Review of capacity assessments and recommendations for examining capacity

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Abstract

Aim To audit the capacity assessments performed since December 2007 by Community Geriatric Services (CGS), Middlemore Hospital, and to develop a resource kit for training health professionals.

Method 1343 clinical letters were reviewed. Demographic data, reason for assessment and outcome of assessment were recorded. Data was analysed to reveal trends.

Results There were 87 capacity assessments on 82 unique patients. The numbers of referrals for capacity assessments have increased since December 2007. 63% of patients were female, and the majority were European (75.6%). The mean age was 80.3 years. 66.7% of patients were referred by their general practitioner (GP). Dementia was the most common diagnosis.

Fifty patients had more than one reason for referral. Thirty-seven were assessed for appointing an enduring power of attorney (EPOA), 44 for financial welfare, 73 for personal welfare, and two for testamentary capacity. Forty-five lacked capacity for all aspects assessed. Twenty-three did not have an EPOA and appointment of a guardian was recommended for 16 patients.

Conclusion The CGS is performing more capacity assessments over time. The majority of the patients are elderly and have dementia. There is a need to train specialist nurses and general practitioners to perform capacity assessments. A resource kit has been developed for this purpose.

The principal of autonomy relies on individuals being able to make informed decisions which involve the four domains: to understand the relevant information, to appreciate the nature of their situation and the consequences of their decision, to consider and reason through the alternatives, and to be able to express their decision to others.1-6

If patients are unable to perform all these domains of informed decision making (often due to cognitive impairment) to an acceptable degree, they lack capacity. Capacity is rarely all or nothing and patients may be able to perform these domains to some extent, in which case they may be considered to be partially competent.

Where a patient lacks capacity, another individual may need to make decisions on behalf of the patient. In New Zealand the next of kin does not automatically have the right to make decisions on behalf of the patient. Instead, prior to losing capacity, patients can appoint someone to act on their behalf (an Enduring Power of Attorney) which can then be enacted by having the patient declared incompetent by a medical professional.
If the individual did not appoint someone as their EPOA and they are declared incompetent, the family court can appoint someone to act on their behalf through the Protection of Personal and Property Rights (PPPR) Act 1988.\(^7\)

Capacity assessments are assessments done by medical professionals to determine whether a patient is competent to make a particular decision where there is potential risk to the patient due to lack of capacity. It is important that there is a particular aspect of capacity in question, rather than a general concern regarding capacity, as capacity can vary across different types of decisions. The most common decisions can be roughly grouped into those related to personal welfare, financial welfare, testamentary capacity, or appointing an EPOA.\(^6\)

Historically, in New Zealand capacity assessments have been done by psychiatrists, however recently geriatricians are increasingly performing capacity assessments. In fact, all doctors may perform capacity assessments as it is considered within their scope of practice.\(^7\)

Counties Manukau District Health Board (CMDHB) is a tertiary hospital serving the South Auckland region. Part of the Adult Rehabilitation and Health of Older People department, the CGS was set up in December 2007 to perform geriatrics home visits, support aged residential care facilities and promote enhanced integration with primary care. The CGS frequently performs capacity assessments at the request of other health care professionals or if the need for a capacity assessment is evident while reviewing a patient for another reason.

Capacity assessments are also performed by other departments from CMDHB, notably Mental Health Services of Older People (MHSOP) and the Geriatrics department, and these capacity assessments are not included in the data below.

This audit aimed to review the trends in capacity assessment by the CGS over the last 3½ years, and to review the literature regarding capacity assessment to form a resource kit for health professionals to use.

**Methods**

This was a retrospective study. Ethics approval for this study was obtained. (NTX/11/EXP/235). A list of all patient contacts made by the CGS between 1 December 2007 and 30 June 2011 was obtained from the hospital database. The clinical letters for each patient were reviewed. The initial referral was not always solely for the purpose of capacity assessment, but the patient was included in this study if the clinician who saw the patient considered a capacity assessment necessary and performed one.

A set of data was recorded on a password-protected spreadsheet; gender, ethnicity, date of birth (age at the time of assessment were calculated using Microsoft Excel 2003 software), date of assessment, diagnosis, referrer, reason for referral, assessor, degree of competence, existence of EPOA, whether referral under the PPPR Act was recommended and the presence of any complex family situations.

Diagnosis was categorised into the most commonly seen clinical causes of cognitive impairment; dementia, mental disorder, intellectual impairment, and delirium. Other diagnoses seen in the study group included various forms of stroke with or without dysphasia, Parkinson’s disease, meningioma, severe chronic obstructive pulmonary disease (COPD), alcoholism, and general frailty.

The degree of capacity was recorded in four separate categories; capacity for personal welfare, financial welfare, ability appoint an EPOA, and testamentary capacity, and the subject was recorded as competent, partially competent or incompetent for each category. Not applicable was recorded if an assessment was not done for a particular category.
The data was analysed to reveal trends. The number of assessments performed for each 6 month interval was calculated.

Results

1343 visits were made by the CGS between 1 January 2008 and 1 July 2011, which included 87 capacity assessments. Of the 87 visits, 12 were made as part of recruitment to another study rather than a referral to the CGS and therefore these visits were excluded from the analysis of the number of capacity assessment referrals.

Four patients had a capacity assessment on more than one visit. One patient had a capacity assessment done on three occasions while three had two assessments each. Consequently, there were 82 unique subjects in this study.

Figure 1. Number of capacity assessment referrals in each 6-month period

Figure 1 shows the number of capacity assessments referred to the CGS between 1 January 2008 and 1 July 2011 in six month intervals. There was a sharp increase in January 2010 and a peak of 25 capacity assessments between 1 July 2010 to 1 January 2011.

Figure 2 shows the age distribution of the 82 patients at the time of capacity assessment. The mean age was 80.3 years and the age group with the most capacity assessments was 85-89 year olds. This is similar to the patients seen by CGS for any reason who have a mean age of 83.8 years old and a peak number of assessments for patients aged 85-89.

Fifty-three of the 82 patients (64.6%) were female. The majority (62 or 75%) of patients were European, nine were Maori (11.0%), six were Pacific Islander (7.3%), three were Indian (3.7%) and two were other ethnicities (2.4%).

This compares with 67% female, 82% European, 2.5% Maori, 6.6% Pacific Islander, 1.8% Indian, 1.8% Chinese and 5.6% other ethnicities for the total CGS sample.
Fifty-eight (66.7%) were referred by GPs, five (5.7%) by Allied Health, 15 (17.2%) by the needs assessment services coordination (NASC) team, eight (9.2%) by the geriatrics department and one (1.1%) by a lawyer. Four patients (5%) had complex family situations triggering the assessment with concerns of financial and personal welfare abuse.

Figure 3. Diagnosis of patient indicating a need for a capacity assessment
Fifty-nine of the 82 patients seen by the CGS for capacity assessment had a diagnosis of dementia, one had intellectual impairment, three had a mental disorder, two had delirium, and 18 other diagnosis. One patient was diagnosed with both dementia and delirium.

Thirty-two (36.8%) of the 87 capacity assessments were done by consultants, 54 (62.1%) by registrars and one (1.1%) by a geriatrics nurse specialist.

Fifty of the 87 (57%) visits were for assessment of more than one category of capacity. Seventy-three patients (84%) were assessed for capacity for personal welfare, 44 (51%) were assessed for financial capacity, 37 (43%) were assessed for capacity to appoint an EPOA and two (2%) patients were assessed for testamentary capacity.

**Figure 4. Graph showing the outcomes of each category of capacity assessed**

![Graph showing the outcomes of each category of capacity assessed](image_url)

**Note:** EPOA is capacity to appoint enduring power of attorney, F is financial capacity, P is personal welfare capacity.

Eighteen (48.6%) were competent to appoint an EPOA, 18 (48.6%) incompetent and one partially competent.

Eight (18.2%) were competent for financial decisions, 33 (75.0%) incompetent and three partially competent.

Twenty-nine (39.7%) were competent for personal welfare, 37 (50.7%) incompetent and seven partially competent.

One of the two patients assessed for testamentary capacity was competent, the other patient was not willing to participate in the assessment and therefore the degree of competence could not be assessed.
Forty-five patients (52%) who were tested lacked capacity for all categories tested. Twenty-three of these patients did not have an EPOA and proceeding under the PPPR act was recommended to 16 patients.

No patients who were competent in some categories tested and incompetent in other categories were referred to the courts under the PPPR Act.

Table 1. Capacity assessment outcome for patients with dementia and non-dementia diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Capacity assessment outcome*</th>
<th></th>
<th>EPOA status**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Competent</td>
<td>Mixed competency</td>
<td>Incompetent</td>
</tr>
<tr>
<td>Dementia</td>
<td>18 (31%)</td>
<td>8 (13.8%)</td>
<td>32 (55.2%)</td>
</tr>
<tr>
<td>Non-dementia</td>
<td>13 (56.5%)</td>
<td>2 (8.7%)</td>
<td>8 (34.8%)</td>
</tr>
</tbody>
</table>

Note: One patient with dementia had unknown competency for testamentary capacity and therefore was excluded from this table.

Where ‘competent’ means competent for all categories tested, mixed competency means competent in some categories tested, and incompetent or partially competent in other categories, and incompetent means incompetent for all categories tested.

* Fisher’s exact test was used to assess the associations between diagnosis and capacity assessment outcome, p>0.90.
** The Chi-squared test was used to assess the associations between diagnosis and EPOA status, p=0.76.

Patients diagnosed with dementia performed markedly worse in capacity assessment with 55.2% determined incompetent, compared to patients without dementia where 34.8% were incompetent (but this was not statistically significant).

Discussion

The number of capacity assessments have increased since 2007 indicating the demand for capacity assessment is increasing. As the population ages we expect the demand for capacity assessment will continue to rise.

Two-thirds of capacity assessments are performed on request by GPs (often because the patient’s lawyer suspects incompetence and asks the GP for a medical certificate or because of family member’s concerns). This indicates that there is a need for general practitioners to be trained in this assessment.

Training for capacity assessment is not usually included in most medical or nursing qualifications. As such, many medical professionals lack training to perform capacity assessments, and therefore patients are frequently referred to specialist services. Another reason for referral may be the limited time GPs can spend with a patient in a consultation. However, it is advantageous for the GP to perform capacity assessments as they are often the health professional who knows the patient, their medical conditions, and their cultural and religious views best. They also have an ongoing relationship with the patient which will allow for a more thorough assessment and the opportunity to re-evaluate capacity in the future. Patients also have improved access to their GP and therefore capacity assessments can be performed promptly without waiting for a specialist appointment.
Referrals for specialist capacity assessments could be reserved for more complicated cases; for example where neglect or abuse is suspected. In this data the investigators identified four (5%) patients that were complicated and needed specialist input.

The majority of the patients on whom capacity assessments were performed had dementia (71.9%). Not all patients with dementia lack capacity. Patients may have partial capacity and may have varying degrees of capacity in different types of decision as each requires different skills. Each type of decision should be assessed separately.

As dementia is a progressive condition, a patient’s capacity is expected to deteriorate with time. Consequently, some patients may need to be assessed more than once. In our data four patients were assessed more than once. Alternatively, some patients with dementia develop an overlying delirium and could be expected to have improved capacity after the delirium has settled.

Considering the often predictable progress of dementia the investigators expected a higher proportion of patients with dementia to have appointed an EPOA. However there was no significant difference in EPOA status between the patients with dementia and non-dementia diagnoses. This highlights a need for more effective public education on the importance of appointing an EPOA especially in early dementia.

Family members of cognitively impaired patients often (erroneously) believe that if they have EPOA for their relative they are legally entitled to act on their behalf. However until the patient is declared incompetent, they are not entitled to make decisions for the patient (unless the patient specified at the time of setting up the EPOA that it would take effect immediately). As such, it is important for medical staff to obtain copies of the relevant documents to ascertain what specifics they contain in order to safeguard a patient’s autonomy.

Competent patients have the right to make autonomous decisions that as medical professionals we may regard as imprudent, and sometimes such decisions are a reflection of the patient’s longstanding personality, beliefs or lifestyle. This right is described in the Health and Disability Consumers Rights Act.

To some extent a patient’s capacity is assessed at any interaction with a health professional as we have a duty to ensure that patients make valid decisions.

There have been attempts to standardise capacity assessments to improve the inter-rater reliability. The Mini Mental Status Examination (MMSE) does correlate with judgments of incapacity at the high and low range of the spectrum, however capacity for those with scores between 19-26 is highly variable. While this cannot determine capacity alone, it provides useful information in the assessment of capacity. Other cognitive tests may be useful such as the Executive Interview (EXIT) or the Revised Addenbrooks Cognitive Examination (ACE-R) however language, education and culture can all affect the results of cognitive tests such as these.

A semi structured interview may be the most clinically applicable method of determining capacity. This is where a clinician raises a functional problem with the patient, discussing in detail the possible options and consequences and asks the patient to make and explain their choice of solution. Frequent reversals of choice and lack of insight or denial of the problem are often associated with lack of capacity.
A variety of assessment tools (e.g. Aid to Capacity Evaluation, Decision-making Instrument for Guardianship, MacArthur Competence Assessment Tool) have been developed, however many deal with hypothetical scenarios and therefore may not be clinically applicable. Others assess the same skills as a semi-structured interview and still require the clinician to make a clinical judgment of capacity. 1-3

Collateral information is important in capacity assessment to determine the accuracy of what the patient says, and to provide information that the patient may not volunteer. However, capacity cannot be decided on collateral information alone. In addition there are other factors such as conflicts of interest that may influence the information obtained. 3

Guidelines for capacity assessment

Step 1: Gathering information

- Find out the reason for the capacity assessment as this will guide the questions asked. Examples include entering a financial contract, managing accommodation, paying bills, appointing an EPOA or writing a will.

- Establish the trigger – Discuss with the referrer and other relevant sources what events led to concerns about capacity and what the risks are as a result. Capacity assessments are invasive; is there any other way to resolve the issue?

- Obtain information about the patient’s cognitive condition.

- Determine the likely timeline of the cognitive impairment

- Decide on the best time to perform the assessment. If the decision does not need to be made immediately and if the patient’s cognition is likely to improve, the assessment could be delayed until the patient is more likely to be competent.

- Conduct the assessment in a private location free from interruption.

Step 2: Performing the assessment

- A translator or other aide to communication such as written information may be required. Patients should be asked if they would like family/whānau/cultural support during the assessment.

- Try to engage the patient in the process, explain what is being done and why.5,6

- Perform a cognitive assessment using a recognised scoring system such as ACE-R or MMSE.

  Consider other assessment questionnaires e.g. EXIT or Geriatric Depression Score.

Part A: Assessing the ability to understand the situation and its consequences

- Discuss the relevant issue with the patient.

  For example when assessing capacity for **personal welfare decisions**, ask detailed questions about the patient’s living arrangements and care needs.
Assess nutrition and medication compliance. Assess potential risks to the patient and ask how they would get medical help. Are they at risk of abuse from others? \(^5\)

When assessing **financial capacity** ask details about the patient’s finances such as which bank they bank with, the value in their accounts, their assets or debts, how they pay their bills, and how much would they expect the bills to be for? If they don’t know the answer to any of these questions ask them how they would find out.

How do they protect themselves from being taken advantage of financially? \(^5\)

When assessing **testamentary capacity** check that the patient understands the nature and effect of making a will, the extent of their estate and the claims of those who might expect to benefit under the will. Ask about and review previous wills and question any changes. \(^5,6,10\)

When assessing **capacity to appoint an EPOA** ensure the patient understands what an EPOA is, when it will take effect and who they are appointing and why. \(^3\)

- Discussing the issue with the patient may reveal that the patient lacks the knowledge needed to make decisions, in which case they should be educated so that they fully understand the issues. \(^6\) After educating the patient ask questions to check their understanding and registration of the issue.

**Part B: Assessing the ability to understand relevant information**

Ask the patient to discuss what options are available and the benefits/risks of each option, and what may happen if no intervention were staged.

**Part C: Assessing the ability to reason and express a choice**

- Ask the patient to discuss which option they prefer and how they reached that decision.

Parts B and C test the patients’ ability to manipulate information.

**Step 3: Acting on the results of the capacity assessment**

- Decide if the patient’s decision-making is sufficient for this particular situation, taking into account the importance and complexity of the decision at hand. Patients are legally considered competent until proven otherwise. Note that the legal test of competence differs depending on which part of capacity is being examined. This is described in sections 10, 25(2)b, 12, and 94(1) of the PPPR act 1988. \(^7\)

- If the patient is competent they may need advice or extra supports arranged. They should be encouraged to appoint an EPOA if they have not done so already.

- If the patient is incompetent and already has appointed an EPOA, the EPOA should take over decision making in this area.

If there is no EPOA, the patient’s capacity to appoint one should be assessed. If capable of appointing an EPOA, one should be appointed and start acting in
this role immediately. If incompetent to appoint an EPOA, an application to the family courts may need to be made for a welfare guardian, property manager or personal order.

Alternatively, if the patient is not competent to give informed consent and there is no one entitled to consent on their behalf Right 7(4) of the Code of Health and Disability Consumer’s Rights\(^9\) may justify emergency treatment.

- Advice can be given to the substitute decision maker for example whether placement in residential care is required etc.
- If patients lack capacity health professionals involved with assessing their capacity have a duty of care to manage any capacity deficits. This may involve ensuring that any overlying delirium is managed, cognitive enhancers considered for dementia and vascular risk factors are optimally controlled. Health professionals should also ensure that patients have community supports such as home help where needed.

**Step 4: Documenting the assessment**

Capacity assessments should contain detailed descriptions of the assessment date, sources of information, medical and cognitive history, current living arrangements and care needs. The capacity assessment should include examples of questions asked and the answers obtained to justify why the assessment on capacity was reached.

Recommendations based on the result of the assessment should be given.


**Competing interests:** None identified.

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**References:**