

Assessment of a Service User's Mental Capacity - Assessment for a Best Interest Decision

A: SERVICE USER'S PERSONAL DETAILS					
Surname:	First Name(s):	Title:			
Age last birthday:	Date of Birth:	Date Service Started:			
B: DETERMINING BEST INTERESTS FOR THE SERVICE USER					
<p>This Form is only to be used when it has been assessed that the service user lacks the mental capacity to make a particular decision affecting their daily living needs and chosen lifestyle at this point in time.</p> <p>All decisions and steps taken for the service user who lacks capacity will be taken in their best interests.</p>					
DETAILS OF THE DECISION TO BE MADE:					
#	Parameter	Guidance Notes	YES	NO	Comments
1	REGAINING CAPACITY:	Is the service user likely to have capacity in the future? Can the decision be delayed until then?	<input type="checkbox"/>	<input type="checkbox"/>	
2	RELEVANT CIRCUMSTANCES:	Has everything the service user would have taken into account if they were making the decision for themselves been considered?	<input type="checkbox"/>	<input type="checkbox"/>	
3	AVOID DISCRIMINATION:	Have assumptions been made on the basis of the service user's age, appearance, condition or behaviour?	<input type="checkbox"/>	<input type="checkbox"/>	
4	ENCOURAGE PARTICIPATION:	Has everything possible been done to encourage and permit the service user to participate in making the decision?	<input type="checkbox"/>	<input type="checkbox"/>	
5	SPECIAL CONSIDERATIONS:	Where the decision relates to life-sustaining treatment, is it ensured that this has not been motivated by a desire to bring about their death.	<input type="checkbox"/>	<input type="checkbox"/>	
6	WRITTEN STATEMENTS:	Has any written statement made by the service user when they had capacity been considered?	<input type="checkbox"/>	<input type="checkbox"/>	
7	THE SERVICE USER'S WISHES:	Have the service user's past and present wishes, feelings, beliefs and values that would likely to influence the decision, been considered?	<input type="checkbox"/>	<input type="checkbox"/>	
8	CONSULT OTHERS:	Has input from others involved in caring for the service user (relatives, friends, legal representatives etc) been considered?	<input type="checkbox"/>	<input type="checkbox"/>	
9	AVOID RESTRICTING RIGHTS:	Has the least restrictive option for the service user been considered?	<input type="checkbox"/>	<input type="checkbox"/>	
10	INDEPENDENT MENTAL CAPACITY ADVOCATE:	Where the decision relates to serious medical treatment or changes in accommodation, has an IMCA been appointed to provide an appropriate report	<input type="checkbox"/>	<input type="checkbox"/>	
11	OTHER CONSIDERATIONS:	Have factors such as emotional bonds and family obligations that the service user would consider when making the decision, been considered?	<input type="checkbox"/>	<input type="checkbox"/>	

C: FINAL DECISION & SIGN-OFF

IMCA INSTRUCTION:

If an Independent Mental Capacity Advocate (IMCA) has been instructed, summarise their involvement below:

Full name of IMCA and contact (telephone / mobile / e-mail) details:

Summary of the IMCA's report:

DECISION:

Action to be taken whilst acting in the Best Interests of the service user:

SIGN-OFF:

Assessor Name (PRINT): _____ Assessor's Signature: _____

Position: _____ Date: _____

SERVICE USER / FAMILY MEMBER / ADVOCATE (as appropriate):

Name (PRINT): _____ Signature: _____

Relationship to Service User: _____ Date: _____