Capacity Assessment – how to decide who can decide

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Legal capacity

- A legal construct which impacts upon medical decision making
- Capacity assumed unless lack of capacity has been established
What is decision making capacity? (legal definition)

A person has decision making capacity if the person can make decisions in relation to the person’s affairs and understands the nature and effect of the decision.

– *Powers of Attorney Act 2006*
Capacity to make decisions: general principles

- Assessing a patient’s decision-making capacity is a part of every patient encounter.
- For the most part, the process is spontaneous & straightforward.
- Through dialogue, the clinician is able to confirm that the patient understands their health situation & options for care.
However..

- Cognitive & physical changes in our older adult population are linked with decline in everyday functioning that includes loss of decision making skills.
- As a result, there are times when there is a need to access a patient’s decision making capacity more thoroughly.
- Failing to access capacity when necessary may result in physical or legal harm by the client continuing to make decisions.
Cognitive domains impacting on decision making

- Attention
- Working memory
- Language
- Executive function (may be disproportionately affected in vulnerable elders and is a better predictor of decision making capacity than global assessments)
- Judgement, insight, mental flexibility, problem solving including abstract thinking, goal directed planning
  - *Griffith et al. Neurology 2005: 65; 483*
  - *Riddle. Brain Aging, CRC Press 2007*
Who has capacity?

A person has capacity to make a decision about a matter if they are able to:

- Understand the information relevant to the decision and the effect of the decision
- Retain that information to the extent necessary to make the decision
- Use or weigh information as part of the process
- Communicate the decision …in some way

Six capacity assessment principles (NSW capacity toolkit, 2008)

1. Always presume capacity
2. Capacity is decision specific
3. Don’t assume a person lacks capacity based on appearances
4. Assess a person’s decision making ability, not the decision they make!
5. Respect a person’s privacy
6. Substitute decision making is a LAST resort
"Your grandma and I have decided to live together"
Limits on finding impaired DMC

A person must not be taken to have a physical, mental, psychological or intellectual condition impairing DMC only because the person:

- Is eccentric
- Does or does not express a particular political or religious opinion or
- Is of a particular sexual orientation or expresses a particular sexual preference
- Engages or has engaged in illegal or immoral conduct or
- Takes or has taken drugs including alcohol

Guardianship and Management of Property Act 1991, Section 6A
Assessment of capacity

- Domain/decision specific - at the point in time when a particular decision is made, does the individual understand the nature and effect of the decision?

- Emphasis on optimal communication/circumstances, provision of information appropriate to person’s circumstances including use of interpreters, communication aids
Capacity

- Difficult to measure
- May fail to find capacity or incapacity-
  - Because it is not present
  - Because the process used was inadequate
  - Because person applying process did not apply properly
Assessing capacity

- Cognitive function scores cannot be used alone
- Functional tests should be domain specific (different for finances/personal care decisions)
Capacity: Six C’s

- A capable person:
  - knows the Context of the decision at hand (is not making choices based on delusional constructs)
  - knows the Choices available
  - appreciates the Consequences of specific choices
  - applies logical reasoning to Compare between choices
  - is Consistent in their choice (no undue influence)
  - is able to Communicate their choice
Who can assess capacity?

- No stipulation in Australia
- Courts/tribunals decide whose evidence to accept
- Generally the responsibility of the person accepting the decision (lawyers for legal documents, doctors for healthcare matters, bank managers for loans etc)
- Lawyers
- Medical professionals
- Neuropsychologists
Six step capacity assessment (Darzins and Strange, 2000)

1. Trigger
2. Assent
3. Information gathering
4. Education
5. Assessment
6. Action
The six step Capacity Assessment Process

Step 1: Pre-assessment tasks
- Ensure valid trigger is present

Step 2: Engage person in the capacity assessment process

Step 3: Capacity assessment
- Gather information about issues, available choices and consequences of choices
- Educate about the issues, choices and reasonably foreseeable consequences of choices
- Assess capacity with respect to the specific issues

Step 4: Post assessment tasks
- Act on the outcome of the assessment
Triggers

- Patient or others at risk
- Known or suspected impaired decision making
- Choices “out of character”
- Previous attempts to solve a problem have failed and appointment of substitute decision makers will solve problem
I hope you won't be offended but there comes a time when the aged don't know what's best for them.

Poor devils.
Assent

- Need to gain co-operation
- Explain process, why and possible outcomes
Information gathering

- Information from others helps define trigger, circumstances, choices available and possible consequences.
- This is where the whole team comes in to play: family/friends/carers/GP/social worker/occupational therapist.
Education

- Need to ensure that patient has received enough information about trigger, choices and consequences to be able to make a rational decision
- ACAT assessment may be part of this education
CAPACITY ASSESSMENT: conditions

- Interview client alone
- use of an independent trained interpreter if not native English speaker
- use of appropriate vision and hearing aids
- complexity of language in communication or documents!
- establish rapport with the client
- spend sufficient time!!
Assessment

- Does individual understand and appreciate decisions they face
  - able to understand problem
  - able to understand choices
  - able to appreciate consequences
  - able to rationalize decision
  - able to communicate decision

- Assessment process should be well documented
Action

- Help competent make and act on decision
- Appoint substitute decision makers if necessary (best interests)
- Appreciate loss of self-esteem, depression etc following loss of decision making ability
Specific decisions: appointing an EPOA

Understanding the nature/effect of making POA includes understanding of:

- That the principal may...state or limit the power to be given to attorney
- That the principal may...instruct the attorney about the exercise of power
- When the power under the POA can be exercised
- That, if the power under POA can be exercised....the attorney has the power to make decisions ...and will have full control ....subject to terms or information about exercising power ...included in POA
- That the principal may revoke the POA at any time the principal is capable of making the POA
- For EPOA: that the power given by the principal continues even if the principal becomes a person with impaired DMC and that at any time the principal is not capable of revoking the POA, the principal cannot effectively oversee the use of the power

- *Powers of Attorney Act 2006*
THE POWER TO CHOOSE

Your guide to completing an enduring power of attorney
Specific decisions: testamentary capacity

Testator should:

- Understand the nature and effect of making a will
- Have an appreciation of the people who are natural beneficiaries
- Understand the need to provide for people who are dependent on him or her
- Realise the effects and consequences of the testamentary provision he or she is making

*Purser & Rosenfeld. MJA 2014; 201(8):483-485*
Specific decisions: financial decision making

- What would you look for?
- What information would be important to have to assist you in your assessment?
Medical decision making and Guardianship in the ACT
Appointment of health attorneys under Guardianship Act

- A senior medical or dental practitioner may appoint a health attorney to consent to medical treatment where the person is unable to consent for themselves and there is no appointed substitute decision maker.

- The health attorney can be (in order of priority):
  - A domestic partner/spouse
  - An unpaid carer
  - A close relative or friend
CHOICE OF HEALTH ATTORNEY
(Guardianship and Management of Property Act 1991)

Hospital Number:

SENIOR DOCTOR/OR DENTIST TO COMPLETE:

1 DETAILS OF THE PROTECTED PERSON (PATIENT)

Full Name........................................... Date of Birth _____ / _____ / _____

What condition impairs the decision-making of the protected person in relation to their health?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2 DETAILS OF NOMINATED HEALTH ATTORNEY

Full Name

Address

Telephone Number

Relationship to protected person
(Please tick appropriate box)

☐ domestic partner  ☐ carer  ☐ close relative or friend

Reason for choice:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3 PRINTED NAME OF HEALTH PROFESSIONAL PREPARING HEALTH ATTORNEY FORM

Full Name

Designation

Signature of health professional:

Date: _____ / _____ / _____

Authorized by the ACT Parliamentary Counsel—also accessible at www.legislation.act.gov.au
Appointment of guardian, s7

ACAT can appoint a guardian if:

- Satisfied the person has impaired decision making capacity
- While they have impaired decision making capacity there is a decision at hand or the person is likely to do something in relation to the matter that involves or is likely to involve unreasonable risk to person
- If a guardian is not appointed person’s needs will not be met or person’s interests will be significantly adversely affected

The appointment of a guardian or financial manager is to be reviewed at least once every three years (s19)
Decision Making Principles under the Guardianship Act

- The protected person’s wishes must be given effect to UNLESS ....likely to significantly adversely effect protected person’s interests
- ....Must give effect to PPs wishes as far as possible
- ...the interests of the PP must be promoted
- The PPs life must be interfered with to the smallest extent necessary
- The PP must be encouraged to look after himself or herself as far as possible
- PP...encouraged to live in the community as far as possible
- The decision maker must consult with each carer of the PP (unless this would adversely effect PPs interest)
Mr. Cecil Fields, aged 90, farmer, neighbour reports safety concerns: property “a mess”, observed burning brush near house but left unattended, wandering outside in Feb. without coat, driving slowly and “swerving”. CCAC previously contacted by neighbour & out to assess but Cecil “suspicious” and hesitant to let them in house. Did not provide any personal information during this visit. Lives with son Angus, aged 60, query if developmentally delayed. Son has never worked outside of farm, thinks he has Grade 6 education. No POAs. Two men have been “loners” & fairly isolated, seen in town for groceries & banking.

Medical history unknown. Cecil smells of urine.

Neighbour recently able to get inside home. Reports home has no running water, well on property, washtub half-full of “black” water, house ++ cluttered, smells musty & stale, open cans of food on counter, outdated food in frig. Both men wearing “worn” clothes. Three cats in house—litter box “full”. Roof of house needs repair, front steps have sagged and pulled away from the house. Neighbour has brought Mr. Fields to your primary care centre, after he showed the neighbour a “gash” on his lower leg.

Mr. Fields demonstrates the complexities of care for older people who are frail, living in the community with minimal or no support and without ongoing medical care/supervision. Although he has “managed” on his own, is there potential to improve his quality of life?

**Assessment**

Physical: 6'1", thin, estimate wt. at 140 lbs, clothes hanging on thin frame, gnarled hands, stooped posture, slow, shuffling gait, balance poor. BP 142/78 sitting, 138/77 standing, visual impairment, 9 Cataracts, reports pain in neck, shoulders, back, hips, knees & hands. Takes Tylenol (only med).

Laceration on right lower leg, 4 cm in length, dried blood on surrounding skin.

Cognitive: Grade 8 education, has always lived & worked on family farm. Presents as “simple”, enjoys watching TV with his son. MMSE 22/27, unable to complete pentagons, sentence and “Close your eyes” due to vision. Did not know 911 address. MoCA 19/30. Unable to complete trail making test or copy cube. Clock draw: drew circle but unable to place numbers within it.

Mood: Presented as “guarded”, was cooperative with testing, but frequently questioned the need. Scored 5/15 on Geriatric Depression Scale.

Functional: Reports that he cooks the meals and Angus helps. Favourite dish is pork & beans and toast.

**How and why? Who and Where?**

What are the issues/risk?
Are the risks actual or potential?
Are any of the risks tolerable?
Are there any risks that make capacity an issue?
How should the Primary Care IPC team approach this situation?
What is your role in a capacity assessment?
Who should be involved in his care? Why?
How will his choices and values be respected? Who will advocate?
How would you have a conversation with Cecil (what would you say)?
What parts of the conversation would you find difficult?
What are your recommendations?
What concerns, if any, do you have for his son?
Mrs. Clara Grey, aged 80, husband admitted to acute care 3 months ago and passed away 2 weeks later. Since her husband’s death, she has been calling her daughter several times daily. Daughter is expressing concerns regarding her mother’s ability to cope at home alone and frustration with the caregiver role.

Past History & Medications: Glaucoma—eye drops BID, Osteoporosis—Calcium and Vitamin D Note: did not tolerate Didrocal, Cataracts removed in summer 2005 and 2007, Dementia—Aricept 10 mg. o.d., Labs—normal 10 months ago. Note: Non-compliance with medication unless cued.

No physical complaints, independent ambulation, no witnessed falls, smoker—1 carton a week, long-standing limited appetite, with 50-35 lbs weight loss over past few years, suspect ETOH abuse, cognitive decline x 5 yrs—started on Aricept 2 yrs ago. Decreased short term memory, some disorientation to time (phoning at 1 am), decreased attention to personal care (not bathing, clothes soiled). Dependent for IADL’s—spouse had done shopping, meal prep, cueing for meds. Uses packaged foods, tea & toast—seldom uses microwave, does not cook. Still has valid driver’s license. ? management of ADL’s.

Retired secretary, son out of province, drt. nearby but had not been involved in care due to “family conflict”. Mood swings & stubbornness reported by drt.

Drt., who is a patient at your primary care centre, has brought Mrs. Grey in for assessment.

Mrs. Grey demonstrates the complexities of care for older people who have chronic illnesses, frailty, and are living in the community. It is questionable if she was really managing with her husband’s assistance. Now that this support is gone, her problems have become more apparent.

Assessment

Physical: has walker but does not use, unsteady gait noted, bruising on arms, legs, abrasion on side of face
Cognitive: socially appropriate to most questions. Showed anger when pressed for details, MMSE 21/30. Did not know medical history. Did not know 911.
Mood: decreased energy, sleeps through night, naps during day. Anger & frustration evident. Perceives daughter “trying to get me out of my house”. Displayed humour appropriate to situation, able to verbalize husband died but showed little emotion.

Functional: Dishevelled, dirty clothes, scratching head frequently, smelled of cigarette smoke, alcohol, body odour. Clara reports bills are being paid but drt. found final notices from hydro & gas companies. Drt. now doing shopping & laundry weekly. Clara “only” drives to local store for milk, bread, cigarettes
Environment: Drt. reports clutter throughout house, several days of unwashed dishes in sink, table & floors “sticky”, cigarette burns on carpet & favourite chair. Scatter mats throughout home, observed lighting cigarette from electric stove burner.

Social: High school education, married 60 yrs, No POAs delegated. Minimizes alcohol use. Denies need for assistance stating “I don’t need your help or anyone else’s”.

How and why? Who and Where?
What are the issues/risks?
Are the risks actual or potential?
Are any of the risks tolerable?
Are there any risks that make capacity an issue?
How should the Primary Care IPC team approach this situation?
What is your role in a capacity assessment?
Who should be involved in her care? Why?
How will her choices and values be respected? Who will advocate?
How would you have a conversation with Clara and her daughter (what would you say)?
What parts of the conversation would you find difficult?
What are your recommendations?