**Level One - Day-to-Day Decisions**

This form is designed for day to day decisions that do not require formal processes. This is particularly for Care Homes, Supported Living, Day Centres and Domiciliary Care, where staff are carrying out activities of daily living for example

**This form must be used to record the outcome of a Mental Capacity Assessment conducted with the service user in accordance with the MCA (2005).**

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| --- | --- |
| **Name of Service User** |  |
| **Date of Assessment** |  | **Electronic Record ID** |  |

|  |  |
| --- | --- |
|  **(1) Is the person unable to make a decision?** | Yes **❑** No **❑** |
| **(2) Is there an impairment or disturbance in the functioning of the person’s mind or brain? If YES, what is the impairment or disturbance?** | Yes **❑** No **❑** |
| **(3) Is the person’s inability to make the decision because of the identified impairment or disturbance?**  | Yes **❑** No **❑** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Decision – please tick specific domain**  |

|  |  |
| --- | --- |
| Washing, showering  |  |
| Feeding / Nutrition |  |
| Changing incontinence pads |  |
| Dressing |  |
| Other (state)  |

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|  |  |
| --- | --- |
| **Please give more detail – what is the exact decision you are assessing capacity for?** |  |

Explain to the service user the purpose of this assessment, including the decision that needs to be made or action that needs to be taken. Explain all available options and the pros and cons of each.

|  |  |
| --- | --- |
| **Can the service user………** | **Yes / No** |
| **Understand the information relevant to the decision?** |  |
| **Retain this information long enough to make a decision?** |  |
| **Discuss the pros and cons of this decision with you? (In other words, can they use the information you’ve given them?)** |  |
| **Communicate their decision?** |  |

If the answer to one or more of the questions is ‘no’ then the person lacks capacity to make this decision.

**Overall Outcome of Assessment (tick one)**

|  |  |
| --- | --- |
| **This person has capacity to make this specific decision for themselves** |  |
| **This person lacks capacity to make this specific decision for themselves** |  |

If the person lacks capacity, you will be making the decision for them in consultation with family / friends / other professionals, and by involving the service user as much as possible.

**Detail below the action you will be taking, evidencing why this is in the person’s best interests. Also make a note of who else you have consulted, and what their feelings were.**

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|  |

If you decide that the person cannot make the decision for themselves, **you** **should review this assessment along with their care plan** **at least every six months,** or sooner if anyone raises concerns that the person’s capacity may have changed.

|  |  |
| --- | --- |
| **Assessment to be reviewed on** |  |
| **Name, signature and contact details for assessor** |  |