Deprivation of Liberty Safeguards Policy (DoLS)

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EXECUTIVE SUMMARY

The Deprivation of Liberty Safeguards (DoLS) have been introduced into the Mental Capacity Act (MCA) 2005 by the Mental Health Act (MHA) 2007. The Deprivation of Liberty Safeguards came into force on 01 April 2009.

The safeguards provide a framework for approving the deprivation of liberty for people who lack the capacity to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty. The safeguards legislation contains detailed requirements about when and how deprivation of liberty may be authorised. It provides for an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

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1.0 INTRODUCTION

1.1 Background

Deprivation of liberty is a legal concept whose origins lie in the European Convention on Human Rights (ECHR). Article 5.1 of the ECHR (Appendix A) states that everyone has a right to liberty and security of person and that no one shall be deprived of their liberty except in accordance with a procedure prescribed by law. It goes on to outline the groups of people who may be lawfully deprived of their liberty and these include prisoners, those under arrest or awaiting trial, young people required to attend +compulsory education, certain people suffering from infectious diseases, those of "unsound mind" (in England and Wales this generally means those detained under the 1983 Mental Health Act) and illegal immigrants or those awaiting deportation. In all these cases, there is a legal process by which the detention of these people may be authorised, reviewed and under which they may appeal to a Court with authority to release them, as required by article 5.4. They are lawfully deprived of their liberty.

The Deprivation of Liberty Safeguards have been introduced because, following a test case (*HL V UK*, known as the Bournewood case), a group of people have been identified who may be unlawfully deprived of their liberty. These are people in hospital or residential care who lack capacity to consent to their care regime. When that care regime is so restrictive as to constitute deprivation of liberty (clarification of this is in the next section), that deprivation is currently unlawful, because it is not in accordance with a procedure prescribed by law and there is no mechanism for appeal and release. The Deprivation of Liberty Safeguards will introduce such mechanisms and make the deprivation lawful if it is necessary in the person's best interests. This aspect of clinical and care practice will then be compatible with the ECHR.

1.2 Scope

The policy covers all in-patient adult admissions age 18years and over at the James Paget University Hospital. It does not apply to day cases

1.3 Responsibilities

All staff with clinical responsibility for patients have a duty to familiarize themselves with the policy content and their individual professional responsibility.

1.4 Monitoring and Review

The Trust Safeguarding Lead will be responsible for monitoring the effectiveness of this policy. This will be achieved by an ongoing evaluation of the processes and a three yearly review of the policy.

The compliance of this policy will be monitored through feedback from the Supervisory Body, the Mental Capacity Act 2005 Implementation Committee for Norfolk, Norfolk DoL Best Interest Assessors and the Independent Mental Capacity Advocacy Service and Implementation Steering Group

1.5 Related Documents

- Mental Capacity Act Code of Practice (2005)
- Deprivation of Liberty Safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice.
- The Department of Health's Mental Capacity Act 2005 Deprivation of Liberty Safeguards – Forms & Record Keeping – Guide for Managing Authorities in England (Hospitals & Care Homes), which can be viewed at

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089772.

- The Department of Health's Mental Capacity Act 2005 Deprivation of Liberty Safeguards – A Guide for Hospitals & Care Homes (which can be viewed at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094348

1.6 Reader Panel

The following formed the Reader Panel that reviewed this document:

Post Title
Head of Education and Practice Development
Practice Development Nurses
Deputy Director of Nursing – Trust Lead for Safeguarding Vulnerable Adults
Clinical Trust Lead Matron for DoLS
Social Worker for Norfolk Mental Health Care Trust

1.7 Trust Values

This Policy conforms to the Trust's values of putting patients first, aiming to get it right, recognising that everybody counts and doing everything openly and honestly. The Policy incorporates these values throughout and an Equality Impact Assessment is completed to ensure this has occurred.

1.8 Glossary

The following terms and abbreviations have been used within this Policy:

Term	Definition
DoLS	Deprivation of Liberty Safeguards
MCA	Mental Capacity Act
IMCA	Independent Mental Capacity Advocate
ECHR	European Convention on Human Rights
BIA	Best Interest Assessor
SB	Supervisory Body
MA	Managing Authority
DoH	Department of Health
MHA	Mental Health Act
CQC	Care Quality Commission

1.9 Distribution Control

Printed copies of this document should be considered out of date. The most up to date version is available from the Trust Intranet.

2.0 STATEMENT OF POLICY

There is no simple definition of deprivation of liberty. Sections 5 and 6 of the Mental Capacity Act offer protection from civil and criminal liability for acts done in connection with care or treatment of a person (P) who lacks capacity to consent to that act, as long as the person doing the act reasonably believes that P lacks capacity to consent and that it is in P's best interests for the act to be done. Section 6 adds the requirement that when an act is intended to restrain P, the person doing it must believe that it is necessary to do it to prevent harm to P and it must be a proportionate response to the likelihood and seriousness of that harm. The MCA therefore authorises many interventions, including the use of proportionate restraint and restriction of liberty. It does not however authorise deprivation of liberty. The following pointers, taken from the Code of Practice, may help to clarify when the one merges into the other.

The possibility that DOL is occurring should be considered when:

1. Restraint including sedation, is used to admit a person to an institution where that person is resisting admission

2. Staff exercise complete and effective control over the care and movement of a person for a significant period

3. Staff exercise control over assessments, treatment, contacts with the outside world and residence

4. A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless staff think it appropriate

5. A request by carers for a person to be discharged into their care is refused

6. The patient is unable to maintain social contacts because of restrictions placed on their access to other people.

7. The patient loses autonomy because they are under constant supervision and control

8. Sedation is used to control the behaviour of a patient for a significant period of time.

9. 'Force' other than in an emergency is needed to give a resisting patient necessary treatment or care.

In general, restraint which is immediately necessary to prevent harm, which is thought to be in the patient's best interests and which is proportionate to the likelihood and severity of harm, is unlikely to constitute DoL.
Any regime of care lasting for less than a week is unlikely to constitute DoL, however, when restraint becomes frequent or regular, or any of the factors above or a combination of them apply, and the situation persists with no obvious end point in sight, then it may well be a deprivation of liberty.

When does restraint become a Deprivation of Liberty? Guidance can be seen Appendix B

.

2.1 Policy Objectives

The objective of the Policy is to:

When a possible DoL is identified a senior manager or matron must be notified immediately and a record made in the patent's notes. The manager/matron will use the flowchart (Appendix C) and the screening checklist (Appendix D) to determine whether a Deprivation of Liberty exists. If it does, he/she will either:

1. Help ward staff review the care plan and change it so that in no longer constitutes DoL, instigating regular reviews so that no further DoL occurs
Or
2. If this is not possible and the DoL is necessary in the person's best interests, the manager will apply for a Standard Authorisation and consider whether to authorise an Urgent Authority.

3.0 Details Section

3.1 The Application Process

Under Schedule 1A of the Mental Capacity Act 2005 the following requirements must be met before a Deprivation of Liberty will be satisfied:

1. The person must be at least 18years of age

2. Must be suffering from a mental disorder as defined by the Mental Health Act (2007)

3. The person must lack mental capacity

4. It is in the best interest of the person, it is necessary to prevent harm to the person and is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm

5. They must not be detained under the Mental Health Act or subject to other restrictions on their freedom

6. There must not be a valid and applicable advance refusal of treatment for which the Deprivation of Liberty is being sought.

The hospital applying for authority to detain is called the *"Managing Authority* (MA)" The application is made to the "*Supervisory Body* (SB)". Delegation of the administration of the process has been given to Norfolk County Council and Suffolk County Council respectively. For patients who live in Suffolk, contact Suffolk County Council. For patients who live in Norfolk, contact Norfolk County Council.
Contact details in Appendices E and F

There are two types of authorisation:

- Urgent - Form 1 and
- Standard - Form 4
- Both forms need to be sent simultaneously
- Forms and guidance to make a referral can be found in the DoLS folders held in the Operation Centre. Guidance can also be found on the Trust intranet and also from the Trust lead for DoLS and Safeguarding Vulnerable Adults on:
  01493 453669 / 01493 452774 Bleep 1525

Urgent Authorisation
This is made using Form 1 (Appendix H) A Managing Authority (MA) can give itself an urgent authorisation for DoL when:

- A DoL is identified as currently occurring and is unavoidable i.e. necessary in the patient's best interests

Or

- The MA intends to make a request to the SB for a standard authorisation, but believes that the need for the person to be deprived of their liberty is so urgent that deprivation needs to begin before the request is made

Or

- A request has been made for a standard authorisation, but DoL needs to begin before the SB can deal with the application.

If possible, the manager considering an urgent authorisation should consult any relatives or carers of the patient, though the final decision rests with the manager.

Urgent authorisation is for a maximum of 7 days, in which time the Supervisory Body should complete its assessment of the need for a standard authorisation. Exceptionally, if the request for a standard authorisation cannot be completed in that time, the MA can request an extension, using Form 2, found in the DoLS folder in the Operation Centre or by phone, fax or email to the SB. (Appendix I)

A record of any such request should be kept. Only one extension of up to 7 days may be granted.
Note that while in the first instance the MA authorises itself, it cannot authorise any extension - this must come from the SB.

The manager completing the form must give a copy of the authorisation to the patient and place a copy in the patient's notes.

An entry should be made in the notes explaining why an urgent authorisation has been given.

If an Independent Mental Capacity Advocate (IMCA) is involved, a copy must be given to him/her.

As far as possible, the patient's relatives, friends and carers should be informed.

The manager must also place a copy of the application into the DoLS folder in the Trust Operation Centre to enable the Trust to meet the DoH record keeping requirements.

Notification of the DoLS referral and outcome should also be given to the CQC. Forms are available in the DoLS folder or contact DoLS Trust Lead for guidance and support.

Copies of CQC notification and outcome need to be forwarded on to:
anna.hills@jpaget.nhs.uk

Standard Authorisation
This is made using Form 4 (Appendix J) Under certain circumstances it may be apparent that, while DoL is not happening now, it will have to in the near future. A request is then made for a standard authorisation.

The SB should complete an assessment in 21 days from receipt of the request. An urgent authorisation should be made if DoL becomes necessary in the interim.
As above, the manager must place a copy of the application into the DoLS folder in the Trust Operation Centre and in the patient's notes.

3.2 Statutory Body Response

On receipt of a request for standard authorisation the SB has 21 days in which to complete its assessment. On being notified of an urgent authorisation it has 7 days to complete its assessment (unless, exceptionally, it grants an extension).

The SB has to complete 6 assessments and the patient must "pass" all 6 if authorisation is to be given. The application forms contain a screening tool so that patients who will *obviously* fail one or more of the assessments are not referred.

The assessments are carried out by a Best Interests Assessor (BIA) and a Mental Health Assessor (MHA). BIAs are mental health professionals with additional training and Mental Health Assessors are S12 doctors with additional training.

3.3 The assessments undertaken by the Best Interest and Mental Health Assessors:

1. *Age assessment* - the patient must be aged 18 or over. Undertaken by BIA.

2. "*No refusals" assessment* - if the patient has made an advance decision to refuse treatment of the type proposed, or if the proposed regime conflicts with a valid decision of a donee or deputy, then a standard authorisation cannot be given. Undertaken by BIA.

3. *Mental capacity assessment* - the patient must lack capacity to make the relevant decision at the necessary time. Undertaken by BIA or mental health assessor

4. *Mental health assessment* - this establishes that the person is "of unsound mind" (and thus within the ambit of Article.5.1 ECHR) by making a medical diagnosis of their mental disorder. Undertaken by mental health assessor.

5. *Eligibility assessment* - this checks that the person is not currently detained under the Mental Health Act or that the authorisation, if given, would not conflict with an obligation imposed under that Act.
Undertaken by mental health assessor (who must be S12 approved) or BIA if the BIA is also an Approved Mental Health Professional as described in the 2007 Mental Health Act.

6. *Best interests assessment* – checks whether a DoL is actually occurring and whether DoL is necessary, is in the patient's best interests and is a proportionate response to the likelihood and severity of harm the patient might otherwise suffer. Undertaken by BIA.

3.4 Duration of Authority

The maximum time for which a Supervisory Body may authorise a Deprivation of Liberty is one year, but this should never be necessary in the context of JPUH.

DoL should last for the shortest time possible.

3.5 Mental Capacity and Best Interest Decisions (Mental Capacity Act- 2005)

5 Principles which underpin the Mental Capacity Act:

In order to protect those who lack capacity and to enable them to take part, as much as possible in decisions that affect then, the following statutory principles apply:

1. You must always assume a person has capacity unless it is proved otherwise

2. You must take all practicable steps to enable people to make their own decisions

3. You must not assume incapacity simply because someone makes an unwise decision

4. Always act, or decide for a person without capacity in their best interests

5. Carefully consider actions to ensure the least restrictive option is taken

A mental capacity assessment can be triggered in one of many ways following the establishment of a need for the patient to make a specific decision e.g. the patient's behaviour, circumstances or previous issues suggests they may lack capacity or someone else has raised concerns.

Assessment of capacity can be made by any registered professional e.g. Nurse, Doctor or Social Worker.

A capacity assessment should be undertaken using the Mental Capacity Act (MCA) 2005 **Two Stage Test**. (Appendix K)

In making a best interest decision you must:

- ✓ Involve the person who lacks capacity as much as practically possible
- ✓ Consider the person's past and present beliefs, values, wishes and feelings
- ✓ Take into account the views of carers, relatives, friends and advocates
- ✓ Consult others who are involved in the person's care and well being
- ✓ Consider whether the patient will regain capacity sometime in the future in relation to the decision required
- ✓ Do not base the decision solely on age, appearance, behaviour or condition

YOU MUST RECORD THE TWO STAGE TEST AND YOUR BEST INTEREST DECISION IN THE PATIENTS CLINICAL RECORDS

3.6 Independent Mental Capacity Advocacy (IMCA)

When someone is assessed as lacking mental capacity to make key decisions in their lives they may have the help of a specialist independent mental capacity advocate (IMCA). This is a legal right for people over 16 who lack mental capacity and who do not have an appropriate family member or friend to represent their views.
To make a referral or for more information visit www.pohwer.net or Tel: 03004562370

3.7 Training

Training is available and can be booked through the corporate training department. Bespoke training can be made available and can be organised through the responsible Practice Development Nurse, via the education and Practice Development department.

Appendix A – European Convention on Human Rights (ECHR) Right to liberty and Security

Article 5 European Convention on Human Rights (ECHR) Right to liberty and security

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
(a) the lawful detention of a person after conviction by a competent court;
(b) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfillment of any obligation prescribed by law;
(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;
(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;
(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;
(f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

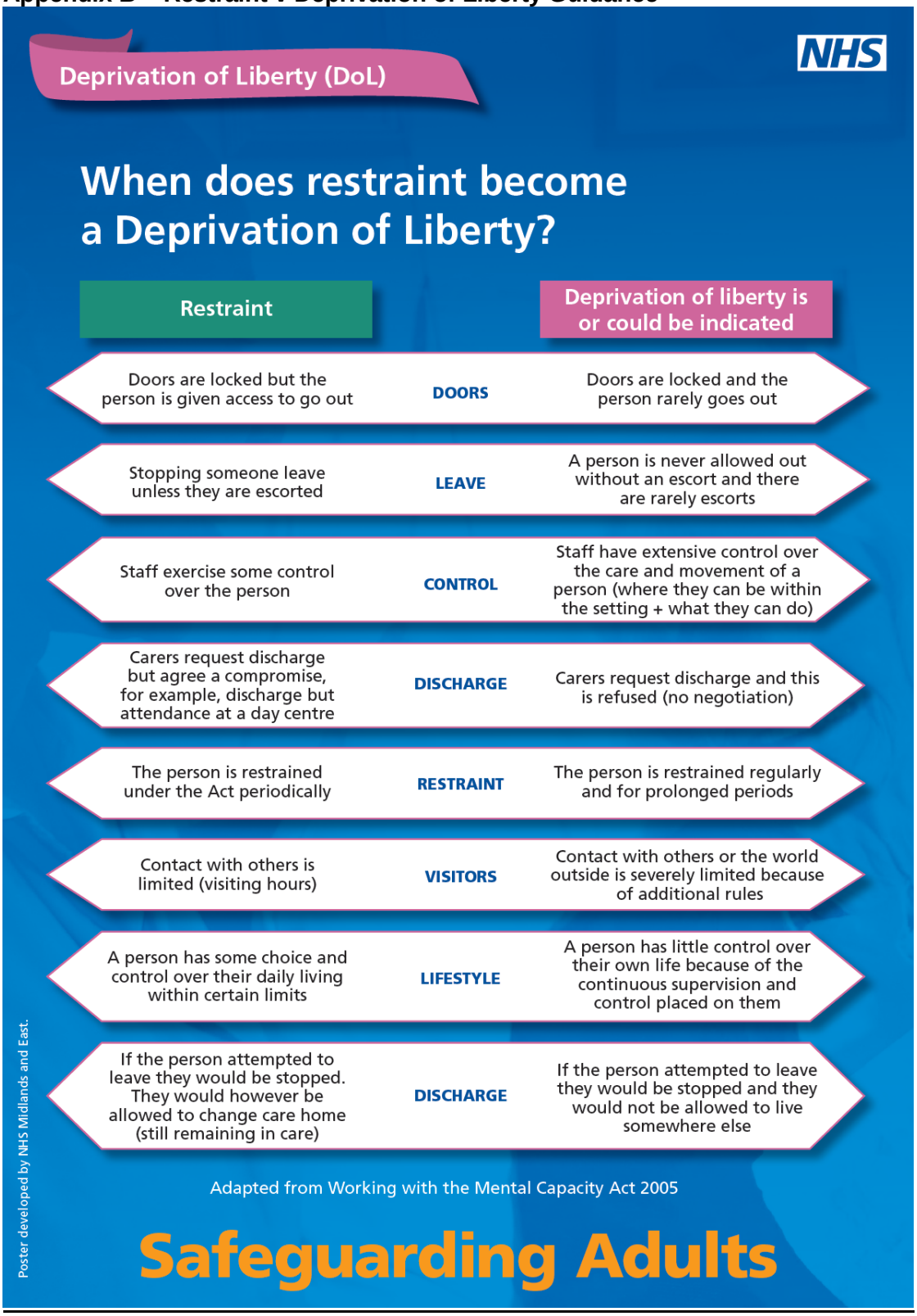
2. Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.

3. Everyone arrested or detained in accordance with the provisions of paragraph 1(c) of this Article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation.

Appendix B – Restraint v Deprivation of Liberty Guidance

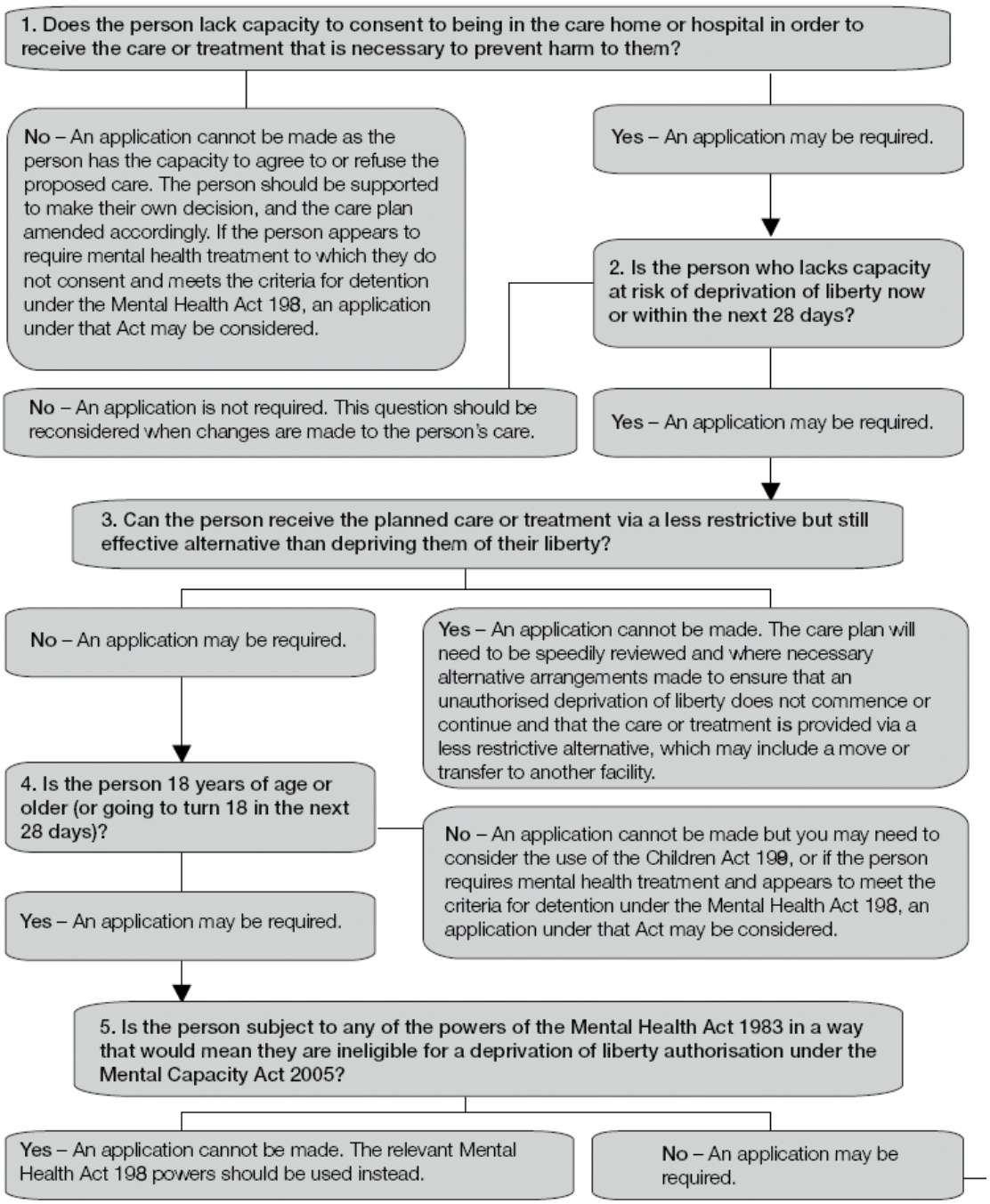


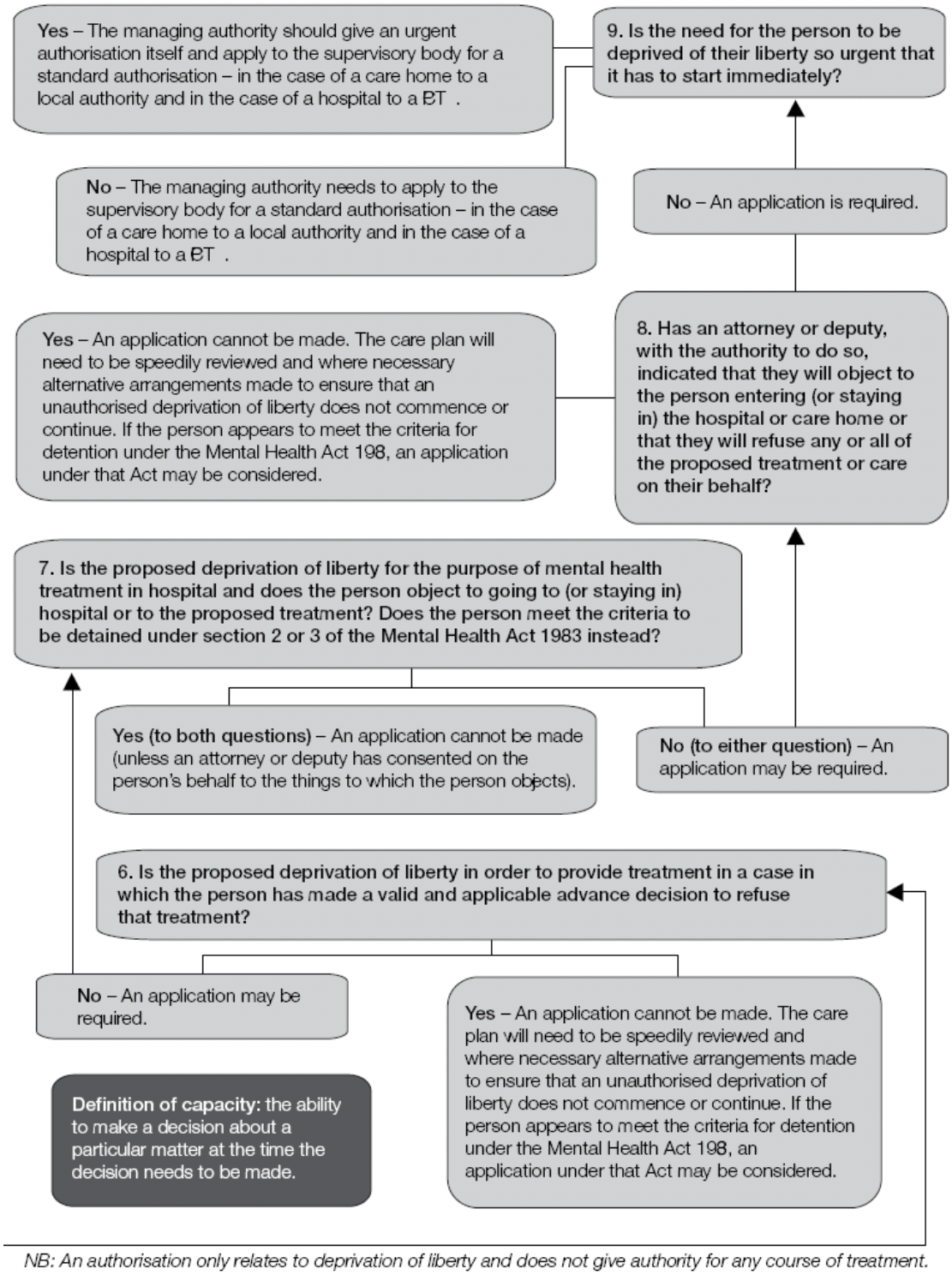
Appendix C – Authorisation Information

Annex 2

What should a managing authority consider before applying for authorisation of deprivation of liberty?

These questions are relevant both at admission and when reviewing the care of patients and residents. By considering the following questions in the following order, a managing authority will be helped to know whether an application for authorisation is required.





NB: An authorisation only relates to deprivation of liberty and does not give authority for any course of treatment.

Appendix D – Deprivation of Liberty

Deprivation of Liberty:
Screening Checklist

Patient Label

The following questions are to be asked about each patient who (after having completed the 2-stage test of capacity according to the Mental Capacity Act 2005) does not have the capacity to give informed consent about being at the hospital. If it is *obvious* that the answer to every question is NO, the person is then UNLIKELY to be being deprived of their liberty.

How the Person was Admitted to the Hospital

1. Were force or sedatives used because the person was resisting being admitted? (This does not include the use of benign force, such as gently guiding someone by the arm)	Yes ☐	No ☐
2. Was the person deceived to make sure they co-operated? – for instance were they misled into believing that they would return home the next day?	Yes ☐	No ☐
3. Did the person's relatives, or carers who live with the person object to them being admitted?	Yes ☐	No ☐

Current Arrangements

4. Is the person sedated to prevent them leaving? Use of sedatives does not itself mean that a person is deprived of liberty - it is only relevant if the purpose is to prevent the person from leaving the establishment	Yes ☐	No ☐
5. Does the patient make persistent or purposeful attempts to leave, which are prevented by means of force or a locked door? A locked door does not constitute deprivation on its own, even if its purpose is to prevent patients from wandering. Likewise for the use of benign force, such as gently guiding someone by the arm to return them to the ward when they are wandering. This test is met only if the patient's attempts to leave are PERSISTENT and/or PURPOSEFUL.	Yes ☐	No ☐

6. Is Force being used to treat the patient when they are resisting, other than in an emergency? Use of benign force to administer medication, or feed or dress someone, does not deprive someone of their liberty. Emergencies could include disturbed, threatening or self-harming behaviour.	Yes ☐ No ☐
7. Have relatives or carers asked for the person to be discharged to their care, and been refused?	Yes ☐ No ☐
8. Have relatives or carers been refused access to the person, or had severe restrictions put on their access? Reasonable restrictions on visiting hours etc are not relevant	Yes ☐ No ☐
9. Has the person been prevented from spending time with the people who matter to them? This would, for instance, include preventing the person from spending time with friends inside or outside of the ward. It would **not** include guiding the person away from casual acquaintances who appear to be abusing or exploiting the person, or reasonable restrictions on the times when the person can socialise with friends, for instance because of the pattern of the hospital's daily routine.	Yes ☐ No ☐
10. Does the way the patient's care is organised severely restrict what they can do in other ways? An example of a severe restriction would be placing the patient for a large portion of their waking time in a position which prevents them from moving (e.g. using furniture that they cannot get up from). It would not be a severe restriction to use furniture designed to keep the person safe, which they cannot get up from unaided, if they are usually able to get help to get to get out of it when they show a persistent or purposeful desire to do so.	Yes ☐ No ☐
11. Has the patient's access to the community been severely restricted because of concerns about public safety? It is not deprivation of liberty to require someone to be escorted on trips out of the hospital, if this is in the interest of their own safety rather than that of others, even if that means that the patients is temporarily not	Yes ☐ No ☐

permitted to leave	

Name:……..

Signature:……
……

Position/Grade:……
……..

Date:……

NB. To be filed in the Patient's notes on completion

Appendix E – Norfolk County Council Information

Norfolk County Council
at your service

What you need to know &Contact Details Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DOLS)

- Residential Care Homes
- Residential Care Homes with Nursing
- Hospitals
- Nursing Homes

Introduction

Do you work in a Hospital, Nursing Home or Care Home that provides care for people who cannot make Decisions about their care or Treatment?

A new system which applies to all hospitals, nursing homes and care homes begins on 1st April 2009.

Some people living in hospitals, nursing homes and care homes cannot make their own decisions about their care and/or treatment because they lack the mental capacity to do so.

People in this situation need more care and protection than others to ensure they don't suffer harm. Caring for and treating people who need extra protection may mean restricting their freedom to the point of depriving them of their liberty.

The MCA DOLS will protect people who cannot make decisions about care or treatment, who need to be cared for in a restrictive way. For example, some people who have dementia, a mental health problem, brain injury or a severe learning disability.

The MCA DOLS must be used for people who receive care and/or treatment in circumstances that amount to a Deprivation of Liberty in order to protect them from harm and which is in their '**Best Interests**'

What does the Law say Hospitals, Nursing Homes and Care Homes must do?

For every person living in a hospital, a nursing home or care home who lacks capacity, you should think about the following questions:

Does the care and/or treatment being provided take away the person's freedom to do what they want to do, to the extent that they are being deprived of their liberty?

Do you believe that the care and/or treatment is in the person's best interests?

If the answer to either of the questions is **'Yes'**, you need to ask yourself: **whether the care and/or treatment could be given in a way which does not take away the person's liberty.**

If the answer to the above is '**No**' and the person cannot be (cared for and/or treated) in any other way, the Primary Care Trust (for hospitals) or Local Authority (for nursing homes and care homes) must be asked to carry out an assessment to decide if it is right to take away the person's liberty.

Not every assessment will result in an authorisation. However, once a person in a hospital, a nursing home or care home has an MCA DOLS authorisation, a representative is appointed to support them and look after their interests.

The Hospital, Nursing Home or Care Home (together with the Primary Care Trust or Local Authority) must:

1 Make regular checks to see if the authorisation is still necessary

2 Remove the Authorisation where it is no longer necessary

3 Provide the person who has an MCA DOLS Authorisation and their Representative with information about the Authorisation and their Rights and Entitlements.

Record Keeping

Hospitals, Nursing Homes and Care Homes must keep **detailed records** as part of the MCA DOLS process.

To help with this record-keeping requirement, and to make sure the administration of the MCA DOLS system is as simple as possible, a number of standard forms have been developed for hospitals, nursing homes and care homes as well as Primary Care Trusts and Local Authorities.

What should I do?

Carers
Raise any concerns you may have with your Manager and ensure your discussions about people who may be deprived of their liberty are documented in their Care Plans.

It is your Manager's Responsibility to forward any concerns to the Primary Care Trust or Local Authority.

In the event that you feel unhappy about the response given to your concerns please ring the Supervisory Body for guidance.

Managers
It is your responsibility to assess people in your care and ensure Deprivation of Liberty is not occurring.

If you assess it is in the person's 'Best Interests' to be deprived of their liberty you must follow the process described in the Deprivation of Liberty Safeguards Code of Practice.

Who Can I Contact?

Supervisory Body
01603 729100
(09.00 am – 5.00 pm)

Out of Office Hours
0844 800 8020

To fax forms to the DoLS Team
01603 762445

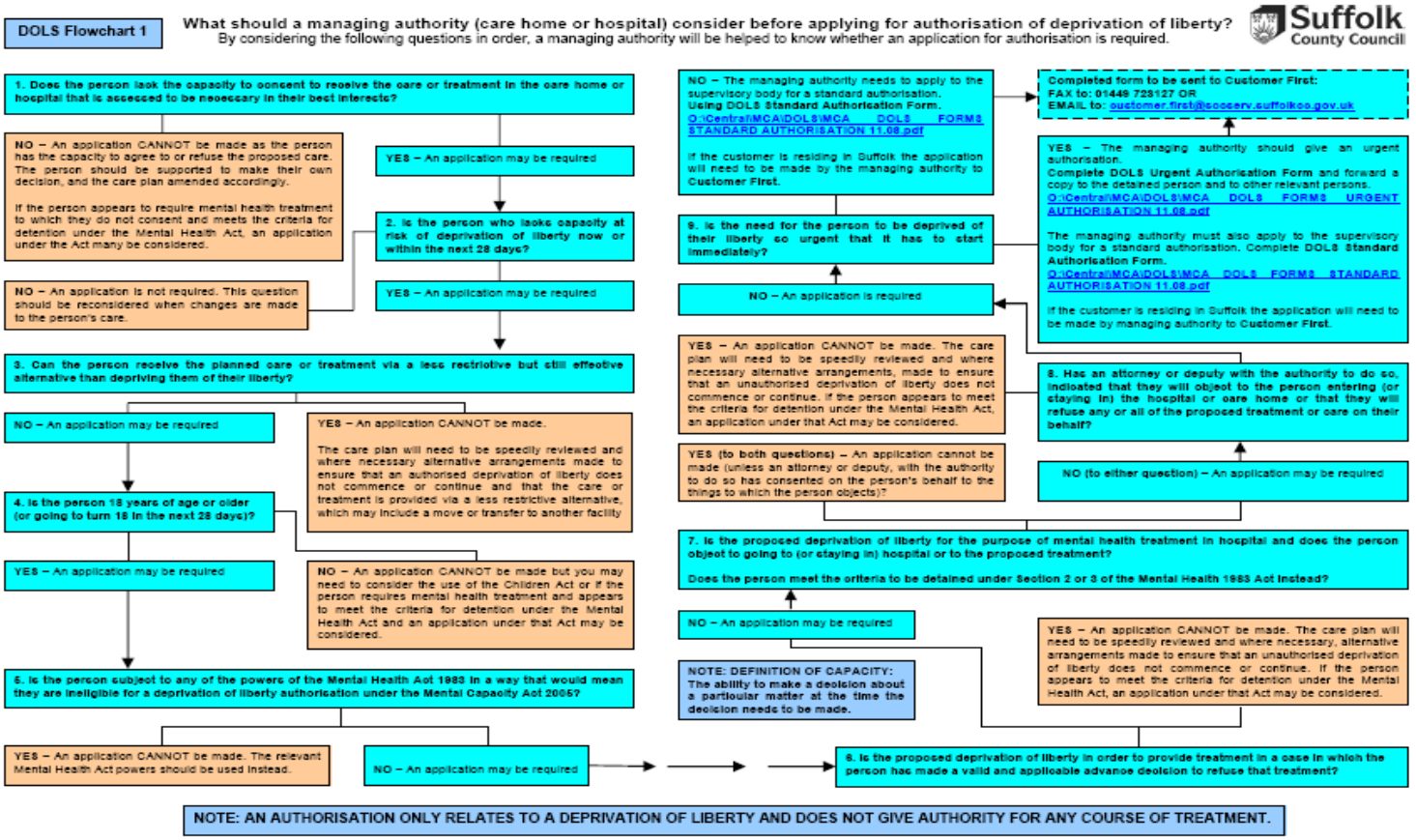
For Further Information visit:

http://www.norfolk.gov.uk/mentalcapacityact
Norfolk County Council, Adult Social Services Mental Capacity Act and Deprivation of Liberty Safeguards web page

http://www.dh.gov.uk
Department of Health

www.publicguardian.gov.uk
This website provides copies of the Codes of Practice (MCA and DOLS) and Making Decision Booklets which are available free to download

Appendix F – Suffolk Contact Information



Appendix G – Supervisory Bodies Contact Details

SUPERVISORY BODIES CONTACT DETAILS

Norfolk Helpline: 01603 729100 (0900 – 1700)
DoLS Team FAX 01603 762445

Suffolk

The application to Customer First must be on the standard application form and be made in writing

This form can be emailed (preferred option) to customer.first@socserv.suffolkcc.gov.uk or faxed to Customer First on 01449 723127

Appendix H – Urgent Authorisation Form 1

For the complete form please click the link:

200984133516_Depr
ivation of Liberty Safe

CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 1

URGENT AUTHORISATION

PART A — BASIC INFORMATION

Full name of the person being deprived of their liberty	Name	
Their date of birth (or estimated age if unknown)	DOB	
	Est. age	Years
Name and address of the hospital or care home where the person is being deprived of their liberty	Name	
	Address	
Person to contact at the hospital or care home	Name	
	Telephone	
	Email	
Name and address of the managing authority responsible for the hospital or care home (the person registered under Part 2 of the Care Standards Act 2000, or the NHS trust that manages the hospital)	Name	
	Address	
Name of the PCT or local authority to whom this form is being sent ('the supervisory body')	Name	

PART B — THE MANAGING AUTHORITY'S DECISION

It appears to the managing authority that ALL of the following conditions are met.

An urgent authorisation may only be given if the person appears to meet ALL of the conditions below (B1–B10). Place a cross in EACH box to confirm that the person appears to meet the particular condition.

1

Appendix I – Extension Authorisation Form 2

For the complete form please click the link:

200984133640_Depr
ivation of Liberty Safe

CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 2

REQUEST FOR EXTENSION OF URGENT AUTHORISATION

Important note: it is essential that you make any necessary request for an extension promptly. You can request an extension by completing this form, or orally (e.g. by telephone) or in some other way (e.g. by email or fax). In all cases, you must give the person being deprived of their liberty, and any section 39A IMCA acting for them, notice in writing that you have made the request.

PART A — BASIC INFORMATION

Full name of the person being deprived of their liberty	Name	
Their date of birth (or estimated age if unknown)	DOB	
	Est. age	Years
Name and address of the hospital or care home where the person is being deprived of their liberty	Name	
	Address	
Person to contact at the hospital or care home	Name	
	Telephone	
	Email	
Name and address of the managing authority responsible for the hospital or care home (the person registered under Part 2 of the Care Standards Act 2000, or the NHS trust that manages the hospital)	Name	
	Address	
Name of the PCT or local authority to whom this form is being sent ('the supervisory body')	Name	

PART B — THE REQUEST FOR AN EXTENSION

A standard authorisation has been requested for this person.

An urgent authorisation is in force. This existing urgent authorisation expires at the end of the day on:

Enter above the date on which the urgent authorisation is due to expire ⇧

1

Appendix J– Standard Authorisation Form 4

For the complete form please click the link:

20098413443_Depri
vation of Liberty Safe

CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 4

REQUEST FOR A STANDARD AUTHORISATION

Important notes: Regulation 16 of The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 (SI 2008 No. 1858) contains requirements about the information to be provided in a request for a standard deprivation of liberty authorisation.

Regulation 16 states that the information in Part A of this form must be included in every request for a standard authorisation.

The information in Part B should be provided if it is available to, or could reasonably be obtained by, the managing authority. The information in Part B does not need to be re-provided in cases where there is already an existing standard authorisation if that information remains the same as supplied with the request for the earlier authorisation. However, this does not apply to the information about an existing authorisation covered in box B14 of this form.

Part C covers further information that might helpfully be provided by the managing authority.

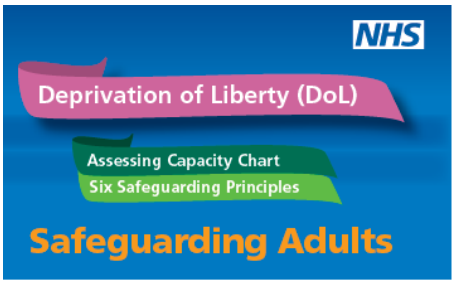
The supervisory body should ensure that each assessor, and any instructed IMCA, receives a copy of this form as soon as possible.

PART A — INFORMATION THAT MUST BE PROVIDED

A1	Full name of the person who needs to be deprived of their liberty in this hospital or care home	Name	
A2	Their gender	Male ☐	Female ☐
A3	Their date of birth (or estimated age if unknown)	DOB	
		Est. Age	Years
	The age range within which the person falls	**Place a cross in ONE of the boxes below ⇩**	
	18–64	☐	
	65–74	☐	
	75–84	☐	
	85+	☐	

1

Appendix K– Assessing Capacity



Safeguarding Adults

Assessing Capacity Chart

1 **Is there an impairment or disturbance** in the functioning of mind or brain? (permanent or temporary)

NO → **Impairment is not present** record refusal and arrange safety netting, the patient is deemed capable

YES ↓

2

With all possible help given, is the person able to understand the information relevant to the decision?
YES / NO

&

Are they able to retain the information long enough to make the decision?
YES / NO

&

Are they able to weigh the information as part of the decision making process?
YES / NO

&

Are they able to communicate the decision?
YES / NO

Has capacity	Lacks capacity

If the answer to 1 is YES and the answer to any of 2 is NO then the person lacks capacity under the Mental Capacity Act 2005.

Adapted from East Midlands Ambulance Service Trust

Your responsibilities

You have a responsibility to follow the 6 safeguarding principles:

Principle 1

Empowerment

Presumption of person led decisions and consent: Adults should be in control of their care and their consent is needed for decisions and actions designed to protect them. There must be clear justification where action is taken without consent such as lack of capacity or other legal or public interest justification. Where a person is not able to control the decision, they will still be included in decisions to the extent that they are able. Decisions made must respect the person's age, culture, beliefs and lifestyle.

Principle 2

Protection

Support and representation for those in greatest need: There is a duty to support all patients to protect themselves. There is a positive obligation to take additional measures for patients who may be less able to protect themselves.

Principle 3

Prevention

Prevention of harm or abuse is a primary goal: Prevention involves helping the person to reduce risks of harm and abuse that are unacceptable to them. Prevention also involves reducing risks of neglect and abuse occurring within health services.

Principle 4

Proportionality

Proportionality and least intrusive response appropriate to the risk presented: Responses to harm and abuse should reflect the nature and seriousness of the concern. Responses must be the least restrictive of the person's rights and take account of the person's age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way.

Principle 5

Partnerships

Local solutions through services working with their communities: Safeguarding adults will be most effective where citizens, services and communities work collaboratively to prevent, identify and respond to harm and abuse.

Principle 6

Accountability

Accountability and transparency in delivering safeguarding: Services are accountable to patients, public and to their governing bodies. Working in partnerships also entails being open and transparent with partner agencies about how safeguarding responsibilities are being met.

(Ref: The role of Health Service Practitioners DH 2011)

Abuse thrives on secrecy. You have a duty to share infomation.

Appendix L - Equality Impact Assessment

Policy or function being assessed: Deprivation of Liberty Safeguards Policy and Procedure **Department/Service: Education and Practice Development**
Assessment completed by: Cherry Townsend/Claire Ward **Date of assessment: 28.11.13**

1.	Describe the aim, objective and purpose of this policy or function.		To inform staff about the deprivation of liberty safeguards and instruct them on the procedure to follow in order to obtain authorisation for a DOL	
2i.	Who is intended to benefit from the policy or function?		**Staff X** **Patients X** **Public □** **Organisation X**	
2ii	How are they likely to benefit?		The Policy ensures that the application for deprivation of Liberty conforms with the DOLS Code of Practice	
2iii	What outcomes are wanted from this policy or function?		A clear understanding of what a DOL may be, and the procedure to follow should a DOL be considered for a JPUH Patient.	
For Questions 3-11 below, please specify whether the policy/function does or could have an impact in relation to each of the nine equality strand headings:				
3.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **race/ethnicity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
4.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **gender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
5.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **disability?** Consider Physical,	**Y**		The policy has the potential to detrimentally affect the liberty of any patient who meets the eligibility criteria but particularly those with learning disabilities or cognitive impairment

	Mental and Social disabilities (e.g. Learning Disability or Autism).			
6.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **sexual orientation?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
7.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **pregnancy or maternity?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
8.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **religion/belief?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
9.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **transgender?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
10.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **age?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
11.	Are there concerns that the policy/function does or could have a detrimental impact on people due to their **marriage or civil partnership?**		**N**	If yes, what evidence do you have of this? E.g. Complaints/Feedback/Research/Data
12.	Could the impact identified in Q.3-11 above, amount to there being the potential for a disadvantage and/or detrimental impact in this policy/function?		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
13.	Can this detrimental impact on one or more of the above groups be justified on the grounds of promoting equality of opportunity for another group? Or for any other reason? E.g. providing specific training to a particular group.		**N**	*Where the detrimental impact is unlawful, the policy/function or the element of it that is unlawful must be changed or abandoned. If a detrimental impact is unavoidable, then it must be justified, as outlined in the question above.*
14.	**Specific Issues Identified**			

	Please list the specific issues that have been identified as being discriminatory/promoting detrimental treatment		Page/paragraph/section of policy/function that the issue relates to
15.	**Proposals**		
	How could the identified detrimental impact be minimised or eradicated?	N/A	
	If such changes were made, would this have repercussions/negative effects on other groups as detailed in Q. 3-11?		**N**
16.	Given this Equality Impact Assessment, does the policy/function need to be reconsidered/redrafted?		**N**
17.	**Policy/Function Implementation**		
	Upon consideration of the information gathered within the equality impact assessment, the Director/Head of Service agrees that the policy/function should be adopted by the Trust. Please print: **Name of Director/Head of Service:** Sharon Crowle **Title: Head of Education and Practice Development** **Date:** 28.11.13 **Name of Policy/function Author:** Claire Ward/ Cherry Townsend **Title: Practice Development Nurse** **Date:** 28.11.13 (A paper copy of the EIA which has been signed is available on request).		
18.	**Proposed Date for Policy/Function Review** November 2016		

	Please detail the date for policy/function review (3 yearly): November 2016
19.	**Explain how you plan to publish the result of the assessment?** *(Completed E.I.A's must be published on the Equality pages of the Trust's website).*
	Standard Trust process
20.	**The Trust Values**
	In addition to the Equality and Diversity considerations detailed above, I can confirm that the four core Trust Values are embedded in all policies and procedures. They are that all staff intend to do their best by: Putting patients first, and they will: Provide the best possible care in a safe clean and friendly environment, Treat everybody with courtesy and respect, Act appropriately with everyone. Aiming to get it right, and they will: Commit to their own personal development, Understand theirs and others roles and responsibilities, Contribute to the development of services Recognising that everyone counts, and they will: Value the contribution and skills of others, Treat everyone fairly, Support the development of colleagues. Doing everything openly and honestly, and they will: Be clear about what they are trying to achieve, Share information appropriately and effectively, Admit to and learn from mistakes. I confirm that this policy/function does not conflict with these values. ☑