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| AIS Number: Click here to enter text. | | | | | | NHS 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 | | | |  | | | | | | | | |
| Name of the Assessor | | | |  | | | Date of visit | | | |  | |
| Address of the Assessor | | | |  | | | | | | | | |
| Profession of the Assessor | | | |  | | | | | | | | |
| Name of the Supervisory Body | | | |  | | | | | | | | |
| The present address of the person if different from the care home or hospital stated above. | | | | Click here to enter text. | | | | | | | | |

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| **In carrying out this assessment I have met or consulted with the following people and informed them that the information gathered, and their views will be recorded in my report. Which will be sent securely by the Deprivation of Liberty Safeguards Team to the Managing Authority and others consulted as appropriate.**  **\*Full privacy notice will be sent with the documentation** | | | | | | | | | | |
| **Privacy Notice advised** | **NAME** | **EMAIL ADDRESS, POSTAL**  **ADDRESS & TEL NO** | | | | **CONNECTION TO PERSON BEING ASSESSED** | | | |
| **Yes/No** | Click here to enter text. | Click here to enter text. | | | | Click here to enter text. | | | |
| **Yes/No** | Click here to enter text. | Click here to enter text. | | | | Click here to enter text. | | | |
| **Yes/No** | Click here to enter text. | Click here to enter text. | | | | Click here to enter text. | | | |
| **Yes/No** | Click here to enter text. | Click here to enter text. | | | | Click here to enter text. | | | |
| **Yes/No** | Click here to enter text. | Click here to enter text. | | | | Click here to enter text. | | | |
| **Yes/No** | Click here to enter text. | Click here to enter text. | | | | Click here to enter text. | | | |
| **The following people 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. | | | | | | |
| **Section 1 : DOCUMENTATION** | | | | |  | | **DATED** | | | |
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| **Section 2 : 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:**   1. What is the impairment of, or disturbance in the functioning of the mind or brain? | | | | | | | | |
| Click here to enter text. | | | | | | | | |
| (ii) Is this thought to be the cause of the Relevant Person’s incapacity? Yes  No | | | | | | | | |
| **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.*  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. | | | | | | | |  |

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| **Section 3 : NO REFUSALS ASSESSMENT** | |
| There is not a valid Advance Decision, Lasting Power of Attorney or Deputy for Health and Welfare in place |  |
| 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, for Health and Welfare. |  |
| *The reasons for my opinion are:*  Click here to enter text. | |

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| **Section 4 : 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 met while 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 current relevant person’s representative appointed for the person 2. any donee of a Lasting Power of Attorney or Deputy for Health and Welfare 3. any IMCA instructed for the person in relation to their current or proposed deprivation of liberty 4. any Interested Persons |  |
| **Section 4.1 : BACKGROUND 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. | |
| **Section 4.2: VIEWS OF THE RELEVANT PERSON****RELEVANT TO THE CURRENT PLACEMENT**  *Provide details of*   * *past and present wishes,* * *values, beliefs* * *matters they would consider if able to do so:*   Click here to enter text. | |
| **Section 4.3 : VIEWS OF OTHERS IN RELATION TO THE CURRENT OR POTENTIAL DEPRIVATION OF LIBERTY AND BEST INTERESTS OF THE RELEVANT PERSON**  Click here to enter text. | |

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| **Section 4.4 :**  **Part A The Relevant 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** | |  |
| **IN APPLYING THE ACID TEST , THE REASONS FOR MY OPINION ARE :**  Click here to enter text.  The placement is imputable to the State: Yes  No | | | |
| **Part B It is necessary to deprive the person of their liberty in this way in order to prevent harm to the person.** | **YES** |  | |
| **NO** |  | |
| * *Describe the risks of harm to the person that* ***may*** *arise which make the deprivation of liberty necessary.*   Click here to enter text. | | | |

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| **Part C 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.** | **YES** | | |  |
| **NO** | | |  |
| *With reference to the risks of potential harm explained above, state the risks the Relevant Person has been subjected to, and/or behavours displayed which have increased their vulnerability.*  Click here to enter text. | | | | |
| **Part D 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. | | | | |

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| **Section 5 : 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 text. | | |  |
| *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. | | | |
| **Section 6 : 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 text.** |  | |
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| **Section 7 : 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 existing 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. | |  |
| **Section 8 : RECOMMENDATIONS, ACTIONS AND / OR OBSERVATIONS FOR CARE MANAGER / SOCIAL WORKER / COMMISSIONER / HEALTH PROFESSIONAL** | | |
| Click here to enter text. | | |

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| **Section 9 : 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 )* | | | |
| 1. The Relevant Person has capacity to select a representative and wishes to do so.   **Name of person selected**: Click here to enter text. | | |  |
| 1. The Relevant Person 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**: Click here to enter text. | | |  |
| (iii) The Relevant Person lacks capacity to select a representative and does not have a Lasting Power of Attorney, or Deputy, for Health and Welfare. Therefore, the Best Interests Assessor will select and recommend a representative. | | |  |
| 1. The Relevant Person does not wish to select a representative. Therefore, the Best Interests Assessor will select and recommend a representative. | | |  |
| 1. The Relevant Person’s Donee or Deputy does not wish to or have the authority to select a representative. Therefore, the Best Interests Assessor will select 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 in section (i) or (ii) above. I 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. | | |  |
| I have selected and recommend that the Supervisory Body appoints the representative identified below. In so doing I confirm that:   * The Relevant Person 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. | | |  |
| 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**  Click here to enter text. | |  | |

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| **PLEASE NOW SIGN AND DATE THIS FORM** | | | |
| Signed | *Best Interests Assessor* | Date |  |
| Print Name |  | Time |  |