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SIAN RIPLEY, SARAH JONES AND ALASTAIR MACDONALD

## Capacity assessments on medical in-patients referred to social workers for care home placement

### AIMS AND METHODS

To investigate the feasibility of a clinical algorithm to assess capacity and examine the relationship between its results and the assessments of capacity by others involved in the decision of a patient to permanently enter a care home from a medical ward.

The definition of capacity given in the Mental Capacity Act for England and Wales (2005) is that, at the time a decision needs to be made, a person is able to understand the information relevant to the decision, retain that information, use or weigh that information as part of the process of making the decision, and communicate his decision (whether by talking, using sign language or any other means).

Capacity is specific to the task in hand. In ambiguous circumstances the risks associated with the decision must be proportionate to the degree of certainty of the person's capacity, a 'sliding scale' of capacity (Stone, 1994). The assessment of capacity is subjective and can be complex.

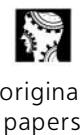
### RESULTS

A total of 23 patients out of 38 (60.5%, 95% CI 44–77) had some mention of capacity in any type of record (medical, social work or nursing). At formal assessment 47% of older patients lacked capacity.

### CLINICAL IMPLICATIONS

The absence of any recorded assessment in at least a third of patients is worrying, given the importance of the decision to the patients' lives and their financial status. It is to be hoped that the implementation of the Mental Capacity Act (2005) will rectify this situation.

Doctors are often asked or take upon themselves to evaluate the ability of older adults to continue living alone in the community; their capacity to make this decision can be more difficult to assess than that for other medical dilemmas. A large number of requests for capacity assessments of medical in-patients are seen in liaison psychiatric services for older people (Mujic et al, 2004): the role of the psychiatrist should be to assess the degree of impairment that may affect capacity. The assessment of the capacity of older people to consent to permanently enter a care home is a major issue. Pressure on beds may preclude both older people and their carers from exercising a genuinely informed choice (Lundh et al, 2000). It is usually a family member who takes the lead in



both the decision to seek and find a care home, but surrogates may frequently misunderstand patient preferences in relation to living permanently in a nursing home (Mattimore *et al*, 1997). The person undertaking the intervention should explain it and assess capacity, in this case the social worker involved. Healy (2003) has examined, in a qualitative study, social workers' ethical tension as they evaluate decisional capacity of older individuals experiencing some degree of cognitive impairment. Ethical tension was particularly strong when participants experienced both pressures from professionals and clinical uncertainty.

Attempts have been made to systematise the assessment of capacity, most prominently the MacArthur Competency Assessment Tool (MacCAT), which can be used in most US jurisdictions (Appelbaum & Grisso, 1995). Measurable subcomponents (understanding, appreciation, reasoning, and ability to express a choice) are assessed. Its use has been reported in decisions about treatment by working-age psychiatric patients in the UK (Cairns *et al*, 2005); however, it remains unvalidated in these jurisdictions and its use has not been reported in older people in the UK at all, let alone in those with cognitive impairment.

The assessment is longer than would normally be feasible in busy medical wards for older people. We therefore developed a clinical algorithm that has been previously used in older people in nursing homes (Macdonald *et al*, 2004) for use in this setting. It was based on the principles outlined by the Law Commission (Law Commission, 1996) and conformed with those outlined in the Mental Capacity Act (2005) which received Royal Assent during the study. We wished to investigate the feasibility of its use and the relationship between its results and the assessments of capacity by doctors, nurses and social workers involved in the decision of an older patient to permanently enter a care home from acute medical wards for older people. We hypothesised that a high proportion of patients confronted with this decision would be cognitively impaired, and that less than 10% of older people entering a care home would have a recorded assessment of their capacity to consent to placement in the medical, social work or nursing documentation.

## Method

All people over 65 years old on all acute general medicine for older people wards of a district general hospital who had been referred to the social services department for new permanent placement in a care home were eligible. Patients who were already residents in a care home or on a specialist stroke/rehabilitation unit were excluded. Lists were obtained twice-weekly, and the wards were visited and the patients approached. Capacity to consent to the study was assessed and those with capacity who refused were excluded, as were those without capacity whose nearest relative declined assent. In the remainder a formal test of capacity to consent to enter a care home was completed according to an algorithm (Fig. 1). The Mini-Mental State Examination (MMSE) (Folstein, 1975) was

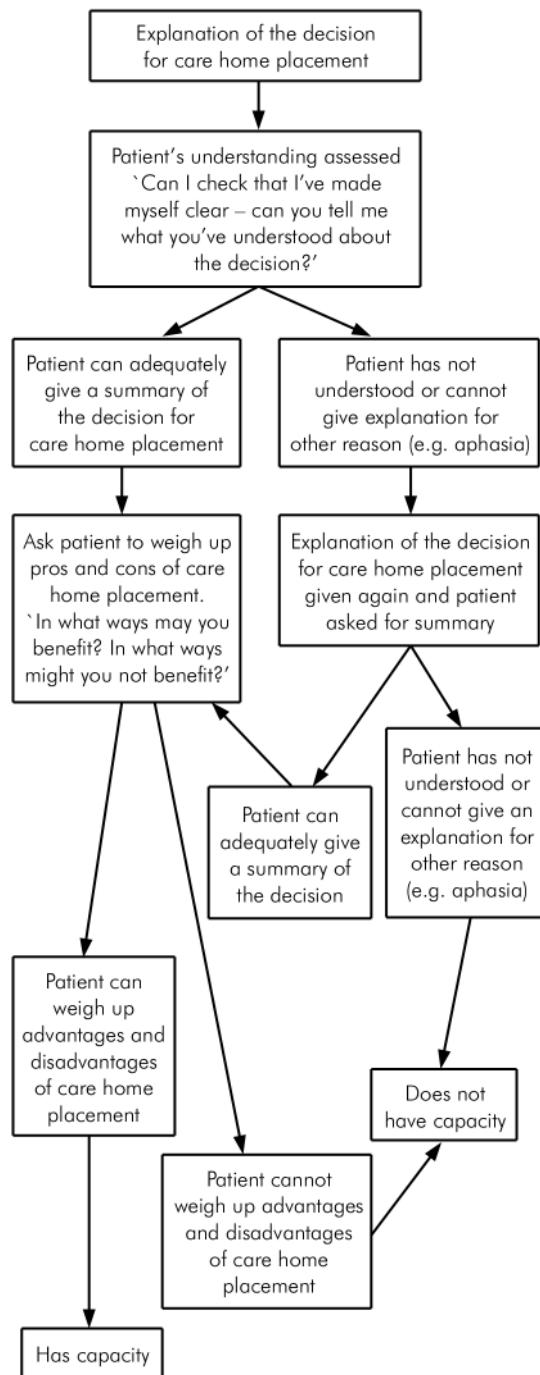


Fig. 1. Algorithm for assessment of capacity to enter a care home.

administered in most cases after the assessment of capacity. In patients with sensory deficits partial scores were normalised to a maximum of 30. Nursing, social work and medical documentation was examined for evidence of a formal or informal assessment of capacity or decision-making ability. In a random sample of 25% of cases an interview was carried out with the relevant ward doctor, social worker and key nurse to obtain a verbal assessment of the patient's capacity for the decision. In these cases notes were examined after this interview. Based on our clinical experience it was estimated that around 10% of patients would have a capacity assessment in their records, and that the study should



identify a range of 0–20% with 95% confidence limits. The sample size necessary to achieve this was 35.

Ethical approval was given by the research committee of the hospital involved. Ethical approval for obtaining data from records of patients not consenting to nor being assented for the study was not sought for this study.

## Results

Data were gathered from November 2004 to July 2005. As recruitment was slow from the specialist wards for older people the study was extended to include all older people referred from any non-specialist medical ward in the hospital from April 2005.

Referrals for placement of 128 patients were made during this period; 61 of these met exclusion criteria (14 already resident in a care home, 16 not on acute general medical ward, 30 not geriatric consultant (until April 2005), 1 no English language). A further 29 patients could not be assessed (4 were placed before assessment, 5 died, 8 had capacity but refused, 4 lacked capacity to enter study and assent declined, 3 relative could not be contacted, 5 other). A total of 38 participants were interviewed and documentation examined and 10 were interviewed by staff.

The sample interviewed were 58% women, with a mean age of 83 years (*s.d.*=8.3); 27 (71%) lived alone prior to admission. Participants were assessed at a mean of 53 days (*s.d.*=27) and median of 46 days after admission. The most frequent physical health problems mentioned in the records were falls (14 participants, 37.8%) and cardiovascular problems (7 participants, 18.4%); 19 participants (50%) had a recorded diagnosis of a dementia, 2 of substance misuse, 1 of a delusional disorder and 1 of affective disorder. Overall, 15 (39.5%) had no recorded mental health problems. In 3 participants the MMSE could not be completed. Of the remainder 26% scored 24 or higher, 29% had scores between 18 and 23, and 46% had scores of 17 or lower. All but 1 participant interviewed eventually entered a care home.

### Assessment of capacity at interview

A total of 20 participants (53%, 95% CI 36–69) had capacity to consent to going into a home as assessed by the algorithm applied at interview. There was no significant difference between male and female participants, nor was this proportion related to the age of the individual. Incapacity was strongly associated with a diagnosis of dementia in the records ( $\chi^2=15.2$ , *d.f.*=1, *P*=0.00) and with lower MMSE scores ( $F=50.7$ , *d.f.*=1, *P*=0.000). The best cut-point on the MMSE to predict incapacity was 16 out of 17; of the 15 participants scoring below 17 only 1 had capacity (7%), whereas of the 23 scoring 17 or above, 19 (83%) had capacity. Using this cut-point in this population the MMSE had a 93% positive predictive value and an 83% negative predictive value against the formal capacity algorithm, with an overall misclassification rate of 13%.

### Recorded assessments of capacity

There were 23 participants (60.5%, 95% CI 44–77) who had some mention of capacity or decision-making ability in any type of record (medical, social work or nursing); 12 had an assessment in one type of record, 9 in two types of record, and 3 in all three types of record. In 10 of the 12 participants with capacity assessments in two or more types of records these were social work and medical records. Agreement between these was complete in 8 out of these 10 ( $\kappa=0.375$ , *s.d.*=0.36). There was no mention of capacity in the nursing notes of 35 (92%), in the medical notes of 20 (71%) and in the social work notes of 16 (42%) participants. In 2, 5 and 8 participants respectively there was mention of a capacity assessment by another discipline (for example a doctor in social work notes or a psychiatrist in medical notes) – in all cases incapacity was noted.

If there was any record of assessment of capacity in social work notes there was good agreement between this and the formal assessment (*n*=22,  $\kappa=0.73$ , *s.d.*=0.15), and this remained true when assessments by doctors recorded in the social work notes were excluded. However, there was poor agreement between the formal assessment and medical notes assessment (*n*=11,  $\kappa=-0.29$ , *s.d.*=0.14). In all 3 participants where there was any assessment in the nursing notes, it was of incapacity; in 2 this was in agreement with the formal assessment.

The percentage agreement and  $\kappa$  values of agreement between each source of information were: for social work and medical, 80% ( $\kappa=0.38$ ); for social work and nursing, 66%; for social work and formal assessment, 87% (0.73); for medical and nursing, 100%; for medical and formal assessment, 54% ( $\kappa=-0.28$ ); for nursing and formal assessment, 66%. There was a strong correlation between MMSE score and assessments of capacity recorded in the social work notes ( $F=35.4$ , *P*=0.000) but no relationship was found in the other types of record.

In the 15 participants in whom there was a record of incapacity in any record, 3 were found to have capacity at formal assessment. In the 10 participants where there was a record of capacity in any record, 2 were found to lack capacity at formal assessment. Since there was disagreement between the different types of records themselves it was not possible to establish an overall level of agreement between the formal assessment and the records.

The participant who returned home lived alone, had a MMSE score of 28 and was formally assessed as having capacity but had no capacity assessment in any record.

### Agreement between interview assessments and other assessments of capacity

Of the 10 participants about which staff were interviewed, 6 were found to have capacity at formal assessment. One primary nurse was unable to give an opinion about one participant. Agreement with the formal assessment occurred in 8 out of 10 of both social worker



## original papers

and doctor responses ( $\kappa=0.58$ , s.e.=0.26), and 6 out of 9 nurse responses ( $\kappa=0.18$ , s.e.=0.33). Agreement between doctor and social work responses was perfect, but agreement between these and nurse assessments only occurred in 5 out of 9 cases ( $\kappa=0.05$ , s.e.=0.3).

In cases interviewed where there was any mention of capacity in the records there was agreement between the social worker interview and the social work records in all 7 cases, disagreement between the doctor interview and the medical records in 1 out of 3 cases, and disagreement between the nurse interview and the nursing records in 1 of 2 cases.

There were insufficient cases to assess the relationship between MMSE and these assessments.

### Summary of results

At formal assessment 47% of older patients referred for permanent care home placement lacked capacity to consent to placement. In about a third of all patients there was no mention of any assessment of capacity in any social work, medical or nursing record. Assessments recorded in social work notes had the best agreement with the formal assessment, whether or not they were records of doctors' assessments. There was a very strong association between lack of capacity and MMSE score. There was evidence of disagreement between assessments in different types of record, and between staff assessments at interview and those in the records.

## Discussion

This study has a number of limitations: the sample size was modest, but over half of those eligible had their documentation assessed. This study was also limited by the lack of a gold standard for capacity assessments in English law (Cairns *et al*, 2005), although the algorithm derived from the Law Commission report is probably as close to one as is achievable. Although feasible in research contexts, use of the MacCAT in the UK may not be appropriate because of differences in the nature of capacity as defined in different jurisdictions.

This study found a very high level of agreement between the MMSE and formal capacity assessments, and were the MMSE to be used routinely in individuals referred for care home placement its utility as a substitute for formal assessment of capacity would be a useful topic for further study. However, caution must be used when making important decisions such as care home placement so as no errors can occur.

There are other studies that have examined the relationship between the MMSE and capacity. Buckles et al (2003) found that MMSE scores were correlated with performance ( $P < 0.0001$ ) for understanding informed consent information for their non-treatment research study. Kim & Caine (2002) found that the MMSE significantly adds to identification of incapacity; however, the effect was modest with no cut-off point yielding both high sensitivity and high specificity. Pucci et al (2001) found a MMSE score below 18 had a positive predictive value of 95% and a negative predictive value of 98%.

63.3%. These studies looked at hypothetical research scenarios and assessments of capacity were for the decision to be involved in the research.

The main finding was a lack of documentation of capacity to give or withhold consent to admission to a care home, although this was better than we had predicted. Where there were more than one recorded assessment these were not necessarily in agreement, which may have been due to fluctuation in capacity, which this study was not designed to corroborate or refute. However, the absence of any recorded assessment in at least a third of patients is worrying, given the importance of the decision to the patients' lives and their financial status. It may be tempting to suggest that all individuals in whom incapacity is suspected should be referred for psychiatric assessment, but that would be unreasonable (Ball & Macdonald, 2002). It is to be hoped that the implementation of the Mental Capacity Act (2005) will rectify this situation, and we plan to repeat this study to confirm this.

## **Declaration of interest**

None.

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