

Deprivation of Liberty Safeguards - Care Plan Guidance Checklist

DETAILS OF SERVICE USER			
Surname:	First Name(s):	Title:	
Age last birthday:	Date of Birth:	Date Service Started:	
CARE PLAN MANAGEMENT			
A: D.O.L. AVOIDANCE - PRELIMINARY ASSESSMENT FOR CARE PLAN			
1	Is it considered that D.O.L. may be a likely outcome for the service user?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2	If so, can the service user's Care Plan be amended to avoid D.O.L.?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
AMENDMENTS TO CARE PLAN:			
Outcomes:			
Person undertaking assessment (PRINT NAME): _____ Signature: _____ Date: _____			
B: D.O.L. MANAGEMENT - THE SERVICE USER'S CARE PLAN			
The Care Plan should consider the following questions in order to help determine whether or not the service user needs to be deprived of his / her liberty. They are designed to address the circumstances and needs of the individual service user as they apply within their own domiciliary environment.			
1	DOES THE CARE PLAN CONFIRM THAT THE SERVICE USER LACKS THE MENTAL CAPACITY TO AGREE TO THE CARE PLAN?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1.1	Have relatives / carers been involved in the Care Plan?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
1.2	When is the Care Plan scheduled to be reviewed?		
1.3	What support measures are provided to involve the service user in the Care Plan?		
Comments:			
Person undertaking assessment (PRINT NAME): _____ Signature: _____ Date: _____			

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CARE PLAN MANAGEMENT

2	DOES THE CARE PLAN CONFIRM THAT THE SERVICE USER LACKS THE MENTAL CAPACITY TO CONSENT TO THE MEDICATION REGIME?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.1	What support measures are provided to help the service user make a decision?		
2.2	How is medication administered?		
2.3	If a degree of force or restraint is needed to administer medication, how is this done?		
2.4	Is medication administered covertly, and if so how?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.5	Is sedation used and if so under what circumstances would this be administered?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2.6	Does the Care Plan refer to the Medical Best Interests decision taken to arrange the medication?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>Comments:</p> <p>Person undertaking assessment (PRINT NAME): _____ Signature: _____ Date: _____</p>			
3	DOES THE CARE PLAN DETERMINE THAT THE SERVICE USER CANNOT CHOOSE TO LIVE OR BE ELSEWHERE INSTEAD OF THEIR OWN HOME ENVIRONMENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.1	Would admission to a Care Home require the use of deception, restraint or force?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.2	Does the Care Plan show that the service user does not want to be admitted to a Home?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3.3	Would the service user's advocates, relatives or carers object to the service user being admitted?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>Comments:</p> <p>Person undertaking assessment (PRINT NAME): _____ Signature: _____ Date: _____</p>			

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CARE PLAN MANAGEMENT

4	DOES THE CARE PLAN CONFIRM THAT THE SERVICE USER WOULD CHOOSE TO LIVE ELSEWHERE OTHER THAN THEIR HOME ENVIRONMENT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.1	Does the service user not wish to be in their home?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.2	Does the service user constantly insist that he / she wants to be elsewhere?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.3	Does the service user make meaningful attempts to leave their home to be elsewhere?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4.4	Has restraint / physical intervention been used to prevent he / she from leaving?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Describe physical intervention measures used:		
	Describe the harm from which the service user is being protected:		
4.6	Does the Care Plan explain why it is in the service user's best interests not to be elsewhere?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Comments: Person undertaking assessment (PRINT NAME): _____ Signature: _____ Date: _____			
5	DOES THE CARE PLAN CONFIRM THAT PHYSICAL INTERVENTION IS REQUIRED TO ENSURE THAT THE SERVICE USER RECEIVES THE NECESSARY CARE OR SUPPORT?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.1	Describe the harm from which the service user is being protected:		
5.2	Nature of physical intervention used:		
5.3	Circumstances under which physical intervention is used:		
5.4	Does the Care Plan record that the service user lacks the capacity to understand the restrictions?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5.5	Does the Care Plan record explain the Best Interests needs for the restrictions?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Comments: Person undertaking assessment (PRINT NAME): _____ Signature: _____ Date: _____			

