Capacity Assessment for Admission to Long-term Care: A Double-edged Sword

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Performing the assessment for capacity to make admission decisions to long-term care can either be simple or fraught with problems. A discussion of two clinical case examples will illustrate how this process, which appears to be straightforward, can become quite complex. The authors assume that the readers have a working knowledge of the process for assessing elders’ capacity to make admission decisions to long-term care.

Key words: admission decisions, long-term care, capacity assessment, Consent and Capacity Board.

In April 1996, the Long Term Care Reform Act was passed in Ontario. The intent of this Act was to streamline nursing home admissions, create a more equitable access system and reinforce the spirit of self determination and civil liberties for older individuals. This Act has enabled these principles to work well for individuals applying to long-term care who do not have complicating or confounding capacity issues. However, difficulties with the capacity assessment process can make implementation of long-term care planning convoluted and unwieldy. In these circumstances, the process then extends to include one or all of the following: the Health Care Consent Act; the Substitute Decisions Act; and the Mental Health Act. This may lead to practical problems that can create difficulties for the older client, their families and the health care system.

Three factors that demonstrate the prevalence and emphasize the importance of the issue of assessment for capacity to make long-term care admission decisions are:

- the cohort of baby boomers are entering old age;
- the fastest growing segment of the Canadian population is older than 85 years; and
- the average age of an elderly person entering a long-term care facility is currently in the mid-80s.

Therefore, the number of complicated assessments is only set to rise, as the likelihood of dementia increases with age. Assessing elders will likely result in a greater number of findings of incapacity and possible Consent and Capacity Board (CCB) hearings. This article will describe how the good intentions of these Acts do not always manifest as good results in clinical practice. The authors hope that the limitations highlighted in this article will assist those clinicians who struggle with similar circumstances.

Case One
An 86-year-old woman with advanced dementia lives at home with her 46-year-old daughter. The woman and her daughter share a symbiotic relationship. The daughter has never left home, is a recipient of government benefits and has been under psychiatric care for most of her life. The daughter is medicated with haloperidol, which causes her to sleep much of the day and when she is awake she has deficits in memory and problem solving.

The patient was admitted to an Acute Geriatric Unit for assessment of severe weight loss NYD, back pain and decline in cognitive functioning. After a comprehensive assessment, the team felt that the patient had advanced dementia, weight loss due to her daughter’s inability to provide adequate food, and pain as a result of the daughter taking her mother’s pain medication for her own discomfort. The team was very concerned with the evidence of burns in the house caused by the mother and her daughter smoking. They recommended that the patient required closer supervision than the daughter was capable of providing, and therefore the patient needed admission to a long-term care facility. The patient also was deemed incapable of managing her finances by a capacity assessor. Her daughter vacillated for weeks as to whether she should assume Power of Attorney for finances, and ultimately passed this responsibility on to the Office of the Public Guardian and Trustee (PG&T). Capacity assessment concerning the patient’s ability to make long-term care admission decisions was conducted. This assessment included a detailed cognitive assessment, and the patient was deemed incapable. The patient appealed the finding of incapacity.

A CCB Hearing was subsequently held and the finding conformed with the team’s impression. However, the daughter insisted on taking her mother home against the team’s recommendations. Despite direct observations that the daughter lacked the skills to adequately care for her mother, and that she continually changed her mind about taking her mother home, the patient was sent home at the daughter’s request, consistent with her rights under the Substitute Decisions Act. There was no mechanism available to overrule the daughter’s decision, even though the daughter’s psychiatrist felt that she was child-like, dependant and concrete. The PG&T was called, as the team felt the Urgent Investigation Unit

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should be notified and, hopefully, would follow-up with this case.

Four months later, the daughter called the social worker on the geriatric team and begged for help with placement as her mother was becoming verbally and physically hostile towards the daughter. The social worker met with the daughter at her home only to discover that the patient had put her housecoat in the oven, started a fire and a neighbour had called 911. The daughter lied to the firefighters as to the cause of the fire. The patient was immediately admitted to Acute Geriatric Unit under Form 1, as the situation was felt to be too urgent to initiate an emergency crisis placement from the community. During this second hospital stay, the patient was again deemed incapable to make admission decisions to long-term care. Yet another CCB Hearing found the patient incapable. Long-term care was applied for with the daughter’s consent, as her desperation outweighed her mother’s insistence to return home.

Issues & Discussion

Although this patient eventually entered long-term care, there was a rather long delay that put the other tenants in her apartment building at potential risk. A tremendous amount of acute hospital care resources was expended, as well as the expense of two CCB hearings. In retrospect, the team could have asked the CCB to rule if the daughter was making decisions in her mother’s best interests. However, this is a difficult route to take as it potentially alienates the daughter from the rest of the team, as well as from her mother. Also, the team may not have had current substantive evidence that the daughter would not cope with her mother following extensive education by the team as to her mother’s current needs.

Case Two

A 77-year-old man was admitted to acute care for failure to cope at home. He did not have any relatives or close friends. His health history included previous strokes, seizures, paranoia, dementia and incontinence. The Community Care Access Centre (CCAC) had provided nursing, occupational therapy and a personal support worker. These care providers were all worried about his inability to take his medication, his poor nutritional and fluid intake, falls and his incontinence. His home was cluttered and strewn with feces. CCAC staff questioned his ability to safely cope with tasks of daily life and thus his ability to live alone. The patient provided a call-girl agency as his next of kin and the CCAC worried that he might be vulnerable to financial abuse and sexually transmitted diseases.

A Cognistat assessment was conducted and revealed the following: profound memory impairment; mild to moderate comprehension; reasonable judgement and; severely impaired abstract thought. He had an MMSE score of 16/30. All of this demonstrated the patient’s inability to make decisions due to his very poor recall and inability to use compensatory problem solving strategies. He was seen in hospital by the geriatric consult team and the psychiatry service. No reversible causes for his dementia could be found. A financial capacity assessment was requested. He was found to be incapable of managing his finances and a referral was subsequently made to the PG&T. He also was found to be incapable of making placement decisions but he appealed this decision. On the same day of the CCB Hearing, before the CCB decision was rendered, his lawyer insisted her client had the right to return home and facilitated this action by signing the patient out against medical advice. The following morning the CCB found the patient to be incapable. However, the CCAC did not have the legal means to admit this client from the community to a nursing home against his wishes. The PG&T Urgent Investigation Unit was notified.

Issues & Discussion

Despite having followed the correct procedure with regard to assessing capacity to make decisions for nursing home placement, the care team was unable to act in the client’s best interests. The patient ended up at home at risk, despite a well documented history of inability to function in that setting.

The patient’s lawyer’s perspective on instituting the practicalities of the legislation simply and naively assumed that a safe environment for the client could be arranged in his own home. In the public home care system, 24-hour monitoring services do not exist. The outcome of this client’s expensive acute care hospital stay was essentially fruitless and only created anxiety for the client, without ensuring his safety or alleviating public risk.

Conclusion

Changes in social and legal systems certainly have the good intentions of striving for efficiency and equality. However, as these two cases illustrate, unanticipated factors often come into play when implementing plans for long-term care in the current complex legal and social systems. Therein lies the challenge for health care providers. No amount of careful planning or foresight can pre-empt every possible circumstance.

References