MOCK HEARING OF THE CONSENT AND CAPACITY BOARD OF ONTARIO

FINDING OF INCAPACITY TO MAKE LONG TERM CARE DECISIONS

Filmed and Funded Jointly
By the
Consent and Capacity Board of Ontario
And
The Ottawa Hospital,
Social Work Department

Video and Toolkit can be viewed at:
http://www.ccboard.on.ca

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Introduction

In the early summer of 2007 a video of a mock hearing of the Consent and Capacity Board was filmed jointly by social workers of The Ottawa Hospital and the Consent and Capacity Board (CCB) of Ontario. This video is intended to help educate health professionals, physicians and Consent and Capacity Board members who are preparing to participate in a hearing held by the CCB. The video shows the process and procedures followed at all Board hearings. The documents that accompany the video will provide additional information on these procedures and on the process of preparing for a hearing.

This video depicts a hearing of a finding of incapacity to make Long Term Care decisions. The evaluator is a hospital based social worker but could be from any discipline with the authority to perform this type of capacity evaluation.

To further prepare anyone presenting before the board and to make the video a more useful tool, a toolkit has been provided in addition to the video. This toolkit contains documents that we hope will further explain board procedures and practice. It also contains the mock documents submitted by the evaluator during the mock hearing. These mock documents are intended to give the viewer of the video examples of the type of documentation that can be given into evidence.

This first document in the toolkit is the Order of the Hearing. All CCB hearings follow the same process. This document summarizes the steps that will be followed in the hearing. The second document is a list of teaching points. This includes those discussed by the narrator in the video and other points that will help the viewer prepare for and participate in the hearing.

ORDER OF THE HEARING

PRELIMINARY MATTERS

Presiding Members Opening Remarks:

1. Explains the purpose and nature of the hearing.
2. Introduces the parties to the hearing and board members.
3. Lists documents that were provided to the board as evidence.
4. Explains the process of the hearing.
5. Determine if the social worker (health practitioner) is the person who made the incapacity finding.
6. Asks if there are any preliminary or procedural matters and deals with them. (i.e. The documents have not been completed properly and therefore the finding of incapacity is invalid. A request can be made to have all witnesses excluded from the hearing unless they are testifying.)

THE HEARING

1. Evaluators present evidence first (i.e. introduce the patient, brief review of clinical summary, capacity evaluation)
2. Patient's lawyer may question the evaluator
3. Other parties to the hearing and board members may question evaluator
4. Evaluator calls and questions witnesses
5. Patient's lawyer questions evaluator's witnesses
6. Other parties to the hearing and board members may question evaluator's witnesses
7. Patient's lawyer calls and questions witnesses
8. Evaluator may question lawyer's witnesses
9. Other parties to the hearing and board members may question lawyer's witnesses

CLOSING SUBMISSIONS

- Closing submissions are presented starting with the evaluator

CLOSING THE HEARING

- Chairperson thanks everyone for attending and reminds them that the decision of the board will be faxed to them within 24 hours.

TEACHING POINTS

The Test for Capacity

This test, as stated in the Health Care Consent Act, describes the nature of capacity. The evaluator must demonstrate that on the day of the hearing the client lacks these abilities and thus is incapable of making long term care decisions.

All CCB hearings are held to determine if the evaluators' finding of incapacity to make long term care decisions meets the test stated in the legislation. The test for a finding of incapacity to make long term care decisions is (Health Care Consent Act):

> 4. **(1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1)**

This symbol indicates teaching points discussed by the narrator during the video.

Pre-hearing Teaching Points:

- The Ontario Consent and Capacity Board will convene a Hearing within 7 days of receiving the application. The hearing takes place somewhere convenient to the parties, usually in a hospital, community centre, care facility or CCAC office, but sometimes at the home of the person found incapable.
- Rules govern who may attend a hearing and the individuals' role during the hearing. The board members, the court reporter and witnesses attend the hearing. The presiding member of the board (the lawyer member) may ask the witnesses to wait outside of the hearing room until they are called to give testimony. Those people who are entitled to attend the hearing are called "parties". They are (Health Care Consent Act):
  50. (3) The parties to the application are:
  1. The person applying for the review (and their lawyer).
  2. The evaluator.

3. The person responsible for authorizing admissions to the care facility (CCAC).
4. Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 50 (3).

- The board for this type of hearing often consists of one member. This person will be a lawyer. When a three person panel is present it consists of a psychiatrist member, a community member and the presiding member.

- It is the role of the presiding member who is always a lawyer to "Preside," which means controlling the Hearing. That includes describing the Hearing process at its beginning, ensuring the parties call and question witnesses in the right order, maintaining order, safety and security and ruling on evidentiary and procedural issues--after consulting with his or her fellow adjudicators where necessary. The presiding member will also sign and fax the Decision and write Reasons when requested.

- Each presiding member will conduct the opening process of a CCB hearing in a somewhat different fashion. This video intends to illustrate the best practice.

- Evaluators, all documents entered as exhibits at the hearing must be made available to the client or their lawyer before the hearing begins. It is best practice for the evaluator to provide copies of these documents to all Board Members and parties to the hearing at least 15 minutes before the hearing is scheduled to begin. The client's lawyer has the right to review all medical and other records without the client's consent.

- It is the job of the client's lawyer to have the finding of incapacity reversed. The lawyer is following the client's instructions

<u>The Evaluator</u>:

- A client must be informed that an evaluation of capacity to make long term care decisions is being made and the possible outcome of this evaluation. The evaluator must demonstrate during the hearing that the client was fully informed.

- When deciding how to conduct yourself at the hearing, what witnesses to call, what documents to submit, what questions to ask **remember the test** and use common sense. If you are wrong, the board will tell you. In this way you will learn more about how a hearing is conducted.

- (Best Practice) Evaluators, all documents entered as exhibits at the hearing must be made available to the client or their lawyer before the hearing begins. It is best practice for the evaluator to provide copies of these documents to all Board Members and parties to the hearing at least 15 minutes before the

hearing is scheduled to begin. The client's lawyer has the right to review all medical and other records without the client's consent.

- Be sure that the client's lawyer has a copy of the documents before the hearing begins or there will be delays.
- Documents submitted to the board can be anything that demonstrates that the test has been met. Examples of these documents include: assessment or capacity evaluation reports, notes from the clients chart, a family physician report or letter, reports and assessment from any health discipline, RAI, police report(s), letters from family, friends and neighbours.
- If a lawyer asks the evaluator for information about the client's case, in advance of the hearing, confirm that he/she is representing the client.
- The evaluator gives a brief introduction of the client. This will help orient the client to the hearing and assist the board in getting to know this client and their current situation. The evaluator refers to the clinical summary at this point in the hearing. Preparing a detailed clinical summary saves time and ensures that the evaluator will not miss any important evidence. It also decreases the possibility of affronting the client's dignity with oral evidence that may be offensive.

- The evaluator's evidence is the first opportunity to demonstrate that the test for a finding of incapacity to make long term care decisions has been met. In the video the evaluator demonstrates that the test has been met by quoting from the reports of the Neuropsychologist and Occupational Therapist. **Know the legal definition of "capacity!!"**

- After the evaluator gives evidence, the client's lawyer and the board may question the evaluator.
- All board members may question anyone who testifies at the hearing.

Witnesses:

- The evaluator may call witnesses to support the finding of incapacity to make long term care decisions but is not obliged to do this. The person/client seeking review or their lawyer can also choose to call witnesses. Many types of witnesses can be called: nurses, family members, friends, any type of health care provider, family physician, neighbours, etc.
- The evaluator may educate the witness about the CCB hearing process, the nature of the test and the need to provide facts over emotion. The evaluator may not tell the witness what answers to give, but can tell the witness what questions to expect.
- The witness can and should be asked to provide information about the nature of their relationship with the client. The witness may be asked the following

questions. How long has the witness known the client? How do you know the client? What problems has the witness observed? When did the problem start and how often did it occur? The details of the problems are more relevant than the emotional impact of the problems. Witnesses who have an on-going relationship with the client may be very helpful in assisting the board to discern any relevant indicators of change during the interval between the assessment and the review of the finding of incapacity.

- Witnesses often find testifying at the hearing emotionally difficult. They worry about damaging their relationship with the client as they are asked to present information that the client can perceive as humiliating. Helping the witness to deal with their emotions prior to the hearing can be beneficial for the hearing and the witness.
- Hearsay evidence, information that is told to you by others, can be admitted but is of less weight than that offered by the person who has first hand knowledge of events.
- A witness must be sure to give all pertinent information when testifying, as this is the only opportunity to provide information. Encourage a witness to organize the information they wish to present prior to the hearing.
- The evaluator, the client (or their lawyer) or board members may cross examine any witness.

Board Issues:

- The hearing reporter must have access to a power outlet and for safety reasons should be seated away from the client.
- The hearing room should be selected and set up with everyone's safety in mind.
- For safety reasons the client should be seated so that they have easy access to the room exit.

Clinical Summary

Reason for Referral: Mr. Edna Watson has been referred to social work on April 2, 2007 to assess her psychosocial situation and assist with discharge planning. Treatment team and patient's daughter have considerable concern about this patient's ability to return home and live independently.

Source of Information: Met with patient and her daughter, chart was reviewed and spoke with staff.

Reason for Admission: On April 1, 2007 she was brought to hospital after being found on the floor of her home by her daughter. Mrs. Watson had a cut on her temple where she hit her head but had no broken bones.

Additional Presenting Problems: During recent months, the patient's daughter (Mrs. Lucy Jones) has become more concerned about her mother's ability to live alone. Lucy has found a scorched pot in her mother's kitchen; medications spilled all over the kitchen floor; milk in the cupboard and sugar in the fridge. Lucy reports having received phone calls from her mother's neighbour reporting that she had found Mrs. Watson wandering outside. It happened twice in March and at least one other time in the month of February. Lucy believes that her mother could have frozen to death as she was only in her slippers and house coat. She further expresses her concern that there may have been other times that her mother wandered outside but that she is not sure if this neighbor has always reported these to her. Lucy reports that her mother's appetite has decreased and she seems weaker and less stable on her feet as there have been other falls. She'll often forget to use her walker although Lucy believes it is becoming quite clear that she needs it more and more. Lucy organized meals on wheels and sent a CCAC worker to help in the house but the pt. refused to let them in. Lucy also reports that she is becoming exhausted from providing care to her mother while looking after her own children. She does not believe that she will able to care for her mother in the future and that her mother cannot live alone any longer. However, when Lucy has discussed this with her mother Mrs. Watson has denied that she needs any help.

Demographics/Cultural Information: Pt. is a widowed 79 yr. old Caucasian woman who has lived in the same small bungalow for more than 20 years.

Health Hx/Diagnosis: Pt. has been diagnosed with early Alzheimer's, Arthritis, high blood pressure and Angina by her family physician. She also had a left hip replacement a year ago. The GP has prescribed medication to assist with some of these conditions.

Family/Social Hx and Support: Pt. has one daughter Mrs. Lucy Jones who is 52 years old and works full time for the federal government. She is a single mother with four children under the age of 16. Lucy visits before and after work to check on medication use, to prepare her evening meal, to paying her mother's bills and do her shopping.

Education/Employment Hx: Lucy reports that her mother completed high school and worked for many years as an executive secretary in the Federal Government prior to her retirement. I was told she was a very accomplished and effective worker. Following retirement, she remained quite active by participating in various volunteer and seniors organizations. She had many leisure activities and frequent outings on a regular basis until about 2 years ago when she started to reduce her involvement at various levels.

Finances/Housing: Prior to admission to hospital the pt. lived alone in a small bungalow that she has owned for the last 20 years. She shared this home with her husband until he died approximately 10 years ago following a heart attack. According to the daughter the house is not well maintained as her mother refused to allow workmen to enter the home during the last year.

The patient has an income of about $3500 a month from a combination of pensions. However, the patient's daughter pays all of the bills and does all the shopping for or with her mother during the last 18 months. Lucy reports that bills were going unpaid until she began to supervise the finances.

Impression/Psychosocial Issues:

1. Mrs. Lucy Jones (pt.'s daughter) appears to be experiencing caregiver burn out and is unable to provide the level of support required for Mrs. Watson to live at home.
2. Mrs. Watson appears to be unsafe to live in her own home as:

- she has been found wandering outside her home in the winter inappropriately dressed and unable to find her way home
- there are concerns about her safety in the kitchen
- she appears unable to manage her medication appropriately
- her memory appears to be declining as demonstrated by the inability to remember previous falls and to pay bills

3. Mrs. Watson lacks insight into the risks of returning home as she denies the existence of any of the above problems.
4. Recommend an OT and Neuropsychology assessment.

Discharge Plan:

1. Provide Mrs. Watson with information about LTC.
2. Complete a capacity evaluation.
3. If found incapable, work with daughter to find suitable housing.

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Evaluator's Signature Date

OTTAWA COMMUNITY CARE ACCESS CENTRE
Capacity Evaluation Form

Name: *Edna Watson* **D.O.B:** *21 – 01 – 1927*

1. **What problems are you having right now (Does client understand his/her condition) e.g. Tell me how well you are managing at present? Do you have any medical conditions that are making it hard to care for yourself at home?**

Mrs. Watson, do you know why you came into the hospital and what your medical problems are?

"*I had an accident and fell down at home, so they say. My daughter brought me to the hospital. I know I had a cut on the side of my head. I must have tripped."*

Do you remember having tripped and falling?

"Not really, but I believe my daughter and I know I had a cut".

Do you remember having fallen in your home at any other times?

"Not that I can remember. I don't think so."

Your daughter tells me that neighbors have found you outside your home and unable to find your way back home. Did this occur?

"This has never happened; that's a lie. I know how to get home."

Your daughter has also reported to me that on one occasion she has found a scorched pot in your kitchen and sometimes milk in the cupboard and sugar in your fridge. Has this happened?

"I'm a good cook and have prepared meals all my life."

Are you aware of having any medical problems?

"Not that I can think of. My health is fine. I just tripped and fell."

2. **Can you think of any other way of looking after your condition/problem (Does client understand his/her condition/problem)?**

Can you think of any other way of looking after yourself where you would be safer?
"I don't need other ways of looking after myself. I look after myself at home. I had an accident and I fell; it happens."

Do you make use of your walker at home?
"*I use it sometimes but I don't need it that much."*

3. **How do you think admission to a nursing home of home f or the aged could help with your condition (Does client appreciate the foreseeable consequences of his/her admission or not)? E.g. What kind of things will they do for you in a**

nursing home? Will you get your meals provided? Will your family and friends be able to visit whenever they want?

Do you think going into a nursing home would help keep you safer?
"Why would I need a nursing home? I look after myself in my own home."

Do you find you have difficulty looking after yourself at home?
I do just fine, thank you."

4. **What could happen if you choose not to live in a nursing home or home for the aged (Does client appreciate the foreseeable consequences of his/her admission or not)? E.g. What kind of problem might you encounter if you choose not to go into a nursing home? Is that likely to happen? What if your caregiver is no longer able to prepare your meals or oversee your health care/medications?**

What kind of problems do you think you will have if you choose to continue to live at home?
"I don't expect to have any problems living at home. I can look after myself; I always have."

5. **What could happen to you if you choose to live in a nursing home or home for the aged (Does client appreciate the foreseeable consequences of his/her admission or not)? E.g. If you did decide to go into a nursing home, how would you go about finding the one suited to your need? At what point would you consider it time to go into a nursing home?**

What do you think it would be like for you to live in a nursing home?
"I don't want to live in a nursing home. I just want to go home."

Finding

Capable		**Incapable**	**X**	**Informed client of finding**	**X**
Incapable, no communication				**Rights Information sheet given**	**X**

Comments: *Based on my assessment, the daughter's report & assessments by Neuropsychology and O.T., I conclude that Mrs. Watson lacks the ability to appreciate the risks to her health and the consequences of refusing consent to admission to a care facility.*

Client's Response to Finding of Incapacity:

Mrs. Watson. Based on your answers to my questions I conclude that you are not capable of appreciating the safety risks when living at home alone and therefore also do not appreciate the consequences of refusing to consent to admission into a nursing home. I will need to ask your daughter to make the decision for your admission into a nursing home. Of course, you have the right to not agree with my evaluation.

"I don't agree with you. I don't need a nursing home and my daughter is not going to put me in one."

Since you don't agree with my evaluation you have the right to apply to the Consent and Capacity Board, which is a review board that will re-examine your situation to either confirm or overturn my finding. Would you like me to help you complete and file an application to the Consent and Capacity Board?

"*I'm not going to a nursing home."*

I'll help you make an application.

Evaluator Name: *Mark Preston* **Professional status:** *Social Worker*

Signature of evaluator: *Mark Preston* **Date:** *April 10th, 2007*

CCB Hearing: Neuropsychology Report

Neuropsychologist: Dr. Francine F-A. Sarazin, C.Psych.

I saw Mrs. Watson for a neuropsychological assessment which is an examination of various cognitive functions. These typically include attention and concentration, expressive and receptive language, memory and learning, visuospatial skills, reasoning, judgment, problem solving and executive functions (e.g. planning, organization, anticipation). When interpreting the results of these assessments, the examinee's scores are always compared to peers of similar age and education.

I understand from Mrs. Watson and her daughter that Mrs. Watson completed high school and her longest occupation was that of an executive secretary in the Federal Government until she retired. I was told she was a very accomplished and effective worker. Following retirement, she remained quite active by participating in various volunteer and seniors organizations. She had many leisure activities and frequent outings on a regular basis until a few years ago when she started to reduce her involvement at various levels. A further decline in activities became apparent after she sustained a fall and had to undergo hip replacement.

During the assessment, Mrs. Watson proved to be an alert and engaging individual who appeared to be eager to do well on testing. In her opinion, she had no decline in higher mental functions other than those expected on the basis of normal aging. Her basic attention skills were intact as she had no difficulty following a conversation or simple test directives. However, deficits became apparent with more complex tasks requiring mental manipulations or divided attention (e.g. she would lose mental set). Her expressive speech was featured some word finding difficulty in casual conversation but a more severe difficulty was noted on formal measures of naming or word fluency. Short-term memory was diminished as evidenced by difficulty recalling simple information within a few minutes, her repetitiveness during the assessment, the need for repeated instructions, and the fact that she was disoriented to time. Even with repetition, she had difficulty learning new information. She could not recall having seen me a few hours earlier that day. When I asked her about her current usual activities, she described her lifestyle dating back to the time before her hip replacement. Other areas of cognitive decline included reduced abstract thinking, difficulty with solving simple financial transactions, reduced visuospatial abilities with inattention to details, and diminished judgment when having to state what she would do in various emergency type situations.

In summary, the present neuropsychological profile depicted a diffuse deterioration in higher mental functions which cannot be explained on the basis of normal aging and warrants a diagnosis of dementia. Given the pattern of results and Mrs. Watson's medical history, she likely has a mixture of early Alzheimer Disease together with cognitive changes secondary to vascular risk factors and diseases (e.g. hypertension, diabetes, coronary artery disease). Finally, Mrs. Watson has no insight into her cognitive

deficits. Even after being informed of these results, she minimized the significance of these and their implication with respect to her safety in living alone. In my clinical opinion, on the basis of Mrs. Watson cognitive decline, she has lost the ability to understand the current circumstances of her cognitive status and functional needs, and his not able to appreciate the potential consequences of her desire to return to independent living.

Date: April 12, 2007

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Dr. Francine F-A. Sarazin, C.Psych.

Mock Hearing
Occupational Therapy Report

As an Occupational Therapist, I was asked to see Mrs. Watson to assess her safety and ability to live alone in her own home.

As part of my assessment I met with her to discuss her home situation. At the time, Mrs. Watson could tell me that she lived in a bungalow but could not state her home address. She did not remember the events leading to her hospital admission, could not give any information regarding her medication and denied any trouble with her memory. Overall she claimed that she would be able to manage her own self care as well as other tasks such as meal preparation and grocery shopping without any difficulty once she returned home. When asked, she did not anticipate any difficulties walking to the grocery store and carrying items home with her walker.

The following day I assessed Mrs. Watson in the OT kitchen, where after a thorough orientation of the kitchen she was asked to prepare three items (egg, toast and coffee). She did not recognize me nor remember our conversation of the previous day, but did agree to the assessment. Throughout the assessment, she required reminders on where to find items and what was asked of her to prepare. On one occasion Mrs. Watson was looking for the milk in the cupboard and needed direction to locate the fridge. She had difficulty managing the controls of the stove and at one point had two empty burners on and in the end forgot to turn one of the burners off. She needed repeated reminders to use her walker and was unstable on her feet without it.

At the end of the assessment she was asked how she felt she managed the task and how she thought she would be able to manage at home. Mrs. Watson replied that she was a good cook and did not anticipate any concerns or difficulty in her ability to manage in or outside of her home. When asked about the need for her to use a walker on a regular basis she stated that she really didn't need one.

Overall I find Mrs. Watson does not understand her current limitations and need for assistance nor does she appreciate the risk associated with returning to live home alone.

Date: April 13, 2007

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Gina Doré

Health Report / Rapport médical

Last name/Nom de famille	Address/Adresse
WATSON	16 Magician Ave.
Given name/Prénom	City/Town/Ville
Edna	Ottawa
Health No./Carte santé no.	Province & Postal Code
555 324 2895	Ontario, M7S 3B2

Medical Diagnosis/Diagnostic medical

Diagnosis and date of onset:/Trouble diagnostiquées et date d'apparition:

- Fall at home (April 1st / 07): small cut near right temple.

Diagnosis discussed with applicant/ Yes
Diagnostic discuté avec le/la patient(e)

Diagnosis discussed with family with applicant's consent/ Yes
Diagnostic discuté avec la famille

History/Antécédens

- Dementia
- Angina
- HTN
- Left hip replacement about 1 year ago
- Arthritis

List any drug sensitivities, allergies, addictions/Énumérez toute sensibilité à certains médicaments

NKDA

Present condition/État actuel

Stable

Last chest X-ray/Derniére radiographie pulmunaire:

N/A

Last MRSA Screening/Dernier test de dépistage du SARM

Date :	Result/Résultat :
2007/04/02	Neg.

Last VRE Screening/Dernier test de dépistage des ERV

Date :	Result/Résultat :
2007/04/02	Neg.

Prognosis/Pronostic	Prognosis discussed with applicant Pronostic discuté avec le/la patient(e)	Prognosis discussed with family: Pronostic discuté avec la famille :
Stable	***Yes***	***Yes***

Current medications/Médicaments actuels

- Aricept
- Nitropatch
- Advil
- Tylenol Pl.

Other special needs/Autres besoins particuliers

Walker

Has applicant been seen by other health care providers/Est-ce que la patiente ou le patient a consulté d'autres fournisseurs de soins de santé

Social Worker for D/C planning

Current treatments required/Traitements en cours

Small dressing on cut near right temple

Person completing form/Nom de la personne **Dr. J. Fielding**	Telephone no./No. de telephone **(613) 555-555**
Address/Adresse **501 Smyth Street**	City/Ville **Ottawa, Ontario, K1H 8L6**
Signature/Signature *Dr. J. Fielding*	Date **2007/04/02**