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**Best Interests Decision**

**Please refer to the associated guidance document (page 4-7) and chapter 5 of the Mental Capacity Act (MCA) Code of Practice – the statutory checklist - before completing a best interests decision.**

**The person should be given every opportunity to be involved in the process.**

|  |  |
| --- | --- |
| Name of adult: |  |
| Date of Birth: |  |
| Person’s first language: |  |
| Micare / Hospital / Patient / District / NHS number: |  |
| Name of decision maker(s):  \* see guidance page 4 |  |
| Job title / role(s): |  |
| Date the decision was made: |  |
| **Section 1: The decision to be made** | |
| **Describe the decision that needs to be made:**  Be as specific and accurate as you can.  **Note** – 1. A best interests decision can only be made once the person has been deemed to lack capacity for the  decision in question  2. The decision should be delayed wherever appropriate – e.g. if it is likely the person will regain capacity | |
| **Section 2: People consulted as part of the decision making process** | |
| Note: A best interest meeting is not a statutory requirement. In many cases, alternative consultation methods e.g. email or telephone are likely to be more appropriate and time efficient.  **Name:**  Role / relationship to the person:  Contact details (where appropriate):  **Name:**  Role / relationship to the person:  Contact details (where appropriate):  **Name:**  Role / relationship to the person:  Contact details (where appropriate):  Add additional names where required | |
| **Section 3: IMCA Instruction** | |
| If an Independent Mental Capacity Advocate (IMCA) has been instructed, summarise their involvement below:  **Full name of IMCA and email/contact details:**  **IMCA’s views:** | |
| **Section 4: Options available in relation to the decision** | |
| List all of the options available to the person | |
| **Section 5: Gathering information** | |
| ***In each case you should list the name and role of the person providing the information.***  (i) What are the person’s past and/or present wishes or feelings relating to the decision?  (ii) What are the person’s values and/or beliefs that relate to the decision(including cultural or religious considerations)  (iii) Are there any other factors that **the person** would want to be considered as part of the decision making process  (iv) What are the risks and benefits of each option?  (iv) What other factors that should be considered – for example: future implications of the decision (welfare, social and medical); safety concerns relating to specific options or how restrictive each choice might be. | |
| **Section 6: The decision reached in the person’s best interests** | |
| State **Clearly state the decision reached and explain your rationale for it:** this    Disagreement: If there is disagreement consider the options outlined in the MCA Code of Practice:   * Involve an advocate * Get a second opinion or attempt some form of mediation * Pursue a complaint through the organisation’s formal procedures * Approach the Court of Protection for a decision where all other attempts to resolve the disagreement have failed | |
| **Section 7: Review** | |
| Describe any circumstances in which a review of the decision would be necessary:  Date of review (if required): | |
| Signature of decision maker(s): Date:  Based at:  Contact telephone number:  Email address: | |
| **This page has purposefully been left blank for your notes. You might wish to include a summary of one or all of the following points:**   * The best interest meeting discussion, including any balance sheets used and/or the views of absent parties * An outline of the capacity assessment (main evidence/views) * Any disadvantages which are inherent in the decision made and how any risks will be mitigated * Any restrictions that might be needed in order to implement the decision * Who will talk to the client about the outcome | |
|  | |

**Best Interests form: Guidance for decision makers**

**Deciding who the decision maker should be:**

The Act is not prescriptive about who the decision maker should be. Instead, the Code of Practice provides a list of factors to consider when deciding who should adopt this role (5.8) and in practice this means that a range of decision makers might be involved with a person who lacks capacity depending on the decision to be made.

As a general rule, the person who will be carrying out/implementing the decision should be the person to make the decision.

In some instances it might be appropriate for the decision to be made jointly by, for example, a multi-disciplinary team. It is important to consider if there is someone, or something, already in place that might have the legal power to make the decision.

See the table below as a guide:

|  |  |
| --- | --- |
| Advanced Decision to Refuse Treatment {ADRT} | If a valid and applicable decision to refuse treatment has been made, it cannot be overruled. Doubts about validity must be determined by the Court of Protection |
| Registered Lasting Power of Attorney – Personal Welfare | Unless restrictions or conditions have been added, the attorney/s can make decisions in the person’s best interests about residence, contact, day-to-day care, medical treatment, care packages, social or educational activities, correspondence and papers, access to personal information and complaints |
| Registered Enduring Power of Attorney or Registered Lasting Power of Attorney – Property and Affairs | Unless specifically restricted, the attorney can make decisions in the person’s best interests about buying/selling property, banking, benefits, pensions, rebates, income, inheritance, tax, mortgages, rent, household expenses, insurance, maintenance of property, investments, repaying loans, payment of medical or care fees, purchasing vehicles, equipment or any other help the person needs. |
| Court Appointed Deputy | Check whether the Deputy has been appointed to manage Property and Affairs or Personal Welfare and what remit/restrictions the Court has placed on their deputyship |

**Section 1: The decision to be made**

The decision maker needs to clarify and document the decision to be made.

It is also important to clarify that the decision is one that can be made under the Act.

The Act covers a vast range of health and social care decisions but **some decisions are specifically excluded** (section 1.10 of the Code of Practice).

These are:

* Decisions concerning family relationships – including sexual relations
* Mental health issues covered by the Mental Health Act
* Voting
* Unlawful killing or assisted suicide

Should issues arise in relation to any of these decisions, the decision maker may wish to seek legal advice or approach the Court of Protection for a decision.

If there is a possibility that the person will regain capacity it might be appropriate to **defer the decision**. These instances might include:

* The cause of the lack of capacity can be treated
* There is scope for the person to learn new skills or have new experiences which could increase their ability to make decisions
* The person’s capacity fluctuates

**Section 2: People consulted as part of the decision making process**

It is a common misconception that it is only the person’s family members that need to be consulted as part of the best interests process. In fact, the Code of Practice doesn’t mention “family” in the best interests guidance at all. The people that the MCA asks the decision maker to include in the process are:

* *Anyone engaged in caring for the person or interested in their welfare*
* *Anyone named by the person to be consulted*

In the majority of cases this will include a family member but it could equally include a close friend or neighbour. Use the time you have to consult the most relevant people involved in the person’s life and any professionals involved with the person.

If there is anyone that you have specifically chosen not to consult you should indicate this on the form and state why you made this decision. If there are safeguarding concerns you should follow your local procedures.

**Section 3: IMCA instruction / representation**

IMCA Instruction

If the incapacitated person has no friends or family who it would be appropriate to consult as part of the decision making process, there are certain situations in which the Decision Maker must or may need to instruct an IMCA

|  |  |
| --- | --- |
| Is this decision about |  |
| **Serious medical treatment**  providing, withholding or stopping | If yes, you have a statutory duty to instruct an IMCA and must do so. |
| **Accommodation**  A Local Authority or NHS organisation proposes to place the person in accommodation - or move them to different accommodation - for a period likely to exceed 8 weeks (or which has turned out to be for more than 8 weeks)  or  An NHS organisation proposes to place the person in hospital – or move them to another hospital - for longer than 28 days (or a period which has turned out to be more than 28 days) | If yes, you have a statutory duty to instruct an IMCA and must do so. |
| **A care review**  Relating to decisions about accommodation | If yes, you should instruct an IMCA if you believe it will be of benefit to the person |
| **Safeguarding adults proceedings**  the incapacitated person may be the adult at risk or the alleged perpetrator | If yes, you should instruct an IMCA if you believe it will be of benefit to the person *even if they have family or friends* |

**Section 4: Options available in relation to the decision**

The options available to the person must be the same as those that would be available to someone who has capacity.

In relation to these options it is best practice to indicate the advantages and disadvantages for each option. How restrictive the decision is will be a factor to consider and it will be important to decide which option (s) are the least restrictive as part of your decision making.

For more complex or contentious decisions you should consider using a “balance sheet”, which can ensure that your information is recorded in a coherent way. **Whilst recording benefits and disadvantages is important, this is not intended as an exercise in “counting the benefits” as some factors (benefits or burdens) will carry more weight than others – e.g. the views of the person or level of restriction associated with an option.**

**Example:** John is 45 years old and lives in supported accommodation. He has been assessed as lacking capacity to decide whether to attend a hospital appointment for an endoscopy to investigate a possible cancerous tumour.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Option 1 He does not attend hospital** | | **Option 2**  **Sister to support him to attend appointment** | | **Option 3 (etc) He is sedated prior to attending hospital with support workers** | |
| Benefit  This is his current strongly expressed wish  He has long term fear of hospitals  Least restrictive option  He may not have a serious illness | Disadvantage  He may have a serious illness, which left untreated may be life threatening | Benefit  John is reassured by presence of sister  Has worked to attend previous hospital appointments  Should enable investigations to be completed | Disadvantage  May damage relationship with sister  John may become distressed and refuse procedure when at the hospital | Benefit  Will enable investigations to be completed  Will protect relationship with sister | Disadvantage  Likely to require covert administration of medication  Likely to lead to distrust to staff  Possible psychological distress  Side-effects of medication  May require a minimal degree of restraint at the hospital |

**Section 5: Gathering information**

One of the most important tasks for the decision maker is to manage the expectations of the person and anyone being consulted as part of the process.

This can help ensure that a consensus is reached and ultimately avoid disagreement and litigation.

A common misconception is that the decision is either a substituted judgement (going with what the person would have decided if they had capacity) or a decision that the family member (s) will make. A best interests decision is much broader than this and all of the factors to be considered should be made explicit early in the process.

The best interests meeting agenda developed by the British Psychological Society might provide a useful guide / structure and is shown below. The full guidance can be accessed from the Dept. of Health website.

**Best Interests Meeting**

**Guide for the decision maker**

1. ***Introductions***
   * Remind those present that **the aim is to establish the best interests of the person** – NOT what attendees think the person would have wanted (this is a consideration not the deciding factor) or what they themselves would want
   * Avoid asking attendees their views on the decision at this point
2. ***Purpose of the meeting***
   * **Outline the nature of the decision** that needs to be made
3. ***Giving Information***

Attendees should share information at this point about;

* + **The person’s past or present wishes, views beliefs or values**
  + **The options available** to the person (ensure you are confident that the same options would be made available to anyone who had capacity to avoid discrimination)

1. ***Discussion***

Encourage everyone to participate and don’t allow one person to dominate with their views

- Some attendees may feel that it is their role to persuade other attendees which may limit their ability to listen to, and use information presented.

**In these cases remind attendees that the aim is to make a decision based on evidence and discussion – not solely on previously held views.**

1. ***Summary and conclusion***
   * Summarise the information gathered and the discussion
   * Ask each attendee their opinion about what is in the person’s best interests
   * Make the decision (remember that leaving things as they are is also a decision)
   * Decide if you wish to review the decision at a later date

**Final notes for chair:**

- consider attaching the balance sheet or minutes to your final best interests documentation

- Send minutes round to each attendee