**APPENDIX 3**

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| **BEST INTERESTS DECISION RECORD FORM** |

 **Record of actions taken to make a best interest decision**

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| **Name of Person:** |  |
| **Name Of Decision Maker:** |  |
| **Date:** |  |
| **Please give the name and status of anyone who assisted with making this best interest decision:** |
| **Name** | **Status** |
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| **Description of the decision to be made:**  |
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| **PART 1 – MENTAL CAPACITY TO MAKE THIS DECISION AT THIS TIME****Every adult should be assumed to have the mental capacity to make a decision** **unless it is proved that they lack capacity.** |
|  | **Response** | **If YES, please provide your comments, including a description of the mental impairment and how it is affecting the person’s ability to make the decision.** |
| **Has the person been deemed to not have the mental capacity to make this particular decision at this moment in time?** | **YES****[ ]**  | **NO****[ ]**  |  |
| If you have answered **YES**, **PROCEED TO PART 2 of this document.** If you have answered **NO**, **then the person is the decision maker** |

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| **PART 2 – DETERMINING BEST INTERESTS** |
| **Working out what is in someone’s best interests cannot be based simply on someone’s age, appearance, condition, or behaviour.** | **Please provide your commentsbelow** |
| **The Persons Wishes:** What are the person’s past and present known wishes, feelings, and values? How have these been taken into account? |  |
| **Written statements:** Have you considered any written statement made by the person when they had capacity? |  |
| **Encourage Participation:** What have you done to enable the person to take part in making the decision? |  |
| **Regaining Capacity:** Is the person likely to have the mental capacity to make this decision at some date in the future and if so can the decision be delayed until then? |  |
| **Independent Mental Capacity Advocate:** Is it appropriate for an IMCA to be instructed regarding this decision? If so, what is the IMCA’s view?[See Chapter 10 of MCA Code of Practice] |  |
| **Relevant Circumstances:** What are the views of other people who know the person best, including any Care Act advocate?  |  |
| **Least restrictive option:** How have you given consideration to a less restrictive options for the person?What would it be? Would the purpose for which the decision is needed be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action?  |  |
| **Other Considerations:** What other factors have you considered such as emotional bonds, family obligations that the person would be likely to consider if they were making the decision? |   |
| **Disagreement or challenges:** Is there any objection from anyone else to this decision? Is a best interests meeting required? |  |
| **The decision:** Having considered all the relevant circumstances, what decision / action do you intend to take? How is this decision in the best interests of the person? Describe any other options and explain why this one is the best for the person. |  |

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| **CONSIDERING THE OPTIONS:** Ensure you have carried out any necessary risk assessments and this is reflected in the best interest option chosen. Ensure wherever possible the least restrictive option is chosen, whilst being in the best interests of the person.NB – the more restrictive the option is (through direct restriction or against the individual’s wishes etc) – the more necessary the need for evidence of the risk of harm is required to evidence that the restraint is proportionate.  |
| **Option 1 :-** |
| **Advantages /Benefits** | **Disadvantages/ Risks** |
| **Option 2:-** |
| **Advantages/ Benefits** | **Disadvantages/ Risks** |
| **Option 3 :-** |
| **Advantages/ Benefits** | **Disadvantages/ Risks** |

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| **Signature:**  |  | **Date:** |  |
| **Print name:** |  |
| **Job title:** |  |