Regional Geriatric Program of Eastern Ontario

INTRODUCING

Dr. Lisa Walker

NEUROPSYCHOLOGIST

THE OTTAWA HOSPITAL

Dr. Walker has worked as a Clinical Neuropsychologist at the Ottawa Hospital for over 25 years. She provides consultation services in an acute care in-patient setting where she conducts cognitive assessments for diagnostic, treatment planning and functional purposes, as well as capacity assessments under the Health Care Consent Act. Dr. Walker is a Clinician Investigator with the Ottawa Hospital Research Institute where she has a research program evaluating cognitive health in multiple sclerosis. She has held leadership roles with the University of Ottawa Brain and Mind Research Institute. She is an Associate Professor of Medicine and an Adjunct Professor of Psychology at the University of Ottawa, as well as an Adjunct Research Professor with Psychology at Carleton University. She also has a private practice where she provides neuropsychological evaluations.

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www.rgpeo.com

CAPACITY

Dr. Lisa Walker

Neuropsychologist

The Ottawa Hospital

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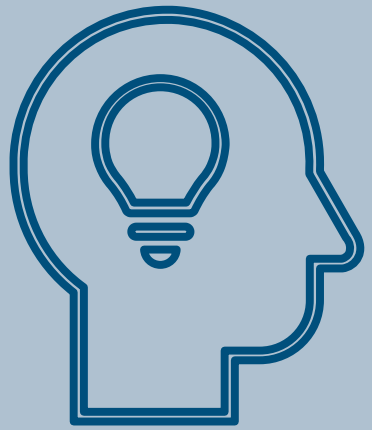
LEARNING OBJECTIVES



1. Review laws and provincial guidelines governing decision-making capacity
   - Health-related decisions
   - Assigning Power of Attorney (property, personal care)

2. Review informal screening of older adults for treatment and placement decisions

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DEFINING CAPACITY

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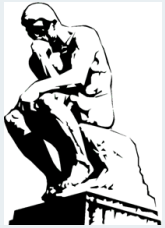
CAPACITY

- A legal construct (changes in legislation in the 1990's)

- Refers to a person's ability to engage in reasoned decision-making
  - –The ability to ***Understand*** the information that is relevant to making a decision
  - –The ability to ***Appreciate*** the reasonably foreseeable consequences of a decision
    - –Ability to manipulate information rationally, weigh options
    - –Ability to apply facts to one's personal situation
    - –Realistically appraise outcome (insight)
    - –Justify choice
    - –Be consistent, come to same conclusion each time



- If a pt is found incapable, the SDM makes the decision (NOT the treating team)

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ETHICAL CONSIDERATIONS

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ETHICAL CONSIDERATIONS

PERSONAL BIAS

- We must be aware of our own biases
- A poor decision (in our opinion) does not necessarily imply incapacity

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ETHICAL CONSIDERATIONS

AUTONOMY vs PROTECTION

- Need to balance
  - Our desire to support an impaired person's autonomy
  - Our desire to protect an impaired person (and ourselves) from risks/dangers caused by their diminished capacity
- This tension informs most competency assessments, and most legal/ethical issues regarding vulnerable persons

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THE CONCEPT OF RISK

- Capacity legislation is meant to provide protection for vulnerable persons who due to disability, illness, or infirmity, cannot act on their wishes
- **"Protecting"**… although we want to protect vulnerable persons, all people have the right to assume risks inherent in their decisions if risks are understood
- **"Their wishes"**…We need to understand the individual's value system, beliefs, eccentricities
- A reasoned decision is not always a reasonable decision
- NOT the *presence of risk* that matters but the *appreciation* of risk

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QUESTIONING CAPACITY

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REFERRAL QUESTION

Please assess patient's capacity.

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APPROPRIATE RESPONSE

Capacity for what?

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GLOBAL VS SPECIFIC

- Capacity is not a global concept
- Must establish the particular type of decision-making capacity that is being questioned
- Types:
  - Treatment consent capacity
  - Discharge planning capacity
  - Financial capacity
  - Capacity to assign POA
  - Research consent capacity
  - Testamentary capacity

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LEGISLATION

- Mental Health Act
- Substitute Decisions Act
- Health Care Consent Act *
- Patient Restraints Minimization Act

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MENTAL HEALTH ACT

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MENTAL HEALTH ACT

- **Form 1**
  - Not an assessment of decision-making capacity
  - Allows a pt to be admitted involuntarily (for up to 72 hours) for psychiatric assessment
- **Form 3**
  - Not an assessment of decision-making capacity
  - Certificate of involuntary admission (for up to 2 weeks)
  - Must be signed by a different physician than the one who signed Form 1
  - Patient must be notified with a Form 30
- When MHA refers to capacity it references HCCA

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SUBSTITUTE DECISIONS ACT

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SUBSTITUTE DECISIONS ACT (Property)

- Can only be assessed by designated capacity assessors
  - Under the Ministry of the Attorney General's office

- Capacity for property management
  - Can ask Capacity Assessment Office for a list of designated capacity assessors
    - https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity.php
    - Fees paid by pt's family or referring unit if an in-pt
    - Pt can refuse (family could then go through court system)
    - If pt has only government assets, consider trusteeship (individual or institution)

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WHEN TO QUESTION CAPACITY FOR PROPERTY

- Confusion
- Isolation
- Blindness
- Illiteracy
- The person cannot buy food, personal care items, pay bills
- Sharing their home without compensation for fair share of expenses
- Large sums taken from accounts
- Person is in debt and does not know why

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WHEN TO QUESTION CAPACITY FOR PROPERTY

- Presence of “new” lawyer or no legal representation
- POA has been unexpectedly changed
- Person asked to sign legal papers without understanding what they mean
- Person cannot remember signing papers or making payments, transfers
- Signatures on cheques or papers look suspicious
- Bank statements no longer sent to the person

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CAPACITY FOR PROPERTY

If an incapable person does not have a continuing POA, the *Substitute Decisions Act of Ontario (SDA)* states that the Ontario Public Guardian and Trustee (PGT), by default, then becomes the entity who will manage an incapable person's financial affairs while that person remains incapable and alive.

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CAPACITY FOR PROPERTY

The *SDA*, however, does give a person the right to apply to the Ontario Superior Court to be appointed as guardian of an incapable person's property/financial affairs in place of the PGT. The application process is relatively costly and requires a capacity assessment of the alleged incapable person; notice of the application to be served on the incapable person as well as that person's family and the PGT; and a management plan of the incapable person's assets to be approved by the Court.

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SUBSTITUTE DECISIONS ACT (Power of Attorney)

- No formal training required
- Need good working knowledge of legal definition
- Different thresholds for assigning POA for personal care and property (finances)
- **Personal Care**
  - Do they have the capacity to *understand* whether the proposed attorney has a genuine concern for their welfare?
  - Do they *appreciate* that they may need to have the attorney make decisions for them?
    - I discuss the types of potential decisions

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POINTS TO CONSIDER

POA is not a blanket privilege

- For each personal care decision, the person's capacity to make the decision MUST be revisited

Knowing there is a POA does **NOT** mean you automatically turn to the attorney for health care decisions (even if POA previously used)

If a person currently has a POA but is found to be incapable of making a new one, the current power of attorney remains in effect.

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SUBSTITUTE DECISIONS ACT (Power of Attorney)

- **Property**
  - Does the person know what kind of property they have and its approximate value?
  - Is the person aware of obligations to his dependents?
  - Do they know that the attorney will be able to do on their behalf anything they could do with their property except make a will (subject to any restrictions in the POA)?
  - Do they know that the attorney must account for the dealings with the property?
  - Do they know that, if capable, they can revoke the POA?
  - Do they understand that unless the attorney manages the property prudently its value may decrease?
  - Do they realize that the attorney could misuse the authority given?

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WHO CAN YOU CONTACT WITH CONCERNS?

1. Ottawa Police - 613-236-1222 x 5822
2. Crime stoppers - 1-800-222-TIPS (8477)
3. Ministry of the Attorney General's Victims Support Line - 1-888-579-2888
4. Senior Safety Line - 1-866-299-1011
5. Ontario Network for the Prevention of Elder Abuse - 1-416-916-6728
6. Advocacy Centre for the Elderly - 1-416-598-2656
7. Public Guardian and Trustee Special Investigation Unit (POA concerns) - 1-844-640-3615

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HEALTH CARE CONSENT ACT

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HEALTH CARE CONSENT ACT

- Primary use at TOH is for treatment decisions and decisions surrounding discharge planning
- Covers care facilities only (i.e. rehab, LTC)
  - *Not* retirement homes or group homes
- No formal training required for evaluators

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EVALUATORS

- Not called assessors (reserved for SDA)
- Evaluators are members of regulated health professions:
  - Physicians
  - Nurses
  - Speech-language pathologists
  - Occupational therapists
  - Physiotherapists
  - Social workers
  - Audiologists
  - Optometrists
  - Psychologists (all Neuropsychologists at TOH have experience)
  - Physician's Assistants cannot be evaluators given that they are not part of a regulatory college (capacity evaluation must be done by the supervising MD)

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PRESUMPTION OF CAPACITY

- All individuals are assumed to be capable unless there are *reasonable grounds* to believe that the person is incapable

- Thus, the individual is capable, unless shown on a balance of probabilities or preponderance of evidence that the individual does not *understand* the facts necessary to make a decision about those matters and is unable to *appreciate* the reasonably foreseeable consequences of a decision or lack of decision

- If capacity is considered “borderline”, law states we must err on side of self-determination and find pt capable

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FUNCTIONAL ABILITIES RELEVANT TO CAPACITY

1. Communicate a choice
2. Understand relevant information
3. Appreciate the relevance of the information for one's own circumstances
4. Manipulate information rationally

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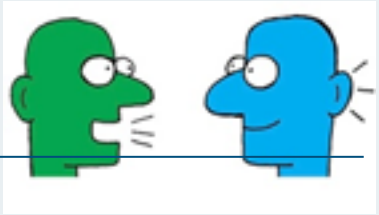
COMMUNICATE A CHOICE



- The ability to communicate a choice is a “threshold” issue; if pts are unable to express a choice, usually there is no need to consider their status regarding other abilities
- May be impacted by disease or dysfunction (e.g. aphasia, severe dementia, etc.)
- May also be that pt vacillates from moment to moment or is unable to make a decision

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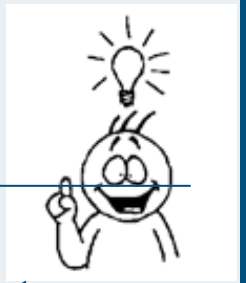
UNDERSTAND



- The ability to comprehend what one is being told about the disorder, its treatment, and its benefits and risks
- To have and retain an adequate factual knowledge base and to be able to take in and retain information about various options
- Must retain only long enough to make a decision
- If person forgets, they must come to same conclusion each time issue is discussed

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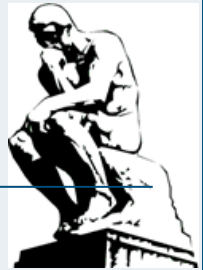
APPRECIATE



- In addition to understanding what they are being told by the medical team, they must also appreciate the significance of that information for their own situation
- A realistic appraisal of various possible outcomes (need sufficient insight) and an ability to justify one's choice through reasoning in a logically consistent way to arrive at a decision
- Reasoning must be based on a personal belief system which cannot be refuted by objective evidence

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RATIONAL MANIPULATION OF INFORMATION

- Ability to reason with and process the information provided by the medical team
- The ability to weigh options (each with its own benefits and risks)
- Being able to work with the information given to reach a decision

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INCAPACITY IS NOT…

- Willingness to take risks
- Making decisions that may be different from most others
- Eccentricity
- Making decisions based on an unusual value system
- Synonymous with a diagnosis or condition (dementia, schizophrenia, low IQ, TBI)

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THREATS TO CAPACITY

- Impaired mental status (delirium)
- Psychiatric illness
- Developmental disability
- Cognitive impairment
  - –20% misclassified as incapable if use MMSE cut-off of 23 alone
- Poor memory
  - –Memory functions should be sufficient to recall information at time of decision making

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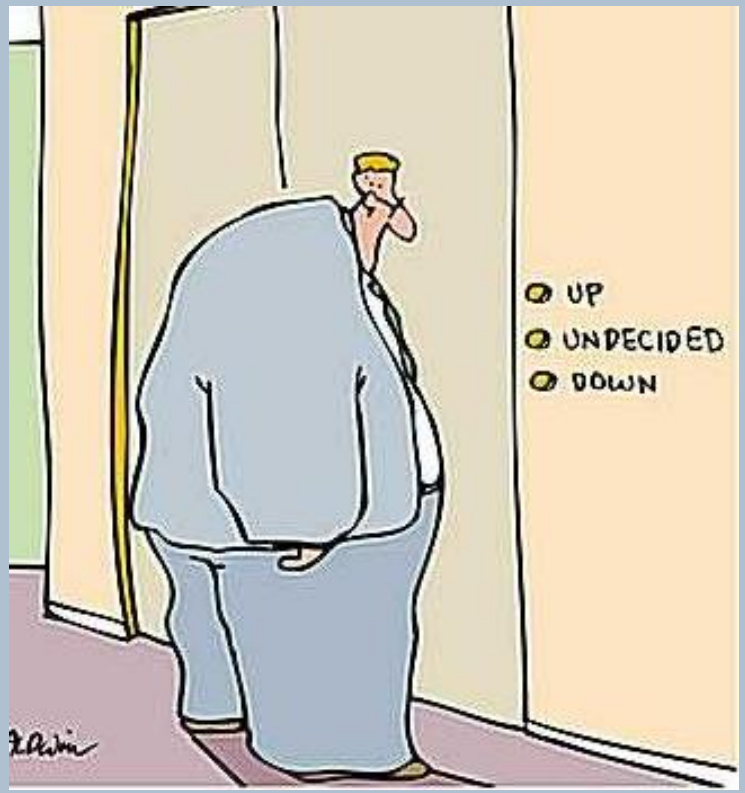
THREATS TO CAPACITY

- Poor insight/denial
  - –Failure to recognize seriousness of illness
  - –Minimizing effects of illness on functional status
- Delusional thinking
  - –Making decision based on inaccurate beliefs (e.g. paranoia)
- Anxiety and stress can cripple or complicate decision making



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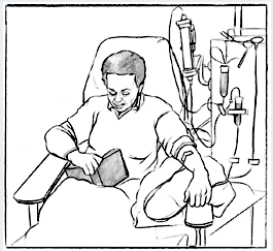
ONCE INCAPABLE, ALWAYS INCAPABLE?

- Capacity can fluctuate over time (e.g. delirium, intoxication)

- Capacity varies with the decision to be made (e.g. aspirin vs. terminating dialysis)



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CAN WE HOLD AN INCAPABLE PERSON AGAINST THEIR WILL?

- HCCA states that, where an SDM consents to treatment on behalf of an incapable person, the SDM may also consent to the incapable person's admission in hospital for purpose of receiving the treatment
- We previously thought that the HCCA had no custodial powers and thus in cases when a patient was actively trying to leave the hospital, we would invoke the MHA and hold someone under a MHA Form
- This is an inappropriate use of the MHA
  - the MHA is appropriate to use when someone requires admission (and confinement) in hospital as a result of a mental illness

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CAN WE HOLD AN INCAPABLE PERSON AGAINST THEIR WILL?

- Although dementia can be considered a mental illness under the DSM-5, these patients are not typically being treated for the dementia per se, but rather are typically admitted because their care needs exceed that which can be provided in the community, or they (or others) are at risk if they return home
- In cases where the patient must remain in hospital for their safety or ongoing care (i.e., they would be at risk in an independent living environment), then we can restrain or confine them according to the **Patient Restraints Minimization Act** if this is part of the treatment plan that the SDM has consented to (under the Health Care Consent Act)

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CAN WE HOLD AN INCAPABLE PERSON AGAINST THEIR WILL?

- The **PRMA** also states that a hospital or facility may restrain or confine a patient or use a monitoring device on him or her if it is necessary to prevent serious bodily harm to him or her or to another person
- There are also provisions under **common law**
  - There is a common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others
  - If the pt is deemed to be at risk of "imminent serious bodily harm"
  - This statement is up to interpretation
  - Best to seek advice from CMPA or College or Professional Liability Insurance provider if unsure

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ELOPEMENT OF INCAPABLE PERSON

- –inform MRP to make decision about whether the person is considered at risk to self or others and should be brought back in
- –Inform Security to search TOH grounds – initiate a Code Yellow (1-5555 @Civic or 7-5555 @General to activate any emergency code)
- –If pt not found, alert SDM and explain situation
  - If they consent to pt being returned, proceed to next step
- –If pt not found by security, alert police
- –Police will likely not be willing to bring pt back unless pt is Formed
  - Thus, may have to issue Form 1 (certificate of involuntary admission)
  - They may also request a Form 9 (order for return), although this is typically only if pt is already admitted under MHA
- –Once pt returned, remove Form 1 (as this is really an inappropriate use of the Form) and continue to hold pt under HCCA and PRMA if this is part of treatment plan approved by SDM
- –Procedures may vary depending on institution, so check policies of your own institution

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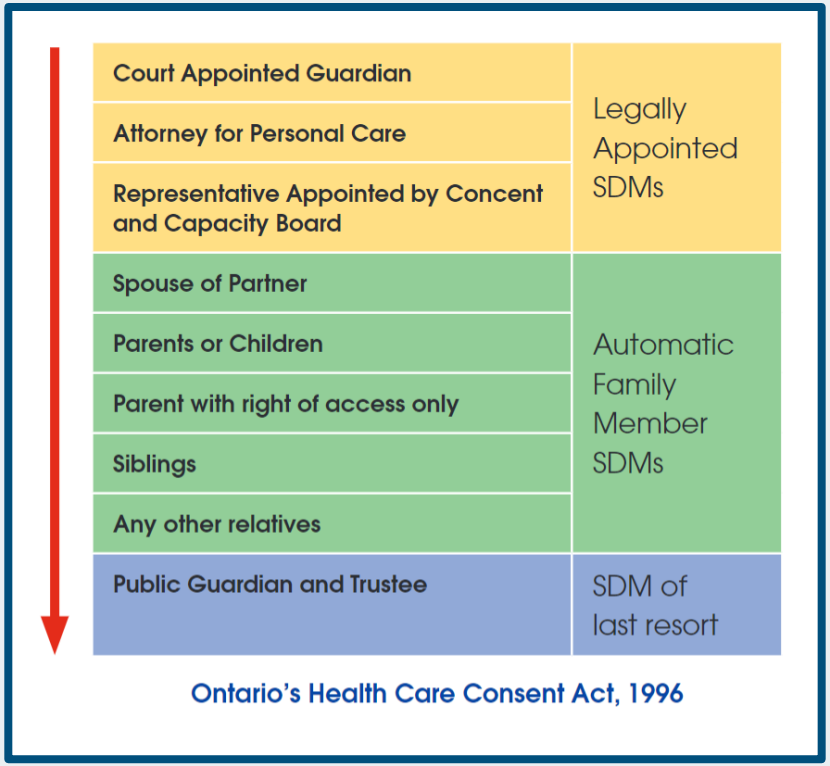
SUBSTITUTE DECISION MAKER HIERARCHY



Notes:

- SDM must be at least 16yo unless the SDM is the parent of the incapable person
- Two persons are not spouses for the purpose of this section if they are living separate and apart as a result of a breakdown of their relationship. 2004, c. 3, Sched. A, s. 84 (4).
- if SDMs, with equal authority to make the decision who meet all the requirements, disagree on whether to give or to refuse consent, then the PGT shall make the decision for them

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THE ELDERLY: SPECIAL CONSIDERATIONS

- Consider cognitive changes, slowed mentation, sensory limitations, fatigue
- Consider divergent cultural, religious beliefs, generational factors
- Privacy, a concern (establish rapport; do not equate vagueness and refusal to answer with incapacity)
- **Time needed to mull it over**
- Superficial social skills can create false sense of decision-making integrity

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WHEN SHOULD WE BE CONCERNED ABOUT CAPACITY?

- Unmet needs (house in shambles, unpaid bills,…)
- Manifest failure, repeated admissions, ED visits
- Imposition of risk to others
- Person makes **no/inconsistent** decisions
- Evidence of threats to ability to “understand” & “appreciate”
  - Cognitive impairment or dementia
  - Impaired reality testing
  - Impaired insight
  - Severe mood or personality disturbance/distorted appraisal of outcomes

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ASSESSING CAPACITY TO CONSENT TO TREATMENT

- Capacity to consent to treatment is *understanding* the information relevant to making the decision and *appreciating* the reasonably foreseeable consequences of a decision or lack of decision
- Must be assessed by the health care professional proposing the treatment
  - –Often an opinion is asked of others with expertise in capacity (e.g. Neuropsychology)

"I know nothing about the subject, but I'm happy to give you my expert opinion."

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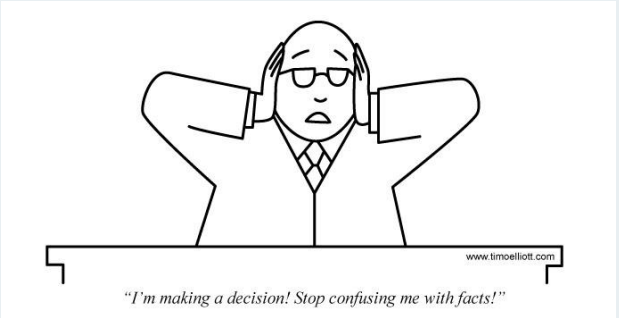
4 ELEMENTS REQUIRED FOR CONSENT

1. The consent must relate to the treatment
2. The consent must be informed
3. The consent must be given voluntarily
4. The consent must not be obtained through misrepresentation or fraud



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ASSESSING CAPACITY TO CONSENT TO TREATMENT

- Treatment must not be given unless consent has been obtained
- Consent must be *informed*
- Person must receive the following info:
  - –nature of treatment
  - –Expected benefits and risks
  - –Potential side effects
  - –Alternative treatment options
  - –Potential consequences of not receiving treatment
  - –Must be given opportunity to ask questions
- *Do not* proceed with capacity interview until patient has been given this information

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ASSESSING CAPACITY TO CONSENT TO TREATMENT

- If evaluator is not part of the treating medical team, he/she must learn about patient's condition and treatment options
  - i.e. evaluator must understand and appreciate in order to assess same in the patient
  - Info must be sought from medical team if not clear in chart
  - Need info on condition, treatment options, prognosis with proposed treatment, prognosis without proposed treatment, etc.
  - Patient does not need to know technical info but must have a basic layperson's understanding

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ASSESSING CAPACITY TO CONSENT TO TREATMENT

Suggested questions:

- Do you have a medical problem that needs treatment?
- What will the treatment likely do for you?
- Why do you think it will have that effect?
- What do you think will happen if you do not receive the treatment (e.g. worst case scenario)?
- Why has this treatment been recommended?
- How did you reach the decision to accept [reject] the recommended treatment?
- What factors were important to you in reaching that decision?
- How did you balance those factors?

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ASSESSING CAPACITY TO CONSENT TO TREATMENT

Additional information that may be required:

- May need to see patient multiple times to determine if their condition fluctuates and to determine if their decision making fluctuates
- Neuropsych testing for examination of reasoning and/or cognitive abilities
- Collateral information to learn of any changes in patients' level of functioning not apparent in examination

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CODE STATUS AND HCCA

- Code status is a special situation
  - **HCCA applies**
    - if need for resuscitation is reasonably likely given patient's current health condition
  - **HCCA does not apply**
    - for routine canvassing; this is advance directive and not eligible for substitute decisions

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ASSESSING CAPACITY FOR DISCHARGE DECISIONS

- TOH **Home First** policy means that we are typically no longer addressing this issue as it relates to discharge to a nursing home (with some exceptions)
- In accordance with the MOH mandate, we are no longer supposed to discharge pts directly to a NH from hospital
- As such, whether or not the person is capable, they are to be discharged home or other suitable arrangements must be made

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ASSESSING CAPACITY FOR DISCHARGE DECISIONS

- Thus, we address discharge planning capacity only when plan is to discharge pt to another care facility (e.g. rehab, chronic care)
  - The health care team cannot place an incapable person into a **RH or Group Home** (i.e., residence) against their will
  - A **POA for Personal Care** can place an incapable person into a residence against their will given that a POA has purview over housing (presuming the RH agrees)
- For **LTC** – OH@H has legislative authority over capacity determination
  - Neuropsychology will offer an opinion only **after** OH@H has comple their assessment and specifically requests our input
  - Please **do not refer to Neuropsychology** for an opinion about LTC capacity until after OH@H has been consulted

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ASSESSING CAPACITY FOR DISCHARGE DECISIONS

- Person must receive the following info:
  - –Proposed discharge plan
  - –Potential benefits of discharge plan and any associated risks
  - –Alternative discharge options
  - –Potential benefits and risks if recommended option is not chosen
  - –Must be given opportunity to ask questions
  - –TIME! (do not tell someone they cannot go home and then expect them to agree with you without adequate time to digest the info)
- *Do not* proceed with capacity interview until patient has this information and has had time to come to a reasoned conclusion

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ASSESSING CAPACITY FOR DISCHARGE DECISIONS

Suggested Questions

- How might your medical/thinking problems interfere with your ability to function?
- How likely is it that you might fall/forget medications/get lost/etc?
- Where would you like to go when you leave the hospital?
- Why have you chosen this option?
- Where does the medical team feel would be the best place for you after you leave the hospital? Why?
- What benefits/risks might there be to either option?
- What is the worst possible scenario to your safety if you were to return home?
- Are you willing to accept these risks?

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RIGHTS ADVICE

- The HCCA does not mandate that rights advice be given
- However, section 1 describes one of the purposes of the HCCA as “the enhancement of the autonomy of persons” to whom treatments are proposed by “allowing those who have been found incapable to apply to a tribunal for a review of the finding” and “to promote communication and understanding between health practitioners and their patients or clients”
- This section is used to interpret the rest of the act
- If a HCP does not advise a person of the finding of incapacity and does not make them aware of the rights of review, how can these purposes be fulfilled?

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INFORMATION THE INCAPABLE PERSON MUST RECEIVE FOLLOWING A FINDING OF INCAPACITY

- Once a HCP finds a person incapable of making decisions the finding must be communicated to the subject of the proposed treatment
- If the treatment proposed is for an individual in a psychiatric facility, written notice of the finding in the approved form must be provided and a rights advisor must be notified (who will inform pt of their right to apply to the CCB for a review and assist pt with application)
- Outside of psychiatric facilities, the information to be imparted to the person found incapable is guided by each professional's governing body (e.g. CPSO, CPO, OCSWSSW, etc.)
- The CPSO directs physicians to inform the pt of the finding and of the right to apply to the CCB

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RIGHTS ADVICE

- A HCP may be negligent and subject to professional misconduct for failing to advise the person that they have been found incapable in respect to treatment if that person then suffers harm from that failure to inform
- The harm is the loss of decision-making authority and being subjected to treatments they may have refused
- It may be considered battery to treat a patient without consent if it is subsequently determined by the CCB/court that the pt was capable and would have refused the treatment

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RIGHTS ADVICE

- The person giving rights advice should be the person responsible for the assessment of capacity (i.e. the person proposing the treatment)
- It is typically the physician who is proposing the treatment so the physician must give rights advice
- There is no specific rights advice form (like in the MHA)
- The pt must simply be provided with the name and contact information for the Consent and Capacity Board
- https://www.ccboard.on.ca/scripts/english/common/contactus.asp

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THANK YOU!

QUESTIONS?

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Contact Us

lwalker@toh.ca

https://www.ottawahospital.on.ca/

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RESOURCES

1. Public Guardian & Trustee's Office www.attorneygeneral.jus.gov.on.ca/english/family/pgt/
2. https://store.lexisnexis.com/en-ca/products/a-guide-to-consent-capacity-law-in-ontario-2025-edition.html
3. https://www.ontario.ca/page/mental-capacity
4. https://www.familyeducationgroup.com/capacity-assessment/
5. https://www.lco-cdo.org/en/our-current-projects/legal-capacity-decision-making-and-guardianship/#:~:text=Ontario's%20laws%20for%20legal%20capacity,decisions%20must%20nonetheless%20be%20made.
6. https://www.ontario.ca/laws/statute/92s30
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