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| 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 assessedand address of the care home or hospital. | | | | | | | |  | | | | | | | | | | | |
| Date of birth  *(or estimated age if unknown)* | | | | | | | |  | | | | | Est. Age | |  | | | | |
| 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 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** | | | | | | | | | |
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| **I have considered all relevant documents** ***and I have no concerns*** *(e.g. current care plan, needs assessment medical notes, daily record sheets, risk assessments*). *Please record any concerns in the best interest section.* | | | | | | | | | | | | | | | |  | | | |
| **MENTAL CAPACITY ASSESSMENT** | | | | | | | | | | | | | | | | | | | |
| The following practicable steps have been taken to enable and support the person to make the decision whether or not to be accommodated for the purpose of care or treatment in circumstances of confinement: | | | | | | | | | | | | | | | | | | | |
| **Question One: Is the person able to do all of the following** | | | | | | | | | | | | | | | | **YES/NO** | | | |
| 1. **The person is able 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 able 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.* | | | | | | | | | | | | | | | |  | | | |
| 1. **The person is able to use and 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 able 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.* | | | | | | | | | | | | | | | |  | | | |
| **Question Two: Does the person have an impairment or disturbance in the functioning of their mind or brain?** | | | | | | | | | | | | | | | | **YES/NO** | | | |
| *Describe:* | | | | | | | | | | | | | | | | | | | |
| **Question Three: Is the person unable to make the decision because of the mental impairment described above** | | | | | | | | | | | | | | | | **YES/NO** | | | |
|  | | | | | | | | | | | | | | | | | | | |
| In my opinion the person **LACKS** capacity to decide whether or not they should be accommodated in this hospital or care home in circumstances of confinement 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 in circumstances of confinement for the purpose of being given the proposed care and/or treatment | | | | | | | | | | | | | | | |  | | | |
| **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 (Remember there may be more than one Attorney). | | | | | | | | | | | | | | | | |  | | |
| 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 needs assessment and care plans in connection with accommodating the person in the hospital or care home for the purpose of care/treatment | | | | | | | | | | | | | | | | | | |  |
| 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 | | | | | | | | | | | | | | | | | | |  |
| **BEST INTERESTS ASSESSOR REPORT – you must address all the following elements in your report, giving a strong voice to the person’s wishes and feelings, beliefs and values. It is important that the report focuses on analysis of whether the matters set out below are met, rather than on history and narrative.** | | | | | | | | | | | | | | | | | | | |
| **IS THE PERSON DEPRIVED OF THEIR LIBERTY:** *explain how the objective and subjective elements are met, and why the placement is imputable to the state.*  **IS IT NECESSARY TO DEPRIVE THE PERSON OF THEIR LIBERTY IN THIS WAY IN ORDER TO PREVENT HARM TO THE PERSON:** *describe the harm to the person which make the deprivation of liberty necessary.*  **IS 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 -** *With reference to the harm explain why deprivation of liberty is a proportionate response. It will be useful here to give a small amount of background detail and history in brief.*  **IS DEPRIVING THE PERSON OF LIBERTY IN THE PERSON’S BEST INTERESTS -** *consider section 4 of the Mental Capacity Act 2005, consider the persons views and the views of those consulted and whether any care or treatment can be provided effectively in a way that is less restrictive of the persons rights and freedom of action.* | | | | | | | | | | | | | | | | | | | |
| **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. Consequently, unless the deprivation of liberty is authorised by a court or under another statute, the person is, or is likely to be, subject to an unauthorised deprivation of liberty. | | | | | | | | | | | | | | | | | | | |
| Any safeguarding issues must be considered for an unauthorised deprivation of liberty and where appropriate a referral should be made. Date of referral if made:  Date of Referral: | | | | | | | | | | | | | | | | | | | |
| **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 |  | | | | | | | | | | | | | | | | | | |
| **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. | | | | | | | | | | | | | | | | | | |  |
| **RECOMMENDATIONS, ACTIONS AND / OR OBSERVATIONS FOR CARE MANAGER / SOCIAL WORKER / COMMISSIONER / HEALTH PROFESSIONAL** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **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 | | | | | | |  | | | | | | | | | | | | |
| 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 the box and record your reason below.** | | | | | | | | | | | | | | | |  | | | |
| **PLEASE NOW SIGN AND DATE THIS FORM** | | | | | | | | | | | | | | | | | | | |
| Signed | | |  | | | | | | Date | | |  | | | | | | | |
| Print Name | | |  | | | | | | Time | | |  | | | | | | | |