



Dorset HealthCare
University NHS Foundation Trust



Mental Capacity Assessment and Best Interests Decision-Making Protocol for possible use of safe holding to enable medical treatment.

(Anyone undertaking an assessment using this form **must** read the Mental Capacity Act Code of Practice)

NAME	DOB	ETHNICITY	FIRST LANGUAGE / METHOD OF COMMUNICATION	Date of treatment (form valid for maximum 1 month)

Present Address / Location	Home Address

Action to be considered for the specific decision of:
(Time specific with review date if course of treatment ongoing)

TWO STAGE TEST

a) Is there an impairment of, or a disturbance in, the functioning of the person's mind or brain?

		YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
		PERMANENT	<input type="checkbox"/>	TEMPORARY	<input type="checkbox"/>

b) Does the impairment or disturbance mean that the person is unable to make the decision? Degree of learning disability?

		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Any health considerations pertinent to this decision/procedure:

ASSESSMENT OF ABILITY TO MAKE DECISIONS		
<p>1. Can the person understand the info relevant to the decision? e.g. What is your understanding of the decision in question? Can you tell me why you think the decision needs to be made? What do you think the consequences of your decision will be?</p> <p>AND</p>	<p>YES - Able to understand info. Record views / evidence to show they understood it.</p>	<p>NO - Unable to understand info. Record steps taken to explain info and views / evidence why they did not understand it.</p>
<p>2. Can they retain the information long enough to make the decision?</p> <p>AND</p>	<p>YES - Able to understand info. Record evidence.</p>	<p>NO - Unable to understand info.</p>
<p>3. Can they weigh the info as part of the decision making process? Are they unable to understand the consequences of making or not making the decision?</p> <p>AND</p>	<p>YES - Able to weigh info Record evidence</p>	<p>NO - Unable to weigh info. Record evidence</p>
<p>4. Can they communicate the decision by any means available?</p>	<p>YES - Able to communicate. Record evidence</p>	<p>NO - Unable to communicate Record evidence of support provided.</p>
<p>CONCLUSION – If the Answer is NO to any of these questions – the person lacks capacity.</p>	<p>Outcome</p> <p>Date Assessor and role</p>	
<p>Assessor's Signature</p>		<p>Date</p>

PART 2: MENTAL CAPACITY - BEST INTERESTS DECISION	
SPECIFIC DECISION / ACTION BEING CONSIDERED	
CONSULTATION WITH PERSON LACKING CAPACITY	SUPPORTING EVIDENCE
Specify their past and present wishes, feelings and concerns in relation to this decision.	
What are the person's values and beliefs (e.g. religious, cultural, moral) in relation to this decision?	
Does the person have any previously held Instructions (e.g Advance Decisions) relevant to this decision? Give details.	
Is there a valid Enduring Or Lasting Power of Attorney? Financial, Health & Welfare.	
Are there any other "relevant circumstances" that should be taken into account in this case? (risk history)	
COMMUNICATION	
Are there any language / communication issues? (give details)	
How have these been dealt with?	

BEST INTERESTS CONSULTATION

KEY PEOPLE CONSULTED (date and sign please) and any comments or opinions.

Name, role & contact details	Date consulted
<ul style="list-style-type: none"> Anyone named by person lacking capacity as someone to consult. 	
<ul style="list-style-type: none"> Anyone engaged in caring for the person or interested in their welfare other than decision makers. 	
<ul style="list-style-type: none"> Advance decision? Or statement? 	
<ul style="list-style-type: none"> Enduring / Lasting Power of Attorney (Financial / Welfare) 	
<ul style="list-style-type: none"> Court of Protection Deputy 	N/A
<ul style="list-style-type: none"> IMCA (see IMCA Policy) 	

THE DECISION MAKER (GP, Dentist, podiatrist etc who decides treatment is required)

Name

Role

Tel:

Date and sign

Comments

THE DECISION MAKER (Community nurse, social worker, support worker) who completes capacity assessment and knows the person best)

Name

Role

Tel:

Date and sign

Comments

THE DECISION MAKER (qualified physical intervention user (GSA) if required and who will be completing the safe holding)

Name

Role

Tel:

Date and sign

Comments

THE DECISION MAKER (the person who will be completing the treatment eg podiatrist, dentist or phlebotomist)

Name

Role

Tel:

Date and sign

Comments

BEST INTERESTS DECISION PROCESS
NB. Ensure you do not make assumptions about what is the person's best interests based on their age, appearance, condition or behaviour.

SPECIFY OPTIONS THAT ARE BEING CONSIDERED*	RECORD BENEFITS / CONSEQUENCES
1.	
2.	
3.	

LEAST RESTRICTIVE INTERVENTION
(Record least restrictive intervention which is in the person's best interests).

FINAL BEST INTERESTS DECISION

Assessor signature		Date	
Review		Date	