

MENTAL CAPACITY ASSESSMENT TOOL

This tool is to be used when

There is reason to believe that the person lacks capacity to make a decision about any one of the issues below

- ❖ **Changes in accommodation / review and/ or**
- ❖ **Serious medical treatment and / or**
- ❖ **Serious safeguarding concerns**

AND

There are no family or friends to represent their best interests

OR

There is dispute between those involved in making best interest decisions.

PATIENT DETAILS			
Patient Name		Consultant	
Date of Birth		Hospital Number	
Gender		Ward / Department	

KEY ROLES DETAILS								
Key Roles	Next of Kin	N/A <input type="checkbox"/>	Lasting/ Enduring Power of Attorney (LPA or EPA)	N/A <input type="checkbox"/>	Independent Mental Capacity Advocate (IMCA)	N/A <input type="checkbox"/>	Court of Protection Deputy (CPD)	N/A <input type="checkbox"/>
Name								
Role								
Address								
Phone Number								

ASSESSOR DETAILS		
Key Roles	Person Conducting Assessment	Supporting Clinician
Name		
Role		
Signature		
Contact Details		

ASSESSMENT OF CAPACITY

Examples of Impairment Conditions that are associated with Mental Capacity are: Dementia Learning Disabilities, long term affects of brain damage, physical or mental conditions that cause confusion, drowsiness or loss of consciousness, delirium, confusion, symptoms of drug or alcohol abuse, which although temporary, can all affect capacity.

Basis of this Assessment

- | | | |
|--|--|---|
| <input type="checkbox"/> Serious medical treatment | <input type="checkbox"/> Care Review | <input type="checkbox"/> Resuscitation |
| <input type="checkbox"/> Adult Protection Procedures | <input type="checkbox"/> Change of accommodation | <input type="checkbox"/> Other – please state |

Presenting Condition

- | | |
|---|--|
| <input type="checkbox"/> Unconsciousness | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Autistic Spectrum Disorder | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Mental Health Issues | <input type="checkbox"/> Acquired Brain Injury |
| <input type="checkbox"/> Other Cognitive Impairment i.e. stroke | <input type="checkbox"/> Other (please state)..... |

Details of the specific decisions to be made: (include precise details of proposed serious medical treatment; change of accommodation; adult protection concern; health, welfare, property or finance concerns, requesting an IMCA for an accommodation or care review or other proposed action/decision that is being considered).

Have all known advance decisions been considered?

YES NO
Comment:

Name of the Decision Maker:

Relationship to the Individual:

Date:

QUESTION 1

Is there an impairment or disturbance in the functioning of mind or brain? (permanent or temporary)

YES **NO**

Record symptoms and / or behaviours , any relevant diagnosis

If NO – The person is deemed to have capacity therefore Assessment has been completed and no further action is needed

If YES – Please proceed to Question 2

QUESTION 2

The person is able to understand the information relevant to the decision being made. Have steps been taken to maximise understanding(E.G. Easy Read / Pictures / BSL).

YES **NO**

Record views / evidence to show they understand it.

The person is able to retain the information long enough to make a decision.

YES **NO**

Record views / evidence to show they understand it.

Does the person have the ability to weigh the information as part of the decision making process? Do they understand the consequences of making or not making the decision including the risks?

YES **NO**

Record views / evidence to show they understand it.

The person is able to communicate the decision.

YES **NO**

Record views / evidence to show they understand it.

FLUCTUATING CAPACITY – Always consider whether the person has fluctuating capacity and if the decision can wait until capacity returns. If this is the case, explain and enter reassessment date in the outcome below.

CONCLUSION: If the answer to Question 1 is Yes and the answer to any parts of Question 2 is NO then the person being assessed LACKS capacity under the Mental Capacity Act 2005

OUTCOME	HAS CAPACITY <input type="checkbox"/>
	LACKS CAPACITY <input type="checkbox"/>
ASSESSOR'S SIGNATURE	
DATE:	

OTHER COMMENTS OR CONSIDERATIONS