Subject: **Capacity Testing**

**Procedure Number:** MNC-CCN-PRO-11

**Desired Outcome:**
A standardised process for capacity assessment for inpatients at Coffs Clinical Network

**Reference/Consultation:**
- Developed by: Kerry Bartlett & John Shibu
- Legislation
  - Children and Young Persons (Care and Protection) Act 1998
  - Commission for Children and Young People Act 1998
  - Guardianship Act 1987
  - Powers of Attorney Act 2003
  - Guardianship Regulation 2010
  - Minor (Property and Contracts) Act 1970
- Policy Directives
  - PD2011 022 - Your Health Rights and Responsibilities
  - PD 2005 406 - Patient Information and Consent to Medical Treatment
- In consultation with:
  - Dr Sergio Diez (Network Director of Clinical Services)
  - Dr O’Callaghan (Geriatrician)
  - Dr Tyagi Vaibhav (Geriatrician)
  - Sandra Everson (CNS – Aged Care)
  - Carol Burfoot (CNC – Aged Care)
  - Dale Casley (Occupational Therapist)
  - Mardi Smith (Occupational Therapist)
  - Sue Selby (HOD Social Work)
  - Kimberlee Soule (Social Worker)
  - Mark Wilson (Manager Allied Health)
  - Roseanne Badham (CNS- Aged Care)
  - Angela Lopes (HOD Social Work)
  - Professor Colleen Cartwright (Director, Cartwright Consulting Australia Pty Ltd & Emeritus Professor, Southern Cross University)

**Distribution:** MNCLHD Network

**Date Effective:** Immediately

**Approved By:**
Original signed 30.4.15
Dr Sergio Diez Alvarez, Director of Clinical Services

**Review Date:** APRIL 2018

**Date Included on Desktop:** 20.5.15
BACKGROUND:

Capacity testing in the acute hospital setting is often poorly undertaken with Medical Officers reluctant to make a decision regarding a person’s capacity (Darzins, 2000). Capacity is a fluid concept and the inability to make a certain decision at a particular time may change depending on a person’s condition. Patients suffering a delirium, depression, delusions or psychosis should not have capacity testing performed. Patients who have suffered a physical illness should be given sufficient time to recover and be deemed medically stable prior to commencing capacity assessment. The Capacity Flow Chart (Appendix 1) has been developed as a guide to assist clinicians in the capacity assessment process.

Considering that people who face losses in decision-making ability may be unaware this is happening and not agree with the advice of health professionals concerning decisions ‘to be made’*, it is of importance to ensure a person-centred and ethical approach to care is implemented. The capacity assessment process and capacity decision should be documented clearly and without bias.

*NB. “Not agreeing with the advice of health professionals is not, of itself, evidence of incapacity.”

What is Capacity?

Capacity is at the very basis of our human rights. Declaring people incapable removes this fundamental right and diminishes their personhood (Darzins, 2000). Capacity is determined by cognitive ability to understand and appreciate contexts and decisions, not the actual outcomes of the choices made. Capacity is determined by whether individuals can understand and appreciate information, not whether they can perform tasks. Capacity and the lack of capacity are legal concepts.

As per the NSW capacity Toolkit, ‘A person who has capacity is able to make decisions about things that affect their daily life’. Broadly speaking, when a person has capacity to make a particular decision, they are able to do all of the following (Capacity Toolkit 2008):

- Understand the facts involved
- Understand the main choices
- Weigh up the consequences of the choices
- Understand how the consequences affect them
- Communicate their decision

Domains of Capacity

Capacity is a broad term. Some of the domains of capacity are the following: (Moye & Marson, 2007):

- Consent to medical treatment
- Independent living
- Financial capacity
- Consent to research participation
- Testamentary capacity
- Sexual consent
- Voting
- Driving

It is very rare that a person has no capacity for all of these decisions, therefore it is very important to assess and understand whether a person lacks capacity to make a particular life decision.
Models of capacity assessments

Global capacity

Using this model, people are considered capable or incapable of all decisions. They were considered capable either for all decisions or none. This works well for people at the extremes who are obviously completely capable or completely incapable (in a coma). However it fails to deal with people who have partial, fluctuating or some impairment of decision making.

Domain specific capacity

Recently the concept of domain specific capacity has replaced global capacity. This model recognises that people may have capacity in one domain (e.g., health care), but lack capacity in another domain (e.g., finance). This model presumes that a person has or lacks capacity for all decisions in that particular domain. Each domain is tested separately.

Decision specific capacity

More recently the concept of decision specific capacity has been developed to deal with decisions within each domain. This model recognises that within a particular domain of capacity (e.g., finance), there is a range of complexity of decision making. A person could be capable of making simple decisions concerning an allowance/bill payment, but incapable of making complex decisions about managing an investment portfolio. In this model, people are tested to determine if they are capable of making the particular decisions they face. This model can be adapted to any decision made within particular domains where there is a hierarchy of decisions (Darzins, 2000).

Capacity assessment principles

Based on the Capacity Toolkit (2008), there are six principles to be applied when assessing a person’s capacity. They aim to support and protect people, and help them to make the most of their decision-making ability.

- Always presume a person has capacity
- Capacity is decision specific
- Don’t assume a person lacks capacity based on appearances
- Assess the person’s decision making ability-not the decision they make
- Respect a person’s privacy
- Substitute decision-making is a last resort

Assisted decision making

Always consider assisted decision making prior to looking into substitute decision making. A person may be able to make a particular decision at a certain time because they have support during decision making process. Before deciding that a person does not have the capacity to make a decision, you should ensure that everything possible has been done to support them to make their decision (e.g., find a particular location or better time of the day; assist the person to get the treatment for a medical condition that may be affecting their capacity; support the person to resolve, or to get the help in resolving, underlying personal or social issues which are causing them stress) (Capacity Toolkit, 2008)
What can affect a person’s capacity?

Capacity varies from person to person and from situation to situation. Each person’s capacity can fluctuate, depending on things such as their mental and physical health, personal strengths, the quality of services they are receiving, and the type and amount of any other support. So the level of capacity a person has at a particular time can depend on the following factors (Capacity Toolkit, 2008):

- The type of decision being made
- The timing of the decision: is the person tired?
- Is the decision simple or complicated?
- How much information has the person been given, and what is their level of understanding about the information?
- The quality of the communication between the assessor and the person
- The physical environment: Is the environment noisy or is the situation stressful?
- The person’s health status: Does the person have an illness or condition that worsens from time to time and affects their capacity (e.g., mental illness, depression, delirium, dementia, drug and alcohol, etc.)

Consent to medical and dental treatment

A widely accepted taxonomy of the functional abilities needed for medical decision-making capacity is: Understanding, Appreciation, Reasoning, and Expression of Choice (Grisso & Appelbaum, 1998).

Understanding is the ability of the individual to comprehend diagnostic and treatment-related information.

Appreciation refers to the ability to relate the treatment information to one’s own situation. In usual clinical practice, appreciation translates into the client’s belief that a well-considered medical diagnosis is valid and that treatment may be beneficial.

Reasoning is the ability to evaluate treatment alternatives by comparing risks and benefits in light of one’s own life. Sometimes reasoning is defined by the ability of the client to provide “rational reasons” behind a treatment choice.

However it is acknowledged under the legislation that a person can make a decision for good reasons, bad reasons or no reason – and they do not have to tell the health care provider what their reason is. Making what someone else thinks is a bad decision is no evidence of incapacity.

Expressing a choice is the ability to communicate a consistent decision about treatment.

For patients 16 years or older, medical and dental practitioners must seek the patient’s consent before giving treatment. If the patient is not capable of consenting to treatment, the practitioner must seek consent from the patient’s ‘person responsible’ except for minor, non-invasive treatment or in an emergency. This is a requirement of the Guardianship Act 1987.

For details please refer to:


PD 2005_406 - Patient Information and Consent to Medical Treatment
Financial Capacity

The term financial capacity refers to the ability to manage one’s financial affairs in a manner that is consistent with self-interest and personal values (Marson & Hebert, 2008). Financial capacity is one of at least eight domains of civil capacity that are relevant to older adults with cognitive impairment. Financial capacity encompasses a broad array of abilities. According to (Marson, 2001) and (Marson et al., 2000) there are three key elements to financial capacity:

(1) **Declarative knowledge**, or the ability to describe financial concepts (e.g. interest rates, knowledge of currency, bank statements)

(2) **Procedural knowledge**, or the ability to carry out motor-based skills (e.g. writing cheques) and

(3) **Judgement**, or the ability to make reasonably sound financial decisions.

If a person lacks financial capacity and is very vulnerable to financial abuse, he/she should be supported by an appointed Power of Attorney/Enduring Power of Attorney/Financial Manager or Public Trustee. For details contact NSW Civil and Administrative Tribunal (NCAT).

Independent Living

For many older adults with dementia, a critical assessment concern may be whether the individual is safe to live independently. A model for assessing the abilities important for independent living focusses on a range of key skills and judgement (American Bar Association Commission on Law & Ageing & American Psychological Association, 2005).

**Skills** are important to demonstrate for independent living and have been described as ‘instrumental activities of daily living’ (IADL). IADLs involve the ability to manage the home, health, medication, money, transportation, meals and communication. One should also have the ability to manage ‘activities of daily living’ (ADL) or have the support of family or community services. ADLs involve the ability to manage personal care, hygiene and continence.

**Judgement** relates to insight and decision-making which are essential for independent living. Examples include the ability to handle emergencies, compensate for areas of incapacitation, exhibit motivation of daily life, and minimize risk for self and others (Anderten, 1979).

If an individual lacks the skills and judgement needed for independent living, he/she should be supported by a substitute decision maker appointed either by the person in advance or by the NCAT.

**Who is the person responsible?** (Refer to Appendix 2: Fact Sheet ‘Person Responsible’)

A person responsible is not necessarily the patient’s ‘next of kin’. A person responsible is someone who has the authority to consent to treatment for an adult who is unable to give a valid consent to their own medical or dental treatment. The person responsible is determined by the health practitioner according to the hierarchy of persons set out in section 33A of the Guardianship Act 1987. A person responsible, in order of priority, is (NCAT Guardianship Division, 2014):

- An appointed guardian (including an enduring guardian) who has been given the right to consent to medical and dental treatments or, if there is no guardian:
• The most recent spouse or de facto spouse (including same-sex partner) when the spouse or de facto has a close and continuing relationship with the person or, if there is no spouse or de facto spouse,

• The unpaid carer or the carer at the time the person entered residential care (note: recipients of a government carer benefit are not considered to be paid) or, if there is no carer,

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

If the first person responsible from the above list cannot or will not make a decision, he or she must decline in writing. The next person on the list will then become the person responsible. If everyone from the above list decline in writing, contact the NCAT. A practitioner or other qualified person can remove the person responsible from their role by certifying, in writing, that the person responsible is not capable of carrying out the role.

If there is no person responsible there are other ways consent to treatment can be obtained. This can be through a medical practitioner or the NCAT.

**Enduring Power of Attorney (EPOA)**

An enduring power of attorney is a legal document appointing an attorney or attorneys who can act on your behalf in financial matters under your instruction while you have capacity or without your instruction if you lose capacity. An EPOA can be appointed by a person with capacity. An enduring power of attorney is made under the *Powers of Attorney Act 2003* and can be used to make decisions about property or finances in NSW.

A general Power of Attorney ceases to have effect after the person loses the mental capacity to make financial decisions. An EPOA will continue even after a person loses mental capacity (e.g., develops dementia, has a stroke or sustains a brain injury). One can appoint a friend or relative, or someone impartial like NSW Trustee & Guardian, or other solicitors or professionals (which involves costs/fees). The person making the appointment of EPOA can choose when the appointed person’s power begins. For further information refer to: [http://www.ncat.nsw.gov.au/Pages/guardianship/gt_matter_about/enduring_poa.aspx](http://www.ncat.nsw.gov.au/Pages/guardianship/gt_matter_about/enduring_poa.aspx)

**Financial manager**

A financial manager is a legally appointed substitute decision-maker with authority to make decisions about and manage a person's financial affairs (e.g. their money, property and other financial assets, such as share portfolios) and their legal affairs (e.g. instructing a solicitor). A private financial manager may be appointed - a family member or friend - provided they are a 'suitable person' as required by the legislation. Otherwise, the Tribunal will appoint the NSW Trustee and Guardian.

**Enduring Guardian (EG)**

An Enduring Guardian can be appointed by a person with capacity, to make decisions relating to health and welfare if required in the future. An Enduring Guardian is someone you choose to make personal or lifestyle decisions on your behalf when you are no longer capable of doing this for yourself. The appointment of an enduring guardian comes into effect only when you lose capacity to make these decisions. You can choose what types of decisions you want your enduring guardian to make. Possible functions include:

• Decide where you live
• Decide what health care you receive
• Decide what other personal services you receive (i.e. meals and home care services)
• Consent to medical or dental treatment for you

An enduring guardian is appointed under the Guardianship Act 1987 and can make decisions which will affect the person under guardianship when they are in NSW.

An Enduring Guardian cannot make financial decisions. For further information refer to

The Public Guardian (PG)

The Public Guardian is an independent statutory official who is administratively supported by NSW Trustee & Guardian. A PG can be appointed by the NCAT or the Supreme Court under the Guardianship Act 1987, to make decisions on behalf of the person in areas concerning accommodation, medical and dental needs, health care and other services. As a substitute decision maker for the length of time specified in the guardianship order, the Public Guardian will also advocate for the services and support needed by the person under guardianship.

The Public Guardian cannot make decisions about financial matters or the person’s estate. The Public Guardian is only appointed when there is no private person who can be appointed as guardian. For further information refer to: http://www.ncat.nsw.gov.au/Pages/guardianship/pg_matter_about/what_is_public_guardianship.aspx

Guardianship Tribunal

From 1 January 2014, the Guardianship Tribunal, along with more than 20 other existing State tribunals, was integrated into the NSW Civil and Administrative Tribunal (NCAT).

The Guardianship Division of NCAT is a specialist disability division within NCAT. The Division conducts hearings to determine applications about adults with a decision making disability who are incapable of making their own decisions and who may require a legally appointed substitute decision maker.

Applications may be made to the Guardianship Division to:

• make guardianship orders to appoint a private guardian (family member or friend) and/or the NSW Public Guardian
• make financial management orders to appoint a private financial manager and/or the NSW Trustee & Guardian
• provide consent for treatment by a doctor or dentist
• review enduring powers of attorney
• review an enduring guardianship appointment
• approve a clinical trial so that people with decision-making disabilities can take part.

The Guardianship Division of NCAT considers applications about people who are in NSW or who have property or other financial assets in NSW.

The Guardianship Act 1987 sets out the limits of its responsibilities and functions and the principles to be applied when making decisions.

Guardianship order

A guardianship order is made by the Tribunal when it is satisfied that an adult has a disability that means they are partially or totally incapable of managing their person and require a guardian to make decisions on their behalf. The order names the guardian who has been appointed by the Tribunal, the length of their appointment and their functions. It authorises the guardian to make certain decisions for and instead of the person under guardianship. For more information, refer to: http://www.ncat.nsw.gov.au/Pages/guardianship/gt_matter_about/matter_guardianship.aspx

Financial management order

A financial management order is an order which the Tribunal makes when it is satisfied that a person is incapable of managing their financial affairs, needs someone else to manage those affairs on their behalf and that it is in their best interests that a financial order be made. It authorises the financial manager to make financial decisions for the person the order is about. Most financial management orders are permanent. For more information, refer to: http://www.ncat.nsw.gov.au/Pages/guardianship/gt_matter_about/financial_management.aspx

PROCEDURE

Reasons for Capacity Assessment:

The Capacity Toolkit (2008) advises that an assessment of a person’s capacity may be required when:

- There is a demonstrated trigger (Note: age per se is not a demonstrated trigger; only 34% of people over 90 in Australia have dementia – which means that 66% do not).
- All other attempts to solve the problem have failed
- There are important legal consequences or the conduct of the person is causing, or is likely to cause, significant harm to the person or someone else.

Consider religious beliefs, cultural and linguistic diversity in capacity assessments

Culture, language, ethnicity and religion are integral factors in how people make decisions, as well as the decisions they make. They shape how people think, behave and communicate. In some communities and in certain cultures, individuals with capacity freely allow others to make important decisions on their behalf (head of a household, elder of a community, etc). (but don’t just accept the word of others that the person wants someone else to make their decisions. Make sure you ask the patient when no-one else is around)

Religious beliefs may impact on the decision made, or how it is made (Jehovah’s witnesses have particular beliefs that might affect their decisions about various medical treatments).

When determining capacity, make sure you take into account the person’s language, ethnicity, cultural values and religious beliefs (Capacity Toolkit, 2008).

Interpreters should be used whenever there is any question of a person not being able to understand the detailed information being discussed, especially where there may be subtle nuances or technical descriptions involved. When there are legal issues involved, ensure there is as comprehensive understanding of what is
being said. Organise an interpreter if you can’t understand the person or have difficulty communicating with the person in English (it is not appropriate to use family members as interpreters). Please refer to Capacity Toolkit section-5 for further tips on assessing capacity.

Always respect, strive to understand and promote the rights of Aboriginal and Torres Strait Islander peoples and their cultures, while assessing capacity. Work collaboratively with Aboriginal and Torres Strait Islander peoples in order to develop and provide culturally responsive practice (AASW, 2013).

**Tell the person about the process:**

Before beginning an assessment, it is important to effectively communicate to the person what you are doing and why:

- There is a concern about their capacity to make a particular decision or decisions. You might briefly outline the decision and concern
- The possibility of risk or harm to themselves or others if they make a decision or decisions without capacity
- What is involved in the assessment process
- The result of the assessment will be either of the following:
  - They have capacity to decide the particular decision for themselves
  - They lack capacity to decide the particular decision and require someone to make this decision on their behalf (Capacity Toolkit, 2008).

**Determine what you are looking for:**

When you assess the capacity of a person to make a particular decision, you are considering whether the person can do the following (Capacity Toolkit, 2008):

- Understand the facts involved in the decision
- Know the main choices that exist
- Weigh up the consequences of the choices
- Understand how the consequences affect them
- Communicate their decision

**Documentation Guidelines:**

- Document the assessment process
- Provide a summary of the questions you asked the person and their answers
- Give an explanation as to the reasons why you made your decision
To be used when concerns are raised about patients’ capacity to make informed decisions or give informed consent in the hospital setting, i.e., “there are valid triggers indicating that an assessment is required.”

**Glossary**
- **DCP**: Discharge Planning
- **EG**: Enduring Guardianship
- **EPOA**: Enduring Power of Attorney
- **GT**: Guardianship Tribunal
- **MDT**: Multi-Disciplinary Team
- **PG**: Public Guardian
- **VMO**: Visiting Medical Officer
Description of the Capacity Flow Chart

- The Capacity Flow Chart can be used when professionals have concerns about in-patients’ capacity to make informed decisions or give informed consent about medical, financial and independent living decisions; or when there are valid triggers indicating that an assessment is required.

- 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. For more information on ‘Triggers’ refer to Capacity Toolkit, page-50.

- In this flow chart, Multidisciplinary Team Assessment refers to an assessment by a minimum of two or more of the following disciplines: Social Workers, Physiotherapists, Occupational Therapists, Dieticians, Speech Pathologists, Discharge Planners, Dementia & Delirium CNC, Nursing staff and other clinicians involved in the patient’s care.

- Multidisciplinary Team (MDT) meeting includes the respective disciplines (Social Workers, Physiotherapists, Occupational Therapists, Dieticians, Speech Pathologists, Discharge Planners, Dementia & Delirium CNC) who have completed assessments and Medical and or other clinicians involved in the patient’s care.

- If valid triggers are raised about a patient’s capacity, the MDT is to complete discipline specific assessments and a MDT meeting is to be organised to discuss the triggers/concerns of the professionals.

- In the MDT meeting, one of the professional assumes the role of an ‘Assessor’ who then becomes the case manager.

- If the Assessor decides that the patient has capacity to make decisions, then the MDT can proceed to discharge planning. But if the Assessor decides that patient has no capacity to make decisions, then the assessor should request a formal capacity assessment by the medical team (VMO/Specialist/Registrars) in consultation with the treating team.

- If the Medical team and the MDT agree that the patient has capacity, proceed with Discharge Planning/ Care Coordination, as per patient wish.

- If the patient has no capacity to make medical decisions, decisions should be made in consultation with Person Responsible (refer to Appendix-2). And if patient has no Person Responsible, then proceed to Guardianship Tribunal (GT).

- If the patient has no capacity to make independent living decisions, decisions should be made in consultation with Enduring Guardian/ Public Guardian. And if patient has no Enduring Guardian/ Public Guardian, then proceed to Guardianship Tribunal (GT).
• If the patient has no capacity to make *financial decisions*, decisions should be made in consultation with the appointed Enduring Power of Attorney (EPOA)/ Financial Manager/Public Trustee. And if the patient has no substitute decision maker appointed, then proceed to Guardianship Tribunal (GT).

• At any stage if the patient disagrees with substitute decision making/ professional opinion or a conflict of consensus arises, please contact Guardianship Tribunal.

• Family meetings and or case conferences to be organised at various stages of the patient’s hospital admission as the need arises.
Fact sheet
‘person responsible’

Consent to medical or dental treatment
Medical and dental practitioners have a legal and professional responsibility to get consent to treatments before treating a patient.

The patient usually gives consent. If the patient is not capable of consenting to their own treatment, the practitioner should seek consent from the patient’s ‘person responsible’. This is required by the Guardianship Act 1987.

Who is the ‘person responsible’?
A ‘person responsible’ is not necessarily the patient’s next of kin. A ‘person responsible’ is either:

- a guardian (including an enduring guardian) who has the function of consenting to medical, or dental treatment
- or, if there is no guardian:
  - the most recent spouse or de facto spouse with whom the person has a close, continuing relationship.
  - a guardian (including an enduring guardian) who has the function of consenting to medical, or dental treatment
  - or, if there is no spouse or de facto spouse:
  - an unpaid carer who is now providing support to the person or provided this support before the person entered residential care
  - or, if there is no carer:
  - a relative or friend who has a close personal relationship with the person.

If a person identified as being a ‘person responsible’ declines in writing to exercise the function of ‘person responsible’ or a medical practitioner or other qualified person certifies in writing that the person identified as ‘person responsible’ is not capable of carrying out those functions, then the person next in the hierarchy is the ‘person responsible’.

If the treatment is special treatment, the practitioner must seek consent from the NSW Civil and Administrative Tribunal before treating the patient.

If there is no ‘person responsible’ and the treatment is major treatment, the practitioner must seek consent from the Tribunal before treating the patient.

If the practitioner considers the treatment to be urgent and necessary, they may treat without consent.
For more information about urgent, special, major and minor treatment, see the guide overleaf.

Rights and responsibilities of a ‘person responsible’
If you are the ‘person responsible’ for someone who cannot consent for themselves you have a right and a responsibility to know and understand:

- what the proposed treatment is
- what the risks and alternatives are
- you can say “yes” or “no” to the proposed treatment
- you can seek a second opinion.

The practitioner has a responsibility to give you this information and seek your consent to the treatment before treating the patient.

Is there anything a ‘person responsible’ cannot do?
When someone is incapable of consenting to their own treatment, a person responsible cannot:
- consent to special medical treatment, such as sterilisation operations, terminations of pregnancy and experimental treatments
- consent to a treatment if the patient objects to the treatment.

Guardianship Division
Postal address Locked Bag 9, Balmain NSW 2041
Street address Level 3, 2a Rowntree St Balmain NSW 2041
Telephone (02) 9556 7600 or 1300 006 228
(Telephone Typewriter) (02) 9556 7634
Fax (02) 9555 9049
Email gd@ncat.nsw.gov.au
Website www.ncat.nsw.gov.au
## Who can give substitute consent for medical or dental treatment?

<table>
<thead>
<tr>
<th>Type of treatment</th>
<th>Consent requirements</th>
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<tbody>
<tr>
<td><strong>Major treatment</strong></td>
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<tr>
<td>Treatment considered urgent and necessary to:</td>
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<tr>
<td>• save patient’s life</td>
<td><strong>No consent needed</strong></td>
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<td>• prevent serious damage to health</td>
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<td>• prevent or alleviate significant pain or distress</td>
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<tr>
<td>Medications affecting the central nervous system (except as listed in Minor below).</td>
<td><strong>Person responsible can consent.</strong></td>
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<tr>
<td>Long-acting injectable hormonal substances for contraception or menstrual regulation.</td>
<td>If there is no person responsible or the person responsible is not available then only the NSW Civil and Administrative Tribunal can consent.</td>
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<td>Any treatment for the purpose of eliminating menstruation.</td>
<td>The request and consent must be in writing or, if not practicable, later confirmed in writing.</td>
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<td>Testing for HIV.</td>
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<td>Any treatment involving substantial risk.</td>
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<td>Any dental treatment resulting in removal of all teeth or significantly impairing ability to chew food.</td>
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<td><strong>Minor treatment</strong></td>
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<tr>
<td>All medical and dental treatments (except those listed in Major or Special).</td>
<td><strong>Person responsible can consent.</strong></td>
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<td>Treatment involving general anaesthetic or other sedation:</td>
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<tr>
<td>• for management of fractured or dislocated limbs</td>
<td>The doctor or dentist may treat without consent if the patient is not objecting and there is no person responsible or the person responsible is not available.</td>
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<tr>
<td>• for endoscopes inserted through an orifice, not penetrating the skin or mucous membrane.</td>
<td>It must be noted on the patient’s record that the treatment is necessary to promote the patient’s health and wellbeing, and that the patient is not objecting.</td>
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<tr>
<td>Medications that affect the central nervous system which are used:</td>
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<td>• for analgesic, antipyretic, antiparkinsonian, enthisterminic, antiemetic, antiulcerant or anticonvulsant purposes</td>
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<td>• only once</td>
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<td>• on a PRN basis (as required) not more than 3 times per month</td>
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<td>• as sedation in minor procedures</td>
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<td><strong>Special treatment</strong></td>
<td>Only the NSW Civil and Administrative Tribunal can consent.</td>
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<td>Androgen-reducing medications for behavioural control.</td>
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<td>Termination of pregnancy.</td>
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<td>Treatments intended or likely to result in permanent infertility.</td>
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<td>Vasectomy and tubal occlusion.</td>
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<tr>
<td>Aversives – mechanical, chemical or physical.</td>
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<td>Any new treatment that has not yet gained the support of a substantial number of doctors or dentists specialising in area.</td>
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<tr>
<td>Use of medication affecting the central nervous system where dosage, duration or combination is outside accepted norms.</td>
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</table>

**Major or minor treatment when the patient is objecting**

If the patient indicates, or has previously indicated, that he or she does not want the treatment carried out.

Only the NSW Civil and Administrative Tribunal can consent.
CAPACITY SCREENING CHECKLISTS & GUIDELINES FOR HEALTH PROFESSIONALS (this template is a guide only and not intended to become part of the medical record)

Patient sticker/Name/MRN/DOB

Reason for Admission

Medical History

Section-1: CAPACITY SCREENING CHECKLISTS

<table>
<thead>
<tr>
<th>Domains of Capacity Concerns</th>
<th>Y/N</th>
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<tbody>
<tr>
<td>Consent to medical treatment</td>
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<tr>
<td>Independent living</td>
<td></td>
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<tr>
<td>Financial</td>
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Is patient currently suffering from

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<tbody>
<tr>
<td>Delirium*</td>
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<tr>
<td>Depression*</td>
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<td>Delusions/Psychosis*</td>
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*If yes, do not to proceed with capacity assessment
Future care planning

- Advance Care Directive (ACD)
- Enduring Power of Attorney (EPOA)
- Enduring Guardian (EG)

Cognitive Assessment / Screening

- 3MS
- Mini Mental State Examination (MMSE)
- Rowland Universal Dementia Assessment Scale (RUDAS)
- CLOCKFACE
- Other.....

Clinical Assessments

- Specialist reports
- General Practitioner report
- Social Work
- Occupational Therapy
- Other.............

Collateral information

- Spouse
- Carer
- Service providers
- Relatives/friends/Neighbours
- Other........

SECTION-2: CAPACITY ASSESSMENT PRINCIPLES

1. Always presume a person has capacity
2. Capacity is decision specific
3. Don’t assume a person lacks capacity based on appearances
4. Assess the person’s decision making ability-not the decision they make
5. Respect person’s privacy
6. Substitute decision -making is a last resort
Section-3: CAPACITY SCREENING GUIDELINES

(The following questions may be used as a guide to assist the assessor to determine capacity. Questions to be modified as required)

**MEDICAL CONDITION**

- What is your understanding of your illness?
- How is it affecting you?

**UNDERSTANDING TREATMENT**

- What does the doctor want you to do?
- What are the benefits of the treatment?
- What are the risks of the treatment?
- What are the risks of not getting the treatment?

**FUNCTIONAL CONDITION**

- What is your current mobility status:
  - Independent with mobility 
  - Mobile with walking aids
  - Mobile with supervision
  - Mobility with walking aids & supervision
  - Mobile with assistance
  - Falls risk
  - Unable to mobilise
- Can you tell me, how will you care for yourself after you leave the hospital?
- Do you have any problems with your bladder or bowel? Please describe:
  - Bladder
  - Bowel
• If you have urine or faecal incontinence how will you manage this?

• Are you able to drive after you leave the hospital?
  (a) Yes □
  (b) No □

• If not, how are you planning to get around after you leave the hospital?

• Can you tell me, how will you prepare your meals after you leave the hospital?

• How are you planning to manage your medication after you leave the hospital?
  (a) Self-Management □
  (b) Webster packs □
  (c) With supervision from family/ carer □

• Can you tell me, how will you do your shopping after you leave the hospital?

• Do you see any risks about returning home?

• Have you considered going into residential care or some other form of supported accommodation?

• Would you consider accepting care from community services after you leave the hospital?

**FINANCIAL DECISIONS**

• Are you able to manage your own finances/ bills?

• How much income do you have every week or fortnight?

• How much expense do you have every month (E.g., What are your common expenses/bills every month?)

• How do you pay your bills (E.g., Direct debit, Post office, etc.)?
Summary

- Does the patient identify any problems or barriers to meeting ongoing care needs? If so, does he or she know how to organise appropriate assistance if s/he needs it? Does the patient demonstrate an understanding of the consequences of their decisions?

- Is there any evidence of patient’s inability to self-manage (E.g., progress notes, reports from carers?).

- Does the person encounter safety or physical health risks because of memory problems? (E.g., Inability to use walking aids, needs regular re-orientation/prompting, becomes lost in the street, forgets to switch off oven etc)

- Is the patient at risk of financial, physical or sexual abuse?

Documentation Guidelines

- Document the trigger for assessment and the assessment process

- Provide a summary of the questions you asked the person and their answers and place in patient’s medical record.

- Give an explanation as to the reasons why you have made a decision as to capacity or lack of capacity eg patient lacks insight regarding the consequences of their decisions
References


- Australian Association of Social Workers (AASW) Practice Standards, 2013.


- Etchells E. *Aid to Capacity Evaluation (ACE)*. Retrieved from: http://www.utoronto.ca/jcb/disclaimers/ace.htm


- NCAT Guardianship Division- Fact Sheet- ‘Person Responsible’- January 2014.
