**Mental Capacity Act Best Interest Decision**

To be completed where a capacity assessment has already been made that the person does **NOT** have capacity to make a specific decision or agree to a specific action.

If a person does not have capacity, they **cannot** consent and therefore decisions / actions will need to be made on the basis of the individual’s best interest.

Ensure that the following principles from the Mental Capacity Act are followed:

* Any decision made or action undertaken must be in the **person’s** best interest
* The **least** restrictive way must be used

Consultation must be undertaken with family and friends, anyone holding Lasting Power of Attorney (LPA) for Health & Welfare &/ or Finances, Enduring Power of Attorney, Court Appointed Deputy and an IMCA (Independent Mental Capacity Advocate) if appointed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Best Interest Decision** | | **Hospital Number** | | **Date** |
|  | |  |
| **Patient Details** | | | | |
| **Name** | | | **Alias** | |
|  | | |  | |
| **Address** | **Gender** | | **Marital status** | |
|  |  | |  | |
| **Age** | | **DOB** | |
|  | |  | |
| **Telephone number** | **Ethnicity** | | **Religion** | |
|  |  | |  | |
| **GP** | | | **Consultant** | |
|  | | |  | |
| **Communication needs** | | | **First language** | |
|  | | |  | |
| If the person is ‘unbefriended’ and the decision is about   * Change of accommodation * Serious medical treatment * Safeguarding concerns   Then an IMCA (Independent Mental Capacity Advocate) **must** be appointed. | | | Person ‘unbefriended’ **Yes / No**  IMCA appointed **Yes / No**  IMCA’s views recorded and report attached | |
| **Is there a Lasting Power of Attorney (LPA)?**  Health & Welfare  Finance & Property | | | **Who is the LPA?** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Decision or Action that needs to be taken**  Give full and precise details | | | |
|  | | | |
| **Who is the Decision Maker?**  This could be the LPA or a Professional | | | |
| Name: | | | |
| **Mental Capacity Assessment undertaken by** | | | |
| Name | | |  |
| Designation | | |  |
| Contact details  Address  Telephone number  Email address | | |  |
| Dated | | |  |
| **Best Interest Checklist** | | | |
| Will the person regain the capacity to make this decision?  If yes can the decision be safely delayed until the person regains capacity? | | **Yes / No**  Details | |
| Has the person been involved as practically as possible | | Details | |
| Consideration has been given to   * The person’s past and present wishes and feelings (including any written statement previously made). * The beliefs and values that would have influenced the person if they had capacity. | | Details | |
| Previous records have been consulted  Identify which records and record relevant information. | | Details | |
| Family and friends have been consulted.  Give details and record their views | | Details | |
| Consulted other staff as appropriate.  Give details and record their views | | Details | |
| **Decision made** | | | |
| Best Interest Decision made after consideration of all the relevant factors | | | |
| **Decision Maker** | | | |
| Name |  | | |
| Signature |  | | |
| Designation |  | | |
| Contact details  Address  Telephone number  Email address |  | | |
| Date |  | | |