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| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 3a****MENTAL CAPACITY ASSESSMENT** |
| Full name of the person being deprived of liberty |  |
| Date of birth (or estimated age if unknown) |  |
| **Person to contact and details of Supervisory Body**  |
| Name  |  |
| Address (including ward if appropriate) |  |
| Telephone |  |
| Email |  |
| Usual address of the person liable to be deprived of liberty (if different to above). |  |
| Name and address of the Managing Authority  |  |
| Details of Care Co-ordinator/Care Manager |  |
| Communication needs and any relevant medical history |  |

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| **In carrying out this assessment I have met or consulted with the following people** |
| **NAME** | **ADDRESS** | **CONNECTION TO PERSON BEING ASSESSED**  |
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| **The following interested persons have not been consulted for the following reasons** |
| **NAME** | **REASON** | **CONNECTION TO THE PERSON BEING ASSESSED** |
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| **I have considered the following documents**(e.g. current care plan, medical notes, daily record sheets, risk assessments) |
| **DOCUMENT NAME** | **DATED** |
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| **MENTAL CAPACITY ASSESSMENT** |
| The following practicable steps have been taken to enable and support the person to participate in the decision making process. Please describe these steps: |
| **Stage One:** What is the impairment of, or disturbance in the functioning of the mind or brain? (source of information) |
| **Stage Two:** |
| 1. **The person is unable to understand the information relevant to the decision**

Record how you have assessed whether the person can understand the information, the questions used, how you presented the information and your findings. |  |
| 1. **The person is unable to retain the information relevant to the decision**

Record how you assessed whether the person could retain the information and your findings*.* |  |
| 1. **The person is unable to use or weigh that information as part of the process of**

 **making the decision** Record how you assessed whether the person could use and weigh the information and your findings. |  |
| 1. **The person is unable to communicate their decision (whether by talking, using**

**sign language or any other means**Record your findings about whether the person can communicate the decision and the methods used to assist. |  |
| Explain why the person is unable to make the decision as to whether or not they should be accommodated in the hospital or care home for the purpose of being given the proposed care and treatment as a result of the impairment or disturbance in the functioning of the mind or brain.  |
| **OUTCOME OF ASSESSMENT** **Tick 1 box only** |
| In my opinion the person **LACKS** capacity to make their own decision about whether they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment because of an impairment of, or a disturbance in the functioning of the mind or brain. |  |
| In my opinion the person **LACKS** capcity and cannot make a decision about their care planning arrangement but knows where they live.  |  |
| In my opinion the person **HAS** capacity to make their own decision about whether they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment |  |

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| **PLEASE NOW SIGN AND DATE THIS FORM**  |
| Signed |  | Date |  |
| Print Name |  |  |  |