Appendix 2: MCA 01 Mental Capacity Assessment Form for LESS Complex Decisions (2024) V2

1	**Name of Relevant Person**	**Address of Relevant Person**						
2	**Preferred Name of Relevant Person**							
3	**Date of Birth**							
4	**NHS Number**							
5	**I am starting this assessment on (insert date and time) …… Although I presume capacity, I doubt the person is able to make this particular decision at this time.**							
6	**What is the decision that needs to be made?**							
7	**Can the decision be delayed because the person is likely to regain capacity in the near future? Give Reasons below:**	Yes		Not likely		Not appropriate to delay		

8	**Assessment:**				
a. Person has ability to <u>understand</u> information related to the decision to be made? If answer is 'No' please provide evidence	Yes		No		
Details:					
b. Person has ability to <u>retain</u> information long enough for the decision to be made? If answer is 'No' please provide evidence	Yes		No		
Details:					
c. Person has the ability to <u>use or weigh up</u> the information in considering the decision? If answer is 'No' please provide evidence	Yes		No		
Details:					
d. Person has ability to <u>communicate</u> their decision by any means? If answer is 'No' please provide evidence	Yes		No		
Details: (State what steps have been taken to achieve communication)					

9	**Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?**	Yes		No	
9a	**Details of Impairment:** (For example: symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with mental illness, a dementia, significant learning disability, brain damage, confusion, drowsiness, or loss of consciousness due to a physical or medical condition)				

If you have answered YES to all of the questions 8a – 8d above, then on the balance of probability, the person is likely to have capacity to make this particular decision at this time. If you have answered **NO** to one or more of those questions then on the balance of probability the person is not likely to have capacity for this decision and you will be required to proceed.

Details of any Advance Decisions to Refuse Treatment (ADRT): (Does any ADRT relate to this particular decision. Reference and attach any relevant documents)

Conclusion:

10	**Person HAS the capacity to make this informed decision at this time?**	Yes		No	

Document and detail your evidence and give reasons for your conclusion:

11 **What is the person's Preferences/Wishes?**

NB. If person has the capacity for this decision you must respect their preferences and wishes, document these here and sign and date below the completion of this capacity decision. If they DO NOT have capacity for this decision you must still respect the rights, will and preferences of the individual and give weight to their views when making a decision in their best interests.

If person is found to lack the capacity to make this decision for themselves please continue

12	**Are there any known relatives or friends to consult with?** If they have Lasting Power of Attorney that covers this decision, i.e. Person Welfare to cover Health decisions) they may be able to make this decision in the best interests of the person, photocopy LPA docs and keep on person's file.	Yes		No	

Names of relatives/friends you have consulted	Contact/Email/ Telephone

13 Where there are NO relatives/friends to consult with, an Independent Mental Capacity Advocate (IMCA) **MUST be instructed** (by the decision maker, i.e. person completing this form) if the decision is about **Serious Medical Treatment, a permanent accommodation move** or you have identified that you are likely to be depriving the relevant person of their liberty; **Deprivation of Liberty Safeguards** (DoLS).

Call the local IMCA for further advice and to make a referral

Name of IMCA allocated	**Referral sent (date)**	**Tel/Email of IMCA**

14 **Detail any disputes or disagreements and who is disputing:**

(Include details of what steps were taken to resolve the disputes) Attach other sheets if required.

Declarations:

I confirm that the following decision has been made without assumption as to the age, appearance, condition or behaviour of the person.
I confirm that where the decision relates to life sustaining treatment, I am satisfied that the decision made has not been motivated in any way, by a desire to bring about the person's death.
I confirm that I have considered all relevant factors. I have taken reasonable steps to establish whether the person lacks capacity in this matter.
I reasonably believe that the person does lack capacity (because of the impairment or disturbance in the functioning of their mind or brain), in relation to this matter and that a best interests meeting will be convened to discuss administering essential medication in a covert manner.

Name of Assessor/Decision maker/person completing this form:	
Role/Job Title of the above:	
Signature:	
Date of completion:	
Date when decision will be reviewed:	