ORIGINAL RESEARCH

The Development and Implementation of a Decision-Making Capacity Assessment Model

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ABSTRACT

Background

Decision-making capacity assessment (DMCA) is an issue of increasing importance for older adults. Current challenges need to be explored, and potential processes and strategies considered in order to address issues of DMCA in a more coordinated manner.

Methods

An iterative process was used to address issues related to DMCA. This began with recognition of challenges associated with capacity assessments (CAs) by staff at Covenant Health (CH). Review of the literature, as well as discussions with and a survey of staff at three CH sites, resulted in determination of issues related to DMCA. Development of a DMCA Model and demonstration of its feasibility followed.

Results

A process was proposed with front-end screening/problem-solving, a well-defined standard assessment, and definition of team member roles. A Capacity Assessment Care Map was formulated based on the process. Documentation was developed consisting of a Capacity Assessment Process Worksheet, Capacity Interview Worksheet, and a brochure. Interactive workshops were delivered to familiarize staff with the DMCA Model. A successful demonstration project led to implementation across all sites in the Capital Health region, and eventual provincial endorsement.

Conclusions

Concerns identified in the survey and in the literature regarding CA were addressed through the holistic interdisciplinary approach offered by the DMCA Model.

Key words: capacity, competency, decision-making, adult cognition, cognitive decline, older adults, autonomy, capacity assessment, model, guardianship

INTRODUCTION

The issue of decision-making capacity (DMC) is increasingly being recognized as a significant concern to society and the healthcare system.[1,2] A person's decision-making ability is dependent on both the complexity of the decision-making process and one's ability to engage in that process. The degree of impairment regarding one's DMC can vary as a result of developmental or disease processes, cognitive impairment, or brain injury. As the life expectancy of Canadians and prevalence of cognitive impairment continues to rise, health-care professionals (HCPs) will encounter more patients with questionable DMC.

A person's right to make autonomous decisions, and the potential loss of those rights, is a multifaceted and complex issue.[3,4] This is due to the nature of patients' challenges and comorbidities, as well as concerns around safety and well-being.[3,5,6] The necessity of a capacity assessment (CA) is often triggered by a person's circumstances involving, for example, their place of residence, finances, or health care. A trigger guides the assessment through providing context, purpose, and focus.[7,8] Patients may demonstrate behaviours which put self or others at risk of significant harm, be known or are suspected of having impaired decision-making abilities, or have made choices that others believe are inconsistent with values previously held when they were apparently capable. Such triggers can signal the potential need for a CA. Means by which to assess a person's DMC and determine the least restrictive and intrusive alternatives to support decision-making are becoming increasingly critical.[1]

Prior to 2006, no particular process was being utilized to conduct CAs at three Covenant Health (CH) (formerly Caritas Health Group) sites. Members of the health-care team (physicians, nurses, social workers (SWs), psychologists,

occupational therapists (OTs), physical therapists (PTs), speech-language pathologists, chaplains, recreation therapists, and therapy/nursing assistants) at that time suggested that the lack of clarity associated with the non-standard approach risks inappropriate, unnecessary, or successive CAs. Full CAs were at times being conducted on patients who were not medically stable, or whose problems could have been resolved less intrusively.

To address this clinical practice challenge, an Interdisciplinary Capacity Assessment Working Group (CAWG) was created comprised of staff from the three CH sites. The group's initial mandate was to better understand the issue, identify clinical best practices, and determine ways to address CAs from an organizational and practice perspective that was mindful of the mission of CH, and ethical and legislative considerations. A client-centred care model, respect for a person's dignity and rights, an inter-disciplinary perspective, and a desire to avoid both unnecessary CAs and declarations of incapacity, guided reflections and decisions made by the CAWG. Four guiding principles from legislative acts were also instructive: 1) the adult is presumed to have capacity and be able to make decisions until the contrary is determined, 2) the ability to communicate verbally is not a determination of capacity, 3) focus is on the autonomy of the adult with a least intrusive and least restrictive approach, and 4) decision-making focuses on the best interests of the adult and how the adult would have made the decision, if capable.[9,10]

The overall goal of this project—recognized as a Quality Assurance activity by the Health Research Ethics Board at the University of Alberta—was to identify issues associated with CAs, and determine strategies and processes that might better facilitate CA. The desired outcome was to improve the quality of CAs, and diffuse situations that may unnecessarily lead to full CAs and declarations of incapacity.

METHODS

An iterative approach was taken. After the challenges associated with CA were identified, a literature review was conducted. Knowledge from the literature review was then used to develop a survey aimed at determining the CA-related issues that staff at three CH sites encountered. Information from the survey and literature eventually informed the development of a CA process and a Decision Making Capacity Assessment (DMCA) Model. Finally, the CAWG educated the staff about DMCA, the DMCA Model, and the application of the process within the clinical context.

Literature

An extensive review of literature on DMCA was conducted, resulting in review of 201 relevant articles published between 2000 and 2012, 71 books (through the NEOS library consortium), and 112 articles in the grey literature. Additionally, the Ontario Model,[8] Moye's Conceptual Model,[11] Regional Capacity Assessment Team (RCAT) Model,[12] Yukon Model of CA,[13] and Skelton's CA and intervention Model[14] were thoroughly reviewed.

Survey and Interviews

Review of literature combined with feedback from the CAWG was used to create a staff survey regarding challenges associated with CA. The survey was administered in person to 17 staff from three CH sites. Additionally, there were 11 in-depth interviews conducted with HCPs routinely involved in DMCA. The survey used open-ended questions to elicit a broad range of answers from the various disciplines, including problems with current process, the level of expertise of staff involved in DMCA, team dynamics, preference for an attending team (unit level staff) or expert-based approach, and suggestions for improvement. Survey and interview results were analyzed through qualitative thematic analysis.

RESULTS

Literature review

The literature review identified the following key issues related to CA: 1) conflict often exists between patient autonomy and safety;[15,16] 2) ethical principles of self-determination and beneficence lie at the heart of issues related to capacity;[17-20] 3) patient and family involvement in CA is central;[21-23] 4) there is a lack of defined standards for declaration of incapacity;[15,24-29] and 5) education for clinicians and medical trainees regarding CA is needed.

Many concerns and pitfalls in the decision-making process have been identified. Ganzini et al.[30] surveyed 395 consultation-liaison psychiatrists, geriatricians, and geriatric psychologists and found 23 major difficulties in the process of CA. They concluded that, since clinicians indicate that misperceptions about CA are common, clinicians and medical trainees require more training regarding CA.

There are many challenges with the CA process. Clinicians have differing interpretations of capacity,[16,30,31] with some holding a belief that capacity is global (all-or-nothing).[24,30,32] HCPs also lack adequate knowledge about CA,[24,33-35] and tend to rely on standardized tests that are not designed for assessment of capacity.[26,27,36-39] Additionally, there is a lack of standardized[36,36-39] and functional, ecologically-valid assessment measures.[24,27,38,40-43] Furthermore, a patient's lack of education is often mistaken for a lack of capacity,[26,37] and those with questionable capacity may have difficulty understanding the CA process. Finally, one professional is often left undertaking the whole burden of the CA.[15,26,28,35]

In sum, determination of capacity is a complex, interdisciplinary process that ideally involves a range of professionals who have medical, ethical, and legal knowledge.[1] A multidisciplinary approach allows for variation in perspectives,

facilitates the holistic identification of possible solutions, and ensures that safeguards are in place (e.g., no single person determines the capacity of any one patient).[7] Furthermore, the involvement of specialist teams, particularly in complex cases, can additionally protect the autonomy of vulnerable adults.[42]

Survey Results

Several themes emerged, including: 1) deficiency in the skillset and knowledge required for CA, 2) absence of a systematic approach to problem solving, 3) lack of tools, guidelines and documentation to conduct assessments, 4) lack of coordination and role allocation in the process, and 5) inadequate resources (staff and time). Preference for access to an expert team versus unit-based teams or a flexible approach varied.

Model Development

Results of the literature review, survey, and interviews, with input from CAWG members, led to the development of the DMCA Model. The DMCA Model included: 1) a well-defined and systematic process, 2) concentration on front-end screening and problem solving, 3) definitions of roles of team members, 4) forms to help organize and document information, and 5) widespread education and support strategies.

DMCA Process—The Capacity Assessment Care Map

The CAWG used an iterative method to develop the DMCA process delineated in a Capacity Assessment Care Map. Various HCPs contributed to the development of the Care Map, reviewing it and suggesting roles that their respective disciplines could contribute to the process. After extensive review and revisions, the CAWG reached consensus on the final rendition of the Care Map, represented in Figure 1.

The Care Map elaborates on the major steps—not necessarily in a linear manner—of the CA process. Consistently, each CA begins with the identification and validation of reasons for assessment, and Capacity Assessment Interviews are only undertaken when less intrusive means cannot be found and a declaration of incapacity is thought to be required.

Due to the invasive and lengthy nature of CAs, they should be conducted only for valid and specific reasons. Characteristics that make the reason for assessments valid should be based on whether the behaviours/decision-making puts the adult being assessed or others at risk, if the adult is known or suspected to have impaired decision-making, and the adult has made choices that others believe are inconsistent with values previously held when they were apparently capable.

Once a reason for assessment has been validated by the member(s) of the person's attending team, several steps are undertaken. Relevant information is first collected related to the person's DMC in an affected domain(s) (i.e., health care, accommodation, choice of associates, social activities, legal affairs, employment, education/vocational training, and financial). These domains are aligned with the Personal Directives Act (PDA)[9] and Adult Guardianship and Trusteeship Act (AGTA).[44] Second, reversible medical conditions are addressed, and referral(s) to SW, OT, PT, and/or psychology for relevant social, cognitive, and/or functional assessments may be made. If the patient is deemed medically stable, the interdisciplinary team meets to explore options, problem-solve, and take appropriate action. DMCA Mentoring Teams (consisting of experienced OTs, SWs, nurses, physicians, psychologists, and designated capacity assessors (DCAs) with expertise in DMCA), are accessed by attending teams for education and support as needed. Third, if the situation warrants a declaration of incapacity, a Capacity Assessment Interview is conducted by the attending physician, and required forms, as per the acts, are completed. Experts (geriatricians, psychologists, psychiatrists, DCAs), are consulted if further assistance is required by the attending team. (Refer to

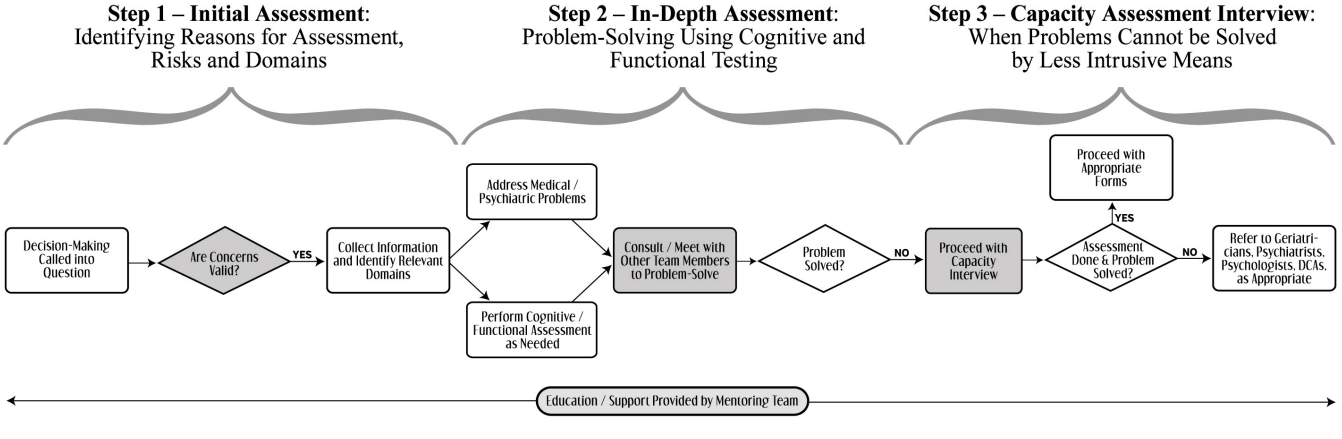


FIGURE 1. Capacity assessment care map

Appendix A for definitions of the different types of teams and roles, and Figure 2 for Roles and Training for HCPs involved in the DMCA Model.)

DMCA Supporting Documents

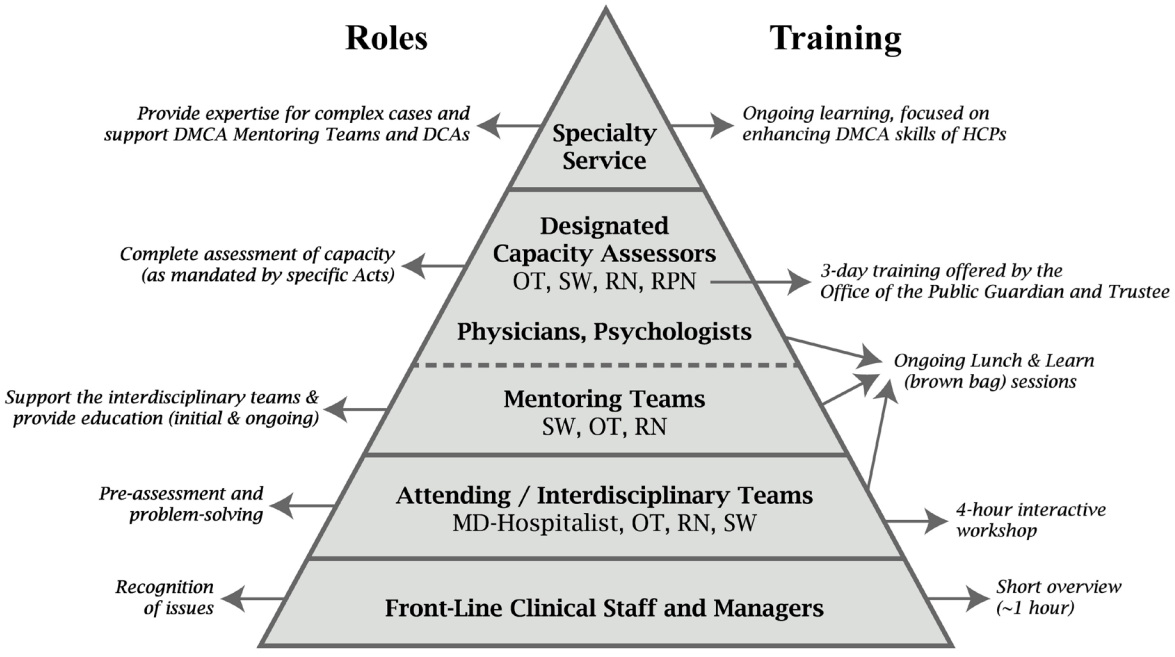
A number of documents were created to support the CA process. These include a brochure, the Capacity Assessment Process Worksheet (Appendix B), and the Capacity Interview Worksheet (Appendix C). The brochure offers an overview of DMCA that is accessible to HCPs, patients, and families. The worksheets enable staff to follow the Care Map, organize information, and document in a central location. The Capacity Assessment Process Worksheet aligns with the Care Map, and ensures that the team completes essential steps in the process (e.g., confirming medical stability and problem solving efforts). It also functions as a place to compile relevant information from members of the interdisciplinary team. The Capacity Interview Worksheet is utilized by physicians, psychologists, and DCAs as a guide to the Capacity Assessment Interview, and to assist in formulation and documentation of an opinion. Both of the worksheets assist them in completing the required schedules and forms required under various legislative acts.

Together, the process, tools, worksheets, brochure, and human resources resulted in the formalization of the Covenant Health DMCA Model. To support DMCA Model implementation, DMCA Mentoring Teams were established at each site to offer education, guidance and advice to staff. When the Dependant Adults Act changed to the AGTA in 2009, DCA roles were added to the DMCA Mentoring Teams.

Demonstration Project

Following the development of the DMCA Model, a year-long demonstration project to assess feasibility was implemented in two settings at two CH sites. The project involved training the attending team in the DMCA Model through interactive workshops, utilizing the DMCA Model in these settings when issues of DMC emerged, and reviewing charts of associated patients. A four-hour interactive education workshop—facilitated by interdisciplinary presenters from the Mentoring Team—was provided to HCPs working in the selected settings. During the workshop, the presenters introduced legislative acts and the DMCA Model, offered clinically relevant CA examples, and explained crucial ethical and legislative guiding principles. CA-related documents were shared, cases discussed, and participants shown how to apply the DMCA process.

During the demonstration project, CAs were initiated with 12 patients (mean age = 72.2). Eleven triggers were validated, ten (83%) of which were resolved through problem-solving, thereby avoiding formal declaration of incapacity. Two patients were found to lack capacity. (See Table 1 for Demographics of Demonstration Project Sample.) At the initiation of the project, 79 referrals were made to the Geriatric Consult Service from other units at



Roles & Training of Health-Care Professionals (HCPs) Involved in the DMCA Model

FIGURE 2. Roles & training for health-care professionals involved in the DMCA Model

TABLE 1.
Demographics of demonstration project sample

Demographic Indicator	*Value*
Age (mean)	72.2
Gender	F = 7 (58%)
Number of valid reasons for CA	11
Number of cognitive assessments performed (mean)	2.2
MMSE score (mean)	20.6
Number of cases resolved through problem-solving	10 (83%)
Number of patients deemed to require a CA interview	2 (17%)

the two sites for primary reason of CA. Of these, 59 (75%) referrals were from six Medicine units.

This limited trial showed that use of the DMCA Model achieved the goal of educating staff, centralizing documentation related to DMCA, encouraging interdisciplinary assessment and problem-solving, and reducing the need for CA interviews. Overall, the project trial demonstrated feasibility of the DMCA Model. Innovation funding was received to fund site-wide implementation at the two demonstration project sites. The DMCA Model was then endorsed by the Capital Health Regional Geriatric Program Council for implementation at all sites.

Educational Strategy for Staff

Given the feasibility of the DMCA Model, interactive education workshops were made widely available to CH staff. The educational materials consisted of background information, results of the staff survey, details of the legislative acts and forms pertinent to CA, and copies of the worksheets and Care Map.

Between 2008 and 2012, 822 people from Covenant Health and Alberta Health Services, Edmonton zone, participated in the workshop. Attendees included 230 nurses (28%), 212 SWs (26%), 193 OTs (23%), 34 clinical nurse educators (4%), 34 physicians (4%), 26 unit supervisors (3%), 22 care coordinators (3%), 18 nurse practitioners (2%), 18 program managers (2%), 13 psychologists (2%), 6 PTs, 4 speech language pathologists, 1 spiritual care worker, and 11 (1%) unknown. The average participant age was 40.66 years, with a range from 20 to 67 years. Over 90% (91.7%) of participants were females. Half (50.2%) of HCPs attending the education workshops had never received formal education in DMCA. According to participant self-report, their understanding of concepts relating to DMCA increased following workshop attendance. Offering of workshops has since continued.

In 2012, the DMCA Model underwent an evaluation across the Edmonton and Calgary zones including representatives from six hospitals, three medical clinics, and continuing care, community, and rural settings. The evaluation involved focus groups (n = 49) with and surveys (n = 126) of DCAs and HCPs on mentoring and attending teams. Of note, 85% (n = 102) of survey respondents agreed/strongly agreed with the statement, "The new DMCA model is followed in my workplace;" and 90% (n = 113) agreed/strongly agreed with the statement, "I follow the guiding principles of DMCA when I am faced with concerns about a patient's decision-making capacity." Participants also identified strengths of the DMCA Model, facilitators and barriers to its implementation and sustainability, and service gaps that yet need to be addressed. Overall, the 2012 evaluation indicated that the DMCA Model—if it is appropriately adapted to differing contexts with unique resources and populations (i.e., culturally diverse urban and rural environments governed by specific regional legislation)—is effective in addressing DMCA from an interdisciplinary perspective.

DISCUSSION

The DMCA Model, with its aim of offering least restrictive and intrusive solutions, provides a standard, interdisciplinary process to DMCA. This process has implications for persons whose DMC has come into question, HCPs involved in CA, and organizations.

For the person whose DMC has come into question, and their primary supports, the DMCA Model demystifies the CA process. Its emphasis on a client-centred approach ensures that the person is an active partner in the CA process, and that options are explored before removal of the person's right to make autonomous decisions is considered. Identification of specific domains versus global capacity confines CA to areas of concern. Addressing reversible medical causes of problems assures that underlying factors potentially compromising DMC are examined. The imperative that pertinent information be gathered (including personal history, risks, conflicts, and the person's values and wishes), and potential solutions be trialed, ensures that least intrusive means are considered. Furthermore, the involvement of multiple HCPs reduces risks associated with one HCP determining DMC. These factors collectively safeguard the person's dignity and rights.

For HCPs, the DMCA Model offers processes, tools, and resources. Interactive education workshops equip HCPs with knowledge critical to understanding CA issues, legislation, principles, and processes. The tools and Care Map guide HCPs through CAs, and facilitate communication and documentation among inter-professional team members. The team approach to problem-solving and assessment fosters creative thought and avoids resting the burden of CA on a single professional. For physicians, psychologists, and DCAs tasked with conducting the CA interview, input from the team clarifies areas of concern, and supports potential application for an alternate legal decision-maker.

For CH, the DMCA Model meets patient, HCP, and organizational needs and requirements. This is facilitated by its alignment with provincial legislation, the organization's mission and ethical framework, clinical best practice, and a person-centred approach. The standard process improves

team work, and communication and collaboration within and across agencies, while emphasis on problem-solving reduces the frequency of inappropriate, unnecessary, or successive CAs. This positively impacts patient and family satisfaction.

Future study of the effectiveness of the DMCA Model is needed beyond the DMCA Model demonstration and implementation project. Potential areas for further research include an examination of the degree to which learnings from the interactive workshop are applied in actual practice, identification of core competencies required by HCPs to conduct CAs, transferability of the DMCA Model to other sites within CH, the region and the province, and a more expansive evaluation of the DMCA Model including barriers and facilitators to its adoption, implementation, sustainability and spread.

Limitations

This study was a quality improvement project aimed at addressing a gap in processes related to DMCA. While the study yielded positive outcomes through its development of the DMCA Model and associated tools and processes, the DMCA Model itself was developed within an urban environment by a well-established, knowledgeable, and resourced inter-disciplinary team. Adaptability of the DMCA Model to various settings (urban, rural, and across the continuum of care) with diverse human and fiscal resources is yet to be explored. The DMCA Model may also have limitations in being applied across cultures (e.g., First Nation seniors), and requires additional consideration in this regard.

Given that the demonstration project involved two settings to evaluate the effectiveness of the DMCA Model, and the 2012 evaluation was limited to sites that had to that point adopted the DMCA Model, more robust evaluation of the Model and its long-term sustainability will be required following broader implementation.

CONCLUSION

The DMCA Model offers a holistic interdisciplinary approach to CA that maximizes client autonomy, offers the least restrictive and intrusive solutions, and facilitates collaboration among HCPs within and among health-care facilities/agencies. Patients will benefit from a standard and organized approach to CA. Concentration on front-end pre-assessment and problem-solving will limit the number of CAs conducted when less intrusive methods can diffuse a situation. The DMCA Model will provide a coordinated and easy-to-follow approach for an interdisciplinary attending team to perform CAs.

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CONFLICT OF INTEREST DISCLOSURES

The authors declare that no conflicts of interest exist.

REFERENCES

1. Moye J, Marson DC. Assessment of decision-making capacity in older adults: an emerging area of practice and research. *J of Gerontology*. 2007;62(1):3–11.
2. Kim SYH, Karlawish JHT, Caine ED. Current state of research on decision-making competence of cognitively impaired elderly persons. *Am J of Geriatr Psychiatry*. 2002;10(2):151–65.
3. Black K, Osman H. Concerned about client decision-making capacity? Considerations for practice. *Care Manag J*. 2005;6(2):50–55.
4. Raymont V, Bingley W, Buchanan A, *et al*. Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. *The Lancet*. 2004;364(9443):1421–27.
5. Naik AD, Pickens S, Burnett J, *et al*. Assessing capacity in the setting of self-neglect: Development of a novel screening tool for decision making capacity. *J Elder Abuse Neglect*. 2006;18(4):79–91.
6. Naik AD, Lai JM, Kunik ME, *et al*. Assessing capacity in suspected cases of self-neglect. *Geriatrics*. 2008;63(2):24–31.
7. Campbell F, Wilson K. Considerations in the assessment of decision making. Alberta, Canada: Department of Psychology, Misericordia Hospital; 2005.
8. Molloy, DW, Darzins, P, Strang, D. Capacity to decide. Ontario: New Grange Press; 1999.
9. Government of Alberta. *Personal Directives Act*: Revised Statutes of Alberta. Chapter P-6. Edmonton, AB: Government of Alberta; 2013. Available from: http://www.qp.alberta.ca/documents/Acts/p06.pdf
10. Government of Alberta. Office of the Public Guardian. Available from: http://humanservices.alberta.ca/guardianship-trusteeship/office-public-guardian.html
11. Moye J, Butz SW, Marson DC, *et al*. A conceptual model and assessment template for capacity evaluation in adult guardianship. *The Gerontologist*. 2007;47(5):591–603.
12. Pachet A, Newberry A, Erskine L. Assessing capacity in the complex patient: RCAT's unique evaluation and consultation model. *Can Psychol*. 2007;48(3):174–86.
13. Yukon Department of Justice. Guidelines for conducting incapability assessments for the purpose of guardianship applications [Internet]. Available from: http://www.publicguardianandtrustee.gov.yk.ca/pdf/guidelines_for_conducting_assessments.pdf

14. Skelton F, Kunik ME, Regev T, *et al*. Determining if an older adult can make and execute decisions to live safely at home: A capacity assessment and intervention model. *Arch Gerontol Geriatr*. 2010;50(3):300–05.
15. Brindle N, Holmes J. Capacity and coercion: dilemmas in the discharge of older people with dementia from general hospital settings. *Age Ageing*. 2004;34(1):16–20.
16. Karlawish JHT, Pearlman RA. Determination of decision-making capacity In: Cassel CK, Leipzig RM, Cohen HJ, Larson EB, Meier DE, Capello CF, editors. Geriatric medicine: an evidence-based approach. New York: Springer-Verlag; 2003. p. 1233–41.
17. Berg, JW, Appelbaum, PS, Lidz, CW, *et al*. Informed consent: legal theory and clinical practice, 2nd edition. Fair Lawn, NJ: Oxford University Press; 2001.
18. Mueller PS, Hook CC, Fleming KC. Ethical issues in geriatrics: a guide for clinicians. *Mayo Clinic Proceedings*. 2004;79(4):554–62.
19. Schneider PL, Bramstedt KA. When psychiatry and bioethics disagree about patient decision making capacity (DMC). *J Med Ethics*. 2006;32(2):90–93.
20. Workman Jr. RH, McCullough LB, Molinari V, *et al*. Clinical and ethical implications of impaired executive control functions for patient autonomy. *Am Psychiatr Assoc*. 2000;51(3):359–63.
21. Schulman-Green DJ, Naik AD, Bradley EH, *et al*. Goal setting as a shared decision making strategy among clinicians and their older patients. *Patient Education and Counseling*. 2006;63(1-2):145–51.
22. Whitlatch CJ. Including the person with dementia in family care-giving research. *Aging Mental Health*. 2001;5(Suppl 1):S20–S22.
23. Nolan M, Ryan T, Enderby P, *et al*. Towards a more inclusive vision of dementia care practice and research. *Dementia*. 2002;1(2):193–211.
24. People with Disability Australia Inc, Blake Dawson Waldron. Attorney General's Department of NSW discussion paper: Are the rights of people whose capacity is in question being adequately promoted and protected? 2006. Available from: http://www.pwd.org.au/documents/pubs/SB06-Capacity.pdf
25. Edelstein B. Challenges in the assessment of decision-making capacity. *J Aging Studies*. 2000;14(4):423–37.
26. Mukherjee S, Shah A. Capacity to consent: issues and controversies. *Brit J Hospital Med*. 2001;62(6):351–54.
27. Lai JM, Karlawish J. Assessing the capacity to make everyday decisions: a guide for clinicians and an agenda for future research. *Am J Geriatr Psychiatry*. 2007;15(2):101–11.
28. Vellinga A, Smit JH, van Leeuwen E, *et al*. Competence to consent to treatment of geriatric patients: judgements of physicians, family members and the vignette method. *Int J Geriatr Psychiatry*. 2004;19(7):645–54.
29. Royall DR. Back to the future of mental capacity assessment. *J Am Geriatr Society*. 2002;50(11):1884–85.
30. Ganzini L, Volicer L, Nelson WA, *et al*. Ten myths about decision-making capacity. *J Am Med Dir Assoc*. 2004;5(4):263–67.
31. Spar JE, La Rue A. Clinical manual of geriatric psychiatry. Washington, DC: American Psychiatric Publishing; 2006.
32. Feinberg LF, Whitlatch CJ. Are persons with cognitive impairment able to state consistent choices? *The Gerontologist*. 2001;41(3):374–82.
33. Hill SA, Mather GI, James AJB. Assessing decision-making capacity: a survey of psychiatrists' knowledge. *Med Sci Law*. 2006;46(1):66–68.
34. Mahler J, Perry S. Assessing competency in the physically ill: guidelines for psychiatric consultants. *Hospital Community Psychiatry*. 1988;39(8):856–61.
35. Marson DC, Earnst KS, Jamil F, *et al*. Consistency of physicians' legal standard and personal judgments of competency in patients with Alzheimer's disease. *J Am Geriatr Soc*. 2000;48(8):911–18.
36. Gurrera RJ, Karel MJ, Azar AR, *et al*. Agreement between instruments for rating treatment decisional capacity. *Am J of Geriatr Psychiatry*. 2007;15(2):168–73.
37. Moye J, Karel MJ, Azar AR, *et al*. Capacity to consent to treatment: Empirical comparison of three instruments in older adults with and without dementia. *The Gerontologist*. 2004;44(2):166–75.
38. Qualls SH. Hopes for an empirical base for clinical practice—commentary on "Assessment of decision-making capacity in older adults". *J Gerontology*. 2007;62(1):16–17.
39. Sullivan K. Neuropsychological assessment of mental capacity. *Neuropsychol Rev*. 2004;14(3):131–42.
40. Moye J, Wood S, Edelstein B, *et al*. Clinical evidence in guardianship of older adults is inadequate: Findings from a tri-state study. *The Gerontologist*. 2007;47(5):604–12.
41. Reynolds CF. Assessing the capacity to make everyday decisions about functional problems: where does the field go from here? *Am J Geriatr Psychiatry*. 2007;15(2):89–91.
42. Mujic F, Von Heising M, Stewart RJ, *et al*. Mental capacity assessments among general hospital inpatients referred to a specialist liaison psychiatry service for older people. *Int Psychogeriatr*. 2009;21(4):729–37.
43. Naik AD, Schulman-Green D, McCorkle R, *et al*. Will older persons and their clinicians use a shared decision-making instrument? *J Gen Internal Med*. 2005;20(7):640–43.
44. Government of Alberta. Adult guardianship and trusteeship. Alberta, Canada: Government of Alberta. Available from: http://humanservices.alberta.ca/guardianship-trusteeship/opg-adult-guardianship-trusteeship.html

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APPENDICES

Appendix A: Glossary of Terms

Attending Teams

Attending teams are comprised of front-line HCPs who work directly with clients in various facilities to provide in-patient, out-patient, rehabilitation, and community-based health-care services. Members of these teams may include physicians, nurses, social workers, psychologists, occupational therapists, physical therapists, speech-language pathologists, chaplains, recreation therapists, and therapy and nursing assistants. As attending team members work with clients on a regular basis and observe both their abilities and challenges, these front-line staff are often the first to identify issues related to decision-making capacity in the clients they serve. While attending team members may or may not have specialized skills in the area of CA, they are often left to determine possible strategies to address challenges associated with a lack of capacity.

DMCA Mentoring Teams

DMCA Mentoring Teams are multi-disciplinary teams that have been established at each facility that has adopted the DMCA Model. Members of these teams—physicians, nurses, social workers, occupational therapist, psychologist, and Designated Capacity Assessors (DCAs)—have a particular interest and expertise in the CA process. The purpose of the mentoring team is to educate facility staff on the CA model and process, and provide support, answer questions, and problem-solve during complex CA situations. Mentoring Teams also champion the implementation of the DMCA Model at the sites, and facilitate training workshops, as well as educational sessions (including the initial four-hour interactive workshop introducing staff to the DMCA Model and its supporting materials, in-services, and continuing education lunch and learn ("brown bad sessions") where they answer questions and discuss case studies or relevant topics).

Designated Capacity Assessors (DCAs)

DCAs are regulated HCPs who have been appointed by the Government of Alberta to conduct CA interviews and offer an opinion to the Office of the Public Guardian/Trustee regarding the decision making ability of an adult in question. Physicians and psychologists are designated as capacity assessors by regulation and, therefore, are not considered DCAs, while nurses, occupational therapists, and social workers need to undergo a mandatory three-day training module to become DCAs, and then complete at least three CAs every two years to remain certified. Recommendations regarding capacity are made by a DCA based on opinions formed during a formal interview process. The DCA's opinion regarding co-decision-making, guardianship or trusteeship applications is then submitted to the court, which makes the legal determination regarding capacity. Ideally, pre-assessment and problem-solving are done with front-line staff and Mentoring Team members before DCAs are asked to conduct a formal CA.

Appendix B: Capacity Assessment Process

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Capacity Assessment Process Worksheet

Do not complete this worksheet if the only concern of capacity is to drive. Consider a referral for driving assesment.

Date of referral *(yyyy-Mon-dd)*	Referred by	Date assessment began *(yyyy-Mon-dd)*

Is the adult making decisions *(or is unable to make decisions)* that are causing significant harm which makes you question his/her decision-making capacity? Does the adult need to be assessed for restoration of decision making capacity?

☐ No

☐ Yes, describe the reasons including risks, severity, conflicts, consequences of behaviours, etc.

Identify areas of authority *(domains)* in which the adult may lack capacity

☐ Healthcare	☐ Accommodation	☐ Choice of associates
☐ Social/leisure activities	☐ Education/vocational training	☐ Employment
☐ Legal matters	☐ Financial matters	

☐ Other *(specify)*_____

Collect and describe relevant domain-specific collateral information.

What are the adult's values and goals, cultural/religious beliefs, including any significant change recently, with regards to decision-making in relation to the domain(s) in question?

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Capacity Assessment Process Worksheet

Has the adult's capacity been assessed on a previous occasion?
☐ No
☐ Yes, describe date of assessment, domain in question, assessment results etc.

Have any and all reversible medical conditions that are likely to impact capacity been ruled out?
☐ No
☐ Yes

Comments

Define the cognitive changes which may affect capacity

Test name	Score	Date *(yyyy-Mon-dd)*

Comments

Does the adult have functional limitations in relation to the domain(s) in question?
☐ No
☐ Yes

Comments

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Capacity Assessment Process Worksheet

Have barriers to a valid assessment, such as language, literacy, vision and hearing, been addressed?
☐ No
☐ Yes
Comments

Can the problem be solved and the risks be managed by a less intrusive and restrictive form of support?
☐ No
☐ Yes, describe the solution *(consider meeting/consulting with other team members to problem-solve)*

Is a formal capacity interview required? *(Is the potential risk of harm to self, or others, high enough to justify the removal of the adult's rights i.e. appointment of an agent/ power of attorney, co-decision maker, guardian or trustee?)*
☐ No
☐ Yes
Comments

Has the adult given consent?	Is it in the best interest of the adult to conduct the assessment?
☐ No, complete this information ►	☐ No
☐ Yes	☐ Yes
	Has the adult has refused to participate in the assessment?
	☐ No
	☐ Yes

Comments

STOP **Conduct the Capacity Interview** *(adequately educate the adult regarding domain(s) in question and use the Capacity Interview Worksheet)* and then complete the following questions.

Identify the domain(s) in which the adult's capacity was assessed

☐ Healthcare
☐ Social/leisure activities
☐ Legal matters
☐ Other *(specify)*
☐ Accommodation
☐ Education/vocational training
☐ Financial matters
☐ Choice of associates
☐ Employment

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Capacity Assessment Process Worksheet

How do you assess the decision-making capacity of this adult with respect to the following domains?
Check (✓) the appropriate box.

Domain	Has capacity	Significantly impaired	Lacks capacity

Plan of action *(depending on the results of assessment)*

☐ Invoke personal directive ☐ Invoke enduring power of attorney ☐ Specific decision making
☐ Apply for co-decision-making ☐ Apply for guardianship ☐ Apply for trusteeship
☐ Restoration of capacity ☐ Other *(specify)* _____

Comments _____

Outcomes

☐ Invoked personal directive ☐ Invoked enduring power of attorney
☐ Used specific decision making ☐ Applied for co-decision-making
☐ Applied for guardianship ☐ Applied for trusteeship
☐ Applied for restoration of capacity ☐ Discussed plan as above with referral source
☐ Informed patient of assessment findings and plan of action

Comments _____

Name *(print)*	Signature	Designation	Date *(yyyy-Mon-dd)*

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Appendix C: Capacity Interview Worksheet

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Capacity Interview Worksheet

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Domain	
Health care	**Response to Query**
Medical conditions ▪ Able to identify medical condition(s) and treatment(s) ▪ Makes and keeps medical appointments ▪ Participates in own care and treatment ▪ Requests assistance, as needed ▪ Recognizes emergencies and uses EMR **Medication Regime** ▪ Aware of current medications and reasons for taking them ▪ Aware of potential side effects ▪ Takes medications as prescribed **Consent to Treatment** ▪ Aware of medical problem(s) ▪ Aware of proposed treatment and alternatives ▪ Aware of consequences of accepting or refusing treatment, when explained	**Opinion *(and rationale regarding opinion)* of the Adult's Capacity** ☐ Has capacity ☐ Significantly Impaired ☐ Lacks capacity
Accommodation	**Response to Query**
Suitability of Residence ▪ Describes current living situation & willing to accept help, if required ▪ Identifies current needs and assistance / services required ▪ Recognizes level of independence and able to organize assistance in areas such as Personal care, Basic Home Maintenance, Meal preparation, Mobility ▪ Aware of other suitable residential alternatives ▪ Can access transportation **Safety: evaluate risk and independence** ▪ Recognizes potential fire hazards ▪ Functions outside familiar environment ▪ Aware of environmental risks (icy conditions, traffic) ▪ Wandering	**Opinion *(and rationale regarding opinion)* of the Adult's Capacity** ☐ Has capacity ☐ Significantly Impaired ☐ Lacks capacity

Name of Assessor(s)	Signature

Alberta Health Services

Capacity Interview Worksheet

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Choice of Associates	Response to Query
▪ Recognizes when others present a danger and takes precautions ▪ Able to choose companions who do not abuse or exploit the patient ▪ Recognizes frequently seen associates ▪ congruence with values and ability to express preferences **Sexuality/Intimacy** ▪ Consent ▪ Knowledge of relational concepts ▪ Social norms	**Opinion *(and rationale regarding opinion)* of the about Adult's Capacity** ☐ Has capacity ☐ Significantly Impaired ☐ Lacks capacity
Participation in social/leisure activities	**Response to Query**
▪ Able to choose social activities to suit interests ▪ Level of independence ▪ Engagement ▪ Ability to identify preferences	**Opinion *(and rationale regarding opinion)* of the about Adult's Capacity** ☐ Has capacity ☐ Significantly Impaired ☐ Lacks capacity
Legal matters *(e.g. PD, EPoA, Will)*	**Response to Query**
General ▪ Aware of legal rights ▪ Able to access counsel (formal and informal) ▪ Understands the implications of signing a legal document ▪ Understands reasons for legal proceedings (e.g. reason for charge, reason for suit, etc.) ▪ Permits / licences are relevant ▪ Able to apply for licences / permits	**Opinion *(and rationale regarding opinion)* of the about Adult's Capacity** ☐ Has capacity ☐ Significantly Impaired ☐ Lacks capacity

Name of Assessor(s)	Signature

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Capacity Interview Worksheet

Participation in employment activities	Response to Query
▪ Makes decisions re: type of work ▪ Able to find and maintain employment suitable to abilities ▪ Ability to identify preferences ▪ Awareness of skill level (strengths & weaknesses) ▪ Able to recognize and avoid workplace hazards ▪ Able to understand wages and benefits ▪ Aware of work alternatives and consequences of not working	**Opinion *(and rationale regarding opinion)* of the about Adult's Capacity** ☐ Has capacity ☐ Significantly Impaired ☐ Lacks capacity
Participation in educational, vocational or other training	**Response to Query**
▪ Education, vocation and / or training is relevant ▪ Ability to identify preferences ▪ Awareness of skill level (strengths & weaknesses) ▪ Awareness of options & able to choose a training program ▪ Initiates or terminates program independently	**Opinion *(and rationale regarding opinion)* of the about Adult's Capacity** ☐ Has capacity ☐ Significantly Impaired ☐ Lacks capacity

Name of Assessor(s)	Signature

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Capacity Interview Worksheet

Financial	Response to Query
Income/Assets ▪ Source(s) and amounts ▪ Bank information and signing authority on accounts ▪ Monitors account activity ▪ Knowledge of types and value of assets ▪ Manages investments ▪ Plans to acquire or dispose of asset(s) **Expenses/Debts** ▪ Types and amounts ▪ Method(s) of bill payment ▪ Gifts and donations ▪ Arranges for tax payments, does income tax return ▪ Debts **Financial Management** ▪ Maintains budget / accesses money ▪ Handles currency / issues cheques ▪ Able to ask for assistance ▪ Safeguards financial documents and information ▪ Manages business **Risks of Exploitation** ▪ Purchases from solicitors ▪ Recognizes abuse by caregivers ▪ Employs protective strategies **Other non-personal/financial legal matters** ▪ awareness of legal rights ▪ understanding the implications of signing legal documents ▪ understanding reasons for legal proceedings ▪ ability to access counsel	**Opinion *(and rationale regarding opinion)* of the about Adult's Capacity** ☐ Has capacity ☐ Significantly Impaired ☐ Lacks capacity

Name of Assessor(s)	Signature

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