|  |
| --- |
| **Case ID Number:**  |
| **CAPACITY ASSESSMENT - All sections must be completed** |
| Full name of the person being assessed |  |
| Date of birth *(or estimated age if unknown)* |  |
| **This also constitutes the Age Assessment. If there is any uncertainty regarding the person’s age, please provide additional information at the end of the form.** |
| Address |  |
| Name of the Assessor |  |
| Address of the Assessor |  |
| Profession of the Assessor |  |
| The present address of the person if different from above. |  |

|  |
| --- |
| **MENTAL CAPACITY ASSESSMENT** |
| **What is the specific decision relevant to this mental capacity assessment? Please ensure that the decision is phrased in a way to enable all viable options to be discussed.** **What concern triggered this assessment?**  |
| **What following practicable steps did you take to enable and support the person to participate in the decision-making process:** |
| **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,* ***what information was presented 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:****Causative Nexus**

|  |
| --- |
| There is a causative link between the impairment or disturbance in the functioning of mind and brain AND the inability to make the required decision. You must be able to evidence that the reason the person is unable to make the decision is **because of** the impairment or disturbance in the functioning of mind or brain and for no other reason.  |

 |
|  |

|  |
| --- |
| **Tick one of the below:**  |
|  | In my opinion the person **LACKS** capacity 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 make this decision.  |
| **NOTE: IF YOU DEEM THE PERSON TO HAVE CAPACITY, BEST INTEREST IS NOT REQUIRED.****NOW PLEASE NOW SIGN AND DATE THIS FORM BELOW** |
| Print Name |  |
| Signature |  |
| Date |  |

|  |
| --- |
| **If you deem the client to have capacity, are you confident that they have made the decision from their own free will and not under due influence or coercion of others?**  |
|  |

**BEST INTEREST DECISION MAKING FORM**

A person trying to work out the best interests of a person who lacks capacity to make a specific decision (‘lacks capacity’) should follow this form.

**Before continuing refresh yourself with the Best Interests Checklist, ensuring to sign and date that you have read the following:**

**Encourage participation -**

* do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision.

**Identify all relevant circumstances -**

* try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.

**Find out the person’s views -**

* try to find out the views of the person who lacks capacity, including:
	+ the person’s past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.
	+ any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
	+ any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

**Avoid discrimination -**

* not make assumptions about someone’s best interests simply on the basis of the person’s age, appearance, condition or behaviour.

**Assess whether the person might regain capacity**

* consider whether the person is likely to regain capacity (eg after receiving medical treatment. If so, can the decision wait until then.

**If the decision concerns life-sustaining treatment -**

* not be motivated in any way by a desire to bring about the person’s death. They should not make assumptions about the person’s quality of life.

**Consult others -**

* if it is practical and appropriate to do so, consult other people for their views about the person’s best interests and to see if they have any information about the person’s wishes and feelings, beliefs and values - in particular, try to consult:
	+ anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues
	+ anyone engaged in caring for the person
	+ close relatives, friends or others who take an interest in the person’s welfare
	+ any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person
	+ any deputy appointed by the Court of Protection to make decisions for the person.
* For decisions about major medical treatment or where the person should live and where there is no-one who fits into any of the above categories, an Independent Mental Advocate (IMCA) must be consulted.
* When consulting, remember that the person who lacks the capacity to make the decision or act for themselves still has a right to keep their affairs private – so it would not be right to share every piece of information with everyone.

**Avoid restricting the persons rights –**

* see if there are other options that may be less restrictive of the person’s rights.

**Take all of this into account –**

* weigh up all of these factors in order to work out what is in the person’s best interests.

**NOTE:** ‘An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.’

|  |
| --- |
| **Name:****Sign:****Date:** |

1. Is an **Independent Mental Capacity Advocate Required (IMCA)?**

**Yes**  N**o**

If Yes, complete IMCA Referral

**Note:** You have a duty to involve IMCA for persons who do not have an appropriate or willing person to be consulted on matters of residency change or serious medical treatment.

**IMCA Contact Details:**

|  |
| --- |
| **Name: Date Allocated:****Address:****Tel:****Mobile:****Email:** |

1. Has the client made a relevant **Advance Decision?** **Yes No**

**Note:** **Advance Decision** can only be to refuse specific medical treatment/intervention.

Is it applicable? **Yes**  **No**

1. Why is the **Advance Decision** not applicable at this stage?

If you validate this **Advance Decision**, explain why -

**Note:** If validated, then this **Advance Decision** must be adhered to.

1. Has the client made an **Advance Statement?**  **Yes** **No**

Is it applicable to take into consideration? **Yes** **No**

1. Why is the **Advance Statement** not applicable at this stage?

If you validate this **Advance Statement**, explain why -

1. Is there any person(s) with **decision-making powers** under the MCA 2005?
2. Lasting Power of Attorney: **Yes No**

Which type?

* Property and Financial Affairs **Yes No**

(This would include Enduring Power

of Attorney)

* Health and Welfare **Yes No**

B. Court of Protection Deputyship Order: **Yes No**

Which type?

* Property and Financial Affairs **Yes No**

* Health and Welfare **Yes No**

**Note:** If Yes to **any** of above, copy original orders before signing/copy stating that you have seen originals and date they were seen. (Put signed copies with these papers).

**If Yes Contact Details:**

**Person 1 -**

|  |
| --- |
| Name:Address:Tel:Mobile: Email: |

**Person 2 -**

|  |
| --- |
| Name:Address:Tel:Mobile: Email: |

7. Is there a named person/befriender requiring to be consulted? **Yes** **No**

**If Yes Contact Details**

|  |
| --- |
| Name:Address:Tel:Mobile: Email: |



1. Is there an identified Carer? **Yes**  **No**

**If Yes Contact Details**

|  |
| --- |
| Name:Address:Tel:Mobile: Email: |

1. Other than those mentioned above, the following have also been consulted:

**Person 1 -**

|  |
| --- |
| Name:Address:Tel:Mobile: Email: |

**Person 2 -**

|  |
| --- |
| Name:Address:Tel:Mobile: Email: |

**Person 3 -**

|  |
| --- |
| Name:Address:Tel:Mobile: Email: |

**Person 4 -**

|  |
| --- |
| Name:Address:Tel:Mobile: Email: |

1. Was IMCA involved? **Yes** **No**

 If Yes attach their report to these papers

1. What was the **Best Interests Decision**?

**Note:** Decision and rationale should be recorded here including any minutes of any meetings held. Best Interest Meetings are not required under the Act but can be the best platform for when there are disputes to enable all opinions to be heard.

 **Options** – what are the viable options? (i.e. A, B, or C)

 **Views of all consulted on viable options** –

 **Note:** Record everyone’s views For and Against the viable options.

1. **Decision-Makers Balance table:**

 **Note:** You will need to do a balance table for each viable option for consideration.

**Option A (describe):**

|  |  |
| --- | --- |
| Pro | Cons |
|  |  |

**Option B (describe):**

|  |  |
| --- | --- |
| Pro | Cons |
|  |  |

**Option C (describe):**

|  |  |
| --- | --- |
| Pro | Cons |
|  |  |

1. **Decision Maker:**

**Note:** The Decision Maker is the Person (not a group of people) requiring the Client to make the decision and carry out the capacity assessment.

|  |
| --- |
| **Name:** **Relationship to Client:** **Signature:** **Date:** |

1. **Best Interest Decision Outcome:**

|  |
| --- |
|  |

1. **How will the Best Interest Decision be implemented?**

|  |
| --- |
|  |

1. **Any other information:**
2. **Signatures:**

**I/We have been involved in a Best Interest Consultation with the relevant**

**professionals over the care, personal circumstances, assessments and treatment of the client.**

**I/We agree that he/she is unable to give his/her own consent, based on the criteria**

**(two stage capacity) set out in this form.**

**I/We also understand that a decision can lawfully be made if it is his/her best interest.**

**Having been involved in the decision-making process and after having everything**

**explained to me in lay terms we understood, and we have no objections to the**

**decision made as it is in the client’s best interest.**

**Person 1 -**

|  |
| --- |
| **Name:****Signature:** |

**Person 2 –**

|  |
| --- |
| **Name:****Signature:** |

**Person 3 -**

|  |
| --- |
| **Name:****Signature:** |

**Person 4 -**

|  |
| --- |
| **Name:****Signature:** |