Deprivation of Liberty Safeguarding (DoLs) Policy

Amendments

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Compiled by: Fiona Mitchell, Safeguarding Adult Lead Nurse

Ratified by: Trust Executive Committee

Date: January 2014

Date Issued: February 2014

Next review date: February 2017 or before as required

Target Audience: All staff

Impact Assessment Carried Out by: Fiona Mitchell

Policy Owner: Safeguarding Adult Lead Nurse

Executive Lead: Chief Nurse
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1 Introduction

This guidance is for staff working within the Ashford and St Peter’s Hospitals NHS Foundation Trust (The Trust) who are involved with an adult patient in the decision making with regards to their care and/or treatment ensuring that the best interest of that patient is considered at all times, using a person centred approach.

This is a new policy on the subject of depriving patients of their liberty ensuring that at all times the staff are considering the methods in which to reduce the risk of harm to the patient/others. This policy will ensure that staff are aware of the processes that need to be followed in order to ensure that the decisions are based on the best interest for the patient.

1.1 Action Needed and Owner of Action

Deprivation of Liberty Safeguards needs to be embedded within the organisation, with a full understanding of the DoLS principles to ensure that no patient is held in hospital and being deprived of their liberty. Staff must adhere closely to the Mental Capacity Policy. Any Institution, ward or professional caring for or providing treatment for people with dementia, mental illness or a learning difficulty or an acquired brain injury should be familiar with DoLS Safeguarding. This is irrespective of the person using the services age once they reach adulthood (18 years), including the funding arrangements for their care or the specialty caring for them.

Any updates will be notified to staff via usual Trust communication methods.

1.2 Implementation Plan

This policy will be implemented via staff education and awareness, and via the intranet.

2 Purpose

The introduction of these Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS) was in response to the 2004 European Court of Human Rights judgment (HL v UK (Application No.45508/99)) (the “Bournewood judgment”) involving an autistic man who was kept at Bournewood Hospital by doctors against the wishes of his carers.

The European Court of Human Rights found that admission to and retention in hospital of HL under the common law of necessity amounted to a breach of Article 5(1) ECHR (deprivation of liberty) and of Article 5 (4) (right to have lawfulness of detention reviewed by a court).

The Deprivation of Liberty Safeguards (DoLS) was introduced into the Mental Capacity Act 2005 by the Mental Health Act 1983 following the Bournewood case. The DoLS are designed to protect adults who lack mental capacity against arbitrary decisions depriving them of their liberty by providing a legal process and protection in situations where deprivation of liberty is considered to be in that person’s best interests and is the least restrictive option for providing care and treatment.

An application at (DoLS) Safeguarding within hospitals should be working to ensure they respect peoples human rights and dignity. This is set in Law and includes:

2.1 Deprivation of Liberty Safeguards

The detention of a person against their will, without legal justification, may be unlawful in a number of ways for example:

- Breach of Article 5 of the Human Rights act which forbids the deprivation of a person’s liberty without lawful process including review and right of appeal to a court against the deprivation of liberty
- False imprisonment

The DoLS apply to hospitals and care homes registered under the Care Standards Act 2000. A deprivation of a person's liberty may be authorised only through the DoLS or otherwise by order of the Court of Protection. The DoLS do not apply to persons detained under the Mental Health Act 1983.

3 Definitions

3.1 What is a Deprivation of Liberty?

Although there is no legal definition of what might constitute a deprivation of liberty, previous case law offers some guidance:

- Patients managed by clinical/social care professional have not been given the opportunity to exercise their choice with regards to their movement or care over a significant period of time.
- The patient would be prevented from leaving the hospital or care home if they attempted to do so.
- The hospital or care home refuses a request by carers to discharge the patient to their care.
- The patient’s autonomy or freedom of association with others whether within the hospital/care home or wider community is denied or severely restricted by reason of the care regime imposed.
- Force, including sedation and threats, used to:
- Take a resisting patient to a hospital or care home
- Preventing the patient from leaving the hospital or care home
- The journey to the hospital or care home is exceptionally long or onerous for the patient.

This is not an exhaustive list and subject to change. Further guidance can be found in the Deprivation of Liberty Safeguards Code of Practice, from the Department of Health.
4 Responsibilities

4.1 Management

Senior managers need to ensure that the Trust’s delivery of care is in line with the Mental Capacity Act 2005. This MCA 2005 consolidates the human rights law for people who might lack capacity to make their own decisions. This is the foundation for DoLS.

4.2 All Staff

Staff are responsible for reporting and identifying where a DoLS is/has occurred or may occur. An incident should be reported to the line manager and escalated to the Clinical Nurse Leader.

All staff must comply with conditions set as part of the granting of an urgent and standard authorisation. Both an urgent and standard application must be made together simultaneously.

The DoLS advisor must be enabled to maintain reasonable contact with the patient. The role is explained to them. Any request for authorisation under DoLS must first meet the general requirements of the MCA. Care planning must be compliant with the Act.

4.3 Deprivation of Liberty Leads

DoLS/Clinical Nurse Leaders are required to:

- Complete the urgent authorisation form for potential Deprivation of Liberty Safeguards and ensure that the form is submitted to the DoLS assessor. DoLS Leads are requested to disseminate learning in their areas regarding DoLS with the support of the Safeguarding Adult Lead Nurse.

- Notifying the patient and their families when urgent authorisations and standard applications have been submitted.

- To monitor the care plan to see that the six qualifying requirements for a DoLS authorisation are still met.

- To report any significant changes, including no longer meeting any of the qualifying requirements or ending of the DoLS, to the supervisory body and a request to review DoLS.

Example from practice: Appendix 1.

5 Process

The ‘Being Open’ process should be followed when a deprivation of liberty case is noted. The patient’s medical record should reflect the discussions that have taken place between the patient, staff and the relatives/carer.

The Trust is responsible as the ‘managing authority’ for making an application to the relevant Supervisory Body (Local Authority) for authorisation of a Deprivation of Liberty. A Standard Authorisation will be granted subject to ‘qualifying requirements’ being met as follows:
• **Age requirement:** the person must be aged 18 or over.

• **Mental health requirement:** the person must be suffering from a mental disorder. This includes learning disability regardless of whether the disability is associated with abnormally aggressive or seriously irresponsible conduct.

• **Mental Capacity requirement:** the person must lack the mental capacity required to make a decision whether or not he should stay in the hospital or care home for the purpose of receiving the relevant care or treatment.

• **Best Interests requirement:** this requires an assessment of whether there is in fact a deprivation of liberty and if so, whether the deprivation is in the person’s best interests, is necessary to prevent harm to the person, and is a proportionate response to the likelihood and seriousness of that harm.

• **Eligibility requirement:** a person may not be deprived of their liberty under the Act if he is, or might be subject to the Mental Health Act 1983.

• **No refusals requirement:** this is to establish whether there is any other existing authority that might prevent DoLS being authorised. This could include decisions by a donee of an enduring or lasting power of attorney, or an advance decision not to have a particular treatment in circumstances where the application is for the purposes of enabling that treatment.

The DoLS process also provides for urgent authorisations to be given as well as review of the authorisation. Persons subject to an authorisation may also appeal directly to the Court of Protection.  

**Complete Urgent Authorisation Deprivation of Liberty Form No. 1 Appendix 2. Complete Standard Authorisation Deprivation of Liberty Form No. 4 Appendix 3.**

• If authorisation is refused or cannot be given because the qualifying criteria has not been met, the matter may need to be referred to the Court of Protection.

### 6 Procedure within the trust for a person who lacks capacity

Refer to Flowchart 1 (Appendix 4) and Flowchart 2 (Appendix 5) to ensure the person meets the criteria for DoLS.

• **For urgent authorisation,** if a person is having to be re-directed from the door 2-3 times a day because they want to go home, or if they are constantly asking their family to take them home then consideration must be given that there could be a deprivation of liberty occurring. It is vital to exclude delirium prior to this decision being made as it is unlawful to stop someone going out of the door if they have capacity.

• Complete an urgent authorisation form and standard authorisation form.  
**Appendix 2 and 3.** The name of the local authority must be included on the forms. This can be completed by a member of staff (band 6-8) who is concerned after discussion with their manager. The form is then sent to the DoLS assessor for review by fax or scan. It is usual to put a request for a 7 day urgent authorisation, as this allows time for assessment to be completed by Best Interest Assessors.

• The DoLS assessor will come out in order to do an assessment for standard
authorisation. This must be completed within seven days of the original request for urgent authorisation. One extension on an urgent authorisation is permissible. The Trust must apply for this in conjunction with a standard authorisation.

- A care plan must be instigated for a person who has had a DoLS authorisation made.

- Staff (bands 6-8) who are responsible for completing the DoLS urgent authorisation form, must ensure that the (Head of Accreditation and Regulation is informed of the potential deprivation of liberty).

- Staff who complete the DoLS forms must have completed training in order to understand the process.

- If a DoLS authorisation is in place and the person should leave Ashford and St Peters Hospital Trust they can be brought back to the hospital.

- Do not put the forms in the post but send via the safe fax number, or scan in the information and e-mail. Once the information has been faxed or scanned, it is vital that the original paperwork is kept in the patients notes and kept confidential.

- If a person has a standard authorisation placed on them and death occurs this means that the coroner has to be informed as this can be treated as death in custody.

- If a person is transferred from a nursing/residential home with a DoLS authorisation in place the Trust may have to apply for a DoLS authorisation prior to them being admitted. It is important that this information is recorded in the notes.

7 Use of DoLS in hospitals

Introduction

The Safeguards have been in operation since 1 April 2009 and hospitals will be familiar with them, the Regulations supporting the Safeguards, the Code of Practice (DoLS code), guidance and forms. Many will have extensive experience of making applications, the assessment process and putting into practice an authorisation.

This section builds on what has been achieved to date and gives practice examples that promote compliance with the Regulations and Code and the continuing protection of the rights of vulnerable people who are unable to consent to their care and treatment.

The guidance applies to all hospitals (including hospices), whether in the public, private or charity sector, irrespective of type (i.e. acute, community, mental health).

There are estimated to be some 2 million people in England and Wales at any one time who are unable to consent, in whole or part, to their care and treatment. Against this, the number of applications annually for authorisation of a deprivation of liberty is around 11,000, of which about half are authorised. About a third of applications come from the hospital sector. Although the number of applications increases year on year, applications are significantly below the number planned for when the Safeguards were introduced.
For many practitioners the need to use the Safeguards will be infrequent. It is, therefore, important that hospitals do not neglect the Safeguards as a result of a lack of familiarity and find themselves unlawfully depriving a person of their liberty or, conversely, letting a person come to harm when use of the Safeguards might have protected them.

Application of the Safeguards is variable across England. If Leicestershire’s application rate was extrapolated across the country there would be just over 37,000 applications per year but if Reading’s was there would be 341. In 2011/12 the total number of applications made was actually 11,393. The reasons for this are unclear but it may suggest that the Safeguards are not being fully embedded in organisations or that training is inconsistent. A report on the use of the Safeguards in hospital settings highlights the range of training and awareness, as well as wide variations in practice concerning who can sign an urgent authorisation to deprive a patient of their liberty.

As a general guide, any institution, ward or professional caring for or providing treatment for people with dementia, a mental illness, a learning disability or an acquired brain injury should be familiar with the Safeguards. This is irrespective of the person using the service’s age once they reach adulthood (18 years), the funding arrangements for their care or the speciality caring for them — for example, a person with a learning disability may be occupying a surgical bed for removal of tonsils or a person with dementia may be receiving treatment in a medical ward.

Organisations will know that it is unlawful to deprive a person of their liberty in a setting other than a hospital or care/nursing home and any such cases should be referred to the Court of Protection for determination. Examples would be a deprivation of liberty in supported living accommodation or in a person’s own home.

The Care Quality Commission (CQC) provides guidance on both the MCA and DoLS. It is important that providers use it to judge whether they are meeting their duties and responsibilities under the Act.

**The Bournewood judgement**

The Safeguards were introduced to provide a legal framework around deprivation of liberty in a care and treatment setting, and prevent breaches of the ECHR such as that identified by the judgement of the ECtHR in the case of HL v. the United Kingdom (commonly referred to as the ‘Bournewood judgement’, from the name of the hospital involved). The case concerned an autistic man (HL) with a learning disability, who lacked the capacity to decide whether he should be admitted to hospital for specific treatment. He was admitted on an informal basis under the common law in his best interests, but the decision was challenged by HL’s carers, who asked to take him home and were refused.

In its judgement in 2002 the Court held that this admission constituted a deprivation of HL’s liberty in that:

- the deprivation had not been in accordance with ‘a procedure prescribed by law’ and was therefore in breach of Article 5(1) of the Convention
- there had been a contravention of Article 5(4) of the Convention because HL had no means of applying quickly to a court to see if the deprivation was lawful.

The MCA 2005 was amended to provide safeguards for people who lack capacity to consent to treatment or care in either a hospital or a care/nursing home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty.
Winterbourne View and Mid Staffordshire Hospital

The circumstances of HL's care are not isolated. Reports into care, including at Winterbourne View and Mid Staffordshire Hospital, have highlighted issues where basic human rights have not been recognised and people have been neglected and abused as a result.

The Safeguards do not authorise abusive practice and applications should not be seen as a way to legitimise this. On the contrary, an application is a demonstration that staff understand people's rights and are acting to promote and protect their rights and best interests.

- The Safeguards are just part of the framework within which hospitals should be working to ensure they respect people's human rights and dignity. This framework is set down in law and includes:

  - Human Rights Act (HRA) 1998
  - Mental Capacity Act (MCA) 2005
  - Disability Discrimination Acts (DDA) 1995 and 2005
  - Equality Act (EA) 2010

DoLS and the experience of people who use services

Applying the Safeguards should not be seen as something separate from providing core health services. It is integral to the measures a hospital must take to protect and promote the rights of people who use services. Auditing the use of the Safeguards should, therefore, be part of an organisations quality improvement programme covering policy, audit, staff training, patient information, relative involvement and reporting on numbers of applications and outcomes. How the Safeguards are managed and implemented should form part of a hospital's governance programme and the section (below) entitled ‘Applying DoLS in practice’ sets out what the programme in respect of the Safeguards might look like.

DoLS and the MCA 2005

The Safeguards are part of the MCA and cannot be effectively applied unless staff are familiar with the Act and have received appropriate training. The five statutory principles set down in Part 1 paragraph 1 of the Act equally apply to a patient for whom the Safeguards might be relevant:

- a presumption of capacity: every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise in respect of each specific decision

- individuals must be supported to make their own decisions: a person must be given all practicable help before anyone treats them as not being able to make their own decisions

- unwise decisions: just because an individual makes an unwise decision, they should not be treated as lacking capacity to make that decision

- best interests: an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in that person's best interests
- **less restrictive option**: a person doing anything for or on behalf of a person who lacks capacity should consider options that are less restrictive of their basic rights and freedoms while meeting the identified need.

The less restrictive option is particularly important in relation to the Safeguards. For example, an incapacitated person on a medical ward receiving treatment for diabetes is prone to wander and might get lost and come to harm. They are persistently trying to leave the ward to the extent an authorisation under the Safeguards might be required. Staff need to consider the steps necessary to protect the person from harm while at the same time ensuring those actions are the least restrictive possible of the person's basic rights and freedoms.

**Applying DoLS in practice**

As part of a hospital's quality improvement and governance arrangements there should be a framework in place that promotes the effective use of the Safeguards. (For the purposes of the legislation, a hospital considering an application for a deprivation of liberty authorisation is known as a 'managing authority'.)

The framework used by all hospitals should include the following.

- **Staff training** on the Safeguards (as part of wider MCA training) so that staff know how to assess for deprivation of liberty and recognise when care goes beyond restriction of movement and restraint which is lawful under the Act and towards deprivation of liberty. This training should feature in induction, training and refresher programmes and records of completed training should be kept.

- An **organisational policy and procedure** with particular reference to sections relating to training, levels of responsibility, access to and completion of requests for standard authorisations, urgent authorisations and situations in which they can be used.

- A **schedule of senior staff authorised to sign off applications** before they are submitted to the supervisory body.

- **Guidance on care planning** which includes the Safeguards and explains how they support an effective care plan and are not a substitute for good care planning. Consideration should always be given to finding wherever possible alternatives to depriving a person of liberty: evidence of such consideration is explicitly required to create an urgent authorisation and in the application process for a standard authorisation.

- **Arrangements for training on restriction and restraint** and associated record-keeping, with particular reference to care that moves from restriction and restraint towards deprivation of liberty. Staff should be sensitive to the relationship between restriction, restraint and deprivation of liberty and aware that whenever restriction is being used or considered it could in fact be a deprivation of liberty. If there is doubt an assessment should be sought, as explained in this resource.

- **Procedures for scrutinising care plans** by the hospital, to ensure that the least restrictive option is chosen which meets the need to prevent any likely harm to the person using the service, and is proportionate to that harm.

- **A policy on how the hospital involves the** person using the service (known within the DoLS process as the ‘relevant person’), and their family and carers in decision-making.
• A programme of **audit work** covering application of the Safeguards.

• A **named person** with responsibility for responding to CQC reports, relating to the hospital's compliance with the MCA and DoLS.

• **Arrangements for urgently reviewing care plans** in circumstances where a best interests assessor finds a relevant person subject to a deprivation of liberty regime which is found not to be in that person's best interests.

• A **named person** with the duty to report DoLS applications and outcomes to the CQC.

• A **named person** with the duty to report DoLS applications, trends and problems to the hospital board overseeing quality.

• A **policy** on where responsibility lies for the preparation and review of care plans.

• A **policy** on working in partnership with supervisory bodies and supporting assessors with access to records, and enabling them to interview the relevant person and their family/carers.

• **Location of application forms** (electronic versions of the forms can be stored at the hospital, and details on how to obtain them are available from any supervisory body).

• **Patient and relative/carer information leaflets** about the Safeguards and the local procedure.

• A **policy** relating to reviewing authorisations and what actions to take when an authorisation ends.

• A **policy** on working with and supporting the relevant person's representative.

• Arrangements for ensuring any conditions attached to an authorisation are complied with.

• Arrangements for access to legal advice, including when to seek advice from the Court of Protection.

Depriving a person of their liberty is not a decision that should be taken lightly even if it is in that person's best interests. Hospitals should, therefore, have a procedure for agreeing who is authorised to sign applications and urgent authorisations, and this list should be formally approved. This is to ensure that there is awareness at senior level when restraint is being practised: it is not intended to discourage the application of the Safeguards.

The person authorised to sign off an application should be aware of, and involved, each time an application is being prepared. The list should be formally reviewed on a regular basis and staff should be trained to undertake their designated roles.

A survey of hospitals showed that the number of staff who sign applications, and urgent authorisations to deprive people of their liberty for up to seven days ranges from one or two to over 100 per hospital. It seems highly unlikely that any hospital management can keep effective governance over an excessively large number of authorisers, nor that large numbers of authorisers can create systems for auditing the use of restriction and restraint in the hospital with a view to minimising their occurrence.
DoLS and the care plan

An authorisation to deprive a person using the service of their liberty is part of that person's care plan and not a substitute for it.

The care plan should be put together in accordance with the framework set down in the MCA 2005 and follow what the Act and subsequent case law says about capacity and best interests assessments. This includes the statutory duty to commission an IMCA if the person has no family or friends to be consulted. The duty in the Act to consult with persons with an interest in the welfare of the relevant person equally applies to the Safeguards. It should of course also be built on the wishes and feelings of the relevant person, and should give reasons if and why these wishes and feelings are not being allowed, and what less restrictive options for the person's care have been considered.

Working with the local authority as the supervisory body

On 1 April 2013 the supervisory body function previously undertaken by primary care trusts transferred to local authorities. Provision was made for this in the Health and Social Care Act (HSCA) 2012. This in no way alters the responsibilities of NHS and private sector hospitals beyond forwarding applications for authorisation to a different organisation. The regulations and guidance in respect of hospitals remain in place and the duty to seek authorisation when a deprivation of liberty is being sought, in the best interests of a person using the service unable to consent, remains.

Hospitals will wish to work with their local authority to secure clear lines of communication and co-operation. Each hospital's local authority will have a DoLS office. For hospitals this means:

- keeping up to date and accurate contact information on their local authority DoLS office
- having a policy and procedure agreed with the local authority that allows assessors to have access to the person using the service in question, their family and carers, and relevant records (DoLS assessors have a statutory right to access relevant patient notes)
- staff knowing their organisation's procedure for applying for a deprivation of liberty
- hospitals and local authorities agreeing a secure method of transferring identifiable information (e.g. encryption, secure network, safe haven, fax).

Case law

The case law relating to the Safeguards is evolving all the time and interpretation can be challenging. It is important that hospitals have access to reliable sources of information and guidance on case law developments so they can be applied to local practice where necessary. Hospitals will wish to ensure that their directly employed or contracted legal advisers are up to date on Court of Protection judgements and that processes exist for these legal advisers to feed the messages and the learning from case law into practice regularly.

Restriction and restraint

When a person lacks capacity to consent to care or treatment, Part 1 section 6 of the MCA defines restraint as the use, or threat to use, force to secure the doing of an act which the person resists, or restricting a person using the service's liberty of movement, whether or not that person resists. Staff can exercise restriction and restraint if they reasonably believe it is
necessary to prevent the person coming to harm and that it is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.

Hospitals will wish to ensure that:

- Staff understand the legal framework around restriction and restraint, in particular that they are able to justify it as being in the person’s best interests and proportionate to the likelihood of harm, and that it is used for the shortest period of time possible.
- Staff are trained in the use of restriction and restraint techniques.
- Records are kept when the use of restriction/restraint has been used.
- Restriction and restraint practice is audited regularly and where improvements are identified an action plan to implement them is developed.
- Staff have access to guidance on the distinction between restriction and restraint, and deprivation of liberty.

If staff reasonably believe that the extent of restriction and restraint required in delivering care and treatment, in the best interests of a person using the service, goes beyond what is allowed under Part 1 paragraph 6 of the MCA and towards deprivation of liberty, then it must be specifically authorised.

The next section deals with this in more detail. A key responsibility of the person responsible for the care of each individual person who uses services is to identify if this is the case and where required prepare the application for authorisation for sign-off by the approved senior member of staff.

When to seek authorisation

Knowing when to complete and seek authorisation for a potential deprivation of liberty is not always straightforward. Hospitals are not required to know exactly what is or is not a deprivation of liberty, only to be alert to when the situation might be a deprivation. Courts have recognised that often this point can be a matter of opinion, and it is the assessment process commissioned by the supervisory body that determines whether a deprivation of liberty is occurring or not.

There is anecdotal evidence that some people have a mistaken belief that seeking and receiving an authorisation is in some way a stigma for the relevant person or the institution caring for them. There is also the view that because around half of applications are approved, an application not being approved is in some way a criticism of the hospital.

It should be remembered that the purpose of the process is to protect the rights of vulnerable people and ensure they are not deprived of their liberty unnecessarily and without representation, review or right of appeal.

The assessment process itself is a protection of the relevant person’s rights irrespective of the outcome. The outcome supports the rights of the relevant person and assures the hospital that the care regime is in that person’s best interests.

Each case should be judged on its own merits with the assessment procedure considering the following questions:

Why do I reasonably believe the person lacks the mental capacity to agree to the restrictions or restraint in place? (For example, a formal capacity assessment has been undertaken and recorded.)

- Is the relevant person free to leave the institution when they want to?
- Is the care regime the least restrictive option available?
• Is the care regime in the relevant person’s best interests?
• It does not follow that all people not free to leave the institution are deprived of their liberty (See ‘What is deprivation of liberty?’ section).

A hospital is far more likely to face criticism and potential legal action for practising deprivation of liberty without the appropriate authorisation than it would if it made application for authorisation in circumstances that were subsequently found not to be a deprivation.

Given the likely profile and the circumstances in which an authorisation might be sought, providers should be able to plan ahead. This allows for a full and proper assessment to be undertaken prior to any authorisation coming into force. However, it is accepted that this will not always be possible in cases of emergency or crisis.

**What is deprivation of liberty?**

This resource is not a review of the case law since 2009. It does, however, provide assistance in making decisions about when an application should be made. The DoLS Code of practice gives guidance in Sections 2.5 and 2.17 to 2.24. However, there are some basic questions a hospital would wish to ask when determining whether deprivation of liberty is occurring and whether it is in the best interests of the relevant person:

• Does the relevant person lack capacity to make their own decision about whether they should be accommodated in hospital?
• Is the relevant person free to leave?
• Is the care regime more than mere restriction of movement?
• Is the person able to consent to their confinement?
• Is the person being confined in some way beyond a short period of time?
• Is the care regime the least restrictive option available?
• Is the care regime in the person’s best interests? (Even if it is, it may still be a deprivation of liberty requiring authorisation).
• Would the person require the same kind of support and assistance wherever they were living and in whatever kind of setting?
• Is the person being prevented from going to live in their own home, or with whom they wish to live?

In simple terms, confining a person in their room, sedating them or placing them under close supervision for a very short period may not be a deprivation, but doing so for an extended period could be. However, what might appear to be mere restriction and restraint, such as a locked door, if repeated cumulatively, could also amount to a deprivation.

Section 2.5 of the DoLS code of practice gives some examples of what could constitute deprivation of liberty, drawn from a range of court cases:

• restraint is used, including sedation, to admit a person to an institution where the person is resisting admission
• staff exercise complete and effective control over the care and movement of a person for a significant period
• staff exercise control over assessments, treatment, contacts and residence
• 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 the staff consider it appropriate
• a request made by carers for a person to be discharged to their care is refused
• the person is unable to maintain social contacts because of restrictions placed on their access to other people
• the person loses autonomy because they are under continuous supervision and control (for example, subject to one-to-one supervision).

Staff need to keep constantly in mind the question `Why do I reasonably believe this person lacks capacity?`, and regularly check the evidence.

Hospitals need to take the above pointers into account when determining whether the restriction and/or restraint being applied to a person who lacks the capacity to consent to their care and treatment, in their best interests, moves towards deprivation of liberty which then requires authorisation. Deprivation of liberty could be occurring if one, some or all the above factors are present. Hospitals should work closely with the local authority's supervisory body, or DoLS team, so that any cases of doubt are immediately identified and discussed.

Use of Restraint

The Trust will ensure that staff understand the local framework around restriction and restraint. In particular they are able to justify it as being in the patients best interest and proportionate to the likelihood of harm.

It is vital that under DoLS, the use of restraint is for the minimum length of time, and is a proportionate response to the risk of harm. Under no circumstance should the person who has requested the restraint leave the presence of the patient, as priority should be given to de-escalation.

Please refer to Urgent High Use Risk of Restraint Tool Appendix 6 and complete Request to Restrain form Appendix 7. This will ensure there is evidence that the actions were undertaken in the patient’s best interest, and ensures compliance with documentation relating to reporting physical assaults on NHS staff.

Decisions must be clearly recorded using the documentation provided, with a copy to be kept in the patient’s notes.

8 Training

Training will be provided via face to face training and via e-learning. All clinical staff should have a basic awareness of the DoLS process and be aware of the appropriate sections under the Mental Health Act, with awareness that DoLS should be regarded as the first approach this includes the use of restraint.

9 DoLs Contact Details and Administration

Please only send the DoLs via a secure route, thereby not compromising the data to information governance breaches: (Contact details found in Appendix 8)

• Staff have access to guidance or the distinction between restriction, restraint and DoLS.
• Staff are trained in the use of restriction and restraint techniques.

• Restriction and restraint practice is audited regularly and where improvements are identified an action plan is implemented.

• Records are kept when the use of restriction/restraint has been used.

10 Monitoring of compliance

The Adult Safeguarding Steering Group will monitor all urgent and standard authorisation requests sent to Surrey County Council DoLs team. It will also monitor the number of requests against the trajectory annually set by Surrey County Council.

The Group will liaise with the Quality Governance & Assurance Committee (IGAC) to ensure compliance with the Clinical Commissioning group, NHS Litigation Authority and Care Quality Commission (CQC) requirements.

The effectiveness of this policy will be monitored through the Adult Safeguarding Steering Group which will report on issues and key findings through Trust Governance structure.

An annual audit of a sample of cases will be conducted to monitor compliance with this policy.

11 References

Deprivation of liberty safeguards Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice.
Appendix 1

Example from practice

Mrs F (88) had a long history of dementia. She lived alone and very independently in a spotless bungalow, maintaining strict routines, but was neglectful of herself (often forgetting to eat and drink properly). One day, Mrs F left an electric heater on, covered by clothing, then tried to put the resulting flames out with water and by cutting the cable to the plug without turning the electricity off. The fire was serious, and she was admitted to hospital. She was very confused, and left the hospital twice, in her nightclothes, trying to go home. On both occasions the police found her in a distressed state, and returned her to the hospital.

The hospital, as the managing authority, gave itself an urgent authorisation in order to make it legal to deprive Mrs F of her liberty, in her best interests. At the same time, the hospital applied for a standard authorisation under DoLS from the supervisory body. The best interests assessor agreed that Mrs F was being deprived of her liberty, and that this was in her best interests. He suggested a short period of standard authorisation, with conditions around care planning, and a best interests meeting to ensure that the least restrictive option for Mrs F's care was identified. This was authorised by the local authority authorising signatory. Due to her lack of family or close friends, an independent mental capacity advocate (IMCA) was part of the assessment process.

When she had recovered from the effects of the fire, Mrs F was admitted to short-term residential care, while her house was being repaired. The care home, the new managing authority, applied in advance of her admission for a standard authorisation, which was approved (authorisations are place-specific, so the hospital authorisation did not 'travel' with Mrs F).

Mrs F's social worker and the best interests assessor both felt she still did not have the mental capacity to make her own decisions about where she should live, but they acknowledged her strong desire to go home.

The repair of her home following the fire took several weeks, during which time a series of best interests meetings identified a plan for her return. Mrs F agreed that it would help her to have a live-in carer, and visited home several times with her social worker and IMCA to prepare for her return home. She returned and all went well for a few days, but then there was an aggressive incident towards her carer. Mrs F asked to go back to the lovely care home to my friends'. She returned to the care home where she remains, now settled and calling it her home.
### Appendix 2  Urgent Authorisation Deprivation of Liberty Form No.1

#### URGENT AUTHORISATION

**PART A — BASIC INFORMATION**

<table>
<thead>
<tr>
<th><strong>Full name of the person being deprived of their liberty</strong></th>
<th><strong>Name</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Their date of birth (or estimated age if unknown)</strong></td>
<td><strong>DOB</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Est. age</strong> <strong>Years</strong></td>
</tr>
<tr>
<td><strong>Name and address of the hospital or care home where the person is being deprived of their liberty</strong></td>
<td><strong>Name</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Address</strong></td>
</tr>
<tr>
<td><strong>Person to contact at the hospital or care home</strong></td>
<td><strong>Name</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Telephone</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Email</strong></td>
</tr>
<tr>
<td><strong>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)</strong></td>
<td><strong>Name</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Address</strong></td>
</tr>
<tr>
<td><strong>Name of the PCT or local authority to whom this form is being sent (the supervisory body)</strong></td>
<td><strong>Name</strong></td>
</tr>
</tbody>
</table>

**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.
| B1 | The person is aged 18 or over. |
| B2 | The person is suffering from mental disorder. |
| B3 | The purpose of accommodating the person here is to give them care or treatment. |
| B4 | The person lacks capacity to make their own decision about whether to be accommodated here for the purpose of being given the proposed care or treatment. |
| B5 | 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. |
| B6 | 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 deputy appointed by the Court of Protection under the Mental Capacity Act 2005. |
| B7 | Even though the circumstances amount to depriving the person of their liberty, it is in their best interests to be accommodated here so that they may be given the proposed care or treatment. |
| B8 | This is necessary in order to prevent harm to them, and is a proportionate response to the harm they are likely to suffer if they are not so deprived of liberty, and the seriousness of that harm. |
| B9 | The need for the person to be deprived of their liberty here is so urgent that it is appropriate for that deprivation to begin immediately. |
| B10 | The person concerned is not, as far as the managing authority is aware, subject to an application or order under the Mental Health Act 19831 or, if they are, that order or application does not prevent an urgent authorisation being given. |

**PART C — DETAILS OF THIS URGENT AUTHORISATION**

This urgent authorisation permits the managing authority to deprive the person of their liberty here, but only for the purpose of enabling them to be given the care or treatment specified below in section C2 of this form.

---

**C1 THE DURATION OF THIS URGENT AUTHORISATION**

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.

Enter number of days in the box above ⬤

This urgent authorisation will expire at the end of the day on: ________________

Enter date in boxes above ⬤

Important note: the day on which the urgent authorisation is given counts as the first of the days. For example, if an urgent authorisation is given for seven days at 11.30pm on Monday, it will expire at the end of the day on the following Sunday.

---

1 References in this form to provisions of the Mental Health Act 1983 include provisions of other enactments that have the same effect.
C2 THE PURPOSE OF THIS URGENT AUTHORISATION

The purpose for which this urgent authorisation is given should be described here.

Note: there is a legal requirement that the giving of a Mental Capacity Act 2005 deprivation of liberty safeguards authorisation must be for the purpose of giving care or treatment to the person to whom the authorisation relates. The entry below should therefore identify the care and/or treatment that constitutes the purpose for which the authorisation is given. It should be borne in mind, however, that the deprivation of liberty authorisation does not itself authorise the care or treatment concerned, the giving of which is subject to the wider provisions of the Mental Capacity Act 2005.

The purpose of this urgent authorisation is to enable the person to be given the following care and/or treatment in this hospital or care home:

Please Use Continuation Sheet
PART D — THE MANAGING AUTHORITY’S REASONS

Explain here:

(a) the nature of the restrictions on the person’s liberty that lead to the conclusion that they are deprived of their liberty
(b) why the care and/or treatment described above cannot be provided in a way that is less restrictive of the person’s rights and freedom of action
(c) to the extent that the managing authority is aware, what alternatives to deprivation of liberty have been considered
(d) what harm the person is likely to come to if they are not immediately deprived of their liberty in this hospital or care home
(e) why the need to deprive the person of their liberty is so urgent that it is appropriate for the deprivation to begin immediately.

The managing authority’s reasons for giving an urgent authorisation are as follows:

Please Use Continuation Sheet
**PART E — NEED FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)**

Place a cross in ONE of the boxes below.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E1</strong></td>
<td>As far as the managing authority is aware, 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. We will therefore immediately inform the supervisory body via Form 4 (managing authority request for a standard authorisation) that it needs to instruct an IMCA to assist the person.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E2</strong></td>
<td>The managing authority believes that there is someone it is appropriate to consult about what is in this person’s best interests who is neither a professional nor is being paid to provide care or treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PART F — PROVIDING COPIES OF THIS URGENT AUTHORISATION AND RIGHTS INFORMATION**

As soon as practicable after this form is signed, the managing authority will give copies of it to:

(a) the person to whom the urgent authorisation relates, and

(b) any section 39A IMCA acting for them.

The managing authority will also, as soon as possible, take all practicable steps to ensure that the person to whom the urgent authorisation relates understands:

(a) the effect of the authorisation

(b) their right to make application to the Court of Protection, challenging the urgent authorisation.

This information will be given both orally and in writing.

**PART G — DETAILS OF THE STANDARD AUTHORISATION REQUESTED**

Place a cross in ONE of the boxes below.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G1</strong></td>
<td>The managing authority has already completed and sent off Form 4 (managing authority request for a standard authorisation).</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>G2</strong></td>
<td>The managing authority will now immediately complete and send off Form 4 (managing authority request for a standard authorisation).</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you placed a cross in box G2, you should now also complete and send off Form 4 immediately (managing authority request for a standard authorisation).
PART H — RECORD THAT THE DURATION OF THIS URGENT AUTHORISATION HAS BEEN EXTENDED

This part of the form must be completed if the duration of the urgent authorisation is extended by the supervisory body. Do not complete this part of the form in any other circumstances. Simply leave it blank.

H1 DETAILS OF ANY EXTENSION

The duration of this urgent authorisation has been extended by the supervisory body.

It is now in force for a FURTHER:

Enter number of days in the box above

The period specified must not exceed seven days.

This urgent authorisation will now expire at the end of the day on:

Enter new date on which it will expire above

H2 PROVIDING COPIES OF ANY EXTENSION

As soon as practicable after signing this form below, the managing authority will give copies of this amended form to:

(a) the person to whom the urgent authorisation relates; and

(b) any section 36A IMCA acting for them.

<table>
<thead>
<tr>
<th>Signed</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>(on behalf of the managing authority)</td>
<td>Print name</td>
</tr>
<tr>
<td></td>
<td>Position</td>
</tr>
<tr>
<td>Dated</td>
<td>Date</td>
</tr>
</tbody>
</table>
## Appendix 3  Standard Authorisation Deprivation of Liberty Form No. 4

**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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td><strong>Full name of the person who needs to be deprived of their liberty in this hospital or care home</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Name</strong></td>
</tr>
<tr>
<td>A2</td>
<td><strong>Their gender</strong></td>
</tr>
<tr>
<td>A3</td>
<td><strong>Their date of birth (or estimated age if unknown)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>DOB</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Est. Age</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Years</strong></td>
</tr>
<tr>
<td></td>
<td><strong>The age range within which the person falls</strong></td>
</tr>
</tbody>
</table>

Place a cross in ONE of the boxes below.

- 18–64
- 65–74
- 75–84
- 85+

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Volume 8  
Patient Care  
First ratified  
February 2014  
Review date  
February 2017  
Issue  
1  
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### A4

The person’s current location

(Place a cross in one box, and then enter the current location) ☑

<table>
<thead>
<tr>
<th>Location</th>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Already in this hospital or care home ☐</td>
</tr>
<tr>
<td></td>
<td>Currently at their own private address ☐</td>
</tr>
<tr>
<td></td>
<td>Currently in another hospital or care home ☐</td>
</tr>
<tr>
<td></td>
<td>Other (please specify):</td>
</tr>
<tr>
<td></td>
<td>Current location (address)</td>
</tr>
<tr>
<td></td>
<td>Post Code</td>
</tr>
<tr>
<td></td>
<td>Telephone</td>
</tr>
</tbody>
</table>

### A5

Name and address of the managing authority

(In the case of an NHS hospital, the NHS body responsible for the running of the hospital in which the relevant person is, or is to be, a resident. In the case of a care home or private hospital, the person registered, or required to be registered, under Part 2 of the Care Standards Act 2000 in respect of the care home or hospital.)

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Postcode</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
</tbody>
</table>

### A6

Person to contact at the hospital or care home

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
</tr>
</tbody>
</table>

### A7 THE PURPOSE FOR WHICH THE AUTHORISATION IS REQUESTED

The purpose for which this standard authorisation is requested should be described here.

**Note:** there is a legal requirement that the giving of a Mental Capacity Act 2005 deprivation of liberty safeguards authorisation must be for the purpose of giving care or treatment to the person to whom the authorisation relates. The entry below should therefore identify the care and/or treatment that constitutes the purpose for which the authorisation is given. It should be borne in mind, however, that the deprivation of liberty authorisation does not itself authorise the care or treatment concerned, the giving of which is subject to the wider provisions of the Mental Capacity Act 2005.

The purpose of the requested standard authorisation is to enable the person to be given the following care and/or treatment in this hospital or care home.
### A8 THE DATE FROM WHICH THE STANDARD AUTHORISATION IS SOUGHT

The standard authorisation is required to start on this date: ____________

This is because:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td>The existing urgent authorisation expires at that time.</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>The existing standard authorisation expires at that time.</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>The existing order of the Court of Protection expires at that time.</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>We expect to receive the person in this hospital or care home at that time, and it is likely that we will need to deprive them of their liberty immediately.</td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>None of the above applies. However, it is likely that the person will need to be deprived of their liberty and will meet all of the requirements for a standard authorisation at that time.</td>
</tr>
</tbody>
</table>

Place a cross in ONE of the boxes below. 
A9 HAS THE MANAGING AUTHORITY GIVEN AN URGENT AUTHORISATION? [Yes] [No]

If yes, please enter the date on which it expires:

PART B – OTHER INFORMATION THAT SHOULD BE PROVIDED IF IT IS AVAILABLE TO, OR COULD REASONABLY BE OBTAINED BY, THE MANAGING AUTHORITY, UNLESS IT HAS BEEN PREVIOUSLY PROVIDED IN RESPECT OF AN EXISTING STANDARD AUTHORISATION AND THAT INFORMATION REMAINS THE SAME

Note: this ‘previously provided’ exemption does not apply to the information about an existing authorisation covered in box B14 of this form.

B1 RELEVANT MEDICAL INFORMATION
Medical information relating to the person’s health that the managing authority considers to be relevant to the proposed restrictions to the person’s liberty:

Please Use Continuation Sheet

B2 DIAGNOSIS OF THE MENTAL DISORDER
Diagnosis of the mental disorder (within the meaning of the Mental Health Act 1983¹, but disregarding any exclusion for persons with learning disability) that the person is suffering from:

Please Use Continuation Sheet

B3 RELEVANT CARE PLANS OR NEEDS ASSESSMENTS
The following relevant care plans and/or needs assessments are attached:

Please Use Continuation Sheet

B4 RACIAL, ETHNIC OR NATIONAL ORIGIN
The person’s racial, ethnic or national origin

Place a cross in ONE of the boxes below ²

White

A British
B Irish
C Any other White background (to include Travellers of Irish heritage and Gypsy/Roma)
D White and Black Caribbean

¹ References in this form to provisions of the Mental Health Act 1983 include provisions of other enactments that have the same effect.
<table>
<thead>
<tr>
<th>Mixed OR Mixed British</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E White and Black African</td>
<td></td>
</tr>
<tr>
<td>F White and Asian</td>
<td></td>
</tr>
<tr>
<td>G Any other mixed background</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asian OR Asian British</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>H Indian</td>
<td></td>
</tr>
<tr>
<td>J Pakistani</td>
<td></td>
</tr>
<tr>
<td>K Bangladeshi</td>
<td></td>
</tr>
<tr>
<td>L Any other Asian background</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Black OR Black British</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>M Caribbean</td>
<td></td>
</tr>
<tr>
<td>N African</td>
<td></td>
</tr>
<tr>
<td>P Any other Black background</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other ethnic groups</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>R Chinese</td>
<td></td>
</tr>
<tr>
<td>S Any other ethnic group</td>
<td></td>
</tr>
<tr>
<td>Z Not stated (to include cases in which the person has refused to divulge their ethnic origin or where their ethnic origin is not yet known)</td>
<td></td>
</tr>
</tbody>
</table>

**B5 THE PERSON’S RELIGION OR BELIEF**

Place a cross in ONE of the boxes below:

| None |  |
| Christian (Christian includes Church of Wales, Catholic, Protestant and all other Christian denominations) |  |
| Buddhist |  |
| Hindu |  |
| Jewish |  |
| Muslim |  |
| Sikh |  |
| Any other religion |  |
| Not stated |  |
B6 THE PERSON’S SEXUAL ORIENTATION

Place a cross in ONE of the boxes below ☐

- Heterosexual
- Lesbian or gay
- Bisexual
- Other
- Prefer not to say
- Not known

B7 THE PERSON’S DISABILITY

Place a cross in EACH of the boxes below that apply ☐

- Physical disability, frailty and/or sensory impairment
- Please identify which of the following apply:
  - Physical disability, frailty and/or temporary illness
  - Hearing impairment
  - Visual Impairment
  - Dual sensory loss

- Mental Health
- Please also place a cross in this box if the Mental Health condition is dementia

- Learning disability

B8 WHETHER THE PERSON HAS A PREFERRED COMMUNICATION OR A PREFERRED FIRST LANGUAGE

Place a cross in one box ☐

- No ☐
- Yes ☐

If yes, describe them, e.g. interpreter required (specify language), BSL signer required, etc.

B9 WHY THE PERSON NEEDS TO BE DEPRIVED OF THEIR LIBERTY

In our opinion:

- the person lacks capacity to make their own decision about whether to be accommodated here for the purpose of being given the proposed care and/or treatment described above
- it is in their best interests to be deprived of their liberty here so that they can be given this care and/or treatment
- this is necessary in order to prevent harm to them, and it is a proportionate response to the harm they are likely to suffer if they are not so deprived of liberty, and the seriousness of that harm.
Explain here:

(a) the nature of the restrictions on the person’s liberty that lead to the conclusion that they are, or will be, deprived of their liberty;
(b) why the necessary care and/or treatment cannot be provided in a way that is less restrictive of the person’s rights and freedom of action;
(c) to the extent that the managing authority is aware, what alternatives to deprivation of liberty have been considered;
(d) what harm the person is likely to come to if they are not deprived of their liberty in this hospital or care home.
B10 WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED

Place a cross in ONE of the boxes below (A or B) 

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>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. If the person has no relevant person’s representative, or this is a request for a first standard authorisation, the supervisory body must therefore instruct an IMCA to support and represent them.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>There is someone whom it is appropriate to consult about what is in this person’s best interests who is neither a professional nor is being paid to provide care or treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B11 WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION

Place a cross in box A, B or C below 

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The person has made an advance decision that may be valid and applicable to some or all of the treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>The proposed deprivation of liberty is not for the purpose of giving treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B12 THE PERSON IS SUBJECT TO THE FOLLOWING MENTAL HEALTH ACT 1983 REGIMES

(The hospital treatment, community treatment and guardianship regimes are defined in paragraphs 8 to 10 of Part 2 of Schedule 1A to the Mental Capacity Act 2005.)

Place a cross in box A, B or C below if any of those options apply, otherwise leave the boxes blank 

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Hospital treatment regime</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Community treatment regime</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Guardianship regime</td>
</tr>
</tbody>
</table>
### B13 INFORMATION ABOUT INTERESTED PERSONS

Please continue on a separate sheet if necessary.

<table>
<thead>
<tr>
<th>Anyone named by the person as someone to be consulted about their welfare</th>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telephone</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anyone engaged in caring for the person or interested in their welfare</th>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telephone</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any donee of a lasting power of attorney granted by the person</th>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telephone</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any deputy appointed for the person by the Court of Protection</th>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telephone</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005</th>
<th>Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Telephone</td>
<td></td>
</tr>
</tbody>
</table>

### B14 IS THERE AN EXISTING STANDARD AUTHORISATION IN RELATION TO THE DEPRIVATION OF LIBERTY OF THE RELEVANT PERSON

Place a cross in box A or B

<table>
<thead>
<tr>
<th>A</th>
<th>There is an existing standard authorisation in relation to the person to be deprived of liberty.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The authorisation expires on:</td>
</tr>
</tbody>
</table>

Fill in the expiry date above
| C1 | The address where the person ordinarily resides | The address given in box A4 above where the person currently is |
|    |                                           | The person was of no fixed abode |
|    |                                           | The following address, at which the person is ordinarily resident: |
|    |                                           | Address |

| C2 | The name of the individual who is considered to be the person most closely involved in looking after the person's welfare. | Name |
|    |                                                            | Relationship |
|    |                                                            | Address |
|    |                                                            | Telephone |

| C3 | Name of the PCT or local authority to whom this form is being sent ('the supervisory body') | Name |

| C4 | How the care is being funded? (Place a cross in the relevant boxes) | Local authority |
|    |                                                                         | PCT |
|    |                                                                         | Local authority and PCT jointly |
|    |                                                                         | Self-funded by the person, their family, etc |
|    |                                                                         | Funded through insurance, etc |
### C5 WHY THIS REQUEST IS BEING MADE

Place a cross in ONE of the boxes below (A–G) 

Boxes A–D relate to people who ARE NOT currently subject to a standard authorisation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong></td>
<td><strong>PERSON WHO IS ALREADY ACCOMMODATED HERE BUT IS NOT YET BEING DEPRIVED OF LIBERTY</strong>&lt;br&gt;The person is already accommodated in this hospital or care home. We are not depriving them of their liberty. However, during the next 28 calendar days, it is likely that we will need to do so and that they will meet all of the qualifying requirements for a standard authorisation.</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td><strong>PERSON WHO IS ALREADY ACCOMMODATED HERE AND BEING DEPRIVED OF THEIR LIBERTY</strong>&lt;br&gt;The person is already accommodated in this hospital or care home. They already appear to meet all of the qualifying requirements for a standard authorisation. An urgent authorisation has been given pending the outcome of the standard authorisation assessment process.</td>
</tr>
<tr>
<td><strong>C</strong></td>
<td><strong>PERSON IS NOT YET ACCOMMODATED HERE BUT WILL NEED TO BE DEPRIVED OF THEIR LIBERTY HERE DURING THE NEXT 28 DAYS</strong>&lt;br&gt;The person is not yet accommodated in this hospital or care home. However, during the next 28 days it is likely that they will be admitted and that they will need to be deprived of their liberty here. It is also likely that they will meet all of the qualifying requirements for a standard authorisation.</td>
</tr>
<tr>
<td><strong>D</strong></td>
<td><strong>COURT OF PROTECTION ORDER ABOUT TO EXPIRE</strong>&lt;br&gt;The person is already accommodated in this hospital or care home. We are already depriving them of their liberty and the Court of Protection has authorised this. However, given the date on which the court’s order is expected to expire, it would be unreasonable to delay any longer requesting a standard authorisation.</td>
</tr>
</tbody>
</table>

Boxes E–G relate to people who ARE currently subject to a standard authorisation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E</strong></td>
<td><strong>EXISTING AUTHORISATION ABOUT TO EXPIRE: NEW STANDARD AUTHORISATION REQUIRED</strong>&lt;br&gt;There is already a standard authorisation in force that covers the person’s deprivation of liberty in this hospital or care home. It is reasonable to request a new standard authorisation to come into force immediately after the expiry of the existing authorisation.</td>
</tr>
<tr>
<td><strong>F</strong></td>
<td><strong>CHANGE IN THE PLACE WHERE THE PERSON IS DEPRIVED OF LIBERTY</strong>&lt;br&gt;There is already a standard authorisation in force. However, it does not authorise the person’s deprivation of liberty in this hospital or care home. We therefore require a new standard authorisation that authorises their deprivation of liberty here.</td>
</tr>
</tbody>
</table>
A PART 8 REVIEW HAS BEEN REQUESTED OR IS IN PROGRESS

There is already a standard authorisation in force that authorises the person’s deprivation of liberty in this hospital or care home. A review of this authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005 has either been requested or is being carried out. Any new standard authorisation that is now given will be in force after the existing authorisation comes to an end.

C6 ANY OTHER RELEVANT INFORMATION

<table>
<thead>
<tr>
<th>Signed</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>(on behalf of the managing authority)</td>
<td>Print name</td>
</tr>
<tr>
<td></td>
<td>Position</td>
</tr>
<tr>
<td>Dated</td>
<td>Date</td>
</tr>
</tbody>
</table>

Please Use Continuation Sheet
Appendix 4

DEPRIVATION OF LIBERTY SAFEGUARDS FLOWCHART 1: THE APPLICATION PROCESS

Unplanned situation: person may already be deprived of liberty

Planned admission: request to be made in advance

Make sure you have the following information:
- How old is the person (must be 18+)
- What essential care and/or treatment are you providing for the person
- What restrictions are being used, and what less restrictive options have been tried or considered
- What harm would the person come to if not deprived of their liberty
- Relevant assessments and care plans
- Details of family or close friends if any
- Identify the right supervisory body and, if possible, alert them

COMPLETE FORM 1 (Urgent Authorisation)
Take steps to help the person understand the effect of the authorisation and their right to appeal

COMPLETE FORM 4 and send WITH FORM 1 to Supervisory Body with relevant assessments and care plans

Tell the relevant person about the reason for the authorisation request and process, give them copies of the forms. Also tell any close family or friends. If suitable, offer access to information in print or on the internet about the right of challenge.
Be ready to give assessors (and IMCA if involved) prompt access to: the person (to interview in private); relevant notes; staff involved in care of the person.
DEPRIVATION OF LIBERTY SAFEGUARDS FLOWCHART 2:
MANAGING AUTHORITY RESPONSIBILITIES DURING AN AUTHORISATION

Standard DOLS authorisation is granted

- Notify CQC and Relevant Person of outcome: help Person to understand. Record end date, details of RPR and any conditions. Ensure staff understand about authorisation.

DOLS authorisation NOT granted

- Notify CQC and Relevant Person of outcome: help Person to understand. Take account of reason. If BIA finds an unlawful deprivation of liberty take urgent steps to remedy this.

Comply with conditions: alert the supervisory body immediately if conditions cannot be met.

Support Person and RPR (Relevant Person’s Representative) to understand right to ask for review or appeal to the Court of Protection: alert supervisory body if RPR fails to visit.

Continue to seek ways to avoid deprivation of liberty, e.g. reduce restrictions wherever possible.

Changes in situation: If the Person moves away, is admitted to hospital, dies, or their situation changes e.g. they regain capacity or you feel they are no longer deprived of liberty, notify the supervisory body (using Form 19) who will review. If the Person dies, also inform the Coroner.

Comply with outcome of review. Change records: inform Person, RPR and staff.

Request a new authorisation: DOLS authorisations cannot be extended. If it is likely that a new authorisation will be required for this person, submit a new request to the supervisory body for a Standard authorisation using Form 4. This should be done if possible four weeks before the expiry of the current authorisation.
Appendix 6  Urgent High Use Risk of Restraint for a Patient Assessed as Lacking Capacity Tool

URGENT HIGH USE RISK OF RESTRAINT OF PATIENT ASSESSED AS LACKING CAPACITY

Patient identified is unaware of their needs and at risk of harm to self or others

Check for any cause of infection e.g. UTI/chest infection/medication/alcohol

Is there a disorder of mind or brain?

Document change in behaviour and start to complete ‘best interest’ paperwork. All comments made in notes must be made relating to ‘best interests’ and the MCA

Check for any sign of reduced cognition. Was AMTS recorded on admission?

Cause noted

No physical cause noted

Treat cause & monitor behaviour

Has person got pre-existing mental health condition? Phone

Does behaviour improve?

Yes

No

Possible delirium

Possible pre-existing cognitive decline

Yes

Contact medical personnel previously involved for previous reaction

No

Ask for urgent Mental Health Assessment Switchboard out of hours

Patient’s behaviour becomes dangerous and they lack capacity

Ask for advice from appropriate person

If restraint is necessary, keep nursing staff with patient and call security to assist. If essential to administer sedation.

Document – done in patient’s best interest and provide rationale behind decision

Complete incident form and request for restraint form

If agreeable, give medication orally without use of restraint
Appendix 7  Request to Restrain

NB: Please note that restraint should be used as a last resort and must not be used on a regular basis.

Reason for requesting restraint:…………………………………………………………
……………………………………………………………………………………………

Prior Actions:…………………………………………………………………………
……………………………………………………………………………………………

Restraint has been requested by:

Name .......................... Surname........................................

Designation.............. Contact Details........................................

To restrain patient:

Name .......................... Surname........................................

Ward.................................

Time ................ Date ................

Has the ‘Tool to Assess Whether an Individual Lacks Mental Capacity’ been used? □ No □ Yes

Has an incident form been completed? □ No □ Yes

Signature ..............................

A copy of this form and the mental capacity assessment sheet must be included in the patient’s notes
Appendix 8 DoLS Contact Details

Surrey County Council
Adult Social Care Directorate

Deprivation of Liberty Safeguards
Supervisory Body – Important changes from 1 April 2013

From 1<sup>st</sup> April 2013 the Supervisory Body for Deprivation of Liberty Safeguards (DOLS), for Surrey residents in Hospitals, will be Surrey County Council and no longer NHS Surrey (Primary Care Trust).

From 1 April 2013 any Urgent DOLS Authorisations or requests for Standard Authorisations should be faxed to Surrey County Council DOLS Team on:

01483 517830 (Fax)

OR signed, scanned and emailed to:

dolsteam@surreycc.gcsx.gov.uk

(It is essential that these forms are faxed or emailed as a matter of priority)

If you require any advice regarding Deprivation of Liberty Safeguards please contact Surrey County Council DOLS Team on:

Tel: 01483 517644
Fax: 01483 517830
E-mail: dolsteam@surreycc.gov.uk

DOLS & Deputyship Team
Surrey County Council
Quadrant Court, 3<sup>rd</sup> Floor
35 Guildford Road
Woking, Surrey, GU22 7QQ
Appendix 9. Equality Impact Assessment Summary

<table>
<thead>
<tr>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Who was involved in the Equality Impact Assessment</td>
</tr>
</tbody>
</table>

The authors completed the EIA.

<table>
<thead>
<tr>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age)</td>
</tr>
<tr>
<td>• The data sources and any other information used</td>
</tr>
<tr>
<td>• The consultation that was carried out (who, why and how?)</td>
</tr>
</tbody>
</table>

The effects to different race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation and age have been considered.

A data collection took place through audit.

<table>
<thead>
<tr>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Describe the results of the assessment</td>
</tr>
<tr>
<td>• Identify if there is adverse or a potentially adverse impacts for any equalities groups</td>
</tr>
</tbody>
</table>

This policy does not have an adverse effect on any equalities group.

<table>
<thead>
<tr>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide a summary of the overall conclusions</td>
</tr>
</tbody>
</table>

This policy does not have an adverse effect on any equalities group. This policy has a positive equality impact on patients lacking mental capacity.
<table>
<thead>
<tr>
<th><strong>Recommendations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• State recommended changes to the proposed policy as a result of the impact assessment</td>
</tr>
<tr>
<td>• Where it has not been possible to amend the policy, provide the detail of any actions that have been identified</td>
</tr>
<tr>
<td>• Describe the plans for reviewing the assessment</td>
</tr>
</tbody>
</table>

n/a