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| **Best Interests Meeting Guidance** | |
| 1. | **Introduction and Apologies**   * Housekeeping * Outline format of meeting – provide clarity that each person will have the opportunity to contribute * Information sharing and confidentiality * Statement of the legal framework |
| 2. | **Purpose of The Best Interest Meeting**   * Outline background facts * Clarification of decision(s) required * Outline mental capacity assessment. If there is no capacity assessment specific to the best interests decision(s), THE MEETING MUST STOP * Consider whether the person may regain capacity at a future date, i.e. should the decision be delayed? Is there therapeutic or any other input that may impact on the person’s capacity and ability to make the decision? |
| 3. | **View of Relevant Person**  What is known about the person’s:   * Past wishes, feelings * Present wishes and feelings * Any relevant written statement made by the person when they had capacity * Beliefs and values * Any other factors that the person would be likely to consider if they were able to do so |
| 4. | **Information from Relevant Parties**   * Views from anyone named to be consulted, any LPA, EPA or Deputy of the Court of Protection * Family members opinion * **Professional opinion (*If decision relates to covert medication, involves views of the G.P, Pharmacist, Representative, Family, LPA for Health and Welfare and if necessary a Speech and Language Therapist))*** * IMCA (if involved) * Anyone engaged or caring for the person or interested in their welfare |
| 5. | **Discussion of Viewpoints**   * Identify and be clear about options **(if the decision relates to covert medication, list the medications to be administered covertly)** * Discuss benefits and advantages and disadvantages of each option * Assess likelihood of each option |
| 6. | **Summary and Evaluation of Options**   * Summary of the information gathered and discussed (consider having this available visually) * Recommendations highlighting and dealing with any counterbalancing factors |

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| \\Ngh-nt01\nightingale share\Marketing & PR\NightingaleHammerson_logo_CMYK.jpg | | **D4 – BEST INTERESTS MEETING** | |
| **RESIDENT’S NAME:** |  | **UNIT:** |  |

# Best Interests Meeting Record Form

Mental Capacity Act (2005)

“*An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests*.“ Section 1(5) Mental Capacity Act (2005)

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| Date of B.I. Meeting: | | Venue: |
| Name of the Person: | | |
| Address:  Postcode: |  | |
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| Chair | | Minute Taker | | | |
| Name of participants | Designation / Location | | invited | present | Consulted | |
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| **Explain the details of the decision to be made: *(if the decision relates to covert medication, additionally list the medications to be administered covertly)*** |
| **Confirmation of the Person’s Capacity to make the above decision:**  **Mental Capacity Record Form completed and attached:**  The Mental Capacity Assessment should be conducted prior the meeting. The MCA form must be available and must give in detail the reasons why the person lacks capacity to make this decision themselves and the name of the person(s) involved in the assessment.  NB: If the Person’s capacity to make the above decision has NOT been assessed, a best interests meeting cannot go ahead.  **Comments:** |

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| **Regaining Capacity to make this decision:** Is it likely that the person may regain capacity? Can the decision wait until that time? If not, why not? What efforts were made to support the person to make the decision? |

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| **What are the persons past and present wishes and feelings?** These may have been expressed verbally, in writing or through behaviour and habits. Has the person been involved in Advance Care Planning? Does the person have an Advance Decision to refuse treatment? (if applicable) |

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| **Are there any beliefs and or values that would be likely to influence the decision, if he/she had capacity?** e.g. religious, cultural, moral or political |

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| **What are the views of the other relevant people in the person’s life?** Family, friends, advocates, neighbours. |

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| **What are the views of the Independent Mental Capacity Advocate (IMCA)?** (If involved) |

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| **Is this the least restrictive option?** If not, explain what has been identified and rejected. |

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| **What alternatives are available?** What other options have been considered then rejected? Why? |

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| **Is there any objection to the proposed decision?** If so, explain: |

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| **Justification for proposed care / treatment:** Explain here; |

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| **Risks related to carrying out the proposed care or treatment decision:** Explain here; |

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| **Risks related to NOT carrying out the proposed care or treatment decision:** Explain here; |

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| **THE BEST INTERESTS OUTCOME: The outcome of the meeting must be recorded at the end of the meeting followed by signing the form by all attendees. Any actions arising need to be recorded in a table below.** |

**Action Plan from this meeting: Confirm who will be responsible for the actions**

|  |  |  |  |
| --- | --- | --- | --- |
| **Action required** | **By whom** | **By when** | **Comments** |
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**Attendees Signature of Agreement of the Best Interest Outcome**

The undersigned believe this to be a fair representation of the discussions that took place. There are reasonable grounds for believing that what they are doing or deciding is in the best interests of the person concerned at this point in time.

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| **Name** | **Designation** | **Signature** |
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**IMPORTANT:** Some decisions **MUST** be referred to the Court of Protection such as:

1. Where a person in a care home or hospital is subject to a Deprivation of Liberty Authorisation and the person’s family are objecting to that person being subject to the authorisation.

Minutes taken by (print name): ……………………………….….. Job Title: ………………………

Signature: ………………………………… Date: …………...……………………………