|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Case ID Number: | | | | | | | | |
| **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 | | | |  | | | | |
| Date of birth  *(or estimated age if unknown)* | | | |  | | Est. Age: |  | |
| This also constitutes the Age Assessment. If any uncertainty 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 | | | |  | | | | |
| 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. | | | |  | | | | |

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

|  |  |
| --- | --- |
| **MENTAL CAPACITY ASSESSMENT** | |
| The following practicable steps have been taken to enable and support the person to participate in the decision making process. ***Please describe these steps:***  Click here to enter text. | |
| In my opinion the person **LACKS** capacity to make their own decision about whether they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment because of an impairment of, or a disturbance in the functioning of the mind or brain. |  |
| In my opinion the person **HAS** capacity to make their own decision about whether 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? | |
|  | |
| **Stage Two:** | |
| 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.* |  |
| 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.* |  |
| 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.* |  |
| 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.* |  |
| **Conclusion** (including any further input needed). Explain why the person is unable to make the specific decision as a result of the impairment or disturbance in the functioning of their mind or brain. Explain why the person’s inability to decide the matter is because of their impairment of, or disturbance in the functioning of, the mind or brain: | |

|  |  |
| --- | --- |
| **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:* | |
| There is not a valid Advance Decision, Lasting Power of Attorney or Deputy for Health  and Welfare in place. |  |

|  |  |
| --- | --- |
| **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 relevant person’s representative appointed for the person. 2. any IMCA instructed for the person in relation to their 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.* | |
| **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:* | |
| **VIEWS OF OTHERS** | |

|  |  |  |
| --- | --- | --- |
| **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 care or treatment in circumstances that amount to depriving them of liberty  **Note:** *if the answer below 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 supervision AND control AND not free to leave. Refer to the descriptors in the Code of Practice in the light of the acid test.*  Objective***:*** *For example, applying the acid test should provide evidence of confinement in a particular restricted space over a not negligible period of time.*  Subjective: *A lack of valid consent to be confined in the accommodation to receive care and/or treatment.*  *The placement is imputable to the State because:* | | |
| **his is necessary in order to prevent harm to the person.**  The reasons for my opinion are:  *Describe the harm the person would experience, which makes 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* | | **Yes**  **No** |
| **This is a proportionate response given the likelihood that the**  **person will otherwise suffer harm and the seriousness of that harm.**  The reasons for my opinion are:  *With reference to the risks described above explain why deprivation of liberty is justified. Why is it least restrictive, what else has been explored? Why is depriving the person of liberty a proportionate response to the harm described above?* | | **Yes**  **No** |

|  |  |
| --- | --- |
| **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:  After giving your reasons above you should now carry out analysis of the benefits and burdens or each option identified**.**  **Option 1:**  Benefits:  Burdens:  **Option 2:**  Benefits:  Burdens:  *(Repeat process if there are more options)* | |

|  |  |
| --- | --- |
| **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 their liberty under the Mental Capacity Act 2005 is not appropriate. Consequently, unless the deprivation of liberty is authorised under other statute, the person is, or is likely to be, subject to an unauthorised deprivation of liberty. |  |
| A Safeguarding Adult enquiry must be made for any unauthorised deprivation of liberty.  Please place a cross in the box to confirm that a referral has been made  Date of Referral: |  |
| *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.* | |
| **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:  **The reasons for choosing this period of time are:** *Please explain your reason(s)*  **DATE WHEN THE STANDARD AUTHORISATION SHOULD COME INTO FORCE**  I recommend that the standard authorisation should come into force on: | |

|  |  |  |
| --- | --- | --- |
| **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 |  | |
| 2 |  | |
| 3 |  | |
| 4 |  | |
| **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 |  | |
| 2 |  | |
| 3 |  | |
| 4 |  | |
| **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.* | | |
|  | | |
| **RECOMMENDATIONS, ACTIONS AND / OR OBSERVATIONS FOR CARE MANAGER / SOCIAL WORKER / COMMISSIONER / HEALTH PROFESSIONAL** | | |
|  | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECTION OF A REPRESENTATIVE** | | | | | | | |
| **CAPACITY OF THE PERSON TO SELECT THEIR OWN REPRESENTATIVE** (place a cross in box of one statement) | | | | | | | |
| 1 | The relevant person has capacity to select a representative. | | | | | |  |
| 2 | The relevant person lacks capacity to select a representative. | | | | | |  |
| 3 | The relevant person who lacks capacity has a Lasting Power of Attorney or Deputy for Health and Welfare and they have selected the following person because (*Please see guidance notes)*: | | | | | | |
| **THE REPRESENTATIVE** | | | | | | | |
| Please enter the details of the person selected to represent the person that this assessment is about and your reasons. In doing so, you are confirming that:   * If you are selecting a representative, then the person and/or their Deputy agree with your recommendation. * That the person you are naming is eligible and agrees to be their representative | | | | | | | |
| 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 to appoint a replacement | | | | | | |  |
| Full name of representative selected | | |  | | | | |
| Their address | | |  | | | | |
| Telephone number(s) | | |  | | | | |
| Relationship to the relevant person | | |  | | | | |
| Reason for selection | | |  | | | | |
| **If you are not able to name a representative please place a cross in tick this box and record your reason below** | | | | | |  | |
| **PLEASE NOW SIGN AND DATE THIS FORM** | | | | | | | |
| Signed | |  | | Date |  | | |
| Print Name | |  | | Time |  | | |