**MCA: Mental Capacity Assessment for LESS complex decisions. PAGE 1**

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| **Name of relevant person** | **Address of Relevant Person** |
| **Preferred Name:**  |  |
| **Date of Birth:**  |  |
| **Date and Time assessment commenced:** …………………………………………………………………………………………………………….*Although I presume capacity, I doubt the person is able to make this particular decision at this time.* |
| **What is the decision that needs to be made?** |
| **Is there an impairment of, or disturbance in, the functioning of the person’s brain or mind?** | **YES** | **NO** |
| **Details of impairment:** *(For example: symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with mental illness, , dementia, significant learning disability, brain damage, confusion.* |
| **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** |
|  |
| **ASSESSMENT** |
| **A: Has the person the ability to understand information related to the decision to be made?** **If the answer is ‘NO’, please provide evidence below** | **YES** | **No** |
| **Details:** |
| **B: Does the person have ability to retain the information long enough for a decision to be made?** **If the answer is no, please provide evidence below** | **YES** | **NO** |
| **Details:** |

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| **C: Does the person have the ability to use or weigh up the information in considering the decision?****If the answer is ‘NO’, please provide evidence below** | **YES** | **NO** |
| **Details:** |
| **D: Does the person have the ability to communicate their decision by any means?** **If the answer is ‘NO’ please provide evidence below** | **YES** | **NO** |
| Details: |
| *If you have answered YES to questions a-d 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 these questions then on the balance of probability the person is not likely to have capacity for this decision and you will need to proceed.*  |
| **Details of any advance decisions: Please reference and attach any documents** |
| **CONCLUSION** |
| **Person HAS the capacity to make this informed decision at this time?** | **YES** | **NO** |
|  |
| **Document and Detail your evidence and give reasons for your conclusions below:** |
| **What is the persons Preferences and Wishes?** |
| **Signed:** |  | **Date of Completion:** |  |
| **If the person is found to lack capacity to make this decision for themselves, please continue** |
| **Are there any known friends or relatives to consult with?***If they have LPA that covers this decision IE Person Welfare to cover health and Well-being or Finance, they may be able to make this decision in the persons best interests. Photocopy LPA and keep on file.*  | **YES** | **NO** |
| **Name of Relatives or friends that you have consulted:** | **Contact Telephone/Email** |

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| ***Where there are no relatives or 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, you have identified that you are likely to be depriving someone of their liberty the IMCA should be instructed.***  |
| **Name of IMCA allocated** | **Referral sent (date)** | **Tel/Email of IMCA** |
|  |  |  |
| **Details of any disputes or disagreements:** |
| **State final decision made in persons best interests: (Please refer to Section 4 of MCA or Chapter 5 of MCA Code of Practice)** |
| **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 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 it will be in the persons best interests for the decision to be made or act to be done.**I can confirm that where the decision is intended to restrain, I believe that restraint used is necessary in order to prevent harm to the person and that it is a proportionate response to the likelihood and seriousness of that harm.* |
| **Name of the Assessor/Decision maker/person completing this form** |  |
| **Role/Job Title of the above:** |  |
| **Signature:** |  |
| **Date of Completion:** |  |
| **Date when decision will be reviewed:** |  |