|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Case ID Number: | | | | | | | | | |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 3B**  **AGE, MENTAL CAPACITY, NO REFUSALS, BEST INTERESTS ASSESSMENTS**  **AND SELECTION OF REPRESENTATIVE** | | | | | | | | | |
| *This combined form is being used for the purpose of assessment where a request for a further authorisation has been made. It will need to be read in conjunction with a full Form 3 from a previous assessment at the same location.* | | | | | | | | | |
| **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 further request for a Standard Authorisation | | | | | | | | |  |
| Full name of the person being assessed | | | |  | | | | | |
| Date of birth | | | |  |  | | |  | |
| *This also constitutes as the Age Assessment.* | | | | | | | | | |
| Name and address of the care home or hospital in which the person is, or may become, deprived of liberty | | | |  | | | | | |
| Name of the Assessor | | | |  | | | | | |
| Address of the Assessor | | | |  | | | | | |
| Profession of the Assessor | | | |  | | | | | |
| Name of the Supervisory Body | | | |  | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **In carrying out this assessment I have met or consulted with the following people** | | | |
| **NAME** | **ADDRESS** | **CONNECTION TO PERSON BEING ASSESSED** | |
|  |  |  | |
|  |  |  | |
|  |  |  | |
| **The following interested persons have not been consulted for the following reasons** | | | |
| **NAME** | **REASON** | **CONNECTION TO THE PERSON BEING ASSESSED** | |
|  |  |  | |
| **I have considered the following documents** *(e.g. current care plan, medical notes, daily record sheets, risk assessments) to confirm all details remain the same.* ***If there are any material changes please use Form 3.*** | | | |
| **DOCUMENT NAME** - I have reviewed the following documents to confirm all details remain the same | | | **DATED** |
|  | | |  |

|  |  |
| --- | --- |
| **MENTAL CAPACITY ASSESSMENT** | |
| The following practicable steps have been taken to enable and support the person to participate in the decision making process: | |
| In my opinion the person **LACKS** capacity to decide whether or not they should be accommodated in this hospital or care home 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 for the purpose of being given the proposed care and/or treatment |  |
| **Stage One:** What is the impairment of, or disturbance in the functioning of the mind or brain? | |
|  | |
| **Stage Two:** Functional test | |
| 1. **The person is unable 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 unable 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 unable to use or 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 unable 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.* |  |
| **Stage Three:** *Explain why the person is unable to make the specific decision because of the impairment of, or disturbance in the functioning of, the mind or brain.* | |
|  | |

|  |  |
| --- | --- |
| **NO REFUSALS ASSESSMENT** *This form should only be used if there continues to be no conflict therefore if any conflict has arisen please fill in Form 3* | |
| 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. |  |
| 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. |  |
| 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 assessments of the person’s needs in connection with accommodating the person in the hospital or care home |  |
| I have taken into account any care plan that sets out how the person’s needs are to be met while the person is accommodated in the hospital or care home |  |
| 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 |  |
| I confirm that I have reviewed the persons case including - **Background Information**,**The persons views** and **The views of others** and all facts remain the same**.**  ***Additional Comments.*** |  |

|  |  |  |
| --- | --- | --- |
| **THE PERSON CONTINUES TO BE DEPRIVED OF THEIR LIBERTY**  In my opinion the person is, or is to be, kept in the hospital or care home for the purpose of being given the relevant care or treatment in circumstances that deprive them of liberty  **Note:** *if the answer is No then the person does not satisfy this requirement*  *The reasons for my opinion remain the same as previously stated*. | **YES** |  |
| **NO** |  |
| **It is necessary to deprive the person of their liberty in this way in order to prevent harm to the person.**  *The reasons for my opinion remain the same as previously stated***.** | **YES** |  |
| **NO** |  |
| **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.**  *The reasons for my opinion remain the same as previously stated***.** | **YES** |  |
| **NO** |  |

|  |  |  |
| --- | --- | --- |
| **This is in the person’s best interests.**  **Note:** *you should consider section 4 of the Mental Capacity Act 2005, the additional factors referred to in paragraph 4.61 of the Deprivation of Liberty Safeguards Code of Practice and all other relevant circumstances. Remember that the purpose of the person’s deprivation of liberty must be to give them care or treatment. You must consider whether any care or treatment can be provided effectively in a way that is less restrictive of their rights and freedom of action. You should provide evidence of the options considered. In line with best practice this should consider not just health related matters but also emotional, social and psychological wellbeing.*  *The reasons for my opinion remain the same as previously stated***.**  ***Please note:******If there are additional options which were not previously considered then this should be a full comprehensive consideration and Form 3 should be used.*** | **YES** |  |
| **NO** |  |
| **SUMMARY**  *Please add any additional information from your scrutiny of the persons case. This would include updating any factual details, any additional restrictions in place or any changes in the care plan which do not substantially affect your earlier decision.* ***Please note: any substantial changes would require a new Form 3*** | | |

|  |
| --- |
| **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**  **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 |  | | | | | | |
| **PREVIOUS CONDITIONS** | | | | | | | |
| Previous conditions set have all been met and are therefore no longer needed. | | | | | | |  |
| At least one of the previous conditions set have not been met so I make the recommendations below in addition to setting the condition/s again | | | | | | |  |
| **RECOMMENDATIONS IN RELATION TO PREVIOUS CONDITIONS** | | | | | | | |
|  | | | | | | | |
| **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 existing representative has been selected to continue to act. | | | | | | |  |
| The existing representative is no longer eligible to act and a new recommendation is made below. | | | | | | |  |
| **RECOMMENDATION OF REPRESENTATIVE** –*place a cross in one box* | | | | | | | |
| I recommend that the Supervisory Body continues to appoint the representative previously selected 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 |  | | |