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| Case ID Number:(For DoLS Office Use)  |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1****REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION**Place an ‘X’ in relevant box |
| 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 if appropriate/required)*** |  |
|  |
| Full name of person being deprived of liberty (hereafter referred to as the **Relevant Person**) |  |
| Date of Birth  |  | Est. Age |  | Gender |  |
| Relevant Medical History (*including diagnosis of mental disorder if known*) |
|  |
| Sensory Loss |  | CommunicationRequirements |   |
| Name and address of the care home or hospital requesting this authorisation |  |
| Usual address of the Relevant Person(If different to above) |  |
| Person to contact at the care home or hospital | Name |  |
| Telephone |  |
| Email |  |
| Ward (if appropriate) |  |
| Name of the Supervisory Body (Where this form is being sent) |  |
| How the care is funded*Care funding affects which authority is responsible for this Case, please see end of form for details.* | Local Authority ***please specify*** |  |
| CCG***please specify*** |  |
| NHS |  | Local Authority and NHS (jointly funded) |  |
| Self-funded by person\* |  | Insurance or other |  |
|  |
| \*Where self-funded, was the placement arranged or assessed by a Local Authority? | Yes | *Please Specify* | No | N/A |
|  |  |  |  |
| \*Where self-funded, is there a continuing service agreement with a Local Authority? | Yes | *Please Specify* | No | N/A |
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| **RESTRICTIONS CHECKLIST** |
| Please indicate which restrictions you believe apply. Details of these, including the frequency and intensity of the restrictions, must be provided in the ‘Purpose of the Standard Authorisation’ section below. Note this is not a full list of restrictions and is used solely for guidance purposes.*Please place ‘X’ in relevant boxes* |
| Unpredictable, unstable or worsening behaviours with potential for harm to self and/ or others |  |
| 1:1 Supervision (E.g. carer performing continuous supervision or observations on 15-30 min schedule) |  |
| Objections to placement, care and/ or treatment, by the Relevant Person(E.g. verbal objections or physical resistance to care/ treatment) |  |
| Objections to placement, care and/ or treatment, by relatives or friends |  |
| Relevant Person making meaningful attempts to leave |  |
| Use of force or restraint to prevent Relevant Person leaving |  |
| Frequent/ regular use of medications or sedation to minimise or control behaviours |  |
| Regular use of physical restraint in order to deliver care and/ or treatment (Equipment or persons) |  |
| Restricted access, or no access, to the community (e.g. staff supervision required/ set times/ staff agreement required) |  |
| Restricted visitor contact (E.g. set visiting hours/ supervised contact limited by staff availability - DoLS cannot be used to restrict specific visitor contact) |  |
| Relevant Person has little or no autonomy in decision making about their care and/ or treatment |  |
| Most, or all, of care delivery is initiated by staff, with no input/ control by the Relevant Person (e.g. relevant person is bedbound, subject to scheduled care, etc.) |  |
| Use of behavioural sanctions(E.g. time out, behavioural rewards, etc.)  |  |
| Use of door locks to restrict movement within the home / hospital |  |
| Restricted access to parts of the building for safety purposes(E.g. kitchen, storage rooms, etc.) |  |
| Support required with activities of daily living and/or personal care |  |
| Lack of flexibility(Timetabled activities, set meal times and/or expected sleep times) |  |
| Lack of access to phones, internet or hobby equipment(Due to safety issues or availability) |  |
| Managing Authority/ Welfare appointee manage finances or restrict access to finance |  |

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| **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 days* |  |
| **PURPOSE OF THE STANDARD AUTHORISATION*** *Please describe the care and / or treatment this person is receiving or will receive 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 or will not be free to leave and why they are under continuous or complete supervision and control.*
* *Describe the proposed restrictions or 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.*
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| **INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT** |
| Family member or friend | 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 | Name |  |
| Address |  |
| Telephone |  |
| Any donee of a Lasting Power of Attorney granted by the person | Name |  |
| Address |  |
| Telephone |  |
| Any Personal Welfare Deputy 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 |  |

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| **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 is 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 e.g. application/order/direction, community treatment order, guardianship* |
|  |
| **OTHER RELEVANT INFORMATION** |
| Names and contact numbers of regular visitors not detailed elsewhere on this form: |
| Any other relevant information including safeguarding issues: |
| **PERSON COMPLETING FORM**  |
| Print Name |  | Signature\* |  |
| Date |  | Time |  |
| **I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION** |  |

*\*N.B. Wolverhampton City Council accept typed or electronic signatures, other supervisory bodies may require ‘wet’ signature.*

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| **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) |  |

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| ***ONLY COMPLETE THIS SECTION IF YOU NEED TO GRANT AN URGENT AUTHORISATION, BECAUSE IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS ALREADY OCCURRING, OR ABOUT TO OCCUR, AND YOU REASONABLY THINK THE FOLLOWING CONDITIONS ARE MET*** |
| **URGENT AUTHORISATION****ALLconditions below must be met to be eligible for Urgent Authorisation**  |
| 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 donee of a Lasting Power of Attorney or Personal Welfare Deputy 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 before the request for the Standard Authorisation is made or has been determined |  |
| **AN URGENT AUTHORISATION IS NOW GRANTED** This Urgent Authorisation comes into force immediately. |
| Urgent Authorisation to be in force for a period of:***Maximum period 7 days*** |  | Days |
| Urgent Authorisation will therefore expire at midnight on: |  |
| Print name |  | Signature\* |  |
| Date |  | Time |  |

*\*N.B. Wolverhampton City Council accept typed or electronic signatures, other supervisory bodies may require ‘wet’ signature.*

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| **REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION***If Supervisory Body is unable to complete the process to give a Standard Authorisation (which has been requested) before the expiry of the existing Urgent Authorisation* |
| An Urgent Authorisation is in force and a Standard Authorisation has been requested. |
| The Managing Authority now requests that the duration of this Urgent Authorisation is extended for a further period of:***Maximum period 7 days***  |  | 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):* |
| Name |  | Date |  |
| **RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED** |
| FOR COMPLETION BY SUPERVISORY BODYThe duration of this Urgent Authorisation has been extended by the Supervisory Body. |
| It is now in force for an additional period of:***Maximum period 7 days*** |  | Days |
| This Urgent Authorisation will now expire at the end of the day on: |  |
| **SIGNED**(on behalf of the Supervisory Body) | Signature |  |
| Print Name |  |
| Date |  | Time |  |

**COMPLETED FORMS SHOULD BE EMAILED TO THE RELEVANT DoLS TEAM, IN LINE WITH YOUR ORGANISATIONS SECURE INFORMATION POLICY**

*Local Authority responsibility for DoLS cases is determined by the Relevant Persons* [Ordinary Residence](https://www.gov.uk/government/collections/ordinary-residence-pages)

**Self-funders**

The Ordinary Residence of a self-funding Service User is the Local Authority area of the Care Home where they are resident, with two exceptions;

* Where the placement was arranged or assessed by another Local Authority
* Where another Local Authority has a continuing service agreement for the Relevant Person

Where these exceptions apply, the involved authority is also responsible for the DoLS case.

**Funded**

Where a Service User is funded by a Local Authority that authority area remains their Ordinary Residence, regardless of the location they are placed in.

Please note Continuing Health Care (CHC) funding is not considered funding by a Local Authority, in these cases the persons last known Ordinary Residence, prior to the CHC funding, should be used.

**Hospital**

Service Users admitted from their home address will remain Ordinary Resident in the Local Authority covering that address; Service users admitted from a Care Home will remain ordinary resident as per the above, please check with the Care Home prior to submitting your referral.

*Please ensure you are sending documentation to the appropriate Local Authority, forwarding information to the incorrect DoLS team may result in delays in processing.*

**DUDLEY DOLS TEAM**

 Email: d.dols@nhs.net

PHONE: 01384324542