

Documentation Guidance for Decision Making Capacity Assessments

Note: This handout was compiled based on guidelines from various sources and is meant as a general list of details to consider including in your reports. Consider the requirements and expectations of your agency/ employer and prospective audiences as well as the context of the particular client and situation to develop your own reporting format and style. This handout is a living document that I will continue to update as best practices and my own learning evolve, so please provide any feedback or suggestions to karin@agingcareconsult.com.

Begin with the end in mind: Be clear ahead of the visit on what type of documentation is needed.

- A **summary letter** (AKA case summary or case letter) can be 1-2 pages in length.
- A more detailed **assessment report** (AKA case report or detailed report) may be 5-10 pages or more, depending on the situation's complexity.

Below are recommendations for sections and types of information to include in your documentation:

Context

- List the date, time, duration, and location of visit, with relevant info of person assessed (full name, DOB).
- List who else was present and their relationship, purpose of their presence, and contact information.
- Summarize your current licensure, credentials, and experience, and any factors that limited your ability to offer opinions on this case.
- Describe who requested the assessment, their role/contact info, and who is paying for the service.
- Include a statement that this assessment was completed in compliance with your scope of practice and professional ethics.
- Describe process of notification and informed consent and the person's understanding and consent/assent.
- Summary of the problem or type of capacity in question, along with related legal standard/laws.
- Throughout: avoid jargon and acronyms; use plain language to explain clinical terms/concepts.

Assessment and related information

- Summarize visit discussion, with direct quotes where possible and description of the person's engagement and response style.
- Describe the person's presentation, including any sensory or other impairments and what supports or accommodations were used/offered during the visit to maximize their participation.
- Summarize medical history with pertinent details, e.g. current conditions/diagnoses, recent surgeries or events like ER visits or hospitalizations, medical providers with contact information, list of current medications and estimation of compliance with prescribed directions.
- Summarize psychosocial and education/work history, relationship/family history and current involvement, living situation, and supports/assistance.
- Relate your assessment of the person's present and historical cognitive/executive functioning; emotional/behavioral functioning; functional abilities; and impact of these on decision making.
- Describe the person's expressed values and preferences related to the situation or decision in question and any related issues.

Cognitive tests and other assessment tools

- List all testing tools administered, including a description of the test and what it evaluates, scoring indications, and any limitations of the test. If applicable, discuss testing tools that were not used and why (particularly if used with client in past). Scan testing forms to include if appropriate.
- Include a validity statement – whether the person's effort and engagement were such that their scores can be considered a valid representation of their abilities.
- Explain the person's score, and relate performance/deficits to steps of decision making process.

Information from collateral contacts and records reviewed

- Itemize information and/or records that were accessed or reviewed (collateral data sources, third party informants, medical records, relevant documents), and information that was sought but not available, with source/contact information of significant collaterals.
- For all of the above, note what information is consistent with or conflicts with what client reported.
- If appropriate, specify that reported information was not further investigated by you (e.g. APS allegations are their investigation, not yours).

Impressions / Discussion

- Explain analysis of decision making abilities, including retained capacities and existing supports – discuss how info in each section (medical, financial) impacts decision making and prognosis.
- Relate observations and testing data to specific steps of decision making process (understanding, appreciating, reasoning, making a choice, and executing/taking action to carry out their choice).
- Explain path of analysis to conclusions, with potential alternative arguments and relative evidence.
- Discuss if/how current decision making differs from the person's historical pattern; the significance/complexity of current situation or decision; risk conditions and impact on the person's safety, health/wellbeing and/or financial security.
- Discuss criteria for diagnosis and prognosis, if underlying condition is static or dynamic, and if their condition/functioning and/or decision making is likely to improve or not.
- Discuss if less restrictive alternatives are likely to be successful, sufficient, or accepted.

Findings

- If appropriate for your licensure, give a clinical diagnosis, and also explain it in lay terms.
- Give your statement of your clinical judgment of capacity (and note this is not a legal determination of capacity). Include any other determinations, e.g. vulnerable adult status, evidence of undue influence, etc.
- State that your findings are based on your assessment and information available at the time of the visit.

Recommendations

- Suggest how capacity can be maximized (e.g., by identifying strategies to reduce risk and/or what supports could be put in place to enhance capacity).
- Advocate for any specific protective measures, follow-up items, and urgency of each.
- If appropriate, provide referrals to resources/services in keeping with your scope/ethics.
- Note any need for a follow-up evaluation, and if so, when and/or under what circumstances.

Format/style/proofreading

- Keep in mind that your report might be faxed or copied by others, and you might be reading from your report in court or consultation. Use a legible 12-point font.
- Be consistent: styles of headings, spacing between paragraphs and sections, type of bullets/tables, etc.
- Format the report with identifying information (client name, DOB) and page numbers in the header/footer.
- Spell-check and proofread before finalizing – read from end of report to beginning to slow yourself down.
- Check placing of page breaks (e.g. tables) so content flows nicely.

Signing

- Sign report above your typed full name and licensure/credentials, including the date and time signed.
- Save your signed document as a PDF so the format is protected when shared (securely) with others.