**BEST INTEREST DECISION MAKING TOOL**

**To be used in conjunction with the guidance on**

[**ASSESSMENT OF MENTAL CAPACITY PROCEDURE**](http://intraweb/stellent/groups/public/documents/policies_and_procedures/cont230738.pdf)

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| **Person’s Details:** | **Swift No:** |
|  |  |
| **Is Person Continuing Health Care Funded** | **Yes/No** |
|  |  |
| **Occupational Therapy Worker Details** | |

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| **Does the person have an Impairment of, or a disturbance in the functioning of, their mind or brain?** | |
| Please describe | |
| **Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?** | |
| Please describe | |
| **Decision to be made:** | Please describe |

**Helping the Person make the Decision**

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| Does the person have all the relevant information they need to make a particular decision?  Please state information given: |
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| If they have a choice, have they been given information on all the alternatives?  Please state all choices given and how. |
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| Has the information been explained or presented in a way that is easier for the person to understand (for example, by using simple language or visual aids)?  Please give details. |
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| Have different methods of communication been explored if required, including non-verbal communication? |
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| Could anyone else help with communication (for example, a family member, support worker, interpreter, speech and language therapist or advocate)?  Could anyone else help or support the person to make this decision. |
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| Are there particular times of day when the person’s understanding is better?  E.g. Day/Night disorientation |
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| **Does this decision need to be made at this point in time?  If so, why? Is capacity likely to regain?** Could the decision be put off to see whether the person can make the decision at a later time when circumstances are right for them?  E.g. UTI or recent hospital admission. |
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| Are there particular locations where they may feel more at ease? |
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**Considering the persons ability to make the decision:**

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| **Does the person have a general understanding of what decision they need to make and why they need to make it?**  **Do they understand:-** | |
| **The nature of the decision** | Yes  No |
| **The reason why the decision is needed,**  **and**  **The likely effects of deciding one way or another, or making no decision?** | Yes  No  Yes  No |
| **The likely consequences of making, or not making, this decision?** | Yes  No |
| **Is the person able to understand, retain, use and weigh up the information relevant to this decision?  Check the person understands after a few minutes.**  **The person should be able to give a rough explanation of the information that was explained** | |
| Comments | Yes  No |
| **Can the person communicate their decision**  **(by talking, using sign language or any other means)?** Avoid questions that need only a ‘yes’ or ‘no’ answer (for example, did you understand what I just said?). They are not enough to assess the person’s capacity to make a decision. | |
| Comments | Yes  No |
| **Would the services of a professional (such as a speech and language therapist) be helpful?** | |
| Comments | Yes  No |
| **Is there a need for a more thorough assessment**  **(perhaps by involving a doctor or other professional expert)?** | |
| Comments | Yes  No |

**Is a decision to be made in the person’s best interest?**

**A person is unable to make a decision if they cannot:**

1. **Understand information about the decision to be made (the Act calls this ‘relevant information’)  
     
   or**
2. **Retain that information in their mind  
     
   or**
3. **Use or weigh that information as part of the decision-making process,   
     
   or**
4. **Communicate their decision (by talking, using sign language or any other means)**

**Decision Made in the Person’s Best Interest**

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| **Take into account as reasonably practical at time of assessment:**   1. **The person’s past and present wishes and feelings (and in particular, any relevant written statements made by him/her when he/she had capacity)** 2. **The beliefs and values that would be likely to influence his decision if he/she had capacity and** 3. **The other factors that he/she would be likely to consider if he/she were able to do so.’** |
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**Who was consulted?:-**

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| 1. **Anyone the person has previously named as someone they want to be consulted** 2. **Anyone involved in caring for the person** 3. **Anyone interested in their welfare (for example, family carers, other close relatives, or an Advocate already working with the person)** 4. **If there is no-one to speak to about the person’s best interests, in some circumstances the person may qualify for an Independent Mental Capacity Advocate (IMCA).** |

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| **Family / Social Support/Carers details involved at Time of Assessment** | | | | | |
| **Name** | **Contact Details** | **Contacted for assessment purposes** | | | |
| **Letter** | **Phone** | **Present** | **Yes/No** |
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| **Professionals & Support Agencies Involved at Time of Assessment** | | | | | | |
| **Name** | **Agency Contact Details** | **Support Provided** | **Contacted for assessment purposes** | | | |
| **Letter** | **Phone** | **Present** | **Yes/No** |
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**When completed please attach to the appropriate**

**paperwork/assessment/risk assessment.**

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| **Authorisation** | |
| **Signed:**  **Print:**  **Occupational Therapist/Social Work Assistant** | **Date:** |
| **Authorisation** | |
| **Signed:**  **Print:**  **Senior Occupational Therapist/Team Manager** | **Date:** |