Capacity Screening

Information Sheet & Checklist

It is a fundamental presumption that an individual has capacity. Care should be taken when using a screening tool in declaring that a person does not have capacity if there is a chance that communication difficulty or pressure of time has led to that decision.

Does the person have difficulties with communication, for example do they suffer from dysphasia or deafness? (Please circle one answer) (If yes then specialist assessment is appropriate)	**Yes / No**
Step 1. Valid trigger A valid trigger requires a situation where the patient is / will be required to make a decision which involves balancing risk and benefit (for themselves or others). Behaviour unusual for the patient, impulsiveness, apathy or an apparently unreasonable decision does not prove incapacity however may trigger a capacity assessment.	
(a) Is there a valid trigger? (e.g. question or function needing assessment) **Details**:_____ _____ _____	**Yes / No**
(b) Is there evidence or reasonable suspicion of the existence of cognitive impairment (e.g. dementia, delirium, brain damage, mental illness)? A poor score on a Mini-Mental State Exam (MMSE) does not mean that the patient is not capable in relation to the particular question at hand, but it does constitute part of a valid trigger to perform a capacity assessment **Details:**_____ _____ _____	**Yes / No**
Step 2. Engage the patient The patient is presumed to be capable until evidence exists otherwise. Therefore normal processes in gaining consent to assessment should be pursued. As it **may be impossible to attain a valid consent using normal processes** it is critical that the valid triggers, as mentioned in Step 1, are established and documented prior to proceeding with the capacity assessment.	

(a) Inform the patient that:

1. Their capacity is being assessed in relation to answering a specific question, group of questions or function and because there is concern that there is risk to themselves or others.

2. The capacity assessment will proceed and they are encouraged to participate.

3. Inform the patient that they do not have to participate but that participation may be of benefit to them because they get the chance to provide their views so the best judgement can be made.
   (Reassure the person that they will not receive any less care if they do not want to participate)

4. Describe to them the steps involved.

5. If they are found to be capable then they will continue to make their own decisions. If they are found to be incapable and they have appointed an Enduring Guardian, that person will be asked to make their decisions; if they have not appointed an Enduring Guardian, the law in NSW provides that a substitute decision-maker (called the *Person Responsible – see below) will be asked to make their decisions.

6. Finally, if uncertainty still remains, it may be that further assessments are required to determine capacity.

***Hierarchy for Person Responsible for substitute decision-making for medical and dental treatments.**

(Note: Being next-of-kin does not automatically give someone authority to be the Person Responsible for making decisions for the patient – it depends upon their position in the following hierarchy).

1. Court Appointed Guardian

2. Patient-appointed Enduring Guardian

3. Spouse or partner including same sex partner (must be a close, continuing relationship)

4. Unpaid carer who supports the person now or before they entered residential care.
   (Note: a person in receipt of a Carer's Pension is not considered to be a "paid" carer).

5. A relative or friend who has a close relationship with the person.

(b) Has the patient been engaged?	**Yes / No**
(c) Is the patient willing to participate?	**Yes / No**

Step 3. Information Gathering

(a) Gather and record:

- **what the question is,**
- **why it has arisen,**
- **what the options are,**
- **what are the reasonably foreseeable consequences of each option**

This step may be time consuming, especially in decisions regarding social issues. A formal assessment may require extensive information gathering and is indicated for important decisions where there is uncertainty about capacity.

(b) Attach a summary of the information gathered.

Step 4. Educate the patient

(a) The patient should be educated about the information and choices determined in Step 3.

Time taken at this stage may enable some patients to retain autonomy about decisions.

It is important that communication difficulties such as deafness, receptive dysphasia, or language barriers do not prevent the patient from learning the relevant information.

(b) Who assisted the patient with the education process?

Name: _____

How long was spent? _____

Step 5. Checking Patient Understanding

(a) Can the patient tell you in his or her own words: *

(i) What the question or issue is. **Yes / No**

(ii) What the options are, including the option of doing nothing. **Yes / No**

(iii) What the reasonably foreseeable consequences of each option are **Yes / No**

(If the answer to any of these points is "No", there is evidence that the person lacks the capacity to make that particular decision.)

*Ideally the person will describe the issues in their own words. The use of interpreters may be required. Non-verbal patients should be referred for specialist assessment. Asking the person if they understand – "yes or no" is not sufficient.

Step 6. Taking Action

(a) Unless evidence of incapacity is found the individual is presumed capable and the individual's decision should be respected and acted on decision. An apparently unreasonable decision does not prove incapacity, but it may be a component of the triggers for a capacity assessment.

(b) If the person is found to not be capable then inform the person and seek out the "Person Responsible" (substitute decision-maker).

(c) If there is any doubt (especially if there is reason to believe that there are potential communication difficulties) then a formal capacity assessment or neuropsychometric testing may be helpful in determining capacity.

(d) Is there evidence of incapacity?	**Yes / No**
(Record the evidence below) _____ _____ Date:_____ Assessor's name: _____ Signature: _____	

(e) Being found incapable may lead to decreased self-esteem, grieving and/or depression. Sensitive handling and counselling can assist. Follow-up of the patient is essential.

(Remember that capacity may be present for some decisions such as medical choices, while being absent for others such as financial choices. Also, capacity may return with the resolution of problems like delirium or mental illness.)

(f) Has counselling been provided?	**Yes / No**
(g) Has follow-up been organised?	**Yes / No**

For life style/service/living arrangement decisions
An informal decision may be made using the same hierarchy as for Person Responsible. However if the person or their family strongly object to that decision (e.g. won't support moving to a Residential Aged Care Facility), then an application must be made to the Guardianship Tribunal.

Reference: Darzins P, Molloy, W & Strang, D 2001, Who can decide? The six step capacity assessment process. Adelaide: Memory Australia Press.