directors of adass
adult social services

Department of Health

DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1

REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION

Request a **Standard Authorisation** (Tick)	**Yes**	○	**No**	○
Grant an **Urgent Authorisation** (Tick)	**Yes**	○	**No**	○

Full name of person being deprived of liberty		Sex	
Date of Birth *(or estimated age if unknown)*		Est. Age	

Relevant Medical History (include both physical and mental health diagnosis and/or symptoms)

Communication Requirements (Interpreter or aids required)		
Name and address of the care home or hospital requesting this authorisation **Care homes must include postcode**		
Telephone Number		
Person to contact at the care home or hospital, (including ward details if appropriate)	Name	
	Telephone	
	Email	
	Ward (if appropriate)	
GP Details If the person has recently moved, please indicate proposed registered GP details. **(must include postcode)**	GP's Name	
	Address	
	Post Code	
	Telephone	

Current or, last known home address of the person in the community **(must include postcode)**	
Name of the Supervisory Body (DoLs Team) where this form is being sent	

How is the care placement funded?
(This information may not be available if the person is currently on an acute hospital ward)

Local Authority *please specify*		NHS Name of CCG if residential or rehab placement			
Local Authority and NHS (jointly funded)	☐	Funded through insurance or other	☐	Self-funded by person	☐

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.

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 <u>one</u> 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)			☐

WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED

Place a cross in <u>EITHER</u> box below

Apart from professionals and other people who are paid to provide care or treatment, this person has **<u>no-one</u>** 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 and their contact details are listed in the following section.	☐

INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT

Family member or friend	Name	
	Relationship	
	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 for Health and Welfare granted by the person	Name	
	Address	
	Telephone	
Any Deputy for Health and Welfare 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 EG Change of Accommodation or Review IMCA	Name	
	Address	
	Telephone	

You have a duty to inform relatives and all individuals listed above that you have applied for an authorisation of deprivation of liberty. Please tick this box to confirm that you have notified or intend to notify all the individuals listed.	☐

If you have not notified any of the above individuals listed, then please state the reason(s) why.

WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION

Place a cross in one box below

The person has made an Advance Decision that may be valid and applicable to some or all of the proposed restrictions and/or 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 that is opposed to within the Advance Decision.	○

THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT (1983)

Yes	○	No	○	

*If **Yes** please describe further:*

TO GRANT AN URGENT AUTHORISATION

*COMPLETE THIS SECTION IF IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS **ALREADY OCCURING** AND ALL THE FOLLOWING CONDITIONS ARE MET*

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 being accommodated here for the purpose of being given care or treatment. ***Please describe further overleaf***	☐
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 Deputy for Health and Welfare 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 is suffering from a mental disorder	☐
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	☐

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	
Position			
Date		Time	

AN URGENT AUTHORISATION IS NOW GRANTED

This Urgent Authorisation comes into force immediately.

*IF YOU HAVE COMPLETED AN URGENT YOU NOW **NEED TO COMPLETE THE SECTION BELOW** REQUESTING A STANDARD AUTHORISATION*

TO REQUEST A STANDARD AUTHORISATION

THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED:
If you do not need to grant yourselves an URGENT AUTHORISATION please state date you will need a STANDARD AUTHORISATION to come into force – this must be within 28 days

PURPOSE OF THE STANDARD AUTHORISATION

BACKGROUND INFORMATION

Please describe briefly the person's background information.

- *When and why was the person admitted to the ward/placement?*
- *Where and with whom do they usually reside?*
- *What is their mental health diagnosis or issue?*
- *RESPITE PLACEMENTS: Please indicate date and length of next admission.*

CURRENT CIRCUMSTANCES

Please describe the person's current circumstances.

- *How long is it anticipated that they will need to remain on the ward/current placement?*
- *What leads you to believe the person lacks capacity to agree to their placement/ward stay?*
- *What care are you providing on a day to day basis*

DEPRIVATION OF LIBERTY

Why do you feel the current care, support or treatment plan amounts to a Deprivation?

Support:

- *What specific support does the person require with their personal care, mobility, medication, support with behavioural or other mental health issues?*

Restrictions:

- *Please **list the restrictions** you have put in place which are necessary to ensure the person receives care and treatment. **How often and how long** these types of restrictions are necessary?*

  For example:

  - *How often does the person receive sedative medication? This could be PRN or covertly?*
  - *What are the observation and supervision levels? How long have then been in place?*
  - *Are any family or friends being prevented or restricted from visiting?*
  - *Is the person being prevented from leaving the building?*
  - *Are covert medications being given?*
  - *Does the person require restraint to support the delivery of care or reduce risks?*
  - *Is there use of monitoring equipment such as sensor mats?*
  - *What key decisions are made by staff for the person?*

Risks:

- *What risk of harm may occur to the person if these restrictions are not in place?*

Please answer the following questions

	YES	NO
Would you allow the person to leave the placement/ward?	◯	◯
Would you or the family allow the person to decide to live elsewhere if they wished to?	◯	◯
Is the person or their relative asking for them to live elsewhere (even if this place no longer exists)?	◯	◯
Is the person requesting contact with a particular individual that is being prevented or controlled?	◯	◯
Is the person resisting any aspect of care and support, including personal care?	◯	◯

OTHER RELEVANT INFORMATION

Names and contact numbers of regular visitors not detailed elsewhere on this form:

Any other relevant information including safeguarding issues:

TO COMPLETE THE REQUEST OF A STANDARD AUTHORISATION

PLEASE NOW SIGN AND DATE THIS FORM

Signature		Print Name	
Position			
Date		Time	

An Extension to the Urgent Authorisation may be granted by the Supervisory Body (DoLs Team) in certain circumstance. Only complete this section <u>if advised to do</u> so by the Supervisory Body.

REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION

A Standard Authorisation has been requested for this person and an Urgent Authorisation is in force.

The Managing Authority now requests that the duration of this Urgent Authorisation is extended for a further period of [ ] DAYS (***up to a maximum of 7 days***)

It is essential for the existing deprivation of liberty to continue until the request for a Standard Authorisation is completed because the person needs to continue to be deprived and exceptional reasons are as follows (*please record your reasons):*

EG:

- *Has there been any key change to the persons circumstances or the level of restrictions within the persons care plan since the initial Urgent DoLs Application?*
- *Why is this extension required ?*

Please now sign, date and send to the SUPERVISORY BODY for authorisation

Signature		Date	

This part of the form must be completed by the **SUPERVISORY BODY** if the duration of the Urgent Authorisation is extended.

The Managing Authority does not complete this part of the form.

RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED

The duration of this Urgent Authorisation has been extended by the Supervisory Body.

It is now in force for a **further** [ ] days

Important note: The period specified must not exceed seven days.

This Urgent Authorisation will now expire at the end of the day on: [ ]

SIGNED (on behalf of the Supervisory Body)	Signature			
	Print Name			
	Position			
	Date		Time	