Surname _____

First Name _____

NHS/Hospital/Swift no _____

Date of birth ____/____/_____

Mental Capacity Assessment Form

To be read in conjunction with sections 2, 3, 4, 5, & 6 of the Mental Capacity Act 2005 (MCA): Code of Practice.

For all decisions relating to accommodation or social care this form must be completed by a Social Worker

For all decisions relating to medical/clinical or health care this form must be completed by a Health Professional involved in the care

(It is important to document all the relevant information. Please record the information within the person's case/clinical records.

SECTION A: Provide details of treatment, procedure, change of accommodation or circumstances and details of the decision that needs to be made: (NB: If the decision in question relates to consent to a procedure / investigation which would, under normal circumstances, require written consent, Form 4 (Form for Adults Who Are Unable To Consent To Investigation To Treatment) must be used in conjunction with this assessment form.

……
……
……...
……
……

When assessing mental capacity, the principles to be considered are :

- The person must be assumed to have mental capacity unless it is established that they lack Capacity.
- The person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
- An individual is not to be treated as unable to make a decision merely because he/she makes an unwise decision.

Is there reason to doubt that the person lacks mental capacity to make the above decision ?

Yes □ continue to section B: Diagnostic Test

No □ Presume that the person has mental capacity to make the above decision. No further action can be taken under the MCA. Please complete signature section at the bottom of this form and then file this form in the healthcare/social care record as evidence of your decision, To document your decision go to Section D.

SECTION B: Diagnostic Test :

Does the person have a temporary or permanent impairment of the mind or brain, or is there some sort of temporary or permanent disturbance affecting the way his/her mind or brain works, e.g. disability, brain damage, significant learning disabilities, dementia, delirium, concussion following a head injury, symptoms of drug or alcohol abuse?

Note – If the impairment is temporary or fluctuating can the decision be delayed until the individuals decision making ability has improved?

Yes □ Please explain and proceed to Section C: Capacity Assessment
……
……
……..
No □ No further action can be taken under the MCA. Please sign below and then file this form in the healthcare/social care record as evidence of your decision.
Signature _____**(Print)** _____ **Date** ____/____/_____

Job Title _____ **Contact Details** _____

Mental Capacity Assessment Form

SECTION C : Capacity Assessment:
Enhancing Capacity : To help a person make a decision for themselves, consider all of the following points before completing section D:

1. Please explain what relevant information the person has been given to make the decision.
……
……
……

2. Is there a choice of treatment/accommodation? **Yes** □ **No** □ if Yes, what information on all the alternative treatments/accommodation options was given
……
……
……
……

3. Has the information been explained in a method that is easy for the person to understand? (e.g. simple language, visual aids, non-verbal communication, etc): **Yes** □ **No** □ If Yes, explain why: If No, Why not ? ……
……
……
……

4. Have you asked anyone to help or support the person to make his or her choices or express a view? (e.g. IMCA if appropriate) **Yes** □ **No** □ If Yes, who? If No, why not?
……
……
……

5. Have you considered putting the decision off to see whether the person will regain capacity so that they can make the decision at a later time, when circumstances are right for them.
Yes □ **No** □ If Yes, explain: If No, why not ……
……
……
……

6. Are there particular times of the day when the person's understanding is better or particular locations where they may feel more at ease? **Yes** □ **No** □ If Yes, how has this been utilized? ……
……
……
……

7. Has anyone helped with communication? (e.g. Family member, support worker, interpreter, speech language therapist, advocate, etc.) **Yes** □ **No** □ If Yes, who? If No, why not?
……
……
……
……

Mental Capacity Assessment Form

SECTION D: Capacity Test
In relation to the decision in question at the time it needs to be made, does the person:-

A. Understand the relevant information about the decision to be made? **Yes** □ **No** □
Please explain: ……
……
……
……
……
B. Retain the information in their mind? **Yes** □ **No** □ please explain: ……..
……
……
……
……
C. Use or weigh that information as part of the decision-making process? **Yes** □ **No** □
Please explain: ……
……
……
……
D. Communicate their decision (by any means)? **Yes** □ **No** □ please explain: …….
……
……
……
……
If you have answered **"NO"** to **any** of the above questions (A-D), the person may lack capacity to make the decision in question and the best interests decision making form needs to be completed.
If the person is able to do all of the above the person is deemed to have capacity and no further action can be taken under the MCA, please complete section below and then file this form within the healthcare/social care record as evidence of your decision.

Signature …….. (PRINT) ……..Date ……../……../…….

Job Title …….. Contact details ……..

Surname_____

First name _____

NHS/Hospital/ Swift no _____

Date of birth _____/_____/_____

Best Interests Decision Making Form

When making 'best interest decisions', the principles to be considered are:

- Decisions made under the MCA must be in the person's best interests.
- The least restrictive option for the person should be used.

Do not make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or aspect of his / her behaviour. **Do not make assumptions about the person's quality of life.**

Please answer the following questions :-

1. Are you aware of a valid and applicable Advance Decision to Refuse Treatment in existence, whether verbal, in writing or documented within the healthcare record? **Yes** □ (Refusal is legally binding if valid and applicable) **No** □ Go to question 2.

2. Are you aware of a registered **valid** and **applicable** Lasting Power of Attorney (LPA) for personal welfare allowing the attorney / donee to make decision detailed in Section A?
Yes □ (if yes, decision can be made by attorney / donee) **Please name:-** ……
No □ Go to question 3.

3. Is there a court appointed deputy who has the power to make the decision detailed in section A? **Yes** □ (if yes, decision can be made by court appointed deputy) **No** □ **(if no, the decision must be made by the decision-maker and all the following questions must be completed).**

A. Is there a less restrictive option or any alternatives to consider? **Yes** □ **No** □ If yes, what Have you considered?: ……
……
……
……

B. Have you identified all the issues and circumstances relating to the decision in question that are most relevant to the person who lacks capacity? Consider the benefits and risks of carrying it out. **Yes** □ **No** □ please explain: ……
……
……
……..

C. have you considered the views of the person including past and present wishes and feelings (e.g. verbal, in writing or through behaviour or habits), beliefs, or values (e.g. religious, cultural or moral) Or any other factors. **Yes** □ **No** □ please explain: ……
……
……
……

D. Have you done anything to permit and encourage the person to participate, or to improve his / her ability to participate, as fully as possible in making the decision? Please explain: ……
……
……
……

E. Have other relevant people been consulted for their views regarding the person's best interests? (e.g. relative, carer, friend, attorney / donee or deputy) include details of persons consulted and their role and views expressed.

Yes □ If yes, please name individuals that have been involved in the decision in question in the table below.

No □ If no, why not? ……
……
……
Name (s) of any individuals that have been involved regarding the decision:

Name	Relationship	Contact Phone No

The above list is not exhaustive, other relevant factors may be considered in addition to them. Please indicate below other factors considered when making the decision

……

Have all those named above given their agreement on the decision reached ?

Yes-

No-

Please specify :……

Remember, relatives cannot give consent on another adult's behalf without a lasting Power of Attorney covering personal welfare.
F.Is the person unbefriended and a decision needs to be made in relation to serious medical treatment or a change of accommodation?

Yes □ **If yes -** use Independent Mental Capacity Advocate (IMCA) Service Referral Form (available on intranet) to decide if a referral is appropriate and then, if necessary, proceed to make the referral.

No □ **If no** – use the family/friend/LPA/Donee/ Deputy to be involved in the Best Interests Decision making process in the person's best interests.

Note – If an IMCA has been instructed, the report of the IMCA must be considered in coming to a decision about what is in the person's best interests. Please attach the report of the IMCA to this form.

Note: You should make an application to the Court of Protection and see legal advice if the decision detailed in **Section A** relates to:

- The proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from a patient in a permanent vegetative state (PVS).
- A proposal that the patient who lacks capacity to consent should donate an organ or bone marrow to another person.
- The proposed non-therapeutic sterilization of a patient who lacks capacity to consent
- A case where serious medical treatment is in question and there is doubt or disagreement whether the treatment is in the best interests of the patient (i.e. the medical treatment has fine balance of the benefit, the choice between treatments is finely balance or there is serious consequence to the patient).

Signature _____ **(PRINT)**_____**Date**____**/**___**/**_____

Job Title _____ **Contact Details** _____

If there is uncertainty or disagreement/dispute about achieving a best interest decision on behalf of the person, a formal Best Interests Meeting will need to be undertaken and evidenced on the Recording Best Interests Decision Proforma . For Wigan Council (People Directorate) the chair of the BIM will need to be either the Team Manager /Service Manager or the MCA/DOLS Co-ordinator.

For the Wrightington,Wigan and Leigh NHS Foundation Trust 5 Boroughs NHS Foundation Trust the chair of the BIM will need to identify the appropriate health care lead.

Following the **Formal Best Interests Meeting** and if no agreement has been reached and there is still uncertainty, or disagreement/dispute about achieving a Best Interests Decision on behalf of the person , then a **Best Interests Case Review Meeting** to be undertaken ,chaired by the Head of Service , and or nominated deputy , for cases surrounding social care decisions.

For clinical/treatment /medical decisions the chair will need to be identified by the appropriate senior health care lead.

To arrange a Best Interests Case Review Meeting on behalf of Wigan Council(People Directorate) please contact ;

MCA/DOLS Co-ordinator
Telephone No: 01942 828329
Email: dols@wigan.gov.uk
Postal Address: MCA/DOLS Office
CDT
Hyndelle Lodge
King Street
Hindley
Wigan

Please provide evidence of the Best Interests Decision making process with names of all those involved their contact details and areas of uncertainty/disagreement/dispute.

To arrange a Best Interests Case Review Meeting on behalf of the Wrightington ,Wigan and Leigh NHS Foundation Trust please contact ;

The Safeguarding Manager
Telephone No: 01942 822333
Email:Margaret.Jolly@wwl.nhs.uk
Postal Address: Safeguarding Manager
Wigan Infirmary
Wigan Lane
Wigan.

Please provide evidence of the Best Interests Decision Making process with names of all those involved their contact details and areas of uncertainty/disagreement/di

spute.