Sinai Health

# FAQs on Decision-Making Capacity

**Information for Patients, Caregivers, and the Sinai Health Community**

The following information is for patients cared for in Ontario.

Prepared by the Department of Bioethics

## What is decision-making capacity?

Decision-making capacity is the ability to make an informed choice. A patient who has decision-making capacity is **capable**. A patient who does not have decision-making capacity is **incapable**.

Capacity is decision specific, one may be capable for certain kinds of decisions and incapable for others. Incapable patients have decisions made on their behalf by a substitute decision maker.

## How do we know if a patient is capable?

A patient is capable if able to:

- Understand the information relevant to the decision and
- Appreciate what might happen as a result of making or not making the decision.

Decision-making capacity involves the process of decision-making, rather than the choice the patient made.

## Who assesses decision-making capacity?

- **For treatment decisions:** The health-care professional who proposes the treatment is responsible for assessing capacity.
- **For personal assistance services:** An evaluator can assess capacity for personal assistance services (assistance with or supervision of hygiene, dressing, grooming, eating, drinking, toileting, walking, or any other routine activity of living).
- **For admission to long-term care:** An evaluator can assess capacity for decisions about long-term care.

## How is capacity assessed?

Capacity is assessed by asking the patient a series of questions that are specific to the decision. These questions help determine if the patient understands the information and appreciates the consequences.

Standardized assessment tools such as Aid to Capacity Evaluation (ACE), Placement Aid to Capacity (PACE) and Communication Aid to Capacity Evaluation (CASE) are commonly used by health-care professionals to make these difficult assessments.

## Is the patient informed before a capacity assessment?

Yes. Before starting the capacity assessment, the assessor must fully explain to the patient the purpose of a capacity assessment, the significance and effect of a finding of incapacity, and the patient's right to refuse to be assessed.

The patient must also be told of the assessment result (capable or incapable). Patients who are found incapable have a right to appeal the finding to the Consent and Capacity Board (see Glossary).

If the patient refuses to participate in the capacity assessment, the health-care professionals will undertake an assessment based on information in the chart.

## What factors can affect capacity?

Capacity may change as a result of physical and psychological conditions such as depression (sadness), dehydration (lack of fluid), delirium (confusion), infection, and fatigue (feeling tired). Capacity maybe reduced as a result of injury (e.g., brain injury) or condition (e.g., brain tumour, Alzheimer's) that is not curable or likely to improve over time.

## What individual indicators do not alone determine incapacity?

Incapacity is not directly related to any of the following factors: age, language barriers, psychiatric illness, physical disability and/or communication orders, refusal of treatment, lower levels of education, cultural or religious background, idiosyncratic or unusual beliefs.

## Four Important Points

1. **Presumption of capacity:** We always assume patients have capacity, unless there are reasonable grounds to believe otherwise. A capacity assessment will be done if, for example, a patient shows signs of: Confused or unreasonable thinking, inability to recall information, constantly changing his/her mind.
2. **Decision specific:** Capacity is specific to a decision. This means a patient may be able to make a simple decision, but not a more complex decision. We assess the patient's capacity decision by decision.
3. **Time specific:** Capacity may fluctuate over time. This means a patient may be capable at one time on one day and incapable at another time. For example, a patient may be incapable when first admitted but with treatment become capable. Alternatively, the patient maybe capable at the onset of illness and become incapable as the illness progresses.
4. **Return to capacity:** Patients who regain capacity are able to resume making decisions for themselves.

### Glossary

**Consent and Capacity Board:** An independent body created by the Government of Ontario to conduct hearings on capacity,consent, civil committal and substitute decision making. Board members are psychiatrists, lawyers and members of the general public appointed by the Lieutenant Governor in Council. The Board sits with one, three, or five members. Hearings are usually recorded.

**Evaluator:** A health-care professional who is specially trained to assess capacity.

**Substitute Decision Maker:** A person given the authority to give or refuse consent on behalf of an incapable person.

**Treatment:** Anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose,and includes a course of treatment, plan of treatment or community treatment plan.

As used in this pamphlet, the terms "capable" and "incapable" refer to mental capacity, NOT functional or physical capacity.

### Resources

**Consent and Capacity Board**
www.ccboard.on.ca/

**Health Care Consent Act**
ontario.ca/laws/statute/96h02

**Substitute Decisions Act**
ontario.ca/laws/statute/92s30

**Ontario Ministry of the Attorney General**
The Capacity Assessment Office: Questions and Answers https:// www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacityoffice.php

## References

Weisstub, David N. Enquiry on Mental Competency, Final Report. Queen's Printer for Ontario,1990. p.31

Health Care Consent Act. S.O. 1996, Chapter2 Sched. A, s. 4 (1)
www.e-laws.gov.on.ca/html/statutes /english/elaws_statutes_96h02_e.htm

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