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| Case ID Number: Click here to enter text.  |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 3****AGE, MENTAL CAPACITY, NO REFUSALS, BEST INTERESTS ASSESSMENTS****AND SELECTION OF REPRESENTATIVE** |
| This combined form contains 4 separate assessments and includes selection of representative. If any assessment is negative there is no need to complete the others unless specifically commissioned to do so by the Supervisory Body. |
| **Please indicate which assessments have been completed***(\*Supervisory Bodies will vary in practice as to who completes the Mental Capacity Assessment)* |
| Age |[ ]  Mental Capacity\* |[ ]  No Refusals |[ ]  Best Interests |[ ]
| This form is being completed in relation to a request for a Standard Authorisation |[ ]
| This form is being completed in relation to a review of an existing Standard Authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005. |[ ]
| Full name of the person being assessed | Click here to enter text. |
| Date of birth *(or estimated age if unknown)* | Click here to enter text. | Est. Age | Click here to enter text. |
| This also constitutes the Age Assessment. If there is any uncertainty regarding the person’s age, please provide additional information at the end of the form. |
| Name and address of the care home or hospital in which the person is, or may become, deprived of liberty | Click here to enter text. |
| Name of the Assessor | Click here to enter text. |
| Address of the Assessor | Click here to enter text. |
| Profession of the Assessor | Click here to enter text. |
| Name of the Supervisory Body | Click here to enter text. |
| The present address of the person if different from the care home or hospital stated above. |   |

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| **In carrying out this assessment I have met or consulted with the following people** |
| **NAME** | **ADDRESS** | **CONNECTION TO PERSON BEING ASSESSED**  |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **The following interested persons have not been consulted for the following reasons** |
| **NAME** | **REASON** | **CONNECTION TO THE PERSON BEING ASSESSED** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **I have considered the following documents** *(e.g. current care plan, medical notes, daily record sheets, risk assessments)* |
| **DOCUMENT NAME** | **DATED** |
| Click here to enter text. | Click here to enter text. |

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| **MENTAL CAPACITY ASSESSMENT** |
| The following practicable steps have been taken to enable and support the person to participate in the decision making process:Click here to enter text. |
| In my opinion the person **LACKS** capacity to decide whether or not they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment, and the person is unable to make this decision because of an impairment of, or a disturbance in the functioning of, the mind or brain. |[ ]
| In my opinion the person **HAS** capacity to decide whether or not they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment |[ ]
| **Stage One:** What is the impairment of, or disturbance in the functioning of the mind or brain? |
| Click here to enter text. |
| **Stage Two:** Functional test  |
| 1. **The person is unable to understand the information relevant to the decision**

 *Record how you have tested whether the person can understand the information, the questions used, how you presented the information and your findings.*Click here to enter text. | [ ]  |
| 1. **The person is unable to retain the information relevant to the decision**

 *Record how you tested whether the person could retain the information and your findings. Note that a person’s ability to retain the information for only a short period does not prevent them from being able to make the decision.*Click here to enter text. | [ ]  |
| 1. **The person is unable to use or weigh that information as part of the process of**

 **making the decision** *Record how you tested whether the person could use and weigh the information and your findings.*Click here to enter text. | [ ]  |
| 1. **The person is unable to communicate their decision (whether by talking, using**

**sign language or any other means)***Record your findings about whether the person can communicate the decision.*Click here to enter text. | [ ]  |
| **Stage Three:** *Explain why the person is unable to make the specific decision because of the impairment of, or disturbance in the functioning of, the mind or brain.* |
| Click here to enter text.  |

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| **NO REFUSALS ASSESSMENT** |
| To the best of my knowledge and belief the requested Standard Authorisation **would not** conflict with an Advance Decision to refuse medical treatment or a decision by a Lasting Power of Attorney, or Deputy, for Health and Welfare. | [ ]  |
| To the best of my knowledge and belief the requested Standard Authorisation **would** conflict with an Advance Decision to refuse medical treatment or a decision by a Lasting Power of Attorney, or Deputy, forHealth and Welfare. |[ ]
| *Please describe further:*Click here to enter text.  |
| There is not a valid Advance Decision, Lasting Power of Attorney or Deputy for Healthand Welfare in place |[ ]

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| **BEST INTERESTS ASSESSMENT**  |
| **MATTERS THAT I HAVE CONSIDERED AND TAKEN INTO ACCOUNT** |
| I have considered and taken into account the views of the relevant person |[ ]
| I have considered what I believe to be all of the relevant circumstances and, in particular, the matters referred to in section 4 of the Mental Capacity Act 2005 |[ ]
| I have taken into account the conclusions of the mental health assessor as to how the person’s mental health is likely to be affected by being deprived of liberty |[ ]
| I have taken into account any assessments of the person’s needs in connection with accommodating the person in the hospital or care home |[ ]
| I have taken into account any care plan that sets out how the person’s needs are to be metwhile the person is accommodated in the hospital or care home |[ ]
| In carrying out this assessment, I have taken into account any information given to me, or submissions made, by any of the following:1. any relevant person’s representative appointed for the person
2. any donee of a Lasting Power of Attorney or Deputy
3. any IMCA instructed for the person in relation to their current or proposed deprivation of liberty
 |[ ]
| **BACKGROUND INFORMATION***Background and historical information relating to the current or potential deprivation of liberty.**For a review look at previous conditions and include comments on previous conditions set.*Click here to enter text. |
| **VIEWS OF THE RELEVANT PERSON***Provide details of their past and present wishes, values, beliefs and matters they would consider if able to do so:*Click here to enter text. |
| **VIEWS OF OTHERS**Click here to enter text. |

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| **THE PERSON IS DEPRIVED OF THEIR LIBERTY** In my opinion the person is, or is to be, kept in the hospital or care home for the purpose of being given the relevant care or treatment in circumstances that deprive them of liberty**Note:** *if the answer is No then the person does not satisfy this requirement* | **YES** |[ ]
|  | **NO** |[ ]
| **The reasons for my opinion:****Note:** *Consider the concrete situation of the person including type, duration, effects and manner of implementation of the measures in question in order to determine whether they meet the acid test of continuous (or complete) supervision AND control AND are not free to leave.* Click here to enter text.Objective***:*** *Applying the acid test should provide evidence of confinement in a particular restricted space for more than a negligible period of time. Refer to the descriptors in the DoLS Code of Practice in light of the acid test.*Click here to enter text.Subjective: *Evidence that the person lacks capacity to consent to being kept in the hospital or care home for the purpose of being given the relevant care or treatment.* Click here to enter text.The placement is imputable to the State because:Click here to enter text. |
| **It is necessary to deprive the person of their liberty in this way in order to prevent harm to the person.** The reasons for my opinion are: | **YES** |[ ]
|  | **NO** |[ ]
| *Describe the risks of harm to the person that could arise which make the deprivation of liberty necessary. Support this with examples and dates where possible. Include severity of any actual harm and the likelihood of this happening again.*Click here to enter text. |
| **Depriving the person of their liberty in this way is a proportionate response to the likelihood that the person will otherwise suffer harm and to the seriousness of that harm.** The reasons for my opinion are: | **YES** |[ ]
|  | **NO** |[ ]
| *With reference to the risks of harm described above explain why deprivation of liberty is justified. Detail how likely it is that harm will arise (i.e. is the level of risk sufficient to justify a step as serious as depriving a person of liberty?). Why is there no less restrictive option? What else has been explored? Why is depriving the person of liberty a proportionate response to the risks of harm described above?*Click here to enter text. |

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| **This is in the person’s best interests.** **Note:** *you should consider section 4 of the Mental Capacity Act 2005, the additional factors referred to in paragraph 4.61 of the Deprivation of Liberty Safeguards Code of Practice and all other relevant circumstances. Remember that the purpose of the person’s deprivation of liberty must be to give them care or treatment. You must consider whether any care or treatment can be provided effectively in a way that is less restrictive of their rights and freedom of action. You should provide evidence of the options considered. In line with best practice this should consider not just health related matters but also emotional, social and psychological wellbeing.* | **YES** | [ ]  |
| **NO** | [ ]  |
| The reasons for my opinion are:Click here to enter text.After giving your reasons above you should now carry out analysis of the benefits and burdens or each option identified**.****Option 1:**Benefits:Click here to enter text.Burdens:Click here to enter text.**Option 2:**Benefits:Click here to enter text.Burdens:Click here to enter text.*(Repeat process if there are more options)* |

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| **BEST INTERESTS REQUIREMENT IS NOT MET*****This section must be completed if you decided that the best interests requirement is not met.*** |
| For the reasons given above, it appears to me that the person **IS, OR IS LIKELY TO BE,** deprived of liberty but this is not in their best interests. In my view, the deprivation of liberty under the Mental Capacity Act 2005 is not appropriate. Consequently, unless the deprivation of liberty is authorised by the Court of Protection or under another statute, the person is, or is likely to be, subject to an unauthorised deprivation of liberty. |[ ]
| A Safeguarding Adult enquiry must be considered for any unauthorised deprivation of liberty.Please place a cross in the box if a referral has been made.Date of Referral: Click here to enter a date. |[ ]
| *Please offer any suggestions that may be beneficial to the Safeguarding Adult process, commissioners and / or providers of services in deciding on their future actions or any others involved in the resolution process.*Click here to enter text. |
| **BEST INTERESTS REQUIREMENT IS MET** ***The maximum authorisation period must not exceed one year*** |
| In my opinion, the maximum period it is appropriate for the person to be deprived of liberty under this Standard Authorisation is: Click here to enter text.  **The reasons for choosing this period of time are:** *Please explain your reason(s)*Click here to enter text.**DATE WHEN THE STANDARD AUTHORISATION SHOULD COME INTO FORCE** I recommend that the Standard Authorisation should come into force on:Click here to enter a date.  |
| *In my opinion* **THE PURPOSE OF THE AUTHORISATION** *is to enable the following care or treatment to be given in the hospital or care home.* |
| Click here to enter text. |

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| **RECOMMENDATIONS AS TO CONDITIONS (Not applicable for review)****Choose ONE option only** |
| I have no recommendations to make as to the conditions to which any Standard Authorisation should or should not be subject (proceed to the ***Any Other Relevant*** information section of this form). |[ ]
| I recommend that any Standard Authorisation should be subject to the following conditions |[ ]
| 1 | Click here to enter text. |
| 2 | Click here to enter text. |
| 3 | Click here to enter text. |
| 4 | Click here to enter text. |
| **RECOMMENDATIONS AS TO VARYING ANY CONDITIONS (Review only)****Choose ONE option only** |
| The exisiting conditions are appropriate and should not be varied |[ ]
| The existing conditions should be varied in the following way: |[ ]
| 1 | Click here to enter text. |
| 2 | Click here to enter text. |
| 3 | Click here to enter text. |
| 4 | Click here to enter text. |
| **SHOULD ANY RECOMMENDED CONDITIONS NOT BE IMPOSED**: |
| I would like to be consulted again, since this may affect some of the other conclusions that I have reached in my assessment. |[ ]
| I do not need to be consulted again, since I do not think that the other conclusions reached in this assessment will be affected. |[ ]
| **ANY OTHER RELEVANT INFORMATION***Please use the space below to record any other relevant information, including any additional conditions that should or should not be imposed and any other interested persons consulted by you.* |
| Click here to enter text. |
| **RECOMMENDATIONS, ACTIONS AND / OR OBSERVATIONS FOR CARE MANAGER / SOCIAL WORKER / COMMISSIONER / HEALTH PROFESSIONAL** |
| Click here to enter text. |
| **SELECTION OF REPRESENTATIVE– *place a cross in one box****(Note that the Best Interests Assessor must confirm below whether the proposed representative is eligible before recommending them )* |
| The relevant person has capacity to select a representative and wishes to do so. **Name of person selected**: |[ ]
| The relevant person who lacks capacity to select a representative but has a Lasting Power of Attorney, or Deputy, for Health and Welfare, this decision is within the scope of their authority and they have selected the following person **Name of person selected**:  |[ ]
| Neither the relevant person nor their Donee or Deputy wish to, or have the authority to, select a representative and therefore the Best Interests Assessor will select and recommend a representative. |[ ]
| **RECOMMENDATION OF REPRESENTATIVE** –*place a cross in one box* |
| I recommend that the Supervisory Body appoints the representative selected by the relevant person above and confirm that they are eligible and would in my opinion maintain contact with the person, represent and support them in matters relating to or connected with the Standard Authorisation if appointed*.* (*Read guidance notes for clarification of eligibility)* |[ ]
| I have selected and recommend that the Supervisory Body appoints the representative identified below. In so doing I confirm that:* the person this assessment is about (who may have capacity but does not wish to select a representative) and / or their Donee or Deputy does not object to my recommendation;
* the proposed representative agrees to act as such, is eligible, and would in my opinion maintain contact with the person, represent and support them in matters relating to or connected with the Standard Authorisation if appointed*.* (*Read guidance notes for clarification of eligibility).*
 |[ ]
| Please tick this box if this section is being completed because an existing representative’s appointment has been terminated before it was due to expire and it is necessary for the Supervisory Body to appoint a replacement | [ ]  |
| Full name of recommended representative  | Click here to enter text. |
| Their address | Click here to enter text. |
| Telephone number(s) | Click here to enter text. |
| Relationship to the relevant person | Click here to enter text. |
| Reason for selection | Click here to enter text. |
| **If you are not able to name a representative please place a cross in the box and record your reason below** | [ ]  |
| **PLEASE NOW SIGN AND DATE THIS FORM** |
| Signed | Click here to enter text. | Date | Click here to enter a date. |
| Print Name | Click here to enter text. | Time | Click here to enter text. |