Best Interests Assessment checklist

First tasks

- Check you have / read copies of:
  - Urgent Authorisation and application for Standard Authorisation (Forms 1/4 (old) or F1 (new)) or F2 (and previous F3/5) if a repeat Standard.
  - Care plan from care home or hospital, if available in advance.
  - Mental health and eligibility assessment (F6/9 or F4), if available.
  - S39A/39D IMCA or paid rep report, if relevant.
  - Contact details for IMCA, paid rep or mental health assessor if assessment/report not yet completed.

- Start a running record for assessment. Fill in information already acquired on F3, including anything from social worker, if relevant.

- Contact care home/hospital to arrange date and time of assessment. Check:
  - Whether anyone who knows the person will be present to assist in assessment if family / friend not available.
  - When is the best time for the person to be assessed e.g. morning or afternoon, before or after meals or medication.
  - Check their communication needs to see if anything needs to be in place for the assessment e.g. interpreter, resources normally used by person.
  - Check the person is funded by the supervisory body or ordinarily resident in the supervisory body area.
  - Need for S39A IMCA?

- Contact main identified relative/friend and ask if they, or another involved family member, can be present for the assessment.
- For capacity assessment, think about what salient points the person will need to understand, based on their planned care. Think about what information you need to present for them to understand.

Before seeing the person at care home/ hospital for assessment

- Check all care plans, daily records, assessments, charts, medication records, risk and capacity assessment, and note title and dates including:
  - Name (including what the person prefers to be known as). Check spelling!
  - Date of birth – check this conforms with F1 and F4 and other records available.
  - Date of admission to setting, including where they came from (home? hospital?), why they came from there, and any previous placements.
  - Diagnosis
  - Nature of care and support provided.
  - What support is needed for them to move around their environment and access outdoors. Who decides when and how often this happens?
  - Levels of capacity and cognition, and any variation in this.
  - Day-to-day activities engaged in or refused.
  - Times and nature of need to restrict.
  - Nature of restrictions within the environment, including locked doors and technology to monitor or restrict movement.
  - Evidence of when, what and how often restriction is needed e.g. as recorded for behaviour or falls, or in risk assessments or charts
  - Expressed views or behaviour from person on restrictions.
  - Risks identified and plans in place to protect from harm.

  - Medication records, including what has been prescribed, what dose, when given, PRN (as required) or regular? Note whether medication was used to sedate or manage behaviour.
  - Nature of communication needs and issues, including specialist input and resources used to communicate effectively.
  - Who visits and how often, including family, friends, LPA, deputy or existing RPR/paid rep.

- Ask to speak to the person on shift who knows the person best and their manager in order to:
  - Explain your role if they are not aware of DoLS.
  - Check their view of the person's care and if there are any less restrictive options available.
  - Warn that the assessment might upset, unsettle or distress the person.
  - Ask if they can accompany you during assessment or who might be most appropriate.
  - Check any views expressed by the person on admission or by family or friends and any differences of opinion.

During the assessment

- Explain your role to the person – i.e. that it is about making sure they are as free as possible to make choices about their lives and to make sure any restrictions are not over the top.
- Explain information related to salient points if assessing capacity. (This will also be useful for best interests discussion.)
- Check their views and understanding.
- Break down into simpler questions or use other communication methods, if not understood.
- Re-check answers to key questions e.g. the name and location of the home to check retention.
- Ask if they are happy living where they are.
- Ask if they are allowed to do what they want to do: 'Does anyone stop you from doing what you want?'
- Check with them if there is anything else they would choose to do or anywhere else they would prefer to be.
- 'If you were to leave here, where would you go? How would you get there from here?'
- 'Is there someone you trust to help you make decisions, including helping you if you don't want to stay here?'

After the assessment

- Contact the main identified relative / friend where known.
- Ask what their views are, including their views on restrictions and any less restrictive options tried in the past. Elicit their narrative of how the person came to be where they are.
- Ask if they are prepared to be RPR including:
  - Whether they are willing to support challenge as far as Court of Protection if person objects.
  - If so, will they need any help e.g. S39D IMCA?
  - If not, explain need for paid rep.
  - Offer information e.g. Age UK / OPG leaflets.

Best Interests Assessment checklist

- Contact placing agency if in a care home (e.g. social worker, CHC nurse, etc.) for information on the best interest decision-making that got the person where they are, any less restrictive options tried, and any still to be tried or plans for the future.
- Write up assessment on Form 3 and complete running record.
- Send completed form securely to supervisory body and await any feedback.