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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| C:\Users\71041439\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Word\DCC logo black.jpgBefore submitting this form, please complete below to confirm you have:   1. Completed a mental capacity assessment for whether the person can make their own decision about being accommodated here for care and/or treatment   Capacity assessment completed by ………………….  Date completed ………………….   1. Checked which local authority is responsible for this person (please see Page 9 for details). | | | | | | | | | | | | | | | | | | | | | | |
| **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 7 or 8)*** | | | | | | | | | | | | | | | | | | | | |  | |
| Grant an **Urgent Authorisation** ***(please ALSO complete pages 7 and 8)*** | | | | | | | | | | | | | | | | | | | | |  | |
| Full name of person being deprived of liberty | | | | | |  | | | | | | | | | | | Sex | | | | | |
| Date of Birth *(or estimated age if unknown)* | | | | | |  | | | | | | | | | | | Est. Age | | | | | |
| Relevant Medical History | | | | | | | | | | | | | | | | | | | | | | |
| 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) | | | |  | | | | | | | | | | | | |
| Usual address of the person, (if different to above) | | | | | |  | | | | | | | | | | | | | | | | |
| 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 | | | |  | | | |
| **CHECKLIST** | | | | | | | | | | | | | | | | | | | | | | |
| *Please place an ‘X’ in all relevant boxes below and give further details in the following page. Please note, this is not a comprehensive list of potential restrictions and relevant factors.* | | | | | | | | | | | | | | | | | | | | | | |
| Does the person regularly ask or try to leave, or object to where they are living? | | | | | | | | | | | | | | | | | | | | | |  |
| Does the person regularly object or become distressed because of their care or treatment? | | | | | | | | | | | | | | | | | | | | | |  |
| Do carers ever physically restrain the person? | | | | | | | | | | | | | | | | | | | | | |  |
| Is the person restrained by equipment? | | | | | | | | | | | | | | | | | | | | | |  |
| Is contact with family or friends restricted or controlled? | | | | | | | | | | | | | | | | | | | | | |  |
| Is the person prescribed sedatives, or medication that causes sedation? | | | | | | | | | | | | | | | | | | | | | |  |
| Is medication given covertly? | | | | | | | | | | | | | | | | | | | | | |  |
| Is medication given PRN (as required) to help reduce agitation or control behaviour? | | | | | | | | | | | | | | | | | | | | | |  |
| Does the person have long periods of 1:1 (or higher) support? | | | | | | | | | | | | | | | | | | | | | |  |
| Is CCTV used in the person’s room? | | | | | | | | | | | | | | | | | | | | | |  |
| Could the person’s needs be met in the community or in a less restrictive placement? | | | | | | | | | | | | | | | | | | | | | |  |
| Are behavioural sanctions used (e.g. time out, seclusion, behavioural rewards, removal of possessions or activities)? | | | | | | | | | | | | | | | | | | | | | |  |
| Restricted access to phones, internet or hobby equipment? | | | | | | | | | | | | | | | | | | | | | |  |
| Are there any current safeguarding investigations or concerns? | | | | | | | | | | | | | | | | | | | | | |  |
| Is the person likely to move within the next three-weeks or so? | | | | | | | | | | | | | | | | | | | | | |  |
| Do family or friends visit less than monthly? | | | | | | | | | | | | | | | | | | | | | |  |
| Do any family or friends object to the person living there or how they are treated?   * If yes to above question, is an allocated Social Worker or Community Care Worker (from Derbyshire Adult Care) aware? | | | | | | | | | | | | | | | | | | | | | |  |
|  |
| **REQUEST FOR STANDARD AUTHORISATION** | | | | | | | | | | | | | | | | | | | | | | | |
| **THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED:**  *If standard only – within 21 days*  *If an urgent authorisation is also attached – within 7 or 14 days* | | | | | | | | | | | | | | | | | | |  | | | | |
| **PURPOSE OF THE STANDARD AUTHORISATION**   * *Please describe the care and / or treatment this person is receiving day-to-day and attach a relevant care plan.* * *Please give as much detail as possible about the type of care the person needs, including personal care, mobility, medication, support with behavioural issues, types of choice the person has and any medical treatment they receive.* | | | | | | | | | | | | | | | | | | | | | | | |
| * *Explain why the person is not free to leave and why they are under continuous or complete supervision and control.* * *Describe the restrictions you have put in place which are necessary to ensure the person receives care and treatment. (It will be helpful if you can describe why less restrictive options are not possible including risks of harm to the person.)* * *Indicate the frequency of the restrictions you have put in place.* | | | | | | | | | | | | | | | | | | | | | | | |
| **INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT** | | | | | | | | | | | | | | | | | | | | | | | |
| Family member or friend  (Please provide the person’s address) | | | | | | | | 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  (This should include allocated Social Worker/CPN/NHS staff etc.) | | | | | | | | 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 | | | | | | | | Name | | | |  | | | | | | | | | | | |
| Address | | | |  | | | | | | | | | | | |
| Telephone | | | |  | | | | | | | | | | | |
| **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 may be 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* | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **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 | | | |  | | | | | | | |
| Position | | |  | | | | | | | | | | | | | | | | | | | | | |
| Date | | |  | | | | | | | | | | Time | | | |  | | | | | | | |
| **I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION** *(Please sign to confirm)* | | | | | | | | | | | | |  | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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) | | | | | | | | | | | | | | | | |  | |
| **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 AND ALL 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 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 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 | | | | | | | | | | | | | | | | | |  |
| **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 | | |  | | | | | |
| Position | |  | | | | | | | | | | | | | | | | |
| Date | |  | | | | | | | | Time | | |  | | | | | |
| **REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION**  *If Supervisory Body is unable to complete the process to authorise the deprivation of liberty* | | | | | | | | | | | | | | | | | | |
| 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):*  ***Please now sign, date and send to the SUPERVISORY BODY for authorisation*** | | | | | | | | | | | | | | | | | | |
| Signature | | |  | | | | | | | | | Date | |  | | | | |
| **RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED**  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.**  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 |  | | |

# Which Local Authority should receive this referral?

This is not always straightforward. Please check where this person is ‘ordinarily resident’ and send this referral to that local authority’s DOLS team. That might not be the local authority where your care home or hospital is located.

In most cases, if a local authority funds a resident’s care and has placed a resident in a care home, the person remains ‘ordinarily resident’ within the funding local authority. For example:

* If Derbyshire County Council funds a resident in a Nottinghamshire care home, the person is likely to remain ordinarily resident in Derbyshire and the DOLS referral should be sent to Derbyshire’s DOLS Team.
* If Derby City funds a person in a Derbyshire care home, Derby City’s DOLS Team is likely to be responsible.

If the person is self-funding in a Derbyshire care home, and was admitted from their own home in Derbyshire, please send their referral to Derbyshire’s DOLS Team. However, if the person is self-funding in a Derbyshire Care Home, but moved from outside of the county, that other local authority may still be responsible for their DOLS referral. This is likely to be the case if:

* The person lacked capacity to consent to their admission; and
* That other local authority contracted with your care home for the person (even if only briefly).

If a resident receives fully funded NHS Continuing Healthcare funding, they remain the responsibility of the local authority in which they were ‘ordinarily resident’ immediately before the NHS funding was first awarded.

If in doubt, please include relevant information on the referral, and contact Derbyshire’s DOLS team to discuss.

Email: [dols@derbyshire.gov.uk](mailto:dols@derbyshire.gov.uk)

Tel: 01629 532 080

Fax: 01629 538 368

**Thank you**