ASSESSMENT OF CAPACITY AND WHERE APPROPRIATE BEST INTERESTS

DATE …………………………………………………….

NAME OF PATIENT………………………………………………………………………..

DATE OF BIRTH……………………………………………………………………………

ADDRESS……………………………………………………………………………………

……………………………………………………………………………………………………

……………………………………………………………………………………………………

WARD/DEPARMENT………………………………………………………………………

DETAILS OF DECISION MAKER(S)…………………………………………………………..

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DETAILS OF DECISION TO BE MADE……………………………………………………….

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DOES THE PATIENT HAVE CAPACITY TO MAKE THE ABOVE DECISION (AS AT THE ABOVE DATE) (NB *ONE OF THE BOXES BELOW MUST ONLY BE TICKED ONCE THE REMAINDER OF THIS FORM HAS BEEN COMPLETED)*

☐ **YES** ☐ **NO**

ASSESSMENT OF CAPACITY

Does the patient:

i. Have an impairment of or a disturbance in the functioning in the mind of the mind or brain?

☐ Yes ☐ No (if no go to v)

If yes please provide details……………………………………………………………………

……………………………………………………………………………………………………..

……………………………………………………………………………………………………

If yes, is the patient able to:

ii. Understand the information relevant to the decision ☐ yes ☐ no

Details …………………………………………………………………………………

and

iii. Retain that information for long enough to make the decision ☐ yes ☐ no

Details ………………………………………………………………………………..

and

iv. Use or weigh that information as part of the process of making the decision?

☐ yes ☐ no

Details …………………………………………………………………………………

Please provide further information, if appropriate/necessary:

……………………………………………………………………………………………………

…………………………………………………………………………………………………...

and/or

v. Is the patient unable to communicate their decision, whether by talking, using sign language or any other means ☐ yes ☐ no

Please provide details……………………………………………………………………………

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If the answer to any of these 4 questions is **NO**, the person lacks the capacity to make the decision. Capacity should be assessed at the time the decision needs to be made. Consider whether this decision can be delayed because the person is likely to regain or develop capacity in the relevant future.

☐ The decision can be delayed

☐ Not appropriate to delay the decision

☐ Person not likely to regain or develop capacity

Determination of Capacity *(complete one of the boxes below)*

I have assessed this person's capacity to make the specific decision and determined that they **have** the capacity to make this decision at this time.
Name ____

Signature ____ Date _______________________

Job Title____

I have assessed this person's capacity to make the specific decision and determined that they **do not have** the capacity to make this decision at this time.
Name (in capitals) ____

Signature ____ Date _______________________

Job Title____

Additional information (including resulting actions)
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If applying this test, the patient is assessed as not having capacity to make this decision, you must consider the best interests checklist before deciding what is in the patient's bests interests. (*If the patient has made a Lasting Power of Attorney or Advance Decision that is applicable to this decision refer to the Trust's policy or seek advice before proceeding*)

BEST INTERESTS CHECKLIST (please tick when task completed)

a) I have encouraged and assisted the patient to participate in the decision ☐

b) I have considered all factors relevant to the decision ☐

c) I have attempted to find out the views of the patient, including their past and present wishes and feelings, and taken these into account ☐

d) I have not based my assessment solely on the patient's age, appearance, condition or behaviour ☐

e) I have considered whether the patient might regain capacity and if so whether the decision can be delayed ☐

Please provide details of how you have applied factors a) – e)

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f) I have consulted the following relevant individuals in coming to my decision:

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Their views were as follows

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It was not practicable/appropriate* to consult……………………………………… for the following reasons

*Delete as appropriate**

…………………………………………………………………………………………………….

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Independent Mental Capacity Advocate Service (if applicable)

i) A referral to the IMCA service is not necessary as I have been able to consult relevant individuals under the best interests checklist/the decision needs to be taken on an urgent basis* [Reason for urgency…………………………………………………………………....]

ii) A referral has been made to the IMCA service and I have taken the IMCA's view into account*

*** Delete where appropriate**

Life sustaining Treatment

g) My decision is not motivated in by a desire to bring about the patient's death. ☐

DETAILS OF DECISION MADE

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DETAILS OF INDIVIDUALS TO BE INFORMED

………………………………………………………………………………………………..

………………………………………………………………………………………………..

SIGNED…………………………………………………………………………………………..

NAME IN CAPITALS…………………………………… JOB TITLE ……………………………

DATE……………………………………………………………………………………………..