

For staff use only:

Hospital number:

Surname:

First names:

Date of birth:

NHS no: _ _ _ / _ _ _ / _ _ _ _

Use hospital identification label

Consultant:

Form for adults who lack the capacity to consent to investigation or treatment

including assessment of mental capacity

Please use 'Procedure completed' stamp below on completion:

Important note:

1. A health professional **must** consult the Trust's **Consent policy for examination, treatment and post mortem, Mental Capacity Act FAQ, Mental Capacity Act 2005 Code of Practice** and **Making Decisions – Independent Mental Capacity Advocate** before completing this form. All sections must be completed by the health professional proposing the procedure.
2. Consider discussing less straightforward cases with a senior colleague.

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Consultant or other responsible health professional

Name and job title:

A Details of procedure or course of treatment proposed

Please refer to the Trust's consent policy for details of situations where court approval must first be sought.

.....
.....

B Assessment of patient's capacity (in accordance with the Mental Capacity Act)

Name of patient (please print):

Location of assessment: Time (24hr): ... H.H.: M.M.....

Name of assessor (please print): Date: D.D./M.M./Y.Y.Y.Y.

Decision type

Specify decision to which this capacity assessment relates (eg. change of accommodation, nutrition, etc)

.....
.....
.....
.....

1 Is there an impairment or disturbance of the person's mind or brain?

Yes If YES, record the reason(s) below (eg. diagnosis, current symptoms) and go to question 2.

No If NO, then the test of capacity (as defined in the Mental Capacity Act 2005) should not be used on this person.

.....
.....

2 In your opinion, is the impairment or disturbance of the person's mind or brain likely to be temporary or permanent?

Temporary Permanent

If temporary, it may be appropriate to delay this assessment until a later date.

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3 Is the person able to understand the information relevant to this decision?

- Yes If YES, go to question 4.
 - No If NO, describe attempts to make the information understandable to the person and continue to question 4.
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-

4 Is the person able to retain the information long enough to make the decision?

- Yes If YES, go to question 5.
 - No If NO, give reasons for your opinion and go to question 5.
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-

5 Is the person able to weigh the information as part of the decision making process?

(e.g. are they able to understand the consequences of not making the decision?)

- Yes If YES, go to question 6.
 - No If NO, give reasons for your opinion and continue to question 6.
-
-

6 Is the person able to communicate their decision in any way?

(If a person is unable to communicate their decision by any means, they are to be considered as lacking capacity regarding the specific decision under the Mental Capacity Act 2005.)

- Yes If YES, describe how the decision has been communicated to you.
 - No If NO, describe the reasons why, and the efforts made to assist them to communicate.
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Please note

If the patient has an impairment of mind or brain (YES to question 1) **AND** the answer is 'NO' to ANY of questions 3, 4, 5 or 6, then the patient may lack capacity with regard to the decision being made.

The presence or absence of mental capacity is judged by the assessor at the time of their appraisal. This tool acts as an aid to documentation only.

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Statement of Capacity

I confirm that I have assessed the mental capacity of the above patient in relation to the decision specified above, and my opinion is that:

(Tick one and record date)

The patient has capacity Date DD / MM / YYYY

The patient lacks capacity Date DD / MM / YYYY

C Independent Mental Capacity Advocate (IMCA)

If the patient is found to lack capacity for the decision in question, do they have a family member/close friend who would be willing to be consulted as part of the best interest decision making process? If not, consider referral to the statutory Independent Mental Capacity Advocate (IMCA) service.

Telephone: 0845 0175 198

Email: imca@voiceability.org

Has an Independent Mental Capacity Advocate (IMCA) been instructed?

No Yes

Details:

Signed (IMCA): **Date:** ... DD / MM / YYYY

Name (PRINT)

D Involvement of the patient's family and others close to the patient

In the absence of an attorney appointed under a Lasting Power of Attorney, or a court appointed deputy, the final responsibility for determining whether a procedure is in an incapacitated patient's best interests lies with the health professional performing the procedure. However, it is good practice to consult with those close to the patient (e.g. spouse/partner, family and friends, carer, supporter or advocate) unless you have good reason to believe that the patient would not have wished particular individuals to be consulted, or unless the urgency of their situation prevents this. 'Best interests' go far wider than 'best medical interests', and include factors such as the patient's wishes and beliefs when competent, their current wishes, their general well-being and their spiritual and religious welfare.

(to be signed by a person or persons close to the patient, if they wish)

I/We have been involved in a discussion with the relevant health professionals over the treatment of:

..... (patient's name)

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I/We understand that he/she is unable to give his/her own consent, based on the criteria set out in this form.

I/We also understand that treatment can lawfully be provided if it is in his/her best interests to receive it.

Any other comments (including any concerns about decision)

.....
.....
.....

Name: **Relationship to patient:**

Address (if not the same as patient):

.....
.....

Signed: **Date:** ... D.D. / M.M. / Y.Y.Y.Y

If a person close to the patient was not available in person, has this matter been discussed in any other way (e.g. over the telephone?)

Yes Details:

No

E Assessment of patient's best interests

I am satisfied that the patient has not refused this procedure in a valid advance decision. As far as is reasonably possible, I have considered the person's past and present wishes and feelings (in particular if they have been written down) any beliefs and values that would be likely to influence the decision in question. As far as possible, I have consulted other people (those involved in caring for the patient, interested in their welfare or the patient has said should be consulted) as appropriate. I have considered the patient's best interests in accordance with the requirements of the Mental Capacity Act and believe the procedure to be in their best interests because:

.....
.....
.....

(Where incapacity is likely to be temporary, for example if the patient is unconscious, or where the patient has fluctuating capacity.)

The treatment cannot wait until the patient recovers capacity because:

.....
.....

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F The patient has an attorney or deputy

Where the patient has authorised an attorney to make decisions about the procedure in question under a Lasting Power of Attorney or a court appointed deputy has been authorised to make decisions about the procedure in question, the attorney or deputy will have the final responsibility for determining whether a procedure is in the patient's best interests.

Signature of attorney or deputy

I have been authorised to make decisions about the procedure in question under a Lasting Power of Attorney / as a court appointed deputy (delete as appropriate). I have considered the relevant circumstances relating to the decision in question (see section E) and believe the procedure to be in the patient's best interests.

Any other comments (including the circumstances considered in assessing the patient's best interests)

.....
.....
.....

Signed: **Date:** D . D / M . M / Y . Y . Y . Y

Name (PRINT):

G Signature of health professional proposing treatment

I confirm that the answers to the questions at Section B are a true and accurate reflection of my assessment and the capacity of the patient in question.

The above procedure is, in my clinical judgement, in the best interests of the patient, who lacks capacity to consent for himself or herself. Where possible and appropriate I have discussed the patient's condition with those close to him or her, and any IMCA, attorney or deputy (as appropriate) and taken their knowledge of the patient's views and beliefs into account in determining his or her best interests.

I have/have not sought a second opinion about the proposed treatment.

Signed (Health professional): **Date:** D . D / M . M / Y . Y . Y . Y

Name (PRINT): **Time (24hr):** H . H : M . M

Designation: **Contact/bleep no:**

Signed (Health professional): **Date:** D . D / M . M / Y . Y . Y . Y

Name (PRINT): **Time (24hr):** H . H : M . M

Designation: **Contact/bleep no:**