communicated to all staff and workers within the Group , in England and Wales.

2.2 Please note that this policy will act as a complement to any pre existing NHS / Local Authority policy. For the purpose of procedural activity , all Acacium Group employees wil be directed in their action through the adoption of , and compliance with, the clients own local policy.

2.3 This to include (but not exhaustively)

- Mental Capacity assessment
- Best Interests Assessments
- Best Interests Decision Making
- Consent
- Completion of local documentation
- Liaison with local Safeguarding Stakeholders and Leads.

3. Definitions

Definition	Explanation
Mental Capacity (MCA)	A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain. An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

	• A stroke or brain injury • A mental health problem • Dementia • A learning disability • Confusion, drowsiness or unconsciousness because of an illness or treatment for it • A substance misuse
Court of Protection (COP)	The specialist Court for all issues relating to people who lack capacity to make specific decisions
Advance Decision To Refuse Treatment (ADRT)	A decision to refuse specified treatment made in advance by a person aged 18 or over who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment.
Decision Maker	the person responsible for deciding if the person has capacity to make a decision and if not, what is in their best interests. Can be any professional or informal carer.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them.
Deprivation of Liberty Safeguards (DoLS)	The procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.
Liberty Protection Safeguards (LPS):	In July 2018, the Government published a Mental Capacity (Amendment) Bill which will see DoLS replaced by the Liberty Protection Safeguards (LPS). Under LPS, there maybe a new streamlined process for authorising deprivations of liberty.
Lasting Power of Attorney (LPA)	An LPA covers decisions about and individuals' financial affairs, health and care. It comes into effect if there is a loss of mental capacity, or if the individual no longer want to make decisions for themselves
Enduring Power of Attorney (EPA)	EPAs were replaced by LPAs in October 2007. However, if an EPA was made and signed an EPA before 1 October 2007, it should still be valid. An EPA covers decisions about property and financial affairs, and it comes into effect if someone loses mental capacity, or if an individual wants someone to act on their behalf.

4. Roles & Responsibilities

4.1 The overall organisational roles and responsibilities are set out in the Acacium Group policy document Corp 10 Policy on Policies.

Job Title	Responsibilities
Global Clinical Director/Group Chief Nurses	Responsible for ensuring that all policies, standard operating procedures (SOPs), protocols, training, and competencies, are in place to support workers or care in the safe delivery of safe and effective care provision. The Global Clinical Director/Group Chief Nurses has specific responsibility to ensure the Group is upholding the principles of the MCA and their obligations in respect of the MCA and in relation to any Deprivation of Liberty.

Staff Members	Professionally qualified Acacium Group staff members have additional responsibilities to ensure their learning and development regarding the MCA and DoL is kept up to date and they apply their learning to their practice. Any employee working directly with people who may lack capacity must be aware of their obligations and understanding in relation to the MCA and the MCA Policy, seeking further direction from their line manager if necessary.
Divisional line managers	Acacium Group Divisional line managers have a responsibility to ensure that staff and workers have the appropriate training and understanding to carry out their roles in line the MCA Policy.
Clinical Advisory Group (CAG)	Review polices and clinical documents for the Group in order to safeguard and improve quality in line with the Groups vision, strategic aims and in a context in which diversity is recognised and widely celebrated

5. Mental Capacity Act 2005 (MCA)

5.1 **Mental Capacity Act Principles**

5.2 The Act sets out 5 statutory principles:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help themdo so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

5.3 Before a decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

5.4 These principles must be considered and followed in every instance when working with someone who may lack capacity to make a decision or decisions for themselves.

5.5 The MCA provides legal protection from liability for carrying out certain actions in connection with care and treatment of people, provided that:

- You have observed the principles of the MCA
- You have carried out and recorded an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in question.
- You reasonably believe the action you have taken is in the best interests of the person.

5.6 Provided you have complied with the MCA in assessing capacity and acting in the person's best interests you will be able to diagnose and treat patients who do not have the capacity to give their consent, if this is within your scope of practice . For example (not an exhaustive list):

- Diagnostic examinations and tests
- Assessments
- Medical and dental treatment
- Psychological treatments
- Surgical procedures

- Admission to hospital for assessment or treatment (except for people detained under the Mental Health Act 2007 (MHA))
- Nursing care
- Emergency procedures – in emergencies it will often be in a person's best interests for you to provide urgent treatment without delay
- Placements in residential care

5.7 The Mental Capacity Act applies to all people over the age of 16, with the exception of making a lasting power of attorney (LPA); making an advance decision to refuse treatment (ADRT) and making a will; in these situations, a person must be aged 18 or over.

5.8 The Independent Mental Capacity Advocate (IMCA)

5.9 Advocacy is taking action to help people:

- Express their views
- Secure their rights
- have their interests represented
- access information and services
- explore choices and options

5.10 An IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker.

5.11 Referrals to an IMCA must be considered when:

- There needs to be a decision relating to serious medical or psychological treatment.
- Changes in long-term care (more than 28 days in a hospital or 8 weeks in a care home)
- A long-term move to different accommodation is being considered for a period of over 8 weeks.
- Care Reviews take place – if the IMCA would provide a particular benefit e.g. continuous care reviews about accommodation or changes to accommodation.
- Adult protection cases take place even if befriended.

6. The Office of the Public Guardian (OPG)

6.1 The Office of the Public Guardian in England and Wales is a government body that, within the framework of the Mental Capacity Act 2005, polices the activities of deputies, attorneys and guardians who act to protect the financial affairs of people who lack the mental capacity for making decisions about such things.

6.2 Further information regarding the Office of the Public Guardian can be found by the following link: http://www.publicguardian.gov.uk/

7. The Court of Protection (COP)

7.1 This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so.

7.2 The Act provides for a COP to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) that lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges, and authority in relation to mental capacity

matters as the High Court. It is a superior court of record and is able to set precedents (i.e. set examples to follow in future cases).

7.3 The Court of Protection has the powers to:

- decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions, or orders on financial or welfare matters affecting people who lack capacity to make such decisions.
- appoint deputies to make decisions for people lacking capacity to make those decisions.
- decide whether an LPA or EPA is valid; and remove deputies or attorneys who fail to carry out their duties, and hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid.

7.4 Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link: http://www.hmcourts-service.gov.uk/HMCSCourtFinder/

8. Advance Decisions to Refuse Treatment (ADRT)

8.1 People may have given advance decisions regarding health treatments, which will relate mainly to medical decisions. These may well be lodged with the person's GP and are legally binding if made in accordance with the Act.

8.2 Making an advance decision to refuse treatment over the age of 18 years allows particular types of treatment you would never want, to be honoured in the event of losing capacity – this is legally binding and doctors etc. must follow directions.

8.3 Life sustaining advance decisions must:

- Be in writing
- Contain a specific statement, which says your decision applies even though your life may be at risk.
- Signed by the person or nominated appointee and in front of a witness
- Signed by the witness in front of the person

8.4 This does not change the law on euthanasia or assisted suicide. You cannot ask foran advance decision to end your life or request treatment in future.

8.5 To establish whether an advance decision is valid and applicable the healthcare professional must try to find out if the person.

- Has done anything that clearly goes against their advance decision.
- Has changed their mind and withdrawn their decision
- Has subsequently conferred the power to make that decision on an attorney,
- Would have changed their decision if they had known more about the current circumstances.

9. Lasting Power of Attorney (LPA)

9.1 This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future.

9.2 This has far reaching effects for healthcare workers because the MCA extends the way people using services can plan ahead for a time when they lack capacity.

9.3 These are Lasting Powers of Attorney (LPAs), advance decisions to refuse treatment and written statement of wishes and feelings. LPAs can be friends, relatives or a professional for:

- Property and affairs LPA re financial and property matters
- Personal Welfare LPA re decisions about health and welfare, where you live day to day care or medical treatment.

9.4 An LPA can only act within the remit of their authority.

- Enduring Powers of Attorney (EPAs) will continue whether registered or not.
- When a person makes an LPA, they must have the capacity to understand the importance of the document.
- Before an LPA can be used it must be registered with the Office of the Public Guardian.
- An LPA for property and affairs can be used when the person still has capacity unless the person (donor) specifies otherwise.
- A personal welfare attorney will have no power to consent to, or refuse treatment whilst a person has the capacity to decide for themselves.
- If a person is in your care and has an LPA, the attorney will be the decision maker on all matters relating to a person's care and treatment.
- If the decision is about life sustaining treatment the attorney will only have the authority to make the decision if the LPA specifies this.
- If you are directly involved in care or treatment of a person you should not agree to act as an attorney.
- It is important to read the LPA to understand the extent of the attorney's power.

10. Assessing and Assumption of Capacity

10.1 It is recognised that a number of different professionals are involved with persons who may lack capacity and in certain circumstances may be required to make decisions on their behalf.

10.2 The extent to which expert input is required, and the degree to which detailed recording is necessary, depends on the nature of the decisions being made. Some decisions will be day to day, such as what to wear, and other decisions many have more lasting or serious consequences such as a change of accommodation.

10.3 It is important to show that in assessing capacity you,

- Have enabled a person, so far as is possible, to make their own decisions,
- Have followed the five key principles which must inform everything you do when providing care or treatment for a person who lacks capacity,
- Have taken reasonable steps to establish lack of capacity,
- Have reasonable belief that the person lacks capacity and have recorded the reasons why you believe this.
- Have demonstrated the action will be in the person's best interest.

10.4 When a person is in your care and needs to make a decision you must assume that person has capacity and make every effort to support and encourage the person to make the decision themselves. Also remember that people can make unwise or eccentric decisions, but this does not mean they lack capacity. Every effort must be made to encourage and support a person to make a decision for themselves.

10.5 When there is reason to believe a person does lack capacity at this time consider:

- Has everything been done to help and support the person?
- Does the decision need to be made without delay?
- Is it possible to wait until the person has the capacity to decide?

10.6 If the person's ability to make a decision still seems questionable then you will need to assess and record capacity, considering the following:

10.7 Does the person have an impairment of, or a disturbance in the functioning of their mind or brain?

10.8 Examples may include the following:

- Dementia
- Learning disability,
- Brain damage,
- Delirium,
- Concussion,
- Symptoms of drug or alcohol use.
- Physical, psychological or medical conditions that cause confusion, drowsiness, or loss of consciousness.

10.9 If no impairment is present, then the person cannot lack capacity under The Act.

10.10 When all practical and appropriate support to help the person make the decision has failed, a person is unable to make a decision if they cannot:

1. Understand information about the decision to be made (the Act calls this relevant information).
2. Retain that information in their mind (long enough to make an effective decision)
3. Use or weigh that information as part of the decision-making process, or
4. Communicate their decision (by talking, using sign language or any other means)

11. Fluctuating Capacity

11.1 Some people may at times be able to make their own decisions but have an impairment of the mind or brain which affects their decision-making ability at other times. Where there is fluctuating or temporary loss of capacity, an assessment of capacity has to be made at the time the decision has to be made.

11.2 If it is possible, the decision should be delayed until the person has recovered and regained their capacity to make that specific decision.

11.3 In emergency medical situations urgent decisions will have to be made and immediate action taken in the person's best interest, for example, cardiac arrest, head injury etc. Even in emergency situations, the person caring should try to communicate with the person and keep them informed of what is happening.

12. Decision Making

12.1 The person responsible for undertaking the capacity test is the Decision Maker. The person who assesses a person's capacity to make a decision will usually be the person who is directly concerned with that person at the time the decision needs to be made. It should be the most appropriate person in relation to the type of decision involved. This means that different people will be involved in assessing a person's capacity at different times and for the CCG they will be a qualified professional as follows:

- Qualified Nurses
- Physiotherapists

- Occupational Therapists
- Other Allied Health Professionals
- GPs
- Psychologists or psychiatrists

12.2 However, if a person has a Lasting Power of Attorney or Court Deputy then that person would act as the decision maker within the remit of their legal powers. For example finance and property or health and welfare or both if stated.

12.3 You must always follow the five key principles of the MCA in any decision-making and assess at a person's best level of functioning for the decision to be taken. See Section 2 of this policy document.

12.4 The MCA states that "assessment of capacity to take day to day decisions or consent to care, require no formal assessment procedures". However, although day to-day assessments of capacity may be informal, they should still be written down by staff. Therefore, if an employee's decision is challenged, they must be able to describe why they had a reasonable belief of a lack of capacity. Therefore, recording should always be inserted within a patient's case notes or care plan.

12.5 In relation to more complex decisions involving perhaps a life changing decision it is essential that there is evidence of a formal, clear, and recorded process. In order to achieve this Record of Capacity Test and Best Interests Assessment form (MCA 1) must be completed – this should be obtained via the relevant NHS/Social Services team for the client's location and completed in collaboration with other professional involved in the individual's care.

12.6 **Decisions to refuse medical treatment for children and young people**

12.6.1 The Mental Capacity Act applies to young people from the age of 16. The law does not provide for young people (until the age of 18) to make legally binding advance decisions to refuse medical treatment. If a young person (as any person), has capacity to decide whether to consent to treatment, they are entitled to refuse treatment. Parental consent should not be relied upon to overrule the refusal of a young person. The Mental Health Act or the Family Division of the High Court may provide legal recourse depending on the individual situation.

12.6.2 If a young person lacks capacity to make the decision, then a decision will need to be made in their best interest according to the principles of the Act. If the young person has recorded their wishes at a time when they had capacity, this should be treated as a written statement of wishes and feelings to be considered as part of any best interest decision. The Court of Protection can make declarations or orders in relation to the health, welfare, property or affairs of young people who lack mental capacity to make the relevant decision themselves. Refer to Acacium Group Consent Policy for further guidance.

13. Best Interests Assessment

13.1 If a person has been assessed as lacking capacity to make that decision then the decision made for, or on behalf of, that person, must be made in his or her best interests. A best interest's decision must be objective; it is about what is in the person's best interests and not the best interests of the decision maker.

13.2 The decision maker must weigh up all the factors involved, consider the advantages and disadvantages of the proposals and determine which course of action is the least restrictive for the person involved. This includes consideration of restriction or deprivation of liberty.

13.3 By best interests we mean:

- The decision maker has considered all relevant circumstances, including any written statements made while the patient had capacity must also be taken into account and any other information relevant to this decision
- Equal consideration and non-discrimination - not to make an assumption that a decision is made merely on the basis of a person's age or condition,
- The decision maker has considered whether the person is likely to regain capacity – can the decision be put off until then?
- Permitting and encouraging participation - the person has been involved as fully as possible in the decision, with the appropriate means of communication or using other people to help the person participate in the decision making process. Healthcare professionals are therefore required to make enquiries of relatives, carer's and friends of the person.

13.4 Consideration must be given as far as reasonably ascertainable to the person's past and present wishes and feelings, and the beliefs, values and any other factors that would be likely to be taken into account if the person had capacity, and to take into account, if practicable and appropriate the views of people who have formally or informally been involved with, or named by, the incapacitated person.

13.5 When determining someone's best interests you must be able to demonstrate:

- That you have carefully assessed any conflicting evidence and
- Provide clear, objective reasons as to why you are acting in the person's best interests

13.6 As far as possible try to ascertain:

- Has the person set out their views in a document, appointed a person to act on their behalf, or do they have friends or family involved in their care?
- If practicable and appropriate you must consult with, and take into account, the views of the following:
    - A Nominated Person
    - Lasting Power of Attorney appointed
    - Enduring Power of Attorney appointed
    - Court Appointed Deputy
    - Other persons engaged in caring for, or interested in, the person

13.7 A Best Interest Meeting will need to be arranged with the relevant consultees.

13.8 Challenging the Result of an Assessment of Capacity or Best Interests Decision.

13.9 Any assessment of capacity may be challenged. It is important that everything is carefully documented.

13.10 It may be challenged in the following ways

- Raised directly with the assessor
- Request for a second opinion
- Involving an advocate – NOT an IMCA
- Complaints procedure
- Court of Protection

13.11 However, every effort should be made to resolve disagreements as informally as possible.

14. Deprivation of Libery Safeguards (DOLs)

14.1 Article 5 of the Human Rights Act 1998 https://www.equalityhumanrights.com/en/human-rights/human-rights-act states that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'. The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

14.2 DoLS ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and, in the person's, best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS.

14.3 Those affected by the DoLS will include people with a "mental disorder", as defined within the Mental Health Act (1983) (2007), who lack the capacity to make informed decisions about arrangements for their care or treatment.

14.4 The DoLS clarify that a person may be deprived of their liberty:

- If they lack the mental capacity to consent to their accommodation and care plans, and;
- It is in their own best interests to protect them from harm, and;
- It is a proportionate response to the likelihood and seriousness of the harm, and;
- It is the least restrictive way of meeting their needs safely.
- The DoLS process only applies to people in care homes or hospital. If the Deprivation of Liberty is in another setting such as supported living or client's home, this requires a application to the Court of Protection. This also applies to 16 and 17 year olds.

14.5 For a person to qualify as being deprived of their liberty, they must;

- Lack the mental capacity to consent to the relevant care and support arrangements, where they have been put in place by the State.

14.6 And be:

- subject to continuous supervision and control
- And not free to leave.

14.7 Liberty Protection Safeguards

14.7.1 ***In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards. The implementation has been postponed beyond the life of the currect parliament.***

15. Associated Policies / SOPs

Policies

CLIN 06 Consent Policy
CLIN 08 Safeguarding and Protecting Children, England Wales, and NI
CLIN 09 Safeguarding Adults at Risk
CORP 10 Policy on Policies
Safeguarding Adults and Children – CHS Policy

16. References

- Mental Capacity Act
  http://www.legislation.gov.uk/ukpga/2005/9/contents
- Mental Capacity Act Code of Practice
  https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Deprivation of Liberty Safeguards Code of Practice
  http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
- Mental Capacity Act 2005: A guide for clinical commissioning groups and other commissioners of healthcare services on Commissioning for Compliance
  https://www.england.nhs.uk/wp-content/uploads/2014/09/guide-for-clinical-commissioning.pdf
- Mental Capacity Law: A brief guide to carrying out capacity assessments
  http://www.39essex.com/content/wp-content/uploads/2016/08/Capacity-Assessments-GuideAugust-2016.pdf
- Mental Capacity Law: A brief guide to carrying out best interests' assessments
  http://www.39essex.com/content/wp-content/uploads/2016/08/Best-Interests-AssessmentsGuide-August-2016.pdf
- Deprivation of liberty: a practical guide
  http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/
- Court of Protection
  https://www.gov.uk/court-of-protection
- Social Care Institute for Excellence MCA directory
  http://www.scie.org.uk/mca-directory
- Lasting Power of Attorney
  https://www.gov.uk/make-decisions-for-someone
- Human Rights Act 1998
  https://www.equalityhumanrights.com/en/human-rights/human-rights-act
- The Mental Capacity Act: Code of Practice
  https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice
- Deprivation of Liberty Safeguards (DoLS): Code of Practice
- http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476
- Decision making and mental capacity Quality standard [QS194]Published:11 August 2020
  https://www.nice.org.uk/guidance/qs194
- Assisted Decision-Making (Capacity) Act 2015
- https://www.hse.ie/eng/about/who/national-office-human-rights-equality-policy/assisted-decision-making-capacity-act/assisted-decision-making-act-copy.pdf

Appendix A: About Acacium Group

Acacium Group consists of a number of trading companies, each providing services within core niche areas of the health and social care industries. Therefore, as this document is a Group Policy, the Policy herein applies to all trading companies detailed below:

GP World Part of Acacium Group	pulse Part of Acacium Group	Proclinical Part of Acacium Group
Bank partners	espirita	INGAGE multistaffing | one solution
Liquid Healthcare Part of Acacium Group	Thornbury Nursing Services Part of Acacium Group	Scottish Nursing Guild Part of Acacium Group
Thornbury Community Services Part of Acacium Group	Hobson Prior Part of Acacium Group	maxxima Part of Acacium Group
xyla health & wellbeing Part of Acacium Group	xyla health & social services Part of Acacium Group	xyla elective care Part of Acacium Group
xyla digital therapies Part of Acacium Group	CHS Healthcare Part of Acacium Group	DRA DUNN REGULATORY ASSOCIATES Part of Acacium Group

Appendix B: Legislation

1. This Policy is supported by legislation and national guidance as set out in the table below.

   National policies, guidance, and legislation, supporting reporting and managing incidents.

Act, policy, guidance	Explanation
Health & Safety at Work Act 1974	The Health & Safety at Work Act 1974 requires that all organisations with more than three staff have in place processes to promote the health and safety of their staff.
Control of Substances Hazardous to Health (COSHH) Regulations 2002	Latex is classed as a hazardous substance which is covered by the Health and Safety Executive's Control of Substances Hazardous to Health (COSHH) Regulations 2002. Under the regulations, organisations have a duty to assess the risk, eliminate, substitute, and limit and control exposure to latex, unless there is a need to use it.
RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995	There is a requirement to report diagnosed cases of Occupational dermatitis (schedule 3) to RIDDOR (The Reporting of Injuries, Diseases and Dangerous Occurrences) Regulations 1995.

2. **Equality and diversity**
   Under the Race Relation (Amendment) Act 2000 Acacium Group has a statutory duty to 'set out arrangements to assess and consult on how their policies and functions impact on race equality', in effect to undertake Equality Impact Assessments (EIA) on all policies and SOPs. The Equality Act October 2010 demands a similar process of Equality Impact Assessment in relation to disability. An EAI must be completed by the author of this policy using the checklist provided in Appendix A. See also Acacium Group Equality and Diversity policy.