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| Case ID Number: | | | | | | | | | | |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1**  **REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION** | | | | | | | | | | |
| Request a **Standard Authorisation** only **(*you DO NOT need to complete pages 6 or 7)*** | | | | | | | | | |  |
| Grant an **Urgent Authorisation** ***(please ALSO complete pages 6 and 7 if appropriate/required)*** | | | | | | | | | |  |
| Full name of person being deprived of liberty | |  | | | | | | Sex | | |
| Date of Birth *(or estimated age if unknown)* | |  | | | | | | Est. Age | | |
| Relevant Medical History (*including diagnosis of mental disorder if known*) | | | | | | | | | | |
| Sensory Loss |  | | | Communication  Requirements | |  | | | | |
| Name and address of the care home or hospital requesting this authorisation | | | |  | | | | | | |
| Telephone Number | |  | | | | | | | | |
| Person to contact at the care home or hospital, (including ward details if appropriate) | | Name | |  | | | | | | |
| Telephone | |  | | | | | | |
| Email | |  | | | | | | |
| Ward (if appropriate) | |  | | | | | | |
| Person being deprived of their liberty home address (before moving into hospital/care home) | |  | | | | | | | | |
| Telephone Number | |  | | | | | | | | |
| Name of the Supervisory Body where this form is being sent | | |  | | | | | | | |
| How the care is funded | | | Local Authority *please specify* | |  | | | | | |
| NHS | |  | | Local Authority and NHS (jointly funded) | |  | |
| Self-funded by person | |  | | Funded through insurance or other | |  | |

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| **REQUEST FOR STANDARD AUTHORISATION** | |
| **THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED:**  *If standard only – within 28 days*  *If an urgent authorisation is also attached – within 7 days* |  |
| **Please provide details around the person’s care and/ or treatment arrangements:**  **Please indicate Yes/ No as appropriate to the following statements and add further detail as requested.** | |
| Please confirm the date the capacity assessment was undertaken concluding the person **lacks** capacity to make decisions about their care and accommodation. | DD/MM/YY |
| When did the person arrive at the care home or hospital setting? |  |
| Do they have a home in the community? | *Yes / No* |
| Is a member of staff always aware of the person’s whereabouts? | *Yes / No* |
| Does the person require prompting to carry out activities such as personal care? | *Yes / No* |
| *If yes, how many staff support with these interventions and how does the person respond:* | |
| Does the person have any 1:1 support? | *Yes/ No* |
| *If yes, how many hours and at what times:* | |
| Is the person administered any medications that may act as a sedative? | *Yes/ No* |
| *If yes, please list these and the dosages:* | |
| Is the person administered any medication covertly? | *Yes/ No* |
| *If yes, please list these:* | |
| Is the person able to mobilise independently? | *Yes/ No* |
| *If no; what support is required?* | |
| Do they have access to the outside? | *Yes/ No* |
| Are bed rails in place? | *Yes/ No* |
| Are sensor mats in place? | *Yes/ No* |
| Do friends/family visit keep in contact with the person? | *Yes/ No* |
| *If yes; how often? Do they visit regularly or telephone?* |  |

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| **ADDITIONAL COMMENTS** |
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| **Please indicate if any of the following apply:**  **Place a cross in the box below.** | | | |
| ***Objection from relevant person:*** Verbal and/or physical (asking to leave, trying to leave, demonstrating unhappiness about being there, distress, strong resistance to care. | | |  |
| ***Objection from family/friend:*** Indicating that they were not involved in the decision making, indication they are unhappy with the placement. | | |  |
| ***Restrictions on family/friend contact:*** Restrictions within or outside the placement. Restricted areas in the home e.g. not allowed in the persons room. Restrictions on taking the person out. | | |  |
| ***Possible challenge to the Court of Protection:*** Notification from solicitor or legal department, awareness of Social Worker taking a care issue to court e.g. safeguarding concern preventing a person going home. | | |  |
| ***Behaviour requiring significant restrictions*:** Challenging behaviour, restrictions to care, use of bucket chair, lap strap, medication: covert, sedative, mood and/or behaviour controlling, PRN medication, confinement to a particular part of the placement, physical restraint. | | |  |
| ***Concerns:*** The placement may not be suitable and therefore not in the person’s best interests. | | |  |
| ***Unmet conditions (Only required for an Authorisation renewal request):*** Which significantly impact on the person and would mean the arrangements are no longer in the person’s best interests | | |  |
| **INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT** | | | |
| Family member or friend | Name |  | |
| Address |  | |
| Telephone |  | |
| Anyone named by the person as someone to be consulted about their welfare | Name |  | |
| Address |  | |
| Telephone |  | |
| Anyone engaged in caring for the person or interested in their welfare | Name |  | |
| Address |  | |
| Telephone |  | |
| Any donee of a Lasting Power of Attorney granted by the person | Name |  | |
| Address |  | |
| Telephone |  | |
| Any Personal Welfare Deputy appointed for the person by the Court of Protection | Name |  | |
| Address |  | |
| Telephone |  | |
| Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005 | Name |  | |
| Address |  | |
| Telephone |  | |

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| **WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED** *Place a cross in EITHER box below* | | | | | | | | |
| Apart from professionals and other people who are paid to provide care or treatment, this person has no-one whom it is appropriate to consult about what is in their best interests | | | | | | | |  |
| There is someone whom it is appropriate to consult about what is in the person’s best interests who is neither a professional nor is being paid to provide care or treatment | | | | | | | |  |
| **WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION**  *Place a cross in one box below* | | | | | | | | |
| The person has made an Advance Decision that is valid and applicable to some or all of the treatment | | | | | | | |  |
| The Managing Authority is not aware that the person has made an Advance Decision that may be valid and applicable to some or all of the treatment | | | | | | | |  |
| The proposed deprivation of liberty **is not** for the purpose of giving treatment | | | | | | | |  |
| **THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT (1983)** | | | | | | | | |
| Yes |  | | No |  | *If* ***Yes*** *please describe further e.g. application/order/direction, community treatment order, guardianship* | | | |
|  | | | | | | | | |
| **OTHER RELEVANT INFORMATION** | | | | | | | | |
| Names and contact numbers of regular visitors not detailed elsewhere on this form: | | | | | | | | |
| Any other relevant information including safeguarding issues: | | | | | | | | |
| **PLEASE NOW SIGN AND DATE THIS FORM** | | | | | | | | |
| Signature | |  | | | | Print Name |  | |
| Date | |  | | | | Time |  | |
| **I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION** *(Please sign to confirm)* | | | | | |  | | |

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| **RACIAL, ETHNIC OR NATIONAL ORIGIN**  *Place a cross in one box only* | | | | | | | | |
| White | |  | | | Mixed / Multiple Ethnic groups | |  | |
| Asian / Asian British | |  | | | Black / Black British | |  | |
| Not Stated | |  | | | Undeclared / Not Known | |  | |
| Other Ethnic Origin *(please state)* | | |  | | | | | |
| **THE PERSON’S SEXUAL ORIENTATION**  *Place a cross in one box only* | | | | | | | | |
| Heterosexual |  | | | | Homosexual | |  | |
| Bisexual |  | | | | Undeclared | |  | |
| Not Known |  | | | |  | | | |
| **OTHER DISABILITY**  *While the person must have a mental disorder as defined under the Mental Health Act 1983, there may be another disability that is primarily associated with the person. This is based on the primary client types used in the Adult Social Care returns.*    *To monitor the use of DoLS, the HSCIC requests information on other disabilities associated with the individual concerned. The presence of “other disability” may be unrelated to an assessment of mental disorder or lack of capacity. Place a cross in one box only* | | | | | | | | |
| Physical Disability: Hearing Impairment | | | |  | | Physical Disability: Visual Impairment | |  |
| Physical Disability: Dual Sensory Loss | | | |  | | Physical Disability: Other | |  |
| Mental Health needs: Dementia | | | |  | | Mental Health needs: Other | |  |
| Learning Disability | | | |  | | Other Disability (none of the above) | |  |
| No Disability | | | |  | |  | |  |
| **RELIGION OR BELIEF**  *Place a cross in one box only* | | | | | | | | |
| None | | | |  | | Not stated | |  |
| Buddhist | | | |  | | Hindu | |  |
| Jewish | | | |  | | Muslim | |  |
| Sikh | | | |  | | Any other religion | |  |
| Christian  (includes Church of Wales, Catholic, Protestant and all other Christian denominations) | | | | | | | |  |

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| **ONLY COMPLETE THIS SECTION IF YOU NEED TO GRANT AN URGENT AUTHORISATION BECAUSE IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS ALREADY OCCURING, OR ABOUT TO OCCUR, AND YOU REASONABLY THINK ALL OF THE FOLLOWING CONDITIONS ARE MET** | | | | |
| **URGENT AUTHORISATION**  ***Place a cross in EACH box to confirm that the person appears to meet the particular condition*** | | | | |
| The person is aged 18 or over | | | |  |
| The person is suffering from a mental disorder | | | |  |
| The person is being accommodated here for the purpose of being given care or treatment. ***Please describe further on page 2*** | | | |  |
| The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment | | | |  |
| The person has not, as far as the Managing Authority is aware, made a valid Advance Decision that prevents them from being given any proposed treatment | | | |  |
| Accommodating the person here, and giving them the proposed care or treatment, does not, as far as the Managing Authority is aware, conflict with a valid decision made by a donee of a Lasting Power of Attorney or Personal Welfare Deputy appointed by the Court of Protection under the Mental Capacity Act 2005 | | | |  |
| It is in the person’s best interests to be accommodated here to receive care or treatment, even though they will be deprived of liberty | | | |  |
| Depriving the person of liberty is necessary to prevent harm to them, and a proportionate response to the harm they are likely to suffer otherwise | | | |  |
| The person concerned is not, as far as the Managing Authority is aware, subject to an application or order under the Mental Health Act 1983 or, if they are, that order or application does not prevent an Urgent Authorisation being given | | | |  |
| The need for the person to be deprived of liberty here is so urgent that it is appropriate for that deprivation to begin immediately before the request for the Standard Authorisation is made or has been determined | | | |  |
| **AN URGENT AUTHORISATION IS NOW GRANTED**  This Urgent Authorisation comes into force immediately.  It is to be in force for a period of: days  ***The maximum period allowed is seven days.***  This Urgent Authorisation will expire at the end of the day on: | | | | |
| Signed |  | Print name |  | |
| Date |  | Time |  | |