



When should capacity be assessed?

Recognise when a formal capacity assessment is proportionate, and avoid using capacity assessment simply because a person refuses, disagrees or lives with a particular diagnosis.

Estimated learning time	Sources checked	Review due
45 minutes	17 September 2026	2027-03-17

Clinical safety: This educational module does not replace current law, statutory guidance, local policy, legal advice or patient-specific clinical judgement. Jurisdiction-specific rules must be checked for the nation in which care is delivered.

Your reflection is private. After completing the assessment you may optionally save a reflection in your Clinical Education account. Reflection is not part of this downloadable reading file, is not shown on the module certificate and is not exposed through the site administrator interface. Do not put identifiable patient, colleague or confidential employer information into reflective notes.

Learning objectives

- Recognise proportionate triggers for considering a capacity assessment.
- Avoid discriminatory or convenience-based assessments.
- Distinguish clinical disagreement from a genuine reason to doubt decision-making ability.
- Adapt the approach when the decision is urgent.

Learning material

When is a formal assessment needed?

Most everyday healthcare decisions do not require a formal capacity assessment. Clinicians normally work from the presumption that adults can decide. A structured assessment becomes necessary when there is a genuine reason to doubt the person's ability to make the specific decision.

The reason for doubt should be factual: for example, acute confusion, marked inconsistency that cannot be explained by changing preferences, inability to grasp material information despite support, or a significant decision in the context of an impairment that may affect decision-making.

Reasonable triggers

Acute illness, delirium, hypoxia, medication effects, intoxication, severe distress or a new neurological event can justify closer assessment. So can evidence that the person repeatedly misunderstands the nature or consequences of a decision despite explanation.

The seriousness and complexity of the decision matter to the depth of assessment, not because high-risk choices automatically mean incapacity, but because the relevant information and consequences may be more demanding.

What is not a trigger by itself

Age, disability, mental illness, dementia, learning disability, residence in a care home, homelessness, a “difficult” personality or professional disagreement are not sufficient reasons on their own. Refusal is also not a trigger by itself.

When a person says no, first explore why. They may have misunderstood the proposal, fear a side effect, prioritise a different goal, have experienced previous harm, or simply value the risk differently. Assessment should not be weaponised to overcome refusal.

Proportionality

The assessment should be proportionate to the decision. A simple, low-consequence choice may require a brief focused conversation. A complex decision about major surgery, discharge to a restrictive setting or refusal of life-sustaining treatment may require more detailed information, time, support and documentation.

Proportionality also means avoiding unnecessary legalistic processes when the person is clearly making the decision and no reasonable doubt exists.

Urgency and emergency context

Urgency changes what can reasonably be done. Where immediate treatment is needed to prevent serious deterioration, there may be little time for repeated assessment or external consultation. The clinician should still involve the person as far as possible, record the reason for concern, and act under the applicable legal framework.

Where the decision can safely wait, urgency should not be manufactured for organisational convenience.

Review when circumstances change

A capacity conclusion is tied to the circumstances in which it was reached. Improvement in delirium, new communication support, a change in treatment options or a different decision may require reassessment. Conversely, deterioration can create a new reason to assess.

A good plan records the trigger for review rather than leaving a capacity label to follow the person indefinitely across settings.

Key terms for review

trigger, doubt, assessment, diagnosis, disagreement, risk, urgent decision, proportionate, clinical change

Documentation exercise

Record the factual observations that created reasonable concern about ability to make one specific decision, avoiding judgemental language.

Official sources and further reading

The links below are the authentic official sources used for this module. They should be rechecked for time-sensitive clinical or legal decisions.

MC-EW-01 - Mental Capacity Act 2005

<https://www.legislation.gov.uk/ukpga/2005/9/contents>

MC-EW-02 - Mental Capacity Act Code of Practice

<https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

MC-S-03 - Adults with incapacity: code of practice for medical practitioners

<https://www.gov.scot/publications/adults-incapacity-scotland-act-2000-code-practice-third-edition-practitioners-authorised-carry-out-medical-treatment-research-under-part-5-act/>

MC-NI-01 - Mental Capacity Act (Northern Ireland) 2016

<https://www.legislation.gov.uk/nia/2016/18/contents>

MC-NI-02 - Mental Capacity Act - Department of Health NI

<https://www.health-ni.gov.uk/topics/mental-capacity-act>

CON-UK-01 - GMC - Decision making and consent

<https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent>

Next step

Return to [clinicaledu.uk](https://www.clinicaledu.uk) to take the module assessment. After a pass, you may obtain the module certificate and, separately, add an optional private reflection and generate a learner-controlled Learning & Reflection Record.

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