PlayDecide: PADMACS

Promoting Assisted Decision Making in Acute Care Settings

Up to 6 players can take part in a game. The facilitator will guide players through the stages of the game, shown below.

Full game (90 min)

1 **Setup & info**	Each player selects one story card, finds the linked issue cards, and then selects two info cards. Next, they read the guidelines and information about the ADMCA on the placemat. **(20 min)**
2 **Discussion**	Players take turns to summarise their cards, then the group identifies and discusses themes related to ADM. **(30 min)** Next, players share their own experiences relevant to the discussed issues. **(20 min)**
3 **Reflection**	Players reflect on the discussions and how they relate to their own experiences, then fill out a perspective sheet. **(20 min)**

Quick game (40 min)

1 **Setup & info**	Players select one story card, find one linked issue card, and select one info card. Next, they read the guidelines and information about the ADMCA on the placemat. **(10 min)**
2 **Discussion**	Players summarise their cards briefly, then the group identifies and discusses themes related to ADM. **(10 min)** Next, players share their own experiences relevant to the discussed issues. **(10 min)**
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Guidelines

1. You have a right to a voice: speak your truth ...
1. But not the whole truth: don’t go on and on.
1. Value your life learning.
1. Respect other people.
1. Allow them to finish before you speak.
1. Delight in diversity.
1. Welcome surprise or confusion as a sign that you’ve let in new thoughts or feelings.
1. Look for common ground.
1. ‘But’ emphasises difference; ‘and’ emphasises similarity.

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My position on assisted decision-making

Older adults | Family carers | Healthcare professionals | Policy makers

What key learnings will I take away from playing this game?

I can apply these key learnings by ...

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PlayDecide: PADMACS

Promoting Assisted Decision Making in Acute Care Settings

ABOUT THE ASSISTED DECISION-MAKING ACT

The Assisted Decision-Making (Capacity) Act 2015 provides new arrangements, procedures, guiding principles and structures for maximising the decision-making capacity of all. There is a statutory presumption that all individuals have decision-making capacity and shall not be deemed to lack that capacity unless all reasonable steps have been taken, without success, to help them.

IMPLICATIONS FOR PRACTICE

Under the Act, capacity is context and time-bound. This means that functional capacity is assessed on the basis of the person's ability to understand, at the time that a decision is to be made, the nature and consequences of that decision, in the context of the available choices at that time.

The Act provides a statutory framework of tiered decision supports appropriate to the level of decision-making capacity of the individual:

1) At the lowest level, a person may appoint a decision-making assistant to help him/her to obtain and assimilate information and communicate the decision
2) At the middle level, a person may appoint a co-decision maker with whom he/she may make decisions jointly
3) At the upper level, the courts may intervene to make a declaration of incapacity in relation to certain matters and appoint a representative to act as a substitute decision-maker

The guiding principles of the Act place the will and preferences, beliefs, and values of the person at the centre of the decision-making process. Therefore, in making any intervention, an intervener must give effect to the past and present will and preferences of the individual. Where tiered decision support is in place for a person, an intervener must consider the views of any decision-making assistant, co-decision maker or decision-making representative. This pertains to healthcare interventions made by healthcare professionals.

The Act also provides for the establishment of the Office of the Decision Support Services which has regulatory and information functions.

(See https://www.mhcirl.ie/DSS/)

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Story Card

Place your chosen story card here

Older adults & patients

Carers

Health professionals

Info Card

Place your chosen info card here

Info Card

Place your chosen info card here

Issue Card

Place your chosen issue card here

Issue Card

Place your chosen issue card here

Key themes

- SHARING INFO
Story cards 1 - 11
- CONTROL & POWER
Story cards 12 - 29
- RESOURCES
Story cards 30 - 41
- ENVIRONMENT
Story cards 41 - 54
- COMMUNICATION
Story cards 55 - 69

Three stages of PlayDecide: PADMACS

	Full game (90 min)	Quick game (40 min)
1 Setup & info	Select a story card, find the linked issue cards, then select two info cards at random. Next, read the guidelines and information about the ADMCA on the placemat. **(20 min)**	Select a story card, find one linked issue card, then select two info cards at random. Next, read the guidelines and information about the ADMCA on the placemat. **(10 min)**
2 Discussion	Summarise your cards for the group, and identify and discuss themes and issues related to ADM, focusing on the perspectives and issues raised by the cards. **(30 min)** Next, share your own perspective and experiences relevant to the discussion. **(20 min)**	Briefly summarise your cards, and identify and discuss themes and issues related to ADM, focusing on the perspectives and issues raised by the cards. **(10 min)** Next, share your own perspective and experiences relevant to the discussion. **(10 min)**
3 Reflection	Reflect on the discussions and your own experience, then fill out a perspective sheet. **(20 min)**	Reflect on the discussions and your own experience, then fill out a perspective sheet. **(10 min)**

Next steps

Action

Think about how you can implement ADM in your working practice to fully incorporate the will and preferences of patients.

PADMACS:

Promoting Assisted Decision Making in Acute Care Settings

play
decide

UCD School of Nursing, Midwifery and Health Systems
UCD College of Health and Agricultural Sciences

Mater Hospital Dublin

ST. VINCENT'S UNIVERSITY HOSPITAL
Elm Park

Family Carers Ireland
Fairness for Carers

THE ALZHEIMER SOCIETY *of* IRELAND

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Supported by HRB Health Research Board

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Story Card 12

Access to services - who decides?

Links to: Issue Cards 13 + 18

Julia is a family carer of an older person with an intellectual disability.

My sister was ill a few years ago with back pain and the physio said she needed a scan. She has a learning disability and I accompanied her to the doctor. The doctor didn’t recommend a scan and seemed dismissive of the pain. I had to really push the doctor to refer her for a scan. After a few months wait my sister was eventually referred to an orthopaedic surgeon where it was discovered that she required a knee replacement. She was without pain in the end, but it took a lot of convincing.

CONTROL & POWER

play
decide

Story Card ⑬

Will and preference

Links to: Issue Cards ⑭ + (42)

Margaret was the partner and carer of an older person with a diagnosis of Parkinson's.

She was admitted to hospital and the staff wanted to treat her. We had talked it over at home and she wasn't afraid to die. She wanted a do-not-resuscitate (DNR) order. She expressed to me that she no longer wanted to continue treatment. It wasn't a major decision for us – it felt right for us at that stage. So I told the consultant. He sat beside her and I left them to discuss options. The consultant came to me afterwards and agreed that she did not want resuscitation. But what about other treatments? I asked the consultant would she still get antibiotics for a UTI. The consultant said antibiotics would make her comfortable but not prolong her life. I didn't entirely agree with it but maybe it did give her comfort.

CONTROL & POWER

play
decide

Story Card 14

I did not want to take the tablet

Links to: Issue Cards 41 + 43

Terry is an older person with a diagnosis of Alzheimer’s.

I was in a hospital ward and I could not sleep. This one particular night I had very bad anxiety. A ward staff member offered me a sleeping tablet. I did not want to take it because I knew it would impact me the following day, resulting in increased memory loss and disorientation. Once I refused the tablet, nothing else was offered to help address my anxiety or my sleeping. I felt that once I turned down the sleeping tablet there wasn’t a whole lot of sympathy for me in a hospital setting. I felt sad and let down by the staff. They did not seem to understand dementia. All I wanted was comfort and reassurance.

CONTROL & POWER


play
decide

Story Card 15

Making the right decision for me

Links to: Issue Cards 15 + 17

Lisa is an older person.

I am almost 80 years of age and have been receiving treatment for recurrent melanomas. Following completion of recent treatment I was referred to an oncology specialist. After spending time explaining the options to me, he recommended a course of preventive chemotherapy. I responded that I was not interested. The doctor was surprised and asked a nurse to come in and talk to me to see if I would change my mind. I have spoken to my family and my local pharmacist who all recommended the treatment. I have decided I have made the right decision for me at this time to not proceed with the treatment.

CONTROL & POWER

play
decide

Story Card ⑯

Building trust

Links to: Issue Cards ⑨ + (35)

Sharon is an older person with a diagnosis of Lewy Body Dementia.

I was in an acute ward and the consultant psychiatrist came in. I was on a lot of different tablets including morphine for pain. The consultant reviewed my notes and ordered me off them all except my blood pressure tables. I said that I was not coming off my morphine patch as my GP had introduced that patch in increments of five millilitres. I said that I would prefer to come off in increments. After listening to me, the consultant agreed with my proposal. After that, I felt I could trust her as she listened to me and was willing to change her mind.

CONTROL & POWER

play
decide

Story Card 17

Engaging too much with the family?

Links to: Issue Cards 20 + 23

Pete is a nurse.

I had an older person in the ward following a stroke. He had a history of alcohol abuse and he was living alone in a council flat. He did not have much contact with his siblings. Initially he was very aggressive but improved. After 3 months we started to discuss discharge. He wanted to go home but his siblings said he could not look after himself and needed to go to a nursing home. The council agreed to move him to a more accessible home, and we arranged lots of additional supports. His family were still not happy but refused to attend the meetings we had arranged. In the end after 10 months in hospital he got his wish and went home. I wish I had engaged less within his family as he would have been discharged much earlier.

CONTROL & POWER

play
decide

Story Card 18

The right to make an unwise decision

Links to: Issue Cards 11 + 19

Liam is a social worker.

A patient, aged 82, was admitted with delirium and had septic leg ulcers. She was living alone in poor conditions with no access to a toilet or running water. Her neighbours said she would wander the streets and would often be agitated. She clearly expressed that she wanted to go home. Both her family and the team felt that she would be better placed in a nursing home. She refused an offer of a commode or any home help but was willing to engage with a public health nurse to look after her dressings. She ended up being discharged home.

CONTROL & POWER

play
decide

Story Card 19

Easier if he didn't have capacity?

Links to: Issue Cards 6 + 46

Saoirse is a social worker.

A patient was admitted with a safeguarding issue. There was a history of family conflicts as well as alcohol and drug addiction. A daughter suggested that he didn't have capacity and a nursing home was his best option. When in her presence he agreed with her. However, when I approached him, he wanted to go home. Myself and an OT undertook an assessment of capacity and he understood the implications of his decision. This caused a massive family argument which played out on the ward. This was very distressing for the patient. The daughter made a complaint about us and our case management was investigated. We continued to support the patient and worked with colleagues in the community to get him home. He is still at home and managing very well there.

CONTROL & POWER

play
decide

Story Card 20

There should have been a plan

Links to: Issue Cards 10 + 27

Inger is a doctor.

We had a patient in his eighties. He had severe cognitive impairment with advanced dementia. He had end-stage kidney disease and was getting dialysis three times a week. He had no English and he arrived to us with a hip fracture following a fall. His family consented to hip replacement surgery. He was transferred to the high dependency unit following the surgery. He had a lot of complications, was in a lot of pain and was very distressed. No translator was available, so I was dependent on his family for information and communication. He remained in full active management of his condition and continued to get dialysis. I think his family were not able to accept he was dying. It should not have been that way. Some efforts should have been made to support him and to ascertain what his care preferences were.

CONTROL & POWER


play
decide

Story Card 21

Balancing supported decision-making with patient's best interest

Links to: Issue Cards 2 + 45

Leah is a doctor.

A 92-year-old woman was admitted with chest pain. She had a mild cognitive impairment upon admission. Tests found that she needed a heart valve replacement, and she expressed a wish for that to be done. She was referred to a cardiologist who advised her that she was not the best candidate for this procedure and was at high risk for complications. The patient was adamant that she wanted to go ahead. The cardiologist undertook a continuous process of consent and provided information over a period of time. There was tension between the cardiologist and patient. The procedure went ahead, despite the cardiologist's reservations. The patient has had a lot of complications post surgery and is still in hospital. I wonder now if maybe I should not have referred her to cardiology at all?

CONTROL & POWER

play
decide

Story Card 22

Shared decision making?

Links to: Issue Cards 9 + 12

Jane is an older person.

I was confirmed to have Lewy Body Dementia. My last outpatient visit was with a junior doctor from my consultant’s team. He said, “you seem to be a lot better than you were a couple of months ago”. I said, “I am”. He said “what has changed?” I said, “I have started to take CBD oil regularly”. With that, he started shaking his head and flung his pen across the desk. He said, “how do I know what you are taking is working, how do I know it’s not the medication?” He said, “we cannot agree with what you are taking. We do not want you back here again.” I said, “with the greatest respect for you doctor, you know absolutely nothing about CBD oil. You should be asking me about it rather than dismissing it.” He said, “how dare you speak to me like that?”, so I left, and they would not give me another appointment.

CONTROL & POWER


play
decide

Story Card 23

I don’t want to be a burden

Links to: Issue Cards 16 + 29

Dawn is a doctor.

A woman in her eighties was admitted and was very deconditioned. Cognitively she was good. She was lacking confidence, but she rehabbed very well. Following assessment she would need 14 hours of home care supports and wanted to go home. Her daughter came to the ward and announced her mother was going to a nursing home. We explained at the family meeting that she did not need to, but the patient was resigned to the nursing home. She said she did not want to be a burden on her daughter. She did change her mind a few times, but her daughter would come in and she would revert back to the nursing home and was eventually transferred there.

CONTROL & POWER

play
decide

Story Card 24

Negotiating palliative care

Links to: Issue Cards 15 + 30

Fernando was caring for his partner.

My partner was in a lot of pain with a bad UTI and there was something wrong with his bone marrow. He was very clear with me that he did not want any further treatment. I had to coax him to go to hospital. He asked me to stop the doctors from doing any further interventions. I spoke to his consultant who was insistent he should continue his treatment. Whilst the consultant was away on leave I asked the nurses very nicely to get the palliative care team in. The locum consultant was in agreement that palliative care was the best option. The staff don’t like being told what to do but I had to ensure that my partner’s wishes were carried out and that he got appropriate end of life care.

CONTROL & POWER

play
decide

Story Card 25

It was challenging because the staff want to keep people safe

Links to: Issue Cards 40 + 44

Caitriona is a doctor.

A patient presented after a fall with marked cognitive impairment and active hallucinosis associated with the type of dementia she had. However, she was able to re-orientate herself and wished to go home. Her family wanted her to be admitted so that she could be supervised continuously. She did not want this. Even though she had problems with memory she did have fleeting capacity. There were times she could recall the plan and understand some of the risks. The OT and I did functional testing and, because of the hallucinations, psychiatry also saw her. Together we supported her decision to go home. It was difficult with the family but also with staff from the emergency department – they can be quite paternalistic as they want to mind people and keep them safe. Even the carer who accompanied her home really struggled with the idea of leaving her in the house.

CONTROL & POWER

play
decide

Story Card 26

The team gave us time to do a full assessment

Links to: Issue Cards 7 + 33

Maria is a speech and language therapist.

We had a patient who had aphasia associated with a stroke. She was with us for about 6-8 weeks before going to a rehab facility, and then had to come back to us due to a life-threatening illness unrelated to the stroke. She survived that but her cognition deteriorated. No single assessment could reveal her ability to function in everyday life, so myself and the OT took a very functional approach to see how she was coping. We used the “communication aid to capacity evaluation” tool which gave us insight into how much the patient understood and her insight into her deficits. This revealed that she knew where she was and what had happened, and that she wanted to go home. We decided she had the capacity to make this decision and the team listened to us. She ended up going home and living independently.

CONTROL & POWER

play
decide

Story Card 27

Sometimes family will make the decisions on capacity

Links to: Issue Card 24

Andy is an occupational therapist.

We saw a man who presented, following a stroke, with severe cognitive impairment. He was dependent living at home with his wife. I was working with him for about 4-5 weeks and I noticed a change in his cognitive profile – he was participating in self-care and functional tasks. I think perhaps the decision was made too early regarding his capacity. He had topographical disorientation which can present as worse than it actually is. The team were reluctant to accept his improvements and it turned out his relationship with his wife was not positive. Under pressure from his wife he was deemed not to have capacity and he went to a nursing home. He absolutely had capacity and it came down to a care issue. There can be a lot of pressure on teams from families. To this day, I'll never forget him. It should never have happened.

CONTROL & POWER

play
decide

Story Card 28

We side-stepped enacting the Enduring Power of Attorney

Links to: Issue Cards 34 + 46

Conor is a doctor.

A man came into the hospital after repeated falls. He had no children but five nieces and nephews. He was keen to go home but was at risk of falling. One of his nieces wanted him to go home because that was his wish, but another wanted him to go into long term care. The patient had an inactivated EPA and that niece wanted it activated. We were concerned because the niece who wanted him in a nursing home would have the financial power, and to an extent the care needs power. We did a risk assessment and noted that he could afford 24-hour care which we felt was the best use of his money, to fulfil his wishes to return home. Two separate solicitors wrote looking for a capacity assessment, but we kept him here long enough to regain capacity and we could sidestep the EPA. He’s now happily living at home, although needs hospital care every so often.

CONTROL & POWER

play
decide

Story Card 29

Working together to make a plan

Links to: Issue Cards 13 + 39

Anthony is an older person.

I had started to have difficulty swallowing, and was seen by the team at my local hospital. Although I have mild cognitive impairment, I don't have much trouble communicating but I still don't feel like they really listened to me. They just gave me a sheet of paper with a plan for a diet of soft foods and sent me home. Many of the things listed in there were new to me and I wouldn't even know how to make them. I had been coping reasonably well on my own, but I wasn't able to manage with this new diet. It was so frustrating, and it wasn't until I had to go into hospital again that I was able to get another team member to sit down with me and listen to my concerns. He helped me to find ways to add more of the foods that I'm used to into my diet plan.

CONTROL & POWER


play
decide

Issue Card ②

ADM is fostered when teamwork is interdisciplinary and guided by a shared vision

Interdisciplinary teams that communicate well together and with the patient can foster quality ADM for patients. What are the characteristics of this type of interdisciplinary team?

play
decide

Issue Card ⑥

Cognitive function assessments versus capacity assessment

Healthcare professionals use screening tests for assessing cognitive function. These tests should never be conflated with capacity, which is decision-specific, functional, and time-bound.

play
decide

Issue Card ⑦

Communication difficulties can often get perceived as cognitive issues

How can a speech & language therapist improve communication to support a patient’s capacity for decision making?

play
decide

Issue Card ⑨

Communication training for healthcare professionals

ADM requires practitioners to be highly skilled and proficient in interpersonal communication. How can this be enabled?

play
decide

Issue Card ⑩

Preferred methods of communication

Oral communication should not be assumed as the preferred method of communication. Patients should be consulted about how they wish to be communicated with.

play
decide

Issue Card ⑪

Communicating with nominated decision supporters and others

Sometimes there is tension between family members and healthcare professionals with respect to the patient’s wishes. What is the difference between healthcare professionals’ responsibilities to communicate with a nominated decision supporter as opposed to other family members, friends, or next of kin?

play
decide

Issue Card ⑫

Still “Best interests” approach

By having a diagnosis of dementia, the will and preference of the person can be overlooked in favour of a ‘best interests’ or ‘professional knows best’ approach. How can we avoid this?


play
decide

Issue Card ⑬

Patients’ assertiveness

Patients can feel frustrated when their experience is not considered or valued in care planning. They may need to be quite assertive to make their voice heard. What could be done to maximise all patients’ participation in the decision-making process?

play
decide

Issue Card ⑭

Speak up

It can be difficult for patients to speak up about their care preferences, in particular when these preferences don’t align with healthcare professionals’ opinions.

play
decide

Issue Card ⑮

Doctor-patient relationship

Historical views of the patient-doctor relationship assumed that the doctor’s role was to act in the best interests of the patient and to direct their care. This may lead the decision supporters and patients to leave the decision entirely to the doctor.

play
decide

Issue Card ⑯

Medicalisation & labelling

Medicalisation and the labelling of a person with dementia may impact their self esteem, self efficacy, and self confidence. How can the need for a timely diagnosis be managed by healthcare professionals in such a way as to reduce this impact?

play
decide

Issue Card ⑰

Unwise decisions

Cognitive impairment may be under greater scrutiny from healthcare professionals, especially when they consider an unwise decision to have been made.

play
decide

Issue Card ⑱

Patient advocates

People in the acute care setting may not have family or friends to call on for support. Should they routinely be offered the services of an independent advocate to support them in their decision making?

play
decide

Issue Card ⑲

Ethical dilemma around the discharge process

Healthcare professionals may face ethical dilemmas in supporting the will and preferences of a patient who wants to be discharged home but is deemed at-risk by family members or community services.

play
decide

Issue Card ⑳

Internal family conflicts

Internal family conflicts are a common source of stress for healthcare professionals when trying to support decisions of care. What strategies can they use to manage these conflicts?

play
decide

Issue Card ㉓

Environmental barriers to assisted decision making

What can healthcare professionals do to overcome social and physical environmental barriers in hospitals in order to maximise a patient’s involvement in decision making?

play
decide

Issue Card ㉔

Building the capacity of patients takes time

Some patients may require additional time to build capacity. How can this be resourced-for in an acute care setting?


play
decide

Issue Card ㉗

Where is a translator when you need one?

In your opinion is there timely access to resources (i.e. translators, assistive technology, visual aids, etc) which would support a patient in the communication of their decision?

play
decide

Issue Card ㉙

When do you know a decision has been made?

Decision making requires time so that information can be processed, questioned and shared with a decision supporter. When the patient is changing their mind, what are the implications for resourcing (e.g. theatre lists)?

play
decide

Issue Card ㉚

Resources for education & training

ADM legislation is new, and there is a need for clear guidance for healthcare professionals. What resources for education and training would support healthcare professionals in ADM implementation?

play
decide

Issue Card ㉝

Are we using all of the resources available to us within the team?

Occupational therapists and speech and language therapists have discipline-specific expertise in relation to functional assessment of capacity. How can we ensure their involvement in the ADM process?

play
decide

Issue Card ㉞

Private health insurance or wealth

Having private health insurance or wealth offers more options for healthcare decision making.

play
decide

Issue Card ㉟

Difficulties in sharing health-related information

Often patients have to repeat their story many times and to many different professionals. This can be very frustrating and a cause of concern to them because details may be forgotten when they are asked to repeat them constantly. What could be done to improve the sharing of health-related information in the care planning process?

play
decide

Issue Card ㊴

What matters to me

Admission to acute care settings can be a very stressful, disorientating, and frightening experience for any patient, especially for patients presenting with fluctuating capacity. Could knowing about likes and dislikes of that patient help reduce anxiety and discomfort?

play
decide

Issue Card ㊵

Interprofessional collaboration

How can we enable good interprofessional collaboration which promotes the sharing of information required for assisted decision making?

play
decide

Issue Card ㊶

The hospital environment can make people feel vulnerable.

Patients often feel 'lucky' to have a hospital bed and accept healthcare conditions and services they would not tolerate elsewhere. Because of this, they can be reluctant to speak up. What can be done?

play
decide

Issue Card ㊷

Readiness to engage in care planning for the future

Receiving a formal diagnosis of dementia can be a very vulnerable time for the person. They may not be ready to engage in conversations about assisted decision making and care planning straight away. Is there a best time? What are your views on how this can be approached?

play
decide

Issue Card ㊸

Dementia-friendly environment?

Acute care is often delivered in noisy and chaotic environments. They may be frightening and distressing for people with dementia and may worsen their levels of confusion and or anxiety. How can we reduce the vulnerability of patients with dementia in the acute care setting?

play
decide

Issue Card ㊹

Fluctuating capacity

Patients may experience fluctuating capacity and anxiety on acute admission. This may be exacerbated by frequent changes in their context of care (i.e. staff changes and moving them to a new bed space). What can be done about this?

play
decide

Issue Card ㊺

Fitness to practise

Some healthcare professionals are afraid of liability issues and fear that their professional practice could be called into question as they attempt to navigate the new ADM legal framework. What supports could help healthcare professionals with this transition?

play
decide

Issue Card ㊻

Healthcare professionals can feel vulnerable

Some healthcare professionals recognise that there is a disparity between a patient’s preferences to be cared for at home and the home care services available within the health system. Healthcare professionals may feel a sense of stress and helplessness.

play
decide

Info Card ①

Assisted Decision-Making Act 2015

The ADMCA 2015 maximises the autonomy and dignity of persons who lack decision-making capacity in relation to one or more matters in the here and now, or who may do so in the future, by supporting them to make decisions based on their will and preferences.

play
decide

Info Card ②

Decision-making capacity

"Decision-making capacity" is the ability to understand, at the time that the decision is to be made, the nature and consequences of the decision to be made in the context of available choices at that time.

play
decide

Info Card ③

Provisions of the Assisted Decision-Making Act 2015

The provisions of the ADMCA apply to day-to-day and personal welfare decisions which include decisions about day-to-day living, finances, property, and healthcare treatment such as whether to consent to, or refuse, medical intervention.

play
decide

Info Card ④

Presumption of decision-making capacity

A person is presumed to have decision-making capacity in respect of the matter concerned. The burden of proving otherwise rests on the person who is questioning their ability to make a decision.

play
decide

Info Card ⑤

Screening

Screening for decision-making capacity involves a functional assessment which focuses on how a person makes a decision, as opposed to the nature or the wisdom of that decision.


play
decide

Info Card ⑥

Lacks capacity

A person can only be said to lack decision-making capacity if, at the point in time when they are being assessed, they cannot understand and retain the relevant information, do not believe the information, cannot weigh the information in the context of the decision-making process, and communicate their decision using whatever means they use to communicate.

play
decide

Info Card ⑦

Practicable steps have been taken

A person shall not be considered unable to make a decision for themselves unless all practicable steps have been taken, without success, to maximise his/her capacity and support him/her to make the decision. The nature of the support required will differ from person to person and depends on many factors.

play
decide

Info Card ⑧

Understand information

A person is not be regarded as unable to understand the information unless the information is provided in a manner that is appropriate to his/her needs.

play
decide

Info Card ⑨

Steps

Steps that support a person to make their own decision involve creating the right environment based on an understanding of the person, providing him/her with appropriate information tailored to his/her individual personality and needs, and providing tailored communication support.


play
decide

Info Card ⑩

Unwise decisions

People have the right to make decisions that others may not agree with. Believing a decision to be unwise is not a reason in itself to question someone's decision making capacity and is not evidence of a lack of capacity (although it may be indicative of this). People's values, beliefs and preferences differ.


play
decide

Info Card ⑪

Functional assessment

The functional assessment of decision-making capacity is issue-specific and time-specific (the ability to make a specific decision at a particular point in time about a specific issue). Blanket assessments for capacity should not be made.

play
decide

Info Card ⑫

No intervention unless necessary

Guiding Principle 4 – no intervention unless necessary. In so far as possible, there should not be any intervention by others in decisions made, or to be made, by a person whose capacity may be called into question in relation to a specific issue in the here and now, or at some time in the future.

play
decide

Info Card ⑬

Scope of the intervention

Guiding Principle 5 – the scope of the intervention should be limited so as to minimise the restriction of the person’s rights and freedom of action. Due regard must be had to respect his/her rights to dignity, bodily integrity, privacy, autonomy, and control over his/her financial affairs and property.

play
decide

Info Card ⑭

Intervention should be proportionate

The intervention should be proportionate to the significance and urgency of the matter, and the subject of the intervention (take into account the individual’s circumstances, will and preferences, beliefs and values, and consider whether there is a less intrusive intervention available).

play
decide

Info Card ⑮

Supporting decision-making

Guiding Principle 6 - Supporting decision-making requires permitting, encouraging, and facilitating, in so far as is practicable, the person to participate/improve his/her ability, as fully as possible, to make the decision, rather than having the decision made by someone else.

play
decide

Info Card ⑯

Past and present will and preference

Supporting decision-making requires, giving effect to a person’s past and present will and preference, taking into account his/her beliefs and values (that may have previously been expressed in writing) and considering the views of anyone named by the person to be consulted.

play
decide

Info Card ⑰

Enduring Power of Attorney

A person who anticipates a future lack of decision-making capacity may enter into an Enduring Power of Attorney (EPOA), with another person, called their Attorney. The Attorney is authorised to make decisions in accordance with the terms of the EPOA. EPOAs are limited in so far as decisions pertaining to restraint of the person (unless exceptional emergency circumstances and conditions exist); the refusal of life-sustaining treatment and decisions that are expressed in an Advance Healthcare Directive, cannot be created/authorised by the EOPA.


play
decide

Info Card ⑱

Advance Healthcare Directive

An Enduring Power of Attorney (EPOA) cannot create/authorise a decision that has already been addressed by the person in an Advance Healthcare Directive (AHD) nor can it create/authorise a decision to refuse life-sustaining treatment, irrespective of whether an AHD exists. An EPOA cannot create/authorise a decision to restrain the person unless there are exceptional emergency circumstances and strict conditions apply.

play
decide

Info Card ⑲

Losing decision-making capacity

A person who anticipates that they may lose decision-making capacity in the future may make an Advance Healthcare Directive (AHD) that expresses their will and preferences regarding medical treatment that may arise in the event of their losing capacity, for example, if they were to become comatose.

play
decide

Info Card ⑳

Advance Care Directive

The Advance Care Directive (ACD) may be a stand-alone directive or the person may appoint a dedicated healthcare representative (DHR) to exercise the powers conferred in the ACD. Significantly, a person may express their wish to refuse life-sustaining treatment through an ACD.

play
decide

Info Card ㉑

Screening

Screening for decision-making capacity involves a functional assessment which focuses on how a person makes a decision as opposed to the nature or the wisdom of the decision.

play
decide

Info Card ㉒

Lacks capacity

A person can only be said to lack decision-making capacity if, at the point in time when they are being assessed, they cannot understand and retain the relevant information, do not believe the information, cannot weigh the information in the context of the decision-making process, and communicate their decision using whatever means they use to communicate.

play
decide

Info Card ㉓

Practicable steps have been taken

A person shall not be considered unable to make a decision for themselves unless all practicable steps have been taken, without success, to maximise his/her capacity and support him/her to make the decision. The nature of the support required will differ from person to person and depends on many factors.

play
decide

Info Card ㉔

Three types of decision-making supports

The ADMCA provides for three types of decision-making supports: 1) Assisted decision-making, 2) Co-decision making with individuals appointed by the person whose capacity is called into question, and 3) Where a person lacks capacity to make a decision with either of these supports, the court may appoint a decision-making representative or may make the decision on the person’s behalf.

play
decide

Info Card ㉕

Decision-making based on the interpretation of the known past

If the present will and preferences of the person cannot be ascertained after all practicable efforts have been tried, the ADMCA 2015 supports decision-making based on the interpretation of the known past will and preferences, taking into account the values and beliefs of the person as opposed to a third party deciding what is in the person’s best interest.

play
decide

Info Card ㉖

Urgency around a decision

If there is urgency around a decision to be made, there may be less time to ascertain the person’s will and preferences, values, and beliefs, but wherever possible, efforts should be made to do so. This could mean talking to the individual nominated by that person or their closest relation, partner or friend, who could help the person with communication or interpret signs that show his/her present will or preferences, or inform you about the person’s last known will and preferences.

play
decide

Info Card ㉗

Role of close family

The role of close family members and next of kin is to guide healthcare and other professionals as to the will and preferences of the relevant person where that person lacks capacity to make the decision in question.

play
decide

Info Card ㉘

Role of Next of Kin

Generally, family members and next of kin of the relevant person do not have authority to make a decision on the part of that person unless they have been given authority to do so through the provisions of the ADMCA.


play
decide

Info Card ㉙

Override a person’s will and preference

It is a very serious step to seek to override a person’s will and preferences by trying to impose an unwanted intervention. Such a person should be facilitated and enabled to challenge an unwanted decision, possibly by the appointment of an advocate.

play
decide

Info Card ㉚

Act in good faith

Anyone making an intervention on behalf of a person whose decision-making capacity is called into question must act in good faith (in accordance with professional codes of conduct or other applicable guidance) and for the benefit of the person which should be construed with references to their known will and preferences. What is/isn’t of overall benefit to the person is unique to that person and should be understood in that way.

play
decide

Info Card ㉛

Judgement on a particular intervention

If it is not possible for the person to make a decision, even with support, and their will and preferences, beliefs and values, cannot be established, then a judgement is required on whether to proceed with a particular intervention. This should be informed by clinical/professional skill/ experience and it is good practice to discuss the matter with other members of the multi-disciplinary team.


play
decide

Info Card ㉜

Third opinion

If there is disagreement as to whether a person has decision-making capacity in respect of a particular decision, it is good practice to seek a third opinion or convene a multi-disciplinary meeting/case conference to discuss the issue. It may be necessary to refer the question to the Circuit or High Court.


play
decide

Info Card ㉝

Making an intervention

The person, e.g. a healthcare professional, who proposes making an intervention (an action or direction in respect of an individual whose decision-making capacity has been called into question) must be able to satisfy him or herself as to whether that individual has the capacity to make the decision. The healthcare professional may call upon colleagues to assist in assessing capacity.

play
decide

Info Card ㉞

Life-saving treatment

In situations involving life-saving treatment, where a person is found to lack decision-making capacity and it is not possible to defer treatment (to a time when they regain decision-making capacity or for their will and preferences to be ascertained), treatment may proceed.


play
decide

Info Card ㉟

Fluctuating decision-making capacity

In circumstances where a person has fluctuating decision-making capacity, non-urgent decisions should always be deferred to a time when their decision-making capacity is optimal.


play
decide

Info Card ㊱

Assessment

The assessment of decision-making capacity must be made by a registered medical practitioner and another healthcare professional in two circumstances: (a) the creation, variation, or revocation of an enduring power of attorney instrument, by applying a functional test at the time the instrument was created/varied/revoked, and (b) where the person wishes to create a co-decision-making agreement to appoint someone to jointly make decisions with them.

play
decide

Info Card ㊲

Called into question

A person whose decision-making capacity is called into question must consent to having their decision-making capacity functionally assessed. If the person is unwilling or refuses to consent to the assessment, steps may be taken to assist them, such as explaining the nature/purpose of the assessment, involving a trusted family member; listening to his/her concerns; providing time, support and reassurance.


play
decide

Info Card ㊳

Reasons for refusal

A person whose decision-making capacity is called into question may refuse to have their decision-making capacity functionally assessed and this, of itself, is not indicative of a lack of capacity. Their reasons for refusal should be documented and, if necessary, an application may be made to the Circuit or High Court for relevant orders.

play
decide