Assessment of Decision making Capacity

Objectives

- Understand Guiding Principles in assessment of capacity
- Review Caritas Capacity Assessment Model
- Learn about the changes in the PDA and AGTA
- Integrate ‘best practices’ when declaring on a maker’s capacity

Definition of Capacity

The ability to understand the information that is relevant to making of a personal decision and the ability to appreciate the reasonable foreseeable consequences of the decision
What is Capacity?

- Capacity is **not** a medical diagnosis
- Health care providers can provide a **clinical opinion** on capacity
- Competency is legal decision made by the Court, based on evidence

Capacity Assessment

- Capacity assessment is a process for determining whether there is sufficient evidence to declare a person incapable of managing their affairs

Guiding Principles

- All adults presumed capable of making their own decisions until contrary demonstrated
- Taking away person’s right to liberty and freedom is a very serious step
- Guardianship is a last resort and there must be evidence that it is absolutely necessary
- The onus is on the assessor to demonstrate lack of capacity, not on the patient to demonstrate capacity
Common Pitfalls

- Practitioner doesn’t understand that capacity is not “all or nothing”, but specific to a decision
- Practitioner fails to ensure that patient has been given relevant information about proposed treatment before making a decision

Risk by Choice

- A risky decision is not necessarily an incompetent decision
  - Stockbrokers, soldiers, medical professionals and patients make them every day.
- It is the process – or the lack of process – by which risky decisions are made that calls into question the capacity of a patient to make that decision.

Costs of Poorly Conducted Assessments

- Unnecessary, uncoordinated and multiple assessments is an assault on patient’s human dignity
- Generates other costs and burdens by delaying services and taxing health care staff resources
- Erodes ethical and moral integrity of the organization and trust
- Generates further conflict, including possible complaints, ethics consults, litigation, etc.
Caritas Capacity Assessment Working Group

- Established January 16, 2006
- Multidisciplinary group, with representation from all 3 Caritas sites
- Goals:
  - Review processes at Caritas for assessing decision-making capacity
  - Develop model to organize process of assessment in acute care setting, with attention to continuing care context also

Goals of Proposed Model

- Concentration on more front-end screening and pre-assessment (problem-solving)
- Development of a well-defined and standardized process
- Definition of team members’ roles
- Documentation and organization of information collected
- Education and mentoring

Care Map
A capacity assessment may be necessary if the trigger meets the following additional criteria:

1. An event or circumstance which potentially places a patient, or others, at risk that
2. Is apparently caused by impaired decision-making which
3. Necessitates investigation, problem-solving (and possibly action) on the part of a health care professional

Common Triggers

- Discharge planning!
- Values/Beliefs in conflict with staff
- Unable to understand different options for solving problems
- Does not appreciate risks and benefits of different choices
- Makes a choice, but unable to carry it out or to direct someone else to do so
- Easily led and taken advantage of
**Valid Trigger: Now what?**

Gather information, identify the effected domains and attempt to problem-solve the issues.

**Domains of Decision-Making**

<table>
<thead>
<tr>
<th>Domains of Decision-Making</th>
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</thead>
<tbody>
<tr>
<td>Healthcare</td>
</tr>
<tr>
<td>Accommodation</td>
</tr>
<tr>
<td>Choice of associates</td>
</tr>
<tr>
<td>Social Activities</td>
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<tr>
<td>Financial and Estate</td>
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- An incapacity to make decisions in one domain does not mean the patient is incapable of making decisions in other domains.

**Care Map – Information Collecting and Team Meeting**
**Information Gathering**

- Collect collateral information:
  - Families
  - Homecare
  - Resident managers
- Investigate reversible causes of incapacity (i.e., delirium, medication, etc.)
- Involve the interdisciplinary team and ask them to provide their perspectives.

**Assess Risk**

- Investigate and document risky and unsafe situations prior to admission (if there were no risky or unsafe situations, what’s changed?).
- Higher the risk to the patient or others, the stricter the standards
- Explore risk reduction strategies

**Problem-solving**

- Involve patients and families in problem-solving
- Seek perspectives from other team members
- Consider formal resources
- Mobilize informal resources
- Issue may be resolved by problem solving without formal capacity assessment
**Reasons to Resort to Formal Capacity Assessment**

- No adequate solutions from problem-solving
- Risk to patient / others too high
- Other, less intrusive methods, have failed
- Appointment of Guardian / Trustee may solve the problem
- Problem persists or becomes worse

**Care Map – Formal Capacity Assessment**

**The Gold Standard**

**Inquiry**

- **Understanding**: adequate factual knowledge base and understanding of options
- **Appreciation**: adequate appraisal of outcome and justification of choices
- **Initiation**: ability to follow through with choices
1. Date and source of referral:

2. Date assessment began:

3. Trigger validity:
   a) Is the patient demonstrating behaviour which puts themselves, or others, at risk of significant harm?
   b) Is the patient known or suspected to have impaired decision-making?

   Is the trigger valid?

4. Identify domains in which the patient may lack capacity:
   - Health care
   - Residence
   - Personal
   - Choice of associates
   - Social / leisure activities
   - Legal affairs
   - Employment
   - Education / vocational training
   - Permits / licences
   - Financial

*Please do not proceed further with this database if the only concern is capacity to drive. Please consider a referral for driving assessment.
5. Please collect relevant domain-specific collateral information.

6. What are the patient’s values and goals, including cultural/religious beliefs, with regards to decision-making in relation to the domain(s) in question?

7. Has the patient’s capacity been assessed on a previous occasion?

8. Have any and all reversible medical and/or psychiatric conditions been ruled out? Is the patient medically stable?

9. Does the patient have cognitive changes which may affect capacity?
   MMSE Score: ___ / 30
   Other tests: Test name: ______ Score: ___ / ___

10. Does the patient have functional limitations in relation to the domain(s) in question?

11. Have barriers to a valid assessment, such as language, literacy, vision and hearing, been addressed?

12. Can the problem be solved and the risks be managed by a less intrusive and restrictive form of support?

*Please consider meeting/consulting with other team members to problem-solve.
13. Is a formal capacity assessment required? [Is the potential risk of harm to self, or others, high enough to justify the removal of the patient’s rights (i.e. appointment of an agent, guardian or trustee)?]

14. Has the patient been engaged in the process, and been adequately educated regarding the domain(s) in question?

*Please proceed with formal capacity assessment (see Patient Interview for Formal Capacity Assessment)

17. How do you assess the mental capacity of this patient with respect to the domain(s) in question?

18. If patient lacks capacity, please note reason:

19. Plan of action:

20. Outcomes:

21. Is there a need for further assistance or a second opinion? Geriatrician, Psychiatrist or Psychologist

23. Mentoring Team consult?:

24. Date of assessment completion:

Interactive Education Workshops

- Background on capacity
- Triggers/Domains: Pre-assessment / problem-solving by SW
- Cognitive/functional assessment by OT
- Care map/database/interview form
- Group work on case studies
- Group presentations on case studies
- Pre/Post-workshop questionnaire
Next Steps: ongoing implementation and sustenance

- Creation of Steering groups and Mentoring teams.
- Monthly Brown-Bag Lunch Sessions
- Workshops for new / rotating staff
- Ongoing education/awareness
- Revision of documents
- Build IT resources
- Analysis of model efficacy

Implementation and Expansion

- Acute care –
  - MCH → Jan, 2008
  - GNH → Feb, 2009
  - SGH → April, 2009
  - RAH → May, 2009 decision made to implement
- Rehab facilities:
  - GRH → Geriatrics/Geriatric Psychiatry Oct, 2009
- Community care
  - Home Living → March 2009
  - Continuing care → May, 2009 decision made to implement
- Rural Facilities
  - Westview Health Region → Mar, 2009 decision made to implement

Under consideration:
- UAH, CHOICE program, Good Samaritan Organization, CCI psych services, Community rehab

Overview of PDA changes since June 30 2008

- **Standardized Declaration of Incapacity**
  - new schedules: 2 and 3
- **Establishing a new process for determining if an adult has regained the ability to make personal decisions**
  - new schedules: 4, 5 and 6
How is capacity assessed in the PDA?

Two scenarios for initiating a capacity assessment:

1. A maker may name someone in their personal directive to initiate the assessment → consult physician / psychologist: Schedule 2

2. No one named in the personal directive → physician / psychologist initiates the assessment → consult with additional health care provider: Schedule 3

Two people must be involved in the assessment.

Declaration of Incapacity: Schedule 2 and 3

Process of Capacity Assessment

The assessor forms an opinion about the ability of the maker to:

- Understand the information that is needed to make a decision
- Retain information that is relevant to making a decision
- Identify and appreciate the consequences of making or not making a decision
- Communicate his/her decision about specific personal matters (checked off in the schedule)

Specific to the decision at hand.

Declaration of Incapacity: Schedule 2

(To be used when the person is designated in the personal directive to determine capacity consult with a physician or psychologist.)

Part 1

(To be completed by the person designated in the personal directive to determine capacity after consultation with a physician or psychologist.)

"Capacity" means the ability to understand the information that is relevant to the making of a personal decision and the ability to appreciate the reasonably foreseeable consequences of the decision(s) (b) of the Personal Directive(s). Any

(_____ name) is designated in the personal directive made by the maker (_____ name) as the person who is to determine his/her capacity.
Declaration of Incapacity: Completing Schedule 2 and 3

- The assessor makes a determination that the maker lacks capacity in specific personal domain(s).

I have determined and declare that ____________________ lacks the capacity to make decisions about the following personal matter(s) of a non-financial nature (check any or all that apply):

- Health care
- Accommodation
- With whom to live and associate
- Participation in social activities
- Participation in educational activities
- Participation in employment activities
- Legal matters
- Other ____________________

Determination of Regained Capacity

A re-assessment of the maker’s capacity should occur when:

The agent, a service provider or the maker believes there has been a significant change in the maker’s capacity.

A significant change is an observable and sustained improvement that does not appear to be temporary.

Regaining Capacity: Schedule 4

Agent initiates process - Part 1

In assessing whether the maker has regained capacity the agent must state that:

- The agent/service provider who provided health care services to the maker has observed a significant change in the maker’s capacity.
- Has considered statements/evidence provided a service provider that there has been a change in the maker’s capacity.
- Has considered the changes in the maker’s capacity over a period of time.

Check off any applicable areas over which the maker regained capacity.
How is capacity assessed in the PDA?

- Two assessors required for assessment of capacity for all schedules
- Assessors: physician/psychologist (2, 3, 6)
  : service provider in health care (3, 4, 5, 6)
- Skills: not defined.
- Recommended: scope of practice and competence

Bill 24: ADULT GUARDIANSHIP AND TRUSTEESHIP ACT

Replaces Dependent Adults Act

Bill 24 – Foundation and Guiding Principles

- Capacity is to be presumed
- A person’s communication method is not relevant to determination of capacity
- Autonomy is to be maintained through least intrusive and least restrictive measures
- Decisions are to be based on best interests and how the person would have made the decision if capable
Continuum of Decision-Making Choices

- Adult Makes Decisions
- Co-Decision Making
- Temporary Guardianship/Trusteeship
- Specific Decision-Making and Emergency Decision-Making
- Guardianship, Trusteeship and Protection

Range of Capacity

- Capable
- Significantly Impaired
- Incapable Temporarily
- Incapable Long-Term

Decision-Making Options: Supported Decision-Making
- An option for capable Albertans who need assistance in making personal decisions
- Decisions made with support of family or friends
- Simple to prepare, use and terminate if needed; no Court application required

Decision-Making Options: Specific Decision-Making
- In areas of Health and Temporary relocation only
  - No court order needed
  - Regulated forms: process and declaration
  - Notification of nearest relatives
  - Appeals process
Decision-Making Options: 
Co-decision making Order

- Court-ordered process
- For Albertans with significantly impaired capacity who are able to make decisions with appropriate guidance and support
- Adult makes decisions jointly with co-decision-maker
- Less intrusive measures (e.g. supported decision making) must be considered and ruled out
- Order must be in adult’s best interest
- Adult must consent
- Limited to personal matters (not financial or property)

Decision-Making Options: 
Temporary Guardianship

- Court-Ordered Process
- Allows fast-track to Court in urgent and high-risk cases
- Requirements for capacity assessment and notification of family and interested person waived
- Order must be reviewed after 90 days

Decision-Making Options: Emergency Healthcare

- A physician may provide emergency health care to save life, prevent serious physical or mental harm, or alleviate severe pain
- Patient must lack capacity, and no guardian or other person with decision-making authority be available or accessible
- Physician must, if practicable, consult with a second physician OR health care provider
Decision-making Options:

Guardianship

- Court-Ordered Process
- For adults who do not have the capacity to make personal decisions
- Revisions include:
  - Provision for guardian to apply for an order to enforce a guardianship order
  - More rigorous expectations for guardian to act in good faith according to the four Guiding Principles

Trusteeship

- Court-Ordered Process
- For adults who do not have capacity to make decisions in financial matters
- Court may appoint trustee if satisfied adult lacks capacity in financial matters and trusteeship is in best interest of adult
- A trustee is authorized to make decisions on behalf of represented adult in financial matters

Capacity Assessment (for Court Orders)

- Bill 24 allows for expansion for the range of trained professionals who may assess an adult’s capacity for purposes of court-order applications
- Revised assessment process:
  - Is standardized
  - Focuses on cognitive and functional abilities
  - Targets the types of decisions the adult will need to make
  - Identifies the level of assistance required
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