La Division de gériatrie de McGill

McGill Division of Geriatric Medicine

Présente / Presents

Le 12ième Séminaire annuel interdisciplinaire en gériatrie de McGill

The 12th Annual McGill Interdisciplinary Geriatric Seminar

À quel moment le tolérable devient intolérable? Quand intervenir?

When does the tolerable become intolerable? When do we intervene?

Le jeudi 13 novembre 2014
Thursday, November 13, 2014

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Bienvenue / Welcome

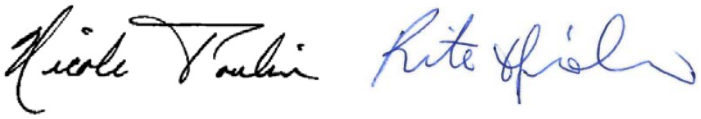
Le jeudi 13 novembre, 2014

Bienvenue au 12ème séminaire annuel interdisciplinaire en gériatrie de la Division de gériatrie de McGill – À quel moment le tolérable devient intolérable? Quand intervenir?

Nous avons assemblé pour vous ce cahier qui porte sur le déroulement de la journée. Il comprend l'horaire des activités, un résumé de chaque présentation, les notes communiquées par les différents conférenciers, ainsi que la liste des participants.

Nous espérons que vous aurez une journée très agréable et forte enrichissante.

Au nom du comité organisateur,



Nicole Poulin et Rita Di Girolamo, Co-présidentes
Séminaires gériatriques interdisciplinaires de McGill

Thursday, November 13, 2014

Welcome to the McGill Division of Geriatric Medicine 12th Annual Interdisciplinary Geriatric Seminar – When does the tolerable become intolerable? When do we intervene?

For your convenience we have put together a program booklet, which includes an agenda for the day, an abstract of each presentation as well as a list of participants.

We hope that you will have a most informative and enjoyable day.

On behalf of the Organizing Committee,

Nicole Poulin and Rita Di Girolamo, Co-chairs
McGill Interdisciplinary Geriatric Seminars

Comité organisateur / Organizing Committee

Nacera Belkhous, MD
Division de gériatrie, HGJ /
Division of Geriatric Medicine, JGH

Anita Brown-Johnson, BSc, MDCM, CCFP
Directrice médicale, Bureau des soins post-hospitaliers et du soutien communautaire;
Directrice médicale de l'Unité de soins secondaires, CUSM /
Medical Director, Office of Post Hospital Care and Community Support;
Medical Director, Hospitalist Care Unit, MUHC

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Infirmière-chef en Médecine Gériatrique, HGJ /
Head Nurse in Geriatric Medicine, JGH

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Technicienne en administration, Division de gériatrie, HGJ et Université McGill /
Administrative Coordinator, Division of Geriatric Medicine, JGH and McGill University

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PPALV – CSSS Cavendish /
Program Manager, PPALV - CSSS Cavendish

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Coordinator of Recreational Therapy, St. Mary's Hospital

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Directeur, Division de gériatrie, McGill /
Director, Division of Geriatric Medicine, McGill

Nicole Poulin, MA, Psych.
Psychologue, chef d'équipe, Services ambulatoires de psychogériatrie, CSSS de la Montagne /
Psychologist, Team leader, Home care, Psychogeriatrics, CSSS de la Montagne

Mary Sullivan, BSc inf / BScN
Coordonnatrice, Hôpital de jour gériatrie, HRV /
Coordinator, Geriatric Day Hospital, RVH

Juliana Tebo, BSc inf. / BScN, GNC©
Infirmière clinicienne, Division de Gériatrie, HGJ /
Nurse Clinician, Division of Geriatric Medicine, JGH

Alyson Turner, inf. / RN MSc (A)
Directrice Associée des Soins Infirmiers, Mission Médicale, CUSM /
Associate Director of Nursing, Medical Mission, MUHC

Conférenciers / Speakers

Eugene Bereza, MD, CM, CCFP
Directeur, Centre d'éthique appliquée, CUSM
Faculté d'éthique biomédicale
Université McGill

Director, MUHC Centre for Applied Ethics
Faculty of Biomedical Ethics
McGill University

Paule Bernier, Dt.P., M.Sc.
Nutritionniste, Équipe des soins intensifs et Équipe de soutien nutritionnel
Hôpital général juif
Présidente, Ordre professionnel des diététistes du Québec

Critical Care Nutritionist & Coordinator of the Nutrition Support Team, Jewish General Hospital
President, Ordre professionnel des diététistes du Québec

Nathalie M.H. Dinh, Ph.D.
Chef professionnel en psychologie
Centre hospitalier de Ste-Mary
Professeure adjointe de psychologie
Faculté de médecine, Université McGill

Professional Chief of Psychology
St. Mary's Hospital Center
Adjunct Professor of Psychiatry
Faculty of Medicine, McGill University

Catherine Ferrier, MD, FCFP
Médecin de famille, Directrice
Clinique d'inaptitude
Division de gériatrie, CUSM
Université McGill

Family Physician, Director
Competency Clinic
Division of Geriatric Medicine, MUHC
McGill University

Carolee Honeywill, BSW, MSc
Spécialiste en activités cliniques, CSSS Cavendish, CLSC René Cassin

Clinical Supervisor (SAC), CSSS Cavendish, CLSC René Cassin

Nicole Souaid, BSW
Travailleuse sociale, CSSS Cavendish, CLSC René Cassin

Social Worker, CSSS Cavendish, CLSC René Cassin

PROGRAMME / PROGRAM

8:00 Inscription et déjeuner continental /
Registration and Continental Breakfast

8:30 Bienvenue / Welcome
Dr. José A. Morais

8:45 Déroulement de la journée / Overview of the day
Nicole Poulin & Rita DiGirolamo

9:00 La tolérance face à la controverse: le fondamentalisme et la perte du discours raisonnable/
Tolerance in the face of controversy: Fundamentalism and the loss of reasonable discourse
Dr. Eugene Bereza

10:00 Tirage et Pause / Raffle and Break

10:15 L'usure de la compassion: Quand cela fait mal d'aider /
Compassion Fatigue: When it hurts to care
Dr. Nathalie Dinh

11:15 La nutrition n'est pas une case à cocher sur une liste...ou l'est-elle? /
Nutrition is not a box on a checklist...or is it?
Paule Bernier, Dt.P., M.Sc.

12:15 Tirage et Dîner / Raffle and Lunch

13:15 Passer de l'évaluation des risques à l'intervention - savoir quand intervenir / Moving from Assessment of Risk to Intervention-knowing when to intervene
Nicole Souaid & Carolee Honeywill

14:15 Évaluation de l'aptitude à prendre des décisions /
Decision-making capacity assessment
Dr. Catherine Ferrier

15:15 Tirage et Mot de la fin / Raffle & Closing Remarks

Traduction simultanée disponible / Simultaneous Translation Available

Continuing Health Professional Education
Faculty of Medicine, McGill University

This event is approved for up to 4 credits by the Office for Continuing Professional Development. The Office for CPD, Faculty of Medicine, McGill University is fully accredited by the Committee on Accreditation of Canadian Medical Education (CACME).

This program meets the accreditation criteria of the College of Family Physicians of Canada for MAINPRO-M1 credits. Members of the American Academy of Family Physicians are eligible to receive credit hours for attendance at this meeting due to a reciprocal agreement with the College of Family Physicians of Canada.

This event is an accredited group learning activity (Section 1) as defined by the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada.

Through an agreement between the Royal College of Physicians and Surgeons of Canada and the American Medical Association, physicians may convert Royal College MOC credits to AMA PRA Category 1 Credits™. Information on the process to convert Royal College MOC credit to AMA credit can be found at www.ama-assn.org/go/internationalcme.

Each physician should claim only credit commensurate with the extent of their participation in the activity.

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Formation continue des professionnels de la santé
Faculté de médecine, Université McGill

Cette activité est accréditée pour 4 crédits par le bureau Développement professionnel continu (DPC). Le bureau DPC de la Faculté de médecine de l'Université McGill est autorisé par le Comité d'agrément pour l'éducation médicale continue (CAÉMC) afin d'accorder les crédits développement professionnel continue (DPC).

Ce programme est conforme aux normes d'accréditation du Collège des médecins de famille du Canada, pour des crédits MAINPRO-M1. Les membres de l'Académie américaine de médecins de famille sont admissibles à ce cours et peuvent en recevoir les crédits, grâce à l'entente réciproque avec le Collège des médecins de famille du Canada.

Cette activité est une activité de formation collective agréée, aux termes de la section 1 du programme de Maintien du certificat du Collège royal des médecins et chirurgiens du Canada.

En vertu d'une entente conclue entre le Collège royal des médecins et chirurgiens du Canada et l'American Medical Association, les médecins peuvent convertir les crédits obtenus au titre du programme de MDC du Collège royal en crédits de catégorie 1 de l'AMA PRAMC. Vous trouverez l'information sur le processus de conversion des crédits du programme de MDC du Collège royal en crédits de l'AMA à l'adresse www.ama-assn.org/go/internationalcme.
Chaque médecin doit demander des crédits seulement pour le nombre d'heures où il/elle a participé à l'activité de formation.

Résumés et Présentations / Abstracts and Presentations

La tolérance face à la controverse: le fondamentalisme et la perte du discours raisonnable / Tolerance in the face of controversy: Fundamentalism and the loss of reasonable discourse

Eugene Bereza

Health care professionals are working at a time of significant social change and upheaval. End-of life care, accommodation of services to recent immigrants from countries with different moral norms, balancing interests of distributive justice in the face of dwindling resources – these and many of other challenges sometimes disturb our core personal and professional values. The presentation will examine some of the dynamics in navigating the murky waters of conscientious objection in the context of moral distress and burn-out.

Notes

Presentation available upon request

L'usure de la compassion: Quand cela fait mal d'aider /
Compassion Fatigue: When it hurts to care

Nathalie Dinh

Compassion fatigue exists in all the helping professions. It is a particular hazard to the professionals caring for a geriatric clientele. This talk highlights the phenomenon of Compassion Fatigue and a comparison with Burnout. It aims to increase awareness of risk factors and symptoms of compassion fatigue and risk management, prevention strategies and adaptation for both staff and institution.

L'usure de compassion existe dans toutes les professions d'aide. Il est un risque particulier pour les professionnels qui prennent soin d'une clientèle gériatrique. Cette présentation met en évidence le phénomène de l'usure de compassion et une comparaison avec l'épuisement professionnel (``Burnout``). Elle vise à accroître la sensibilisation aux facteurs de risque et les symptômes de l'usure de la compassion ainsi que la gestion de risque,les stratégies de prévention et d'adaptation autant pour le personnel que pour l'institution.

Notes

Presentation available upon request

La nutrition n'est pas une case à cocher sur une liste...ou l'est-elle? /
Nutrition is not a box on a checklist...or is it?

Paule Bernier

Cette présentation explorera quelques uns des obstacles à une nutrition optimale chez les personnes vieillissantes et la tolérance des professionnels de la santé face aux différences de valeurs ou d'opinions professionnelles concernant une intervention ou une non intervention, à la qualité de l'alimentation, à la qualité du suivi et à la conformité au plan de soins nutritionnels. Plus globalement cette présentation discutera de la problématique de la dénutrition et de la non prise en charge adéquate des maladies chroniques.

Notes

12IÈME SÉMINAIRE ANNUEL INTERDISCIPLINAIRE EN GÉRIATRIE DE MCGILL
À quel moment le tolérable devient intolérable? Quand intervenir?

NUTRITON

Paule Bernier Dt.P., M.Sc.

13 novembre 2014

Divulgation

Subvention sans restriction:

Abbott nutrition

À quel moment le tolérable devient intolérable?

- Avant de foncer dans un mur!
- Donc agir tôt pour éviter de réagir

À quel moment le tolérable devient intolérable?

- Agir en amont avec la nutrition
- Éviter les Bris de service dans le réseau: Exemples choisis
  - Les maladies chroniques
  - La dénutrition
- Savoir quand cesser d'intervenir

Quand intervenir?

- Interventions micro:
  - les professionnels seuls ou en équipe
  - Pratiques exemplaires
  - Lignes directrices etc
- Interventions macro ou méso: système
  - Le MSSSS
  - Les établissements de santé
  - Les ordres professionnels
  - Le protecteur du citoyen
  - Le Commissaire à la santé et au bien-être
  - L'INESSS
  - etc

À quel moment le tolérable devient intolérable?

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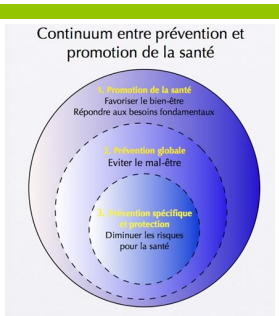
  - Les maladies chroniques
  - La dénutrition
- Savoir quand cesser d'intervenir

Cherchez l'erreur…



http://www.transat.ch/transat_prevention_communautaire.html

À quel moment le tolérable devient intolérable?

Agir en amont avec la nutrition

Éviter les Bris de service dans le réseau: Exemples choisis

- Les maladies chroniques
- La dénutrition

Savoir quand cesser d'intervenir

Les maladies chroniques

Prévalence et nombre de problèmes de santé de longue durée selon le sexe et l'âge, population de 15 ans et plus[1], Québec, 2010-2011

	Aucun problème de santé	Un problème de santé	Deux problèmes de santé ou plus	Au moins un problème de santé
		%		
Sexe				
Hommes	55,8	23,5	20,8	44,2
Femmes	47,7	25,7	26,5	52,3
Groupe d'âge				
15-64 ans	**59,6**	**24,0**	**16,4**	**40,4**
15-24 ans	80,9	15,4	3,7	19,1
25-49 ans	67,1	22,6	10,4	32,9
50-64 ans	35,6	31,2	33,1	64,4
65 ans et plus	**16,1**	**27,4**	**56,6**	**83,9**
65-74 ans	18,7	26,7	52,7	81,3
75 ans et plus	12,8	25,6	61,6	87,2
75-84 ans	13,4	26,6	60,0	86,6
85 ans et plus	11,1	22,8	66,1	88,9
Ensemble de la population	**51,7**	**24,6**	**23,7**	**48,3**
Pe (k)	3 437,8	1 637,4	1 575,5	3 212,9

1. Population vivant en ménage privé ou en ménage collectif non institutionnel.

Source : Institut de la statistique du Québec, *Enquête québécoise sur les limitations d'activités, les maladies chroniques et le vieillissement 2010-2011.*

Maladies chroniques- prévalence

- **l'arthrite** (ou arthrose ou rhumatisme),
- le diabète,
- la bronchite chronique (ou emphysème ou MPOC),
- l'**hypertension** et les maladies cardiaques,
- l'ostéoporose,
- La dépression chronique,
- le cancer.

http://www.stat.gouv.qc.ca/statistiques/sante/services/incapacites/limitations-maladies-chroniques-probleme-sante-longue.pdf

Maladies chroniques (MSSS et AQESSS)

- les maux de dos
- le diabète
- l'hypertension
- les migraines
- les maladies cardiaques
- les MPOC
- le cancer
- Ont toutes une composante nutritionnelle

« Au cours de l'année passée, lorsque vous avez reçu des soins, un professionnel de la santé que vous avez vu pour votre/vos condition(s), vous a-t-il aidé à faire un plan de traitement que vous pourriez exécuter dans votre vie quotidienne ? »

Au Québec, 59 % des répondants ayant une maladie chronique ont préparé un plan de

traitement avec un professionnel de la santé, ce qui est dans la moyenne des pays participants

Commissaire à la santé et au bien-être 2012

« Entre les visites chez le médecin, y a-t-il un professionnel de la santé qui vous contacte pour voir comment vous allez ? »

- Au Québec, 16 % des répondants ayant une maladie chronique indiquent qu'un professionnel de la santé les contacte entre les visites. Cette proportion est plus faible que celle de la plupart des pays participants.
- É.U.: 33 %

Commissaire à la santé et au bien-être 2012

Prise en charge recommandée
MSSS et AQESSS

- Première ligne
- Équipe Interdisciplinaire
- Composition indéterminée
  - Dont nutritionniste (optionnel)

Prise en charge recommandée
MSSS et AQESSS

- Difficulté d'accès
- Manque de continuité et de coordination
  - ex endocrinologues et nutritionnistes
- Les patients ne reçoivent pas les soins nutritionnels auxquels ils ont droit

Recommandation, en se basant sur les diagnostics des maladies à traiter:

- Garder le patient au centre des soins
- Inclure une nutritionniste dans les GMF et première ligne Expérience de Sherbrooke
- Définir les rôles pour maximiser l'interdisciplinarité/ la complémentarité. Éviter l'approche micro

À quel moment le tolérable devient intolérable?

- Agir en amont avec la nutrition
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  - Les maladies chroniques
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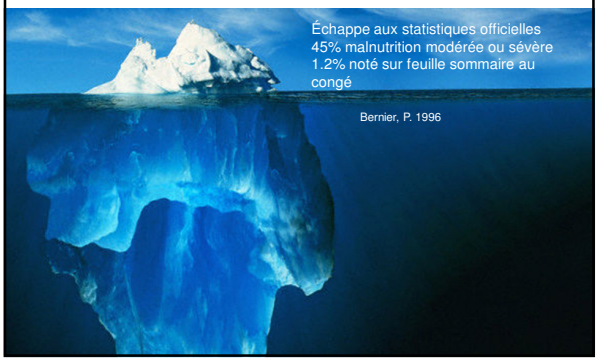
La dénutrition

État nutritionnel

équilibre entre les apports nutritionnels et les besoins des différents organes, tissus et cellules d'un individu

Prévalence de la malnutrition au Canada



Nutrition care in hospital study- Canadian malnutrition task force

- 8 provinces
- 18 CH courte durée
  - Universitaires et non universitaires
  - 3 du Québec
- 1118 patients
  - Unités médecine et chirurgie
  - Excluant soins intensifs, soins palliatifs, obstétrique, psychiatrie , hôpital de jour

Étiologie de la dénutrition: Apports insuffisants

- Appétit
- Préférences
- Distorsion goût et odorat
- Interruptions lors des repas
- Manque d'aide
- Contrôle de la douleur
- Difficulté à respirer

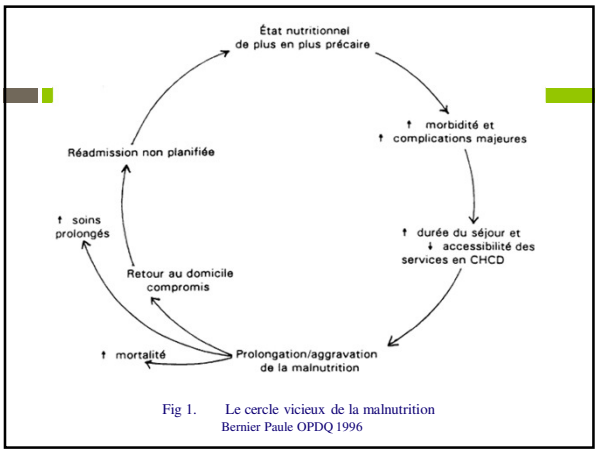
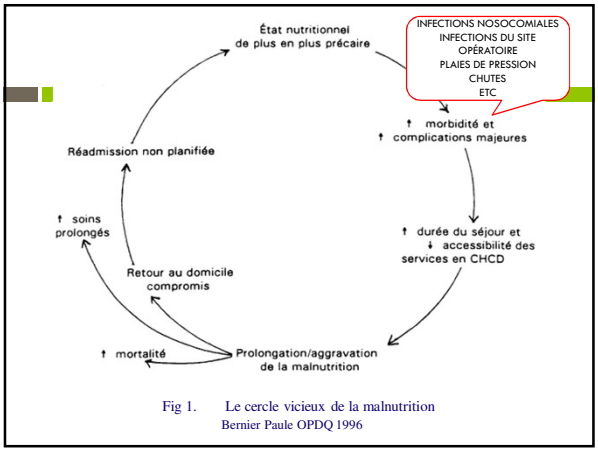


Fig 1. Le cercle vicieux de la malnutrition
Bernier Paule OPDQ 1996



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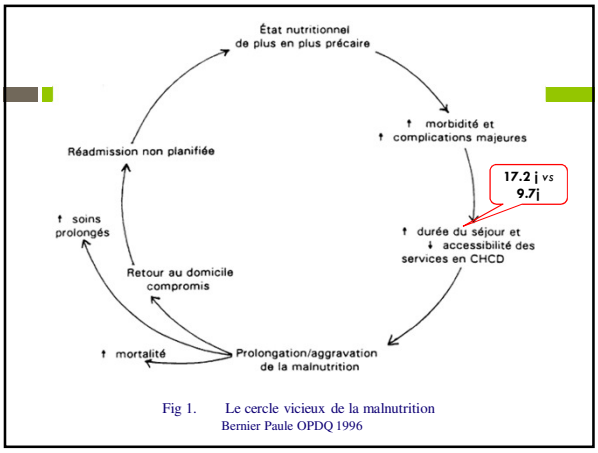

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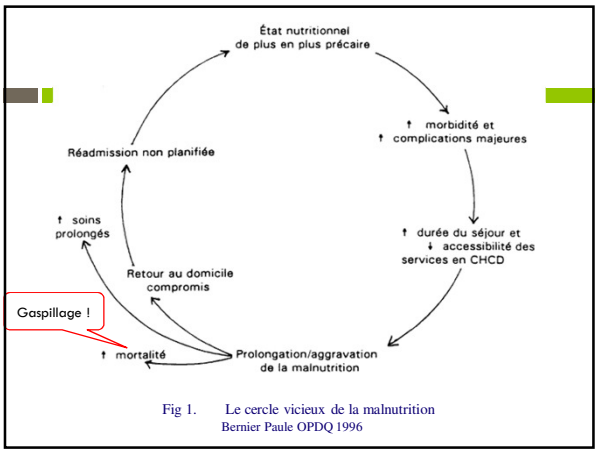

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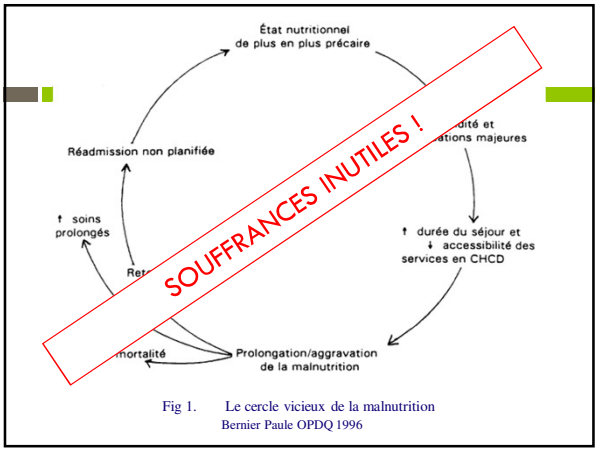
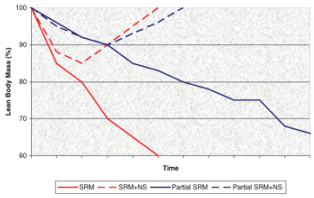


Fig 1. Le cercle vicieux de la malnutrition
Bernier Paule OPDQ 1996

↑coûts d'hospitalisation chez pts avec malnutrition ou risque de malnutrition à l'admission

Études	Résultats
Robinson 1987	$16691±4389 si malnourris et $14118±4962 si état limite versus $7692±687 in normal
Epstein 1987 Reilly 1988	Si IMC ≤ 75% idéal: ↑ de 35% coûts ↑ coûts de $3357 pts chirurgie
Chima 1997	coût moyen plus élevé si faible nutrition $6196 vs $4563
Gallagher 1996 Meguid1993	risque nutritionnel: ↑ coûts de 35-75% vs normal coûts annuels USA $18 milliards attribué à durée de séjour ↑ chez pts avec malnutrition
Braunsweig 2000 Correia 2003	détérioration état nutritionnel depuis admission: ↑ coûts: $28631±1835 vs $45762±4021 Malnutrition ↑ coûts de 60.5%

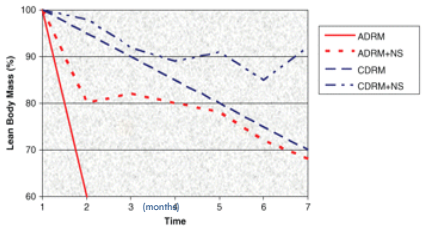
Starvation-related malnutrition(SRM)
± Nutritional support(NS)



N.B.: absence de processus inflammatoire ex anorexie nerveuse

Jensen *et al.* JPEN J Parenter Enteral Nutr 2010;34 156-159

Acute vs Chronic disease-related malnutrition
± Nutritional support(NS)



N.B.: présence de processus inflammatoire ex: MOFdéfaillance multiviscérale, sarcopénie de l'obésité

Jensen *et al.* JPEN J Parenter Enteral Nutr 2010;34 156-159

IATROGENIC MALNUTRITION

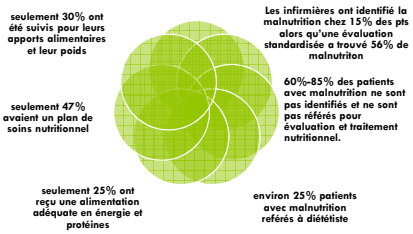
The Skeleton in the Hospital Closet

As awareness of the role of nutrition in recovery from disease increases, physicians are becoming alarmed by the frequency with which patients in our hospitals are being malnourished and even starved. One authority regards physician-induced malnutrition as one of the most serious nutritional problems of our time.

by CHARLES E. BUTTERWORTH, Jr., M.D.

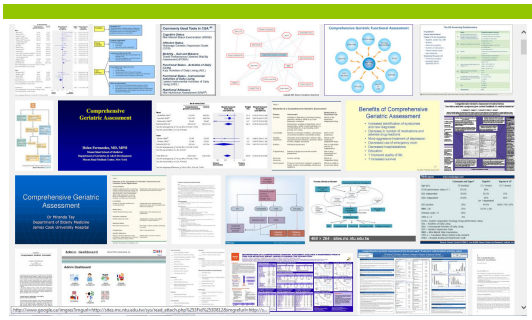
Nutrition Today
March/April 1974 - Volume 9 - Issue 2 - ppg 4-8

Admission:
dépistage et plan de traitement nutritionnel



Elia M et al. *Clin Nutr* 2005;24:867-884; McWhirter, Pennington. *Br J Med.* 1994;308:945-948;Kelly IE et al. *Quart J Med.* 2000;93:93-98;Kondrup J et al. *Clin Nutr.* 2002;21:461-468;Thibault et al., Clin Nutr 2010:1-8

Comprehensive geriatric assessment



When providing care to an older patient, the graduating medical student will be able to:

F. Adverse events

14. Identify and participate in efforts to reduce the potential hazards of hospital/institutional care (e.g., delirium, falls, immobility, pressure ulcers, incontinence, indwelling catheters, medication-related adverse events, malnutrition)

Parmar S. Core Competencies in the Care of Older Persons for Canadian Medical Students. Canadian Journal of Geriatrics 12: 2, 2009

Services alimentaires et dénutrition

Besoins nutritionnels

male 65ans,75 kg,180cm

Activité, stress	Énergie (Cal)	Protéines(g)
Ambulant	2025	60
Alité	1870	60
Alité, post-op	2245	75
" + infection	3000	94
Alité + plaies de pression	2925	150

Budget aliments

- Coût panier nutritif , personnes en santé: ± 8.00$ / jour
- Dépenses aliments MSSS ± 5.00$ / jour

- Services alimentation ≠ service d'hôtellerie!
- Font partie du traitement médical, chirurgical

À quel moment le tolérable devient intolérable?

Agir en amont avec la nutrition

Éviter les Bris de service dans le réseau: Exemples choisis

- Les maladies chroniques
- La dénutrition

Savoir quand cesser d'intervenir

Controversy

Tube feeding in advanced dementia: the metabolic perspective

L John Hoffer

Summary points

Patients with advanced dementia should be weighed at four week intervals

Constant body weight rules out starvation even if the patient is disinclined to eat what seems to be an adequate amount of food

Medically stable patients who lose weight require attention to the characteristics, quality, and presentation of their food

A patient who continues to lose weight despite optimisation of the diet but whose body mass index remains greater than 18.5 is more likely to be harmed than helped by tube feeding

BMJ 2006;333:1214–5

conclusion

- En nutrition, tout commence à la naissance
- Mieux vaut prévenir que réagir tardivement
- Ne pas négliger la prévention secondaire
- La bonne action, le bon professionnel, au bon moment

Mais les conditions suivantes sont essentielles

- Orientations ministérielles
- Préservation de la santé publique
- La prise en compte et l'atténuation des facteurs sociaux et économiques (ex déserts alimentaires, isolement social…)
- Organisation efficace du réseau «curatif» pour éviter les bris de service
- Éducation en nutrition des médecins et infirmières

Passer de l'évaluation des risques à l'intervention - savoir quand intervenir / Moving from Assessment of Risk to Intervention-knowing when to intervene

Nicole Souaid & Carolee Honeywill

Knowing when to intervene in cases of abuse or other high risk situations can be challenging for workers in all disciplines. When dealing with client's who present with a loss of autonomy in a homecare setting, we see a spectrum of risk factors, ranging from risk of falls, wandering behaviour and elder abuse, to name a few. A bio-psycho-social approach is used to evaluate level of risk, identify goals and prioritize interventions. Identifying the nature of the problem and the level of risk allows us to determine the priorities for interventions, as well as the discipline or sectors best able to intervene. This presentation aims to demonstrate this model, using case examples from our own practice in SAPA homecare at CSSS Cavendish. We believe that it is important to understand the limits of our roles and responsibilities in the area of risk assessment and intervention.

Notes

Moving from assessment of Risk to Intervention

KNOWING WHEN TO INTERVENE

CAROLEE HONEYWILL, SAC
CSSS CAVENDISH
NICOLE SOUAID, SOCIAL WORKER,
CSSS CAVENDISH

Introduction

What we hope you retain from our presentation

Definition of Risk

Probability or threat of injury, loss. Or any other negative occurance that is caused by external or internal vulnerabilities and that may be avoided through preeruptive action.

Evolving Nature of Risk

- Risk is fluid.
- But assessed in a moment of time
- Assessment must be ongoing
- Communication
- Consultation

Professional Responsabitlity

- Imminent Risk
- Decision making capacity
- Protocols, procedures, obligations

Risk Factors

abuse, falls, fire, refusal to take medication, care giving burn out, suicide/homicide, dehyrdration, conflict, lack of knowledge of rights and legal system, isolation, dependence, intergenerational conflicts, behaviour problems, negligence with medication, cultural isolation, post traumatic stress, bed sores, depression, eviction, anxiety, inabiltiy to pay for basic needs, hours alone, wandering, restraints, health problems, malnutrition, immigration status, intoxication, cognitive deficits, psychotic state, aggressivity, smoking, poor judgement, panic attacks, minimal support system, language barrier

Profile of person at Risk

Client

- Recognizes the existence of risk and accepts intervention
- Does not recognize the existance of risk
- Refuses intervention .

Miss. R.

- 77 year old single woman, diagnosed with schizophrenia
- Lives with friend, paying no rent, apt. is cluttered, dirty and smells, Miss R. takes in stray animals
- No immediate family in Montreal
- Lends money without money being paid back
- Miss R. fell while walking the dogs and broke her arm, has fallen on way to bathroom
- Needs assistance with bathing

Risk Assessment: Bio-Psycho-Social Model

	Profile	Risks	Objectives
Bio	Schizophrenic (with medication), falls, fractured shoulder, confusion, loss of autonomy	Disorganization, decline in physical and psychological health status, acute loss of autonomy,	Client takes medicaiton as prescribed, improvement in general health, client's home will be accessible
Psycho	Decline in memory, disoriented to place, Too trusting of others	Poor judgement, inappropriate decision making, getting lost, abuse	Prevent abuse, reduce the impact of wandering
Social	Lack of caregiver, no natural support network in area, « insalubrité »?	Risk of fall related to environment, unknown living arrangements	Create clear pathways to reduce risk of falls and maximize safety,

Risk Assessment: Bio-Psycho-Social Model

	Interventions	Resources
Home Care	Global evaluation, OT evaluation, bathing assistance	SW/RN, OT/PT, ASSS
Medical	Law 90, Cognitive Assessment	Rn, ASSS, Doctor
Psychosocial	Evaluation and Mobilization of Network	SW
Legal	Consult with Municipality	Community Organizer,
Other		

Risk Assessment: Bio-Psycho-Social Model

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Risk Assessment: Bio-Psycho-Social Model

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Other		

Challenges of Working in Risk

How do we live with the fact that client's can choose to live at risk?

Building a Tolerance for Risk

Dos:

- ✓ Consult- multisectorial, interdisciplinary, ongoing supervision
- ✓ Ongoing assessment,
- ✓ Reduce risk

Don'ts:

X judge, X save

Building a Tolerance for Risk

Know that at the end of the day if you have assessed risk, assessed decision making capacity, followed protocols and procedures you can go to sleep .

Évaluation de l’aptitude à prendre des décisions /
Decision-making capacity assessment/

Dr. Catherine Ferrier

In this presentation we will discuss clinical and psychosocial situations in which it becomes necessary to assess a patient's decision-making capacity. We will review the assessment process, which we will then apply together in cases drawn from the author's practice.

Notes

Assessment of decision-making capacity

Catherine Ferrier, MD, FCFP
McGill University Health Centre
November 13, 2014

I have no conflict of interest

Informed consent

Valid informed consent is premised on the disclosure of appropriate information to a competent patient who is permitted to make a voluntary choice.

When patients lack the competence to make a decision about treatment, substitute decision-makers must be sought.

Appelbaum, 2007

Definition

Competency (decision-making capacity) is a person's ability to make, and act on, his or her own decisions.

(Silberfeld, 1994)

Competency (decision-making capacity) is NOT a person's ability to live alone safely and care for oneself and one's home adequately.

What do we look at?

- Diagnosis? (status approach)
- Reasonableness of the decision? (outcome approach)
- Functional approach
- Integrated approach:
  - Outcome & functional
  - Status & functional

Criteria

- Ability to **understand** information relevant to decision-making
- Ability to **appreciate** the significance of that information for one's own situation
- Ability to **reason** with relevant information so as to engage in a logical process of weighing treatment options
- Ability to express a **choice**

(Grisso and Appelbaum, 1998)

Criteria

- **understand**
- **appreciate**
- **reason**
- **express a choice**

Areas of decision-making

Personal:

- Medical
- Living arrangement

Financial

Power of attorney, mandate, will

Screening

- Is the assessment needed to solve a problem?
  - Is an informal solution possible?
  - Is it in the patient's best interest?
  - Is there a plan to act on the conclusion?
- Has the patient been informed?
- Capacity for **what**?
- Do we have objective information on the patient's behaviour, skills and judgment?
- Do we have objective information on the financial situation? Why we need this info.

Mental Status Examination

- MMSE:
  - Incapacity more likely if less than 20
  - Capacity more likely if more than 24
- Psychiatric examination:
  - Is there a mood disorder that is severe enough to affect decision-making?
  - Is there psychosis that is relevant to decision-making?

Capacity to consent to medical treatment

- **understand**
- **appreciate**
- **reason**
- **express a choice**

Capacity to consent to medical treatment

- **Understand:**
  - the nature of the illness
  - the nature and purpose of the proposed treatment
  - the benefits and risks of the proposed treatment
  - alternative treatment options

Capacity to consent to medical treatment

- **Appreciate:**
  - Acknowledge the presence of the medical condition
  - The expected consequences (**to oneself**) of the proposed treatment and of the alternatives, including no treatment

Capacity to consent to medical treatment

- Reason
  - Engage in a rational process of manipulating the relevant information
- Express a choice
  - and the reasons for the choice.
  - does the patient consistently express the same choice?

Capacity to consent to medical treatment: tools

- Aid to Capacity Evaluation:
  - Structured interview using patient's own situation
- Nova Scotia criteria

Aid to Capacity Evaluation

http://www.jointcentreforbioethics.ca/tools/ace_download.shtml

- **ACE SAMPLE QUESTIONS**
- 1. Medical Condition:
  - • What problems are you having right now?
  - • What problem is bothering you most?
  - • Why are you in the hospital?
  - • Do you have [name problem here]?
- 2. Proposed Treatment:
  - • What is the treatment for [your problem]?
  - • What else can we do to help you?
  - • Can you have [proposed treatment]?

- 3. Alternatives:
  - • Are there any other [treatments]?
  - • What other options do you have?
  - • Can you have [alternative treatment]?
- 4. Option of Refusing Proposed Treatment (including withholding or withdrawing proposed treatment):
  - • Can you refuse [proposed treatment]?
  - • Can we stop [proposed treatment]?

- 5. Consequences of Accepting Proposed Treatment:
  - • What could happen to you if you have [proposed treatment]?
  - • Can [proposed treatment] cause problems/side effects?
  - • Can [proposed treatment] help you live longer?
- 6. Consequences of Refusing Proposed Treatment:
  - • What could happen to you if you don't have [proposed treatment]?
  - • Could you get sicker/die if you don't have [proposed treatment]?
  - • What could happen if you have [alternative treatment]? *(If alternatives are available)*

- 7a. The Person's Decision is Affected by Depression:
  - • Can you help me understand why you've decided to accept/refuse treatment?
  - • Do you feel that you're being punished?
  - • Do you think you're a bad person?
  - • Do you have any hope for the future?
  - • Do you deserve to be treated?
- 7b. The Person's Decision is Affected by Psychosis:
  - • Can you help me understand why you've decided to accept/refuse treatment?
  - • Do you think anyone is trying to hurt/harm you?
  - • Do you trust your doctor/nurse?

Nova Scotia criteria

In determining whether or not a person in a hospital or a psychiatric facility is capable of consenting to treatment, the examining psychiatrist shall consider whether the person understands and appreciates

- (a) the condition for which the specific treatment is proposed;
- (b) the nature and purpose of the specific treatment;
- (c) the risks and benefits involved in undergoing the specific treatment; and
- (d) the risks and benefits involved in not undergoing the specific treatment.

Hospitals Act

Capacity to make personal decisions (living situation)

- understand
- appreciate
- reason
- express a choice

Capacity to make personal decisions (living situation)

- **Understand:**
  - any change of health status or circumstances that might affect the living situation
  - potential risks related to the living situation
  - possible interventions to reduce the risk (get help, move, etc.)

Capacity to make personal decisions (living situation)

Appreciate:

the expected consequences of living with the risks or of intervening

Capacity to make personal decisions (living situation)

- **Reason:**
  - Engage in a rational process of manipulating the relevant information
- **Express a choice:**
  - and the reasons for the choice.
  - does the patient consistently express the same choice?

Financial competency

- **understand**
- **appreciate**
- **reason**
- **express a choice**
- **functional skills**

Financial competency

- **Understand:**
  - financial situation
  - problems with financial management
  - changes in health that could make it difficult to manage finances
  - a possible need for help
  - other decisions that need to be made

Financial competency

- **Appreciate:**

  the expected consequences of:
  - continuing as is, having help, having someone take over
  - a possibly abusive situation
  - the various alternatives, in the case of other decisions

Financial competency

- **Reason:**
  - Engage in a rational process of manipulating the relevant information
- **Express a choice:**
  - for whatever decision needs to be made

Financial competency

- **Functional skills:**
  - receive income and pay expenses
  - banking
  - calculation
  - budget management

- Power of attorney
- Mandate
- Will

Protective supervision

- Curatorship (Totally incapable)
- Tutorship (Partially incapable)
- Advisor to a person of full age (conseiller au majeur)
- Mandate homologation

Suggested reading: articles

- Appelbaum PS, Grisso T. Assessing patients' capacity to consent to treatment. NEJM 1988; 319:1635-1638
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- Appelbaum PS Assessment of patients' competence to consent to treatment. NEJM 2007; 357: 1834-1840

Suggested reading: books

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- Molloy DW, Darzins P, Strang D. Capacity to decide. Troy, Ont.: Newgrange Press, 1999.
- Silberfeld M, Fish A. When the mind fails: a guide to dealing with incompetency. Toronto: University of Toronto press, 1994

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