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Coláiste na Tríonóide, Baile Átha Cliath

The University of Dublin

**Assessment of older adults'
decision-making capacity
in relation to independent living:
The role of occupational therapy**

**A dissertation submitted to the University of Dublin for the
Degree of Doctor of Philosophy**

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Trinity College Dublin, February 2022

Discipline of Occupational Therapy

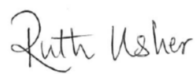
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Ruth Usher

September 2021

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List of Research Outputs to Date

Papers published in peer reviewed journals

Usher, R., Stapleton, T. (2018) Overview of the Assisted Decision-Making (Capacity) Act (2015): Implications and opportunities for occupational therapy. *Irish Journal of Occupational Therapy* 46(2), 130-140. <https://doi.org/10.1108/IJOT-08-2018-0013>

Usher, R., Stapleton, T. (2020) Approaches for assessing decision-making capacity in older adults: A scoping review protocol *JBI Evidence Synthesis* 18(4):832-840 <https://doi.org/10.11124/JBISRIR-D-19-00068>

Usher, R. and Stapleton, T. (2020) Occupational therapy and decision-making capacity assessment: A survey of practice in Ireland *Australian Occupational Therapy Journal* 67(2), 110-120 <https://doi.org/10.1111/1440-1630.12629>

Usher, R., & Stapleton, T. (2021). Assessment of older adults' decision-making capacity in relation to independent living: A scoping review. *Health & Social Care in the Community*, 00, 1– 23. <https://doi.org/10.1111/hsc.13487>

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Usher, R. (2020) Decision-making capacity of older adults for independent living: Occupational therapists' role in assessment and support. *Association of Occupational Therapists Ireland (AOTI) National Conference*, 9/10/2020.

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Forthcoming conference presentations:

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- Short oral presentation: *Occupational Therapy Practice in Assessment of Older Adults' Decision-Making Capacity for Independent Living in the Irish Context: Findings from a Consensus Meeting*
- Poster presentation: *Assessing Older Adults' Decision-Making Capacity for Independent Living: Challenges and Opportunities for Occupational Therapy*

Invited speaker

- Usher, R. (2019) Decision-Making Capacity Assessment: Implications and Opportunities. Invited speaker at *Mental Health Older Persons Occupational Therapy Special Interest Group and Psychiatry for Later Life Medical Social Workers Special Interest Group Study Day*, Dublin, 15/2/2019
- Usher, R. (2018) Occupational Therapy and decision-making capacity assessment: Preliminary findings from an Irish study. *AOTI Older Person Advisory Group Study Day*, Dublin, 12/10/2018

List of Abbreviations

ADL – Activities of Daily Living

DMC – Decision Making Capacity

HSE – Health Service Executive (Ireland)

IL – independent living

UNCRPD – United Nations Convention on the Rights of Persons with Disabilities (2006)

Summary

Introduction

Decision-making capacity (DMC) is the extent to which an individual is capable of understanding and remembering information and using this to make and communicate their choices regarding their personal, financial and healthcare affairs. Increasing age and life expectancy, alongside the growing incidence of chronic conditions and dementia-related diseases, indicate more older individuals are likely to experience challenges regarding DMC. However, all adults, including those with disabilities, have a right to participate in decisions that may have an impact on their lives. Internationally, equality and human rights policy and legislation protects and upholds these rights. In Ireland, the Assisted Decision Making (Capacity) Act 2015 provides a statutory framework for adults who are experiencing difficulties with decision-making. This legislation has significant implications for all health and social care professionals, especially those working with older adults or people with cognitive disabilities. Occupational therapists are frequently involved in and contribute to the assessment of older adults' DMC in relation to independent living (IL), yet little is known about the extent of their involvement or the nature of occupational therapists' contribution to DMC assessment of older people. The overall aim of this research study was to explore the role of occupational therapy in the assessment of DMC of older people in relation to IL, within an Irish context of practice.

Objectives

This study explored the current involvement of occupational therapists in the assessment of older adults' DMC in Ireland, alongside their awareness of, attitudes towards and application of recent legislation regarding DMC and the factors that impact on their engagement in DMC assessment, specifically in relation to IL. Additionally, this study aimed to form a consensus on recommended approaches for occupational therapists in Ireland that address DMC assessment of older adults for IL, from a client-centred, occupation-based perspective, that aligns with current DMC policy and legislation.

Methods

The study was conducted via a four-phased sequential mixed methods design. A combination of qualitative and quantitative approaches was utilised in the three phases of empirical data collection, in conjunction with the scoping review. The design of the study facilitated an iterative and sequential approach to data collection, with each phase emerging as a result of the findings of the previous phase, and findings from all phases were combined in drawing inferences from the overall study.

Phase 1 comprised of an online cross-sectional survey among practising occupational therapists, to explore occupational therapy practices regarding DMC assessment in Ireland. This national survey aimed to provide an overview of current occupational therapy practices in DMC assessment within an Irish context by exploring if and to what extent occupational therapists were involved in DMC assessment. The results from Phase 1 indicated that occupational therapists who work with older adults were likely to be involved in DMC assessment and they were most concerned with the DMC domain of IL. Thus, the scoping review conducted in Phase 2 explored DMC assessment approaches for IL among older adults from an international and multidisciplinary perspective. Findings from Phase 1 survey and Phase 2 scoping review informed and shaped the subsequent design and data collection methods in Phase 3. Qualitative focus group interviews were used to explore in detail the assessment practices of occupational therapists in Ireland who were actively involved in DMC assessment with older adults and to identify the challenges encountered by occupational therapists in addressing this area. An interpretive descriptive methodology guided Phase 3 and qualitative data from this phase were analysed using thematic analysis. The issues identified in this phase informed Phase 4, which employed a nominal group technique (NGT) meeting as a structured approach to obtaining consensus on recommended processes for occupational therapists in Ireland to address IL DMC assessment of older adults, from a client-centred, occupation-based perspective, aligning with current legislation. Occupational therapists identified, ranked and rated critical dimensions of assessment of older adults' DMC, specifically for IL.

Findings

The survey was responded to by one hundred and seventy-two occupational therapists. Most occupational therapists (65.77%, n=98) reported involvement in DMC assessments, particularly those working with older adults. Occupational therapists were predominantly involved in the contribution to assessments of DMC regarding IL (79.19%, n=118), and to a lesser extent they were involved in assessment of other DMC domains, such as driving (45.89%, n=67), and financial management (44.44%, n=64). Occupational therapists reported using a combination of approaches to inform DMC assessment, including interviews, observations and assessments of cognition and functional performance. Findings indicated that DMC assessment is one of the most complex of occupational therapists' practice and a large proportion of respondents were dissatisfied with current DMC assessment procedures in their practice settings. The majority of respondents (91.86%, n=113) emphasised the need for additional training and practice resources to enhance current DMC assessment.

Nine focus groups discussions were conducted with fifty-two occupational therapists, from a range of hospital and community practice settings in Ireland. Findings highlight a good awareness of DMC legislation among occupational therapists, many whom had sought education and training

opportunities to enhance their knowledge in this area. However, many practice constraints and resources issues were identified as barriers to occupational therapists' implementation of optimal DMC assessment. Occupational therapists identified having a relevant skill set and clear role in contributing to a comprehensive occupation-based and client-centred assessment of older adult's DMC, that is in line with current legislation. The need for further education, resources and guidelines for occupational therapists and other healthcare professionals to better guide DMC assessment and support was highlighted.

A one-day consensus meeting was held with twenty occupational therapists experienced in contributing to IL DMC assessment of older adults from a range of practice settings. Strong consensus was achieved on key triggers that indicate the need for IL DMC assessment, including perceived risk, conflicting stakeholder perspectives on older person's needs, and reduced insight. Strong consensus was also agreed that occupational therapy's contribution to DMC assessment should include observations of function, cognitive assessment, and home-based assessment. Strong consensus was achieved regarding the need to ensure that the older person's will and preference was central within occupational therapy's assessment of DMC for IL. Participants strongly agreed that a responsive and individualised approach to DMC assessment is required to support the person's participation in the process.

Conclusion

The study confirms that occupational therapists have a role to play in assessment of older adult's DMC, particularly regarding IL, within the multidisciplinary context. Overall, the occupational therapists recognised that a thorough assessment of older adults DMC for IL requires a multicomponent and multidisciplinary approach, with consideration of the older person's values and preferences. They emphasised the relevant skill set held by occupational therapists that enables them to make a significant contribution to the multicomponent assessment of DMC for IL. This study provides insight to factors that both challenge and facilitate occupational therapists' engagement in assessing and supporting older adults DMC for IL as well as highlighting a potential leadership role for occupational therapy in this area. The findings from this study provide a foundation that will enable the development of resources and guidelines for occupational therapists to consolidate and advance their practice in this area.

1.0 Chapter 1

1.1 Introduction

In this chapter, a background to this research study exploring the role of occupational therapy in decision-making capacity assessment will be presented. The study has two principal concerns: namely the assessment of older adults' decision-making capacity for independent living, and the participation of occupational therapists in decision-making assessment processes. By way of introduction to this study, relevant contextual background across three areas will be overviewed in this chapter:

- Decision making capacity assessment and the current legislative framework in the Republic of Ireland,
- An overview of occupational therapist's participation in the decision-making capacity assessment process, and
- The domains of decision-making capacity relevant to older people, with specific emphasis on DMC for independent living.

The rationale for the study and the aims of the overall study will be outlined. Additionally, the researcher's role and background as an occupational therapist with experience in working with older adults and contributing to decision-making capacity assessment is acknowledged as this also contextualises the study. Finally, an overview of the thesis structure will be provided.

1.2 Decision-making capacity

Decision-making capacity (DMC) refers to an individual's ability to make their own decisions. In the literature, numerous terms are used, often interchangeably, such as "competency," "capacity," "mental capacity" and "decision-making capacity", which reflects the diversity in understanding what is a complex legal, ethical, clinical and social concept (Hoptof, 2005). Moye et al. (2013) observe that DMC is "a status that is almost as hard to define as it is to assess" (p. 159). Nonetheless, it is widely accepted that four core abilities are essential in decision-making capacity: *understanding, appreciation, reasoning, and expressing a choice* (Appelbaum & Grisso, 1995; 1998; Moye et al., 2007; Moye & Marson, 2007; Smyer, 2007). Therefore, DMC is generally understood as the extent to which an individual is capable of understanding and remembering information relevant to a particular decision and using this information to make and communicate their choice (Barry and Docherty, 2018).

In most Western democratic countries, it is assumed that, unless proven otherwise, adults have the right and capacity to make decisions about issues affecting their lives, ranging from simple everyday

choices to decisions with more serious consequences, such as where to live, personal care preferences, financial decisions and healthcare decisions. DMC is increasingly being recognised as a significant concern within society and healthcare systems (Moye & Marson, 2007; Parmar et al., 2015), however, the complex issues associated with the determination of DMC cannot be understood without consideration of the social, political and professional contexts within jurisdictions (Davidson et al., 2016).

1.3 Background Legislation and Policy Context to the Research

DMC is an evolving aspect of law, policy and clinical practice. Legal and policy developments provide context for the increasing salience of issues of DMC and also influence health and social care professionals' (HSCP) practices (Smyer, 2007); therefore, it is important to consider how the legislative and policy context has framed the way DMC is considered and addressed within clinical practice.

Internationally, legislation guiding DMC assessment in many Western societies has undergone recent reform in order to support individuals to make their own decisions wherever possible and secondly to protect those who lack DMC. Examples of such legislative advances include the Mental Capacity Act 2005 in England and Wales; the Adults with Incapacity (Scotland) Act 2000 in Scotland; the Mental Capacity Act (Northern Ireland) 2016; the Health Care Consent Act (1996) in Ontario, Canada; Powers of Attorney Act 2014 in Victoria, Australia and the Assisted Decision Making (Capacity) Act 2015 in Ireland. In these western countries, legislation has been developed to align with the United Nations Convention of the Rights of Person with Disabilities (United Nations, 2006) and the underpinning assumption that adults are competent in decision-making, however the operationalisation of the convention through legislation varies across jurisdictions.

1.3.1 *United Nations Convention on the Rights of Persons with Disabilities*

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (United Nations, 2006) clearly states the rights of all people with disabilities to equal recognition before the law, to enjoy legal capacity on an equal basis with others and to participate in decision-making in all aspects of their lives, such as health, finances, and decisions related to independent living. UNCRPD recognises the importance of human autonomy and self-determination. Therefore, it calls for an end to substitute decision-making practices that are included in most guardianship laws, whereby a decision is made on behalf of the individual who is deemed unable to make that decision for themselves. Instead, the UNCRPD places the relevant individuals at the centre of decision-making

regarding their lives and emphasises due regard for their will and preferences (Davies et al., 2019). UNCRPD uses the specific term ‘supported decision-making’ and outlines the provision of appropriate assistance to maximise the DMC of a relevant person. If deemed necessary, a person can nominate trusted people to assist them in their decision-making. UNCRPD holds nations who have ratified the Convention responsible for the development of appropriate supports to allow persons with disabilities to exercise their legal capacity and participate in decision-making through their legislation, policies, and practices. This obligation on states to provide these supports, as detailed in Article 12 of the Convention, has turned the practice of supported decision-making into a human rights imperative (Arstein-Kerslake et al., 2017). Furthermore, in relation to DMC for independent living (IL), Article 19 is also of particular relevance to the placement of older people in nursing homes. It explicitly states that all people with disabilities have the right to live and participate in the community and requires states to develop a range of supports to facilitate people with disabilities to live in the community. Many countries such as Australia, Canada, Israel, Germany, the United Kingdom and some states in the United States of America have ratified the Convention. The Irish Government signed the Convention in 2007 and ratified it in March 2018, which has required legislative reform and development of a range of national strategies and programmes to be established to ensure the State can meet the obligations it assumes under the terms of the UNCRPD.

1.3.2 Irish legislative context

In Ireland, the Assisted Decision Making (Capacity) Act 2015 provides legal framework and definitions of DMC. It sets out an understanding of DMC which is functional and time-, issue- and context-specific. Rather than defining DMC, the Act defines mental incapacity by stating that:

‘a person lacks the capacity to make a decision if he or she is unable

(a) to understand the information relevant to the decision,

(b) to retain that information long enough to make a voluntary choice,

(c) to use or weigh that information as part of the process of making the decision, or

(d) to communicate his or her decision’

(Section 3(2)).

This definition bears a close semblance to definitions of DMC in legislation in a number of other countries, though approaches to assessment and underpinning principles vary. Davidson et al. (2016) highlight the importance of being aware of the crucial, but often nuanced differences in decision-

making processes and legal frameworks for DMC. They highlighted commonalities and differences relating to the criteria for intervention, the assessment process, the safeguards, and issues in practice across four jurisdictions (Ontario, Canada; Victoria, Australia; England and Wales, United Kingdom (UK); and Northern Ireland, UK). Irish legislation does not contain any reference to the 'best interests' standard that has provided the basis for decision-making in other jurisdictions, such as the UK. The 'best interest' standard in the UK legislation allows for decision-making on behalf of individuals with impaired DMC and requires others acting on behalf of the individual with impaired DMC to act in their 'best interests'. The concept of 'best interests' is ill-defined but generally implies the person's own wishes and preferences be taken into account as well as what is clinically viewed as the most appropriate action (Denning et al., 2019). Although it is intended to benefit the individual whose DMC is impaired, concern has been raised about inconsistencies in interpretation of 'best interests' and given it is subject to prejudice and bias, the autonomy, rights and interests of cognitively impaired individuals may be compromised (Taylor, 2016). In contrast to the UK legislation, the Irish Assisted Decision Making (Capacity) Act 2015 has remained closer to the UNCRPD Article 12 and places the 'will and preference' of individuals at the centre of all decision-making in relation to welfare, property and affairs. It necessitates that any interventions be least restrictive to the individual, respecting their rights to dignity, bodily integrity, privacy, autonomy and control over financial and property affairs. Nonetheless, this principle has been critiqued as 'will and preferences' remains undefined and practice implications are poorly understood (Carney et al., 2019; Donnelly, 2016; Szmukler, 2019).

The Assisted Decision Making (Capacity) Act 2015 is underpinned by a statutory presumption that all individuals have DMC and key principles guiding the Act and the approach to DMC assessment are set out in Figure 1.1.

Figure 1.1

Guiding Principles of the Assisted Decision Making (Capacity) Act 2015

Guiding Principles of the Assisted Decision Making (Capacity) Act 2015

1. a person is presumed to have capacity in respect of the matter concerned unless the contrary is shown
2. a person shall not be considered as unable to make a decision unless all practicable steps have been taken to help him or her do so
3. a person shall not be considered as unable to make a decision merely because the decision made or likely to be made is an unwise decision
4. intervention should only take place on the basis of necessity and individual circumstances
5. intervention must be made in accordance with human rights, be proportionate and limited in duration
6. the intervenor must make maximum efforts to meet the wishes of that individual and take account of other specified requirements and interests

The Assisted Decision Making (Capacity) Act 2015 is a significant piece of legislation and will extensively reform the law for people whose capacity is in question and who need help making decisions now or in the future (Kelly, 2017). It will replace the antiquated Lunacy Regulation (Ireland) Act 1871 and as it moves away from older practices of guardianship, best interests and substituted decision-making, it will require further legislative change, such as the existing Ward of Court System which will need to be revised. These changes are broadly welcomed in clinical and legal communities where the preceding legislation and associated structures encompassed an inadequate conceptualisation of DMC and insufficient provision of human rights for those with impaired DMC (Donnelly, 2016; Kelly, 2017).

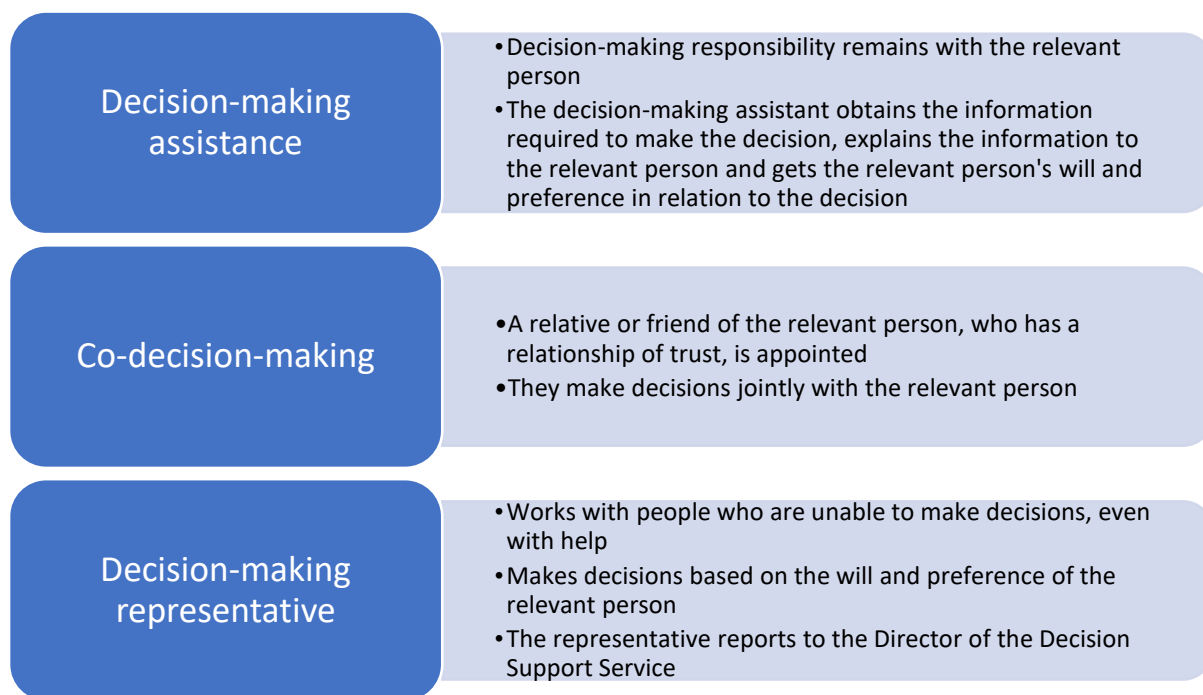
As it applies to health and social care, the provisions of the Act ensure people will be treated according to their will and preference, will promote the person's autonomy concerning their choices, and will provide health and social care professionals (HSCPs) with important information about person and their choices in relation to health and social care related decisions in hospital, residential and community settings (Ní Shé et al., 2020). This will include day-to-day decisions, such as personal care preferences, and more complex decisions such as those regarding consent to treatment, finances and where to live. The Act places a two-fold obligation on all HSCPs to (i) support a person to make their own decisions as far as possible, and (ii) where the person's DMC is in question, to provide all practicable support to facilitate the person to make the particular decision. All HSCPs, including occupational therapists, who work with persons who require assistance in exercising their DMC should be familiar with the Act and consider its implications for practice.

1.3.2.1 Supported decision-making

The second guiding principle of the Act requires that all practicable steps to support a person to make a decision must be taken before it can be concluded that they lack DMC. Following this, a key area addressed within the Act is the development of new mechanisms for supporting people with cognitive disabilities in decision-making about their lives. To allow those whose capacity is in question to retain as much autonomy as possible while making a decision, the Act outlines three levels of supported decision-making: “decision-making assistant”, “co-decision-maker” (joint decision-making) and “decision-making representative” (substitute decision-making), which will apply to all persons with questionable DMC, including older adults. It also introduces statutory Advance Healthcare Directives into law, along with potential for Enduring Power of Attorney to assist an individual in the decision-making process. Advance directives allow persons proclaim their treatment choices and preferences for future situations where their DMC may be impaired and while they may not carry the same authority as the informed and voluntary treatment choices, it is commonly accepted that in the absence of strong countervailing reasons they must be respected (Scholten and Gather, 2018). The three levels of supported decision making delineated in the Act are summarised below (Figure 1.2):

Figure 1.2

Supported decision-making levels



Supported decision-making generally involves providing the individual with impaired DMC the support they need to make their own decisions. The three levels of supported decision-making set out in Irish legislation reflect the conceptualisation of decision-making on a spectrum, with autonomous, independent decision-making on one end, through to substitute decision-making at the other end. Rather than focus on either end of the spectrum, it is increasingly acknowledged that most people require some level of support with many aspects of decision-making (Webb et al., 2020a). As decision-making is recognised as a key aspect of independence, personhood and rights (Webb et al., 2020b), supported decision-making is arguably a universal concept, relevant to all citizens rather than specifically those with disabilities (Carney et al., 2019; Webb et al., 2020b).

Regarding the Irish legislation, there has been some critique that a co-decision maker must be “a relative or friend of the appointer who has had such personal contact with the appointer over such period of time that a relationship of trust exists between them” (Part 4, 17, 2a) as it suggests that people who live alone or do not have a relative or friend fitting this criterion may be more likely to be deprived of their DMC (Alzheimer’s Europe, 2020). Nevertheless, this much anticipated legislation, which abolishes use of negative terms such as ‘lunatic’ and ‘idiot’ from the previous legislation, has been widely welcomed in legal and disability groups. The Act has yet to be fully commenced, though preparation is underway for full implementation in June 2022.

The establishment of the Decision Support Service is underway, though not yet operational at time of writing, Despite preparations being underway Despite preparations being underway with a plan to

launch the service in mid-2022, alongside full commencement of the Act. The Health Service Executive (HSE) has established the HSE National Office of Human Rights and Equality Policy (formerly the HSE National Assisted Decision Making and Consent Office) in order to prepare healthcare staff and services. Though early codes of practice were drafted for professional consultation and training resources are under development by the HSE, these are not yet available to HSCPs. Despite preparations being underway, it is difficult to see how the legislation will be implemented into practice and in the absence of practice guidelines, the implications of the Act for many HSCPs remain unclear (Kelly, 2017; Kelly et al., 2018). Ní Shé et al. (2020) raise concern about how health and social care services will respond to the increasing numbers that will need assistance with their decision-making once the Irish legislation is fully commenced, given the existing healthcare system is currently under significant resource and time strain. In order to enable assisted decision-making, it has been proposed that healthcare systems will need to reorganise their service delivery and ensure that staff are supported via ongoing education on topics such as legal and ethical issues, communication skills, and training to specifically address the needs of older people with cognitive impairment and people with dementia (Davies et al., 2019; Donnelly et al., 2021; Ní Shé et al., 2020). As all HSCPs are required to contribute to DMC assessments, each professional discipline will require clarity on their roles in assessing and supporting DMC and how the legislation impacts their practice. In order to operationalise the legislation, HSCPs are likely to need discipline specific guidelines, protocol and training to enable them to effectively implement the Act in a manner that is within the remit of their respective professions and relevant to the specific client groups with whom they work. Occupational therapists are one of the HSCPs that will have a key role in implementing the DMC guidelines within their practice and the current study was designed to specifically investigate the potential role of occupational therapists in contributing to DMC assessment.

1.3.3 HSE National Consent Policy

As specific training resources and codes of practice for DMC assessment are not yet available, HSCPs rely on the HSE National Consent Policy (2014; 2017; 2019) for some guidance around DMC assessment. The National Consent Policy has undergone numerous recent revisions to align itself with the Assisted Decision Making (Capacity) Act 2015. It is prudent to review this policy, not only due to delays in legislative commencement and associated guidance, but given the concept of DMC is arguably the central tenet of informed consent, which intends to promote and protect the autonomy of individuals in health and social care context (Bigby et al., 2017; Moye & Marson, 2007; Lamont et al., 2019). The HSE National Consent Policy (2019) provides one overarching policy to guide HSCPs and sets out the need for consent, and the application of the general principles in this policy as it extends to all interventions conducted by HSCPs and applies to those receiving care and treatment in

hospitals, in the community and in residential settings. It summarises the constituent elements of valid consent, which is dependent on: DMC, disclosure of information, comprehension, voluntariness and agreement. It provides guidance for clinical circumstances when an individual's DMC and consent are disputed and the policy is clear in its requirement for HSCPs to use a 'functional' approach to assessing DMC, in relation to the particular decision to be made, at the time it is to be made. In line with the Act, this policy clarifies that DMC depends upon the ability of an individual to comprehend, reason with and express a choice with regard to information about the specific decision. It also sets out the requirement of HSCPs to work on the presumption of the service user as having DMC and recognises that there is a hierarchy of complexity in decisions and that cognitive deficits are only relevant if they actually impact on decision-making. Similar to the Assisted Decision Making (Capacity) Act 2015, the consent policy guidelines emphasise the HSCPs' duty to maximise DMC through provision of supports and to maximise the services user's participation in decision-making "even in the presence of incapacity, the expressed view of the service user carries great weight" (p. 33).

1.3.4 Guidance on a Human Rights-based Approach in Health and Social Care Services

These legislative changes which articulate the formal right for people to supported and assisted decision-making coincide with a general move toward a more human rights-based approach to health and social care. In Ireland, the Health Information and Quality Authority (HIQA) is a statutory body with responsibility for driving high-quality and safe care for people using health and social care services. HIQA has developed a number of national standards relevant to those HSCPs working in health and social care services which promote up-to-date practice, and emphasise protecting and promoting the rights and respecting the autonomy, privacy and dignity of services users. In conjunction with Safeguarding Ireland and the Irish Human Rights and Equality Commission, HIQA (2019a) published a guidance document to assist HSCPs to uphold human rights in their work. In addition to providing a description of key human rights that are relevant to health and social care services, this guidance provides a decision-making aid that uses a human rights-based approach. It specifically refers to HSCPs' responsibility to presume and support DMC and adhere to the Assisted Decision-Making (Capacity) Act 2015. The decision-making flow chart in this guidance prompts the HSCP to clarify what the decision in question, who it affects and how, who has made the decision, whether it affects anyone's rights and if the decision involves a human rights restriction, to clarify if it is lawful, legitimate and proportionate (HIQA, 2019b).

1.4 Decision-making capacity assessment

Legislative reform is likely to raise interest in DMC as a concept and also in DMC assessments in healthcare (Brémault-Phillips et al., 2018). Therefore, more DMC assessments may be requested of HSCPs which will also require more consistent, best-practice processes to assess DMC. Although adults in most developed societies are presumed to be competent in decision-making regarding their personal, financial and healthcare affairs, when DMC is doubted, a comprehensive and fair assessment process is required, to maximise autonomy and safeguard from harm.

The recently enacted Irish legislation advocates a 'functional' approach to DMC assessment whereby the focus is on the person's *process of making a decision* rather than the outcome of the decision itself, that is, their ability to understand the nature and consequence of the decision at the time of decision-making and express their choice. Figure 1.3 outlines the functional approach to DMC assessment as outlined in the Act.

Figure 1.3

Functional approach to DMC assessment

A functional approach to the assessment of DMC as set out in Assisted Decision Making (Capacity) Act 2015

A person is considered to lack capacity to make a specific decision if they are unable:

- To understand the information relevant to the decision
 - To retain that information for long enough to make a voluntary choice
 - To use and weigh up that information as part of the process of making the decision, or
 - To communicate their decision by any means (whether by talking, writing, using sign language, assistive technology, or any other means)
-

However, DMC assessment is widely considered one of the most conceptually and ethically challenging areas of clinical practice (Banner, 2012; Bigby et al., 2017; Parmar et al., 2015). This 'functional' approach to DMC assessment is still not clearly understood and it is not easily operationalised into practice due to a lack of standardised DMC assessment processes.

Internationally, challenges with DMC assessment have been identified including differing understanding of DMC, limited resources and time pressures, and lack of education and training (Donnelly, Begley, & O'Brien, 2019; Jayes et al., 2017; Lamont et al., 2019; John et al., 2020). Many HSCPs report little confidence in their knowledge and skills in this area (Jayes et al., 2017; Young et al., 2018). DMC assessment processes and best-practices should be standardised and integrated into routine care to ensure HSCPs can determine least restrictive and intrusive person-centred outcomes

(Brémault-Phillips et al., 2018). In order to develop such DMC assessment processes and best-practices and to implement the nuances of the Act, it is necessary to first explore HSCP's current practices, beliefs and challenges.

1.5 Role of Occupational Therapy in DMC assessment

Occupational therapists are one of the many HSCPs who have a key role in the assessment of DMC. As assessment of capacity and decision-making should be core skill of all clinicians (Barry and Docherty, 2018), occupational therapists must therefore give consideration to how the functional approach to assessment of DMC, as specified in the Act, is to be operationalised in their clinical practice. Due to the complexity of the Act and potential far-reaching ramifications for those who it affects, the commencement and implementation of the Act into practice poses many challenges for all HSCPs, including occupational therapists, as they use it to guide their assessment and determination of DMC. In order to facilitate supported decision-making in practice, interprofessional collaboration is required, with clear recognition and utilisation of each HSCP's knowledge, skill and expertise in supporting DMC (Donnelly et al., 2021). While occupational therapists have been included in multidisciplinary research examining DMC assessments, (Cliff and McGraw, 2016; Donnelly et al., 2021; Jayes et al., 2017; Lamont et al., 2019) limited research exploring the role of occupational therapy in DMC assessment has been conducted to date. DMC-related reviews which have focused on the knowledge and experience of HSCPs in England and Wales of capacity legislation (Scott et al., 2020) and how they assess capacity (Jayes et al., 2020) recommend a collaborative approach to DMC assessment and refer to occupational therapists' role in DMC assessments, specifically in relation to decisions concerning discharge destination and independent living.

There is increasing recognition that occupational therapy must fit within the complex social, political and cultural contexts in which therapy occurs (World Federation of Occupational Therapy [WFOT], 2010) and for occupational therapy practice to be client-centred, occupation-centred, evidence-based and culturally relevant (Boyt Schell et al., 2019; Mroz et al., 2015). Occupational therapists must explore the potential of their roles in assessing and supporting DMC, to ensure that individuals are given the support and accommodations that they require in order to maximise their participation in decision-making about important aspects of their lives, such as independent living. Given the multifaceted, and widespread consequences of DMC assessment, it is important to examine occupational therapist's knowledge, practice, and attitudes to DMC and their role and contribution to DMC assessment.

Prior to the design and commencement of this research project, the researcher was not aware of any previous research studies in Ireland or internationally that specifically explored the role of

occupational therapy in assessing DMC among older adults. Therefore, this research was purposively designed to explore the role of occupational therapists in assessing and supporting DMC of older adults in preparation for the formal implementation of the Assisted Decision-Making (Capacity) Act 2015 in the Republic of Ireland.

1.6 Prevalence of DMC impairment

Recent findings emerging from international studies suggest that approximately 25-50% of all hospitalised patients across a variety of medical and psychiatric settings lack DMC for treatment decisions at any period of time (Bilanakis et al., 2014; Lepping et al., 2015; Okai et al., 2007; Raymont et al., 2004; Sessums et al., 2011). While research in Ireland is limited, similar findings have been reported. Curley et al. (2019a) who found only 47.4% of in psychiatry inpatients in Ireland were considered to have full mental capacity. They also found that increased age to be associated with diminished capacity, though they also argue that other factors such as symptom severity appear more significant (Curley et al., 2019b). Mental incapacity was also found to be common in medical and surgical hospital inpatients in Ireland, with over one quarter of participants (27.7%) lacking DMC for treatment decisions and mental incapacity is also apparently associated with demographic variables such as increased age (Murphy et al., 2018). In the UK, Raymont et al. (2004), who estimated 40% of patients in acute medical care lacked DMC, also suggested that older age and cognitive impairment are independently associated with diminished DMC. It has estimated that up to 40% of people receiving home care support may lack DMC and up to 75% of care home residents in the United Kingdom (UK) may lack capacity to make certain decisions (Wade, 2019). Hoptof (2005) reviewed previous research and concluded that up to one third of hospital inpatients may lack DMC, often due to cognitive impairment caused by delirium or dementia. These research findings indicate that older patients, whether in psychiatry or general medical settings, are more at risk of not having DMC. Many findings indicate that patients' incapacity was often not readily recognised by HSCPs (Bilanakis et al., 2014; Hoptof, 2005; Raymont et al., 2004; Sessums et al., 2011). This lack of explicit identification and management of patients that may not have DMC to make important decisions, such as discharge from hospital to a nursing home, could lead to undesirable practices and highlights that more should be done to enable HSCPs to better address this issue of assessing and supporting DMC when working with older adults (Hoptof, 2005; Raymont et al., 2004).

1.7 Decision-making capacity and older people

Decision-making is more complex for older people with multiple health and care needs due to the cumulative effects of long-term conditions and compounding issues, such as resource availability, polypharmacy and safeguarding (Bunn et al., 2018). In line with global trends, Ireland has a growing ageing population, with an increasing prevalence of dementia (Central Statistics Office [CSO], 2017; O' Shea et al., 2019) and subsequent complex support needs, which is further compounded by changing family structures and inequities in availability of and access to support services.

Internationally it has been suggested that due to ageing population trends and the associated prevalence and incidence of chronic conditions, the number of persons requiring DMC assessments is likely to increase (Brémault-Phillips et al., 2018; Charles et al., 2017; Moye & Marson, 2007). Moye et al. (2005; 2013) highlighted the significant consequences of DMC assessment outcomes for older adults and the need for DMC research to develop theories, models and focus on DMC among a wide range of cohorts among older people. Moye and Marson (2007) identified at least eight categories of DMC requiring assessment among older adults: independent living, financial management, driving, consent to treatment, sexual consent, research consent, voting and testamentary consent. While there is a growing body of research on older adults' DMC, to date the literature has focussed on their DMC for medical treatment, research participation, and financial decision-making.

In Ireland, recent research has been published as part of the Promoting Assisted Decision-Making in Acute Care Settings (PADMACS) project which developed an educational tool to promote understanding of DMC legislation among HSCPs working in an acute care setting and to encourage their adoption of this understanding into their care planning with older people (O'Donnell et al., 2018). As part of this PADMACS project, research highlighted the need for formal assisted decision-making services, strategies for leadership, environmental and social re-structuring and training to enhance HSCP's implementation of assisted decision-making in Irish healthcare (Davies et al., 2019). In practice, many barriers and challenges hamper the smooth implementation of DMC legislation into everyday clinical practice. Donnelly et al. (2019; 2021) identified barriers influencing the promotion of assisted decision-making among older adults in acute settings in Ireland, including the physical environment, communication, time and timing, and the need for education and training. Interprofessional working between different HSCPs is seen as key to decision-making for older adults with complex needs (Bunn et al., 2018) and implementation of legal and policy reform relating to assessing and supporting DMC requires an understanding of inter-professional differences in perceived roles relating to the practice of supporting DMC (Sinclair et al., 2021). However, challenges relating to professional hierarchy, lack of multidisciplinary collaboration, reluctance to assess DMC and deferral to others have been identified in the Irish context, with medical practitioners

predominantly taking responsibility for assessing DMC (Davies et al., 2019; Donnelly et al., 2021; O'Brien & Clyne, 2021).

Occupational therapists may be involved in DMC assessment of older adults across the various DMC domains identified by Moye and Marson (2007), according to their practice areas, yet the scope of occupational therapy practice is currently unclear in relation to their contribution DMC assessment or how best to approach such assessment. In the absence of practice guidelines and clarity on the role of occupational therapy, combined with the lack of previous research in the area, the current study was designed to specifically examine the role and responsibilities of occupational therapists in the assessment of DMC in Ireland.

1.7.1 Decision-making capacity for independent living

Independent living (IL) is one of eight DMC domains identified by Moye and Marson (2007) as requiring assessment among older adults as many older people experience at least one medical condition or disability which may threaten their independence, safety and quality of life. In Ireland, the majority of older adults live in their own homes, with many preferring to remain and continue living in their homes as long as possible (Donnelly, O'Brien, Begley and Brennan, 2016; Walsh et al., 2020). Internationally, public policy on 'ageing in place' generally supports this and Irish policies also espouse a commitment in principle to supporting older people to age-in-place (Department of Health, 2013; 2014). However, the formal and informal supports and resources necessary to support IL in the community are often not available, which can make the issue of IL contentious and to date, there is no guidance for HSCPs on how best to assess a person's DMC for IL.

IL typically encompasses a range of skills including, but not limited to, preparing meals, shopping, managing money and transportation, using the telephone, managing medications, personal hygiene, responding to emergencies and other tasks that require higher levels of cognitive abilities than physical abilities (Feng et al., 2015; Lahav and Katz, 2020). IL demands cognitive processes such as coping with unfamiliar situations, unexpected events and interruptions, selecting, applying and switching strategies when needed and integrating multiple steps and actions (Toglia et al., 2019). Occupational therapy aims to maximise the older person's functional ability and promote their continued participation in valued daily activities and life roles. Occupational therapists analyse the interaction between the person, environment and occupation to develop client-centered interventions and recommendations that promote healthy ageing (American Occupational Therapy Association [AOTA], 2016). Occupational therapists have a significant role in facilitating IL for older people and it is a major part of their everyday practice with older people. As occupational therapists are often called upon to determine older adults cognitive and functional abilities within the context

of performing activities of daily living, it is important that occupational therapists are aware of how to assess older adult's DMC for IL decisions, alongside their functional abilities for IL, in order to ensure that occupational therapists contribute relevant information and thorough clinical judgment to inform multidisciplinary care planning.

As DMC is decision-specific, it must be considered relative to the particular decision being made rather than against any absolute standard and some decisions are more complex than others (Wade, 2019). IL decisions are usually complicated, with significant ramifications for older people. DMC for IL requires a person to have knowledge and understanding of what is required to live independently and the ability to apply this knowledge, to problem solve, and have an appreciation of the consequences of potential choices (American Bar Association and American Psychological Association [ABA-APA], 2008). Supporting older people to live independently generally requires a multi-faceted evaluation of the older person's individual situation, including their health, functional capacity, resources, personal attributes, living circumstances and environment (Ahlqvist et al., 2015). Given the frequency of lack of DMC as highlighted earlier, and the professional and legal consequences of not assessing DMC adequately, Wade (2019) argues it is unwise not to evaluate a person's DMC to make significant decisions about health and welfare matters and HSCPs should satisfy themselves that a person does not lack the capacity to make a decision. Considering the importance of IL decisions such as place of residence, acceptance of home care supports, admission to residential care, a comprehensive and consistent DMC assessment process is required.

1.8 Aims of the Research

The overall aim of this research study was to explore the role of occupational therapy in assessment of decision-making capacity of older people within an Irish context of practice. The specific research objectives are:

1. To examine the extent to which occupational therapists in Ireland are currently involved in the formal assessment of DMC within their practice
2. To explore occupational therapists' awareness of, and attitudes towards recent legislation regarding DMC and the potential implications of this legislation for their practice
3. To examine current international practice in the area of DMC assessment of older adults for independent living through a scoping review
4. To explore factors influencing occupational therapist's practices in DMC assessment of older adults, particularly in relation to independent living

5. To identify assessment approaches for occupational therapists in Ireland that address DMC for independent living of older adults

In order to achieve the aims of the study, a multiphase, exploratory sequential mixed methods design, using a combination of qualitative and quantitative approaches, was utilised.

- Aim 1 was met by conducting a national survey of current occupational therapy practice in assessing DMC.
- Aim 2 was addressed through the survey and through focus groups interviews to explore occupational therapists' DMC assessment practices with older adults, in relation to independent living.
- Aim 3 was achieved by conducting a scoping review of the literature regarding multidisciplinary assessment approaches used to evaluate older adults' DMC, in relation to independent living decisions.
- Aim 4 was addressed by utilising focus groups and an expert nominal group meeting to explore factors influencing occupational therapist's practices in DMC assessment of older adults, particularly in relation to independent living.
- Aim 5 was addressed through a nominal group technique to form consensus on occupational therapy assessment components and procedures in addressing DMC assessment of older adults, in relation to independent living.

1.9 Researcher's background and role

Background knowledge, theories and experiences affect what topics are researched, and the attitudes, values and beliefs of the research communities in which researchers are embedded also affects what and how research is interpreted (Bazley, 2018). This research is intended to address a clinical issue, therefore the disciplinary orientation of the researcher as an occupational therapist explains the motivation for the study and identifies the potential audience for the study findings. As the researcher is an integral part of the research process, the impact of the researcher's background, interest, training and beliefs on the study execution and findings must be stated (Carpenter and Suto, 2008). Therefore, the researcher's prior knowledge and previous clinical experience in working as an occupational therapist with older adults in a variety of settings, including rehabilitation, reablement and long-term care services is acknowledged. The researcher contributed to decision-making capacity assessments in previous employment within these clinical settings. However, similar to occupational therapists practising in Ireland, the researcher did not have any specialist training in this

area of practice, though she had attended public and professional information seminars on the introduction of the legislation.

The researcher designed, planned and coordinated the four phases of the research study with supervision from the research supervisor. Thorne (2016) recognises that despite intentions to remain true to the researcher role, the social mandate of engaging in research of one's profession is difficult to discard and therefore recommends regular critical self-inquiry to develop multidimensional understanding from learner and clinical perspectives. The researcher utilised reflective notes, voice memos and reflexive discussion with the research supervisor in effort to situate herself within the research role.

From the outset of the study, the researcher expected that many occupational therapists were involved in the multidisciplinary assessment of DMC for many different client populations who experienced cognitive challenges such as older people, people with dementia, people with intellectual disabilities and people with mental health difficulties. The researcher also expected that many occupational therapists may have found this to be a difficult area of practice and were experiencing challenges in implementing the legislation. Based on her practice experience, the researcher suspected that occupational therapists may have been primarily using cognitive assessments to inform their clinical judgment regarding their clients' DMC. Reading of international multidisciplinary literature on challenges of DMC assessment also shaped her thinking and expectations. The researcher had not considered which domains of DMC occupational therapy would be most involved in but on reading international literature realised there was many potential areas where occupational therapists may be involved. The researcher's thinking therefore shaped the development of research questions and subsequently the design of the overall study.

Based on the researcher's expectations that this was a relevant area of practice for many occupational therapists, the initial phase of the study set out to explore current practices and attitudes of occupational therapists working in Ireland. It became apparent that this was a relevant topic particularly for occupational therapists working with older adults, and particularly in relation to decisions about independent living. Many participants had declined to complete the assessment process section of the survey, which the researcher felt may have been indicative of a lack of confidence in declaring what they currently did and that perhaps there was a lack of clarity regarding best practices in this area. The researcher also expected that the clinical settings in which DMC assessments were undertaken may have posed challenges to the assessment process and felt this required further exploration.

It was within this background that the follow-up qualitative component of the study was designed and executed. The researcher's approach to planning and executing this phase was shaped by the

earlier findings, the literature and previous clinical experience. The reasoning was to explore why so many respondents had not articulated the assessment processes currently adopted in practice and why so few respondents were satisfied with current DMC assessment practices. The researcher was aware of her own experiences and biases when designing this qualitative phase. While previous clinical experience brought a level of applied understanding that was useful in engaging in the research, efforts were made to minimise the influence of bias on the research conduct through reflexive discussion with the research supervisor. During this phase of the study, factors that impacted on DMC assessments were explored and the researcher attempted to phrase questions in a neutral way and to be open to unexpected findings. The researcher's thinking was shaped by the focus group discussions and international literature as she undertook the scoping review and these findings along with previous phases findings influenced the design and execution of the final phase of research. Given the dearth of literature in this area, the researcher reasoned that a consensus method would be useful to inform practice development. Following discussion with the research supervisor, it was agreed that a nominal group technique may be a suitable method to gain multiple perspectives and this more structured approach would lessen the influence of the researcher. While the researcher's clinical experience provided background context for the conceptualisation of the study, the overall study was designed with careful consideration of methods to minimise researcher influence.

1.10 Overview of the thesis

Chapter 2: In this chapter, the current literature and rationale for this research study will be presented. The conceptualisation of DMC will be introduced and current DMC assessment practices and issues which are deemed important for this study will be outlined.

Chapter 3: In this chapter, the results and findings of the scoping review which details current international multidisciplinary practices in DMC assessment of older people regarding independent living will be presented.

Chapter 4: This chapter outlines the overall study methodology and the specific methods used within each phase of the study.

Chapter 5: The survey findings from the quantitative first phase of the research are presented in this chapter.

Chapter 6: This chapter presents findings from the qualitative focus group interview analyses of the third phase.

Chapter 7: In this chapter, the consensus formation findings from the final phase of the research are presented.

Chapter 8: This final chapter aims to provide an overall discussion of the findings and how these relate to existing research and literature in this field. It offers a series of conclusions in relation to the research and how the research questions have been answered. Here, specific actions and recommendations are put forward as well as the identification of areas requiring further research.

1.11 Summary

In this chapter, an overview of the current context of DMC assessment of older adults has been provided. The current study was designed and executed in the context of Ireland's ageing population and recently developed legislative framework in the Republic of Ireland. Internationally, legislative and policy developments have drawn attention to the issue of DMC and raised questions about how older adults' DMC is assessed and supported. The need to clarify the role and practices of occupational therapy within multidisciplinary practice was highlighted, thus the overall aim of this research study, to explore the role of occupational therapy in assessment of DMC of older people, was presented. Additionally, the researchers background was outlined in acknowledgement of how this may influence the design and conduct of the research.

2.0 Literature review

2.1 Introduction

This chapter will address some of the complex and nuanced issues of decision-making capacity and consider the ethical principles pertaining to lack of DMC on the lives of older people. The preceding introductory chapter provided a general overview of the legal framework that provides the context for DMC assessment and support practices in Ireland, and this chapter further explains key issues relating to the conceptualisation of DMC, reviews issues relating to DMC assessment in clinical practice and outlines HSCP approaches to evaluation of DMC for further consideration.

2.2 Conceptualisation of DMC

As previously highlighted, DMC is a complex legal, ethical, clinical and social concept (Hotpof, 2005) but generally refers to an individuals' ability to make a specific decision at a specific time (Moberg and Rick, 2008). Definitions of DMC and incapacity have changed over time, reflecting the three main approaches to conceptualising a person's DMC: the status, outcome and functional approaches, as summarised in Figure 2.1.

Figure 2.1

Conceptualisations of DMC

Status	DMC is equated to a particular <i>characteristic</i> of the decision-maker (e.g. a diagnosis/medical condition/impairment) and the presence of a condition is used to evaluate the quality of the decision
Outcome	DMC is based on the predicted <i>consequences</i> of the choice being made, whereby an 'unwise' or risky decision is seen to indicate impaired DMC
Functional	The <i>process</i> of decision-making is analysed, related to the specific decision at a specific time, within a specific context

2.2.1 The status approach

The 'status approach' reflects the earliest model of DMC, as a construct determined by some characteristic such as chronological age, intellect, medical condition, impairment or psychiatric diagnosis (Wong et al., 1999). The very presence of such a condition or impairment is viewed as sufficient grounds to withdraw DMC, regardless of a person's actual abilities or the level of supports offered. This traditionally dominant approach adopts a global view of capacity in 'all-or-nothing' terms, whereby once an individual is considered to lack capacity for one situation, this is subsequently applied to every aspect of their life and functioning. The status approach reflects the medical model of disability and as it is often based on assumptions and stereotypes, this approach is now considered outdated and discriminatory and is no longer promoted (Alzheimer's Europe, 2020).

2.2.2 The 'outcome approach'

The 'outcome approach' to DMC is concerned with the perceived reasonableness of decisions that are made. If the individual makes a decision that some people would consider unwise, such as a refusal of treatment considered by others as being essential, this may lead to the person's DMC being denied. This approach is problematic because it determines a person's DMC based on the 'correctness' of their choice, as determined by others, rather than the decision-making process they adopted. Thus, it denies people the right to make mistakes and take risks. Additionally, it limits people's autonomy and the right to make individual choices according to cultural, social and religious beliefs and values which may differ from those of the majority population (Alzheimer's Europe, 2020). This approach is also considered outdated and is no longer acceptable as it suggests that there are 'right' and 'wrong' decisions, and thus the assessor may project their own values onto the decision of the individual. The focus of capacity shifts away from the patient's abilities and values to the desirability of the outcome or the risk of the decision, which are often determined by the HSCP, and thus may lead to paternalism (Wong et al., 1999).

2.2.3 The 'functional approach'

In more recent years, the 'functional approach' to DMC is favoured in international legislation and clinical practice over the much-criticised status and outcome approaches. This approach requires that a person can demonstrate their ability to make an informed decision, by demonstrating understanding of the nature and potential consequences of a particular decision. The functional approach to assessment of decision-making requires an assessor to establish whether a person is able to understand, retain, and use or weigh relevant information in order to make a decision and then communicate a choice. It reflects a broader conceptualisation of DMC which entails multiple functional and contextual components (Grisso, 2003). The functional approach recognises and emphasises that DMC is time and issue specific, and highlights that the determination of a person's DMC must consider the interaction between the person's functional abilities and the given situation. Additionally, it recognises that DMC may be fluid and that loss of DMC may be temporary, fluctuating or permanent. This distinction between situation-specific functional capacities rather than global capacity is an important development in DMC conceptualisation as medical diagnosis, age or scores on standardised assessments do not predict DMC (McSwiggan et al., 2016). Smyer (2007) observes that the shift away from status and outcome approaches to the functional approach in DMC assessment paralleled with increased attention to activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in clinical and research practice (e.g., Lawton, 1988).

Within this functional approach, there are two conceptual complexities that require further clarification. Firstly, is the distinction drawn between DMC and executorial capacity, which is the practical ability to implement a decision (Boyle, 2008; Collopy, 1995; McSwiggan et al., 2016; Smyer,

1993). Importantly, the physical inability to enact the choice or loss of 'executorial capacity' does not constitute decision-making incapacity, as the individual who retains DMC may direct another person to perform the task (APA-ABA, 2008). Furthermore, within gerontology and clinical practice, the term 'functional' assessment is typically used in reference to evaluation of a person's ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) (Quinn et al., 2011). In relation to DMC assessment, a functional approach refers to the assessment of the person's decision-making abilities, across the four dimensions of understanding relevant information about their situation, appreciation of how relevant information applies to oneself in the situation, reasoning and rational deliberation about available options in order to make and communicate a choice.

Research has helped to advance this functional understanding of DMC, as studies have reliably demonstrated that cognitive and psychiatric diagnoses alone do not predict impaired DMC (Okai et al., 2007; Moye et al., 2006; van Staden, 2009), highlighting the shortcomings of adopting a 'status' approach to the determination of DMC. While cognitive screening may provide some relevant information to inform staging of cognitive impairment (Pachet et al., 2010), no single neuropsychological test or particular cognitive domain consistently predicts DMC impairment (Moberg and Rick, 2008; Okai et al., 2007; Palmer and Savla, 2007). Therefore, the functional approach, if employed correctly and when combined with supported decision-making, does not discriminate against people with cognitive disabilities (Scholten et al., 2021). It recognises that a person may have DMC for some decisions but not for other more complex decisions and may require support to participate in decision-making.

2.2.4 DMC conceptualisation in the Irish context

These models of DMC have developed over recent decades based on empirical research, expert consensus and case law. In Ireland, the legislation guiding DMC conceptualisation and practice has also evolved based on the developments in these conceptual models. The previous legislation, the Lunacy Regulation (Ireland) Act 1871, adopted a status approach to DMC, and was regarded as paternalistic and not in keeping with the social and human rights models of disability (Law Reform Commission (LRC), 2006). The LRC in 2006 recommended the introduction of comprehensive legislation regarding DMC to repeal the previous legislation and to place emphasis on capacity, rather than incapacity and to be enabling rather than restrictive. Thus, the Assisted Decision Making (Capacity) Act 2015 was developed and encompasses the recommendations from the LRC to adopt a functional approach to DMC and is consistent with the United Nations Convention of the Rights of Person with Disabilities (UNCRPD), of which Ireland is signatory.

As outlined in Chapter 1, the HSE National Consent Policy (2014; 2017; 2019) has undergone numerous revisions to align itself with the Assisted Decision Making (Capacity) Act 2015 and provides HSCPs in Ireland with some guidance on DMC assessment, in the absence of specific training resources and codes of practice for DMC assessment. This consent policy explicitly discards the previously adopted status approach and directs that there must not be an assumption that an individual lacks DMC solely because of *“their age, disability, appearance, behaviour, medical condition (including intellectual disability, mental illness, dementia or scores on tests of cognitive function), their beliefs, their apparent inability to communicate”* (Section 5.3, p. 31). Equally the consent policy rejects the outcome approach and directs that DMC *“should not be confused with a health and social care professional’s assessment of the reasonableness of the service user’s decision. The person who has capacity can make their own choices, however foolish, irrational or idiosyncratic others may consider those choices”* (p.31). In adopting a functional approach to DMC, the consent policy clearly states that even if an individual has been found to lack DMC on a particular occasion, this does not mean that they lack overall DMC, or that they will not be able to make similar or other decisions in the future. Additionally, the consent policy recognises the responsibility and duty that exists for HSCPs to maximise DMC where possible and support individuals to make their own decisions.

While the functional approach to the assessment of DMC is explicit in recent legislative reform across various jurisdictions including Ireland, and while empirical studies have supported the feasibility of such an approach (Wong et al., 2000), the use of status and outcome approaches to determine capacity may still pervade due to HSCP’s paternalistic assumptions that people with cognitive impairments are unable to understand or remember the relevant information or to assess risks or that they are vulnerable. Walsh et al. (2020) observe that a legacy of the paternalistic culture of care and the biomedical model dominance in Ireland is the inaccurate assumption that once a person is diagnosed with dementia, their abilities, autonomy and DMC are gone. Donnelly et al. (2019) found little evidence that a functional approach to DMC assessment is employed in Irish practice and suggested a collective effort is required to ensure the Assisted Decision Making (Capacity) Act 2015 informs practice in a meaningful way.

As highlighted in the previous chapter, current Irish DMC legislation does not contain any reference to the ‘best interests’ standard. Guided by Article 12 of the UNCRPD, the Assisted Decision-Making (Capacity) Act 2015 focuses on the will and preferences of the person as the determining factor in decisions about their life. ‘Best interests’ has been described as an ill-defined, indeterminate term, with evidence to suggest that ‘best interests’ may be conflated with HSCP’s evaluation of ‘best medical interests’, leading to paternalistic and risk averse practices (Donnelly, 2016; Taylor, 2016). The recent DMC legislation privileges the person’s will and preference and places a requirement on

HSCPs to consider what they can do to support the person's will and preference, even if risk is identified. Implementation of this legislation requires a substantial shift in culture in moving from the 'best interests' approach, which is currently embedded in healthcare practice.

As observed by Donnelly (2021), implementation of the recent Assisted Decision Making (Capacity) Act poses challenges for various HSCPs owing to the clear tensions between the legislation's requirement to uphold 'will and preference' and wording used in the Code of Professional Conduct and Ethics that CORU sets out for regulatory boards of registered health and social care professionals, which requires registrants act in the 'best interests of service users' (OTRB, 2019, p.6). As registrants of the Occupational Therapists Registration Board, occupational therapists practicing in Ireland must comply with the Code of Professional Conduct and Ethics set out by CORU (OTRB, 2019) and any potential breaches of this Code may be held to be professional misconduct or poor professional performance and could result in a disciplinary sanction being imposed following a fitness to practise inquiry.

Further, the Code requires registrants obey laws, regulations and guidelines (item 7) and also sets out how registrants must assess service users' capacity to consent where necessary (item 12) in accordance with the capacity legislation. Section 12.2 of the Code states that any interventions carried out with a service user who may lack capacity should 'give effect as far as practicable to the service user's past and present will and preferences' (OTRB, 2019, p. 18). This reference to contradictory approaches within HSCPs' codes of conduct may lead to confusion as while occupational therapists are obliged to follow the DMC legislation, reference to 'best interests' in the CORU Code of Conduct may indicate that outdated status and outcome approaches to assessing DMC could be justified on the grounds of a 'best interests' analysis, indicating that greater clarity may be needed in CORU's codes of practice.

2.3 Assessment of DMC in clinical practice

The assessment of DMC is an intrinsic aspect of every clinician-patient interaction, since DMC is required for valid informed consent (Applebaum, 2007). While the majority of people are presumed to have DMC, without support, some people may be deemed to have impaired DMC for certain decisions and therefore there needs to be a process to assess DMC and provide the most effective support for decision-making (Applebaum, 2007; Webb et al., 2020a). Additionally, it has been observed internationally that following the introduction of DMC-related legislation, there is often increased demand for DMC assessment (Kornfeld, Muskin and Tahil, 2009) and therefore it may be expected that recent developments in Irish legislation will increase interest in DMC as a concept and bring attention to DMC assessment practices. Given that practices in Ireland appears to be still

influenced by status and outcome approaches, the adaptation of the functional approach as required by recent legislation will likely to be challenging to implement.

The previously described conceptualisation of DMC, as a multicomponent and dynamic construct, has influenced the current functional approach to DMC assessment. As outlined in Chapter 1, general consensus has emerged in the literature regarding the core functional abilities essential in the decision-making process (Applebaum and Grisso, 1998; Moye & Marson, 2007; Moye et al., 2006; Smyer, 2007). These four core functional abilities entail:

- *Understanding* - the ability to remember and comprehend the information relevant to the decision, which may be demonstrated by paraphrasing this information.
- *Appreciation* - the ability to relate the information regarding the nature of the decision and the possible options and outcomes to one's own situation and personal beliefs.
- *Reasoning* - the ability to evaluate alternatives by integrating, analysing, and processing information so as to compare them in light of potential consequences and their likely impact on everyday life.
- *Expressing a choice* - the ability to communicate a decision.

2.3.1 Supporting DMC

Reflecting the paradigm shift in the concept of DMC, the approach to DMC assessment has also expanded beyond the mere assessment of these functional abilities and judgement of whether people are able to decide "autonomously," but rather the DMC assessment approach should ascertain what kinds of support people with decision-making difficulties need in order to be involved in decision-making, and thus to promote their autonomy (Peisah et al., 2013). As Article 12 in UNCRPD guarantees that all people with disabilities have the right to enjoy legal capacity on equal basis with others in all aspects of life, the onus is on the signatory nations to provide supports to allow all people to exercise their capacity. Therefore, the focus of DMC assessment should shift from the focus on establishing whether the person has DMC, to identifying which supports are required to assist the individual in their decision-making (Nilsson, 2012). This is echoed by Scholten and Gather (2018), who assert that DMC assessment should not only determine the level and type of support needed, but also serve to ensure the supports provided to enable people to make their own decisions are adequate.

2.3.2 Concept of autonomy in DMC assessment

The obligation for supported decision-making poses a major challenge for HSCPs, and as supported decision-making is founded in ethical and human rights frameworks, the evolution of the concept of autonomy is relevant (Peisah et al., 2013). Autonomy is recognised as one of four broad ethical principles in Western ethics and philosophy, along with nonmaleficence, beneficence and justice (Beauchamp and Childress, 2001). It is understood in terms of freedom of will, independence, self-determination, self-governance, and leading one's life according to one's own reasons and values, thus it is often linked to the concepts of personhood and dignity (Gómez-Vírveda et al., 2019). Healthcare is moving away from paternalistic approaches, tending towards transparency and collaboration with patients, emphasising the right to self-determination. Therefore, respect and promotion of an individual's autonomy is increasingly referenced as an underpinning for all DMC evaluations, while balancing the responsibility to safeguard the individual from harm, including protecting them from exploitation or undue influence from family, friends or HSCP (Moye & Marson, 2007; Mullaly et al., 2007; Smyer, 2007).

When there is doubt about an individual's DMC, an ethical dilemma may arise as respect for autonomy needs to be balanced with other principles, values and ethical approaches such as beneficence and non-maleficence (i.e. acting for the benefit of others and not inflicting harm), (Aldous et al., 2014; Usher and Stapleton, 2018; Wong et al., 1999). The challenge for HSCPs in assessing and supporting DMC is to provide guidance on available options, rather than coercion, and to promote welfare and prevent harm from likely risks.

Due to the complexity of health systems, diversity of patient needs, and high workloads and pressures, ethical tensions have been recognised as an unavoidable part of occupational therapy practice (Atwal & Caldwell, 2003; Bushby et al., 2015; Hazelwood et al., 2019), not least for those working with older adults who are living longer with increased disability and multiple needs (Durocher and Gibson, 2010). Complex discharge planning is a prominent source of ethical tension for occupational therapists as it requires consideration of client's safety and their autonomy. Occupational therapy literature examining discharge planning highlights challenges in implementing client-centred practice when risks are perceived to be high and safety is prioritised (Durocher et al., 2015; Moats, 2007; Moats and Doble, 2006). This ethical tension between promoting autonomy and safeguarding from harm is pertinent in the context of older adults' DMC for IL, especially when persons with dementia wish to live at home (Smebye, Kirkevold and Engedal, 2016). Ruchinskas (2005) argues that the determination of DMC is difficult in clinical settings due to the group dynamics of MDTs, comprised of many diverse HSCPs, each with their own ethical standards and opinions regarding patient care, and often results in an inherent draw towards beneficence in HSCPs' practice. Similarly, Darzins (2010) reports that due to cultures of risk aversion in clinical settings, many HSCPs

favour beneficence over respect for autonomy. This ethical tension can lead to HSCPs unnecessarily constraining the choices or restricting the actions of an autonomous individual in effort to prevent the person making decisions that put them at risk of harm.

However, some scholars argue against creating a hierarchy of ethical principles, whereby autonomy is claimed to be more important than beneficence, or that beneficence is more important than justice etc (Alzheimer's Europe, 2020). Rather, the context, the people concerned and the relevance of different ethical approaches, principles and values in that particular situation need to be considered in any debate surrounding DMC.

Even though the HSE National Consent Policy (2019), which provides some guidance on DMC, describes the individual's right to self-determination or autonomy as the ethical rationale behind the importance of consent, it also acknowledges that autonomy is not the only relevant ethical principle:

“Health and social care professionals also have a responsibility to try and maximise the health and well-being of, and to minimise harm to, service users and others. They also have an obligation to ensure the fair and appropriate use of resources. This means that service users (whether contemporaneously or in an advance healthcare directive) cannot demand whatever interventions they want, regardless of their effectiveness” (p.21).

In the context of healthcare practice, the overemphasis of individual autonomy as the fundamental ideal underpinning DMC assessment and support is problematic. In the literature, there is growing criticism for the tendency to emphasise respect for autonomy as a universal ethical principle in healthcare, where the realities of practice pressures, such as shortages of time, staffing and resources, affect the actual conditions and experience of the patient in making decisions. The ideal of respect for patient autonomy in clinical practice assumes that patients are able to draw upon all the resources necessary, deliberate objectively, arrive at independent judgements and communicate their decisions effectively. Sherwin and Winsby (2011) argue that such an interpretation does not fit the experiences of many patients in busy and pressured healthcare settings where care provision is efficient but regimented, and the current emphasis is on evaluating the competency of the patient, rather than giving sufficient consideration to the range and nature of the options from which each patient must choose.

The portrayal of individual autonomy in healthcare and research has been described by Gómez-Vírveda et al. (2019, p.6) as being based on a 'misconception of the individual self', and criticised for promoting a Western ethnocentric bias that overlooks other values such as family harmony, filial piety and related concepts from collectivist and interdependent societies, where it is common for decisions to be made collectively and even to defer decision-making to others. Hanssen (2004) suggests that this interpretation of autonomy has become so deeply embedded in our view of DMC,

and combined with our efforts to avoid paternalism, it potentially pressures people to make decisions that they would rather make with others or potentially defer to others.

Increased awareness of the need for culturally sensitive practice among HSCPs has led to increasing criticism of the emphasis on independence in relation to autonomy. Agich (2003) criticises the abstract presentation of autonomous persons as independent, self-sufficient centres of decision-making and encourages a broader concrete view of autonomy that acknowledges the concrete experiential and social situation of persons. This broader, more nuanced understanding of autonomy allows a concurrent recognition of dependency. Autonomy is not the same as independence and it can be developed in relationships with others (Widdershoven and Abma, 2011). Agich (2003) argues that the standard conceptualisation of autonomy which emphasises the ideals of independence is incongruent with the range of impairments that cause individuals to need long-term care and does not give sufficient attention to the fiduciary relationship between HSCPs and their patients, whereby patients entrust the HSCP to act on their behalf with respect to their health, in trust, confidence and good faith. Since people with dementia need practical support and are dependent on others to enable their social participation, the concept of 'assisted autonomy' is particularly relevant in dementia care, where support is required to enable the exercise of agency (Boyle, 2014). In fact, there is a growing recognition that all people experience varying degrees of dependence and interdependence in their lives, and as we all rely on others in some way, interdependence on others is a central part of any human relationship (Boyle, 2014; Kittay, 2011). This issue of interdependence in exercising autonomy is relevant to the issue of shared and supported decision-making and the need to provide people with the appropriate and necessary support to make decision-making possible. Therefore, in the debate about caring for older people, which has traditionally focused on their 'dependency', a shift in focus is required to allow assistance to be viewed as a resource, not a limitation.

Subtler approaches to autonomy empower more people, regardless of their DMC, to participate in decision-making about aspects of their lives. Gómez-Virseda et al. (2019) argue that the influence of other people in the decision-making process enhances rather than impedes autonomy. For example, in the case of older people making decisions about IL; HSCPs, relatives and supporters can present different options and provide emotional support, removing social barriers and bridging the gap between the person making the decision and the social environment. Relational autonomy refers to an alternative approach to autonomy which emphasises, rather than ignores, the social, political and economic conditions which serve as background context against which choices are made (Sherwin and Winsby, 2011). It recognises that people are essentially social beings, whose identities, priorities, concerns, values and beliefs are developed and maintained within a context of social relations and this social context also determines the person's opportunities to develop the necessary skills for

exercising control over important decisions. Adopting a relational autonomy approach promotes DMC by emphasising a multi-directional information-sharing process, whereby HSCPs learn about the person’s needs, values, preferences and life circumstances and the person learns of the various options available to them, allowing a decision to be reached that is closer to the person’s will and preferences (Durocher et al., 2017; Hunt et al., 2021; Sherwin and Winsby, 2011). For many people with dementia, participating or sharing in the decision-making process is as important as making the actual decision (Daly, Bunn and Goodman 2018). Similar to the supported decision-making model proposed by Scholten and Gather (2018), the supported decision-making mechanism set out in Irish legislation requires the necessary supports be provided in order to enhance the person’s abilities to make their own decisions.

2.4 Frequently used DMC assessment tools

Over the past two decades many assessment instruments and interview guides for evaluating DMC have been developed in response to the theoretical development of DMC as a multicomponent concept. These standardised assessment instruments aim to improve upon the low reliability of more general evaluation of DMC by focusing clinical assessment on the most relevant functional skills (Moye & Marson, 2007). Most of these tools incorporate the key dimensions of DMC evaluation regarding the person’s ability to understand the relevant information regarding the decision; the ability to appreciate this information; to use it to compare and weigh up options; and to express a choice. The majority relate to consent to medical treatment or research participation (Figure 2.2).

Figure 2.2

Examples of DMC assessment tools

DMC assessment tools	Aid to capacity evaluation (ACE) (Etchells et al., 1999)
	Assessment of Capacity for Everyday Decision-Making (ACED) (Lai et al., 2008)
	Capacity assessment tool (CAT) (Carney, Neugroschl, Morrison, Marin, & Siu, 2001)
	Capacity to consent to treatment instrument (CCTI) (Marson, Ingram et al., 1995)
	Competency interview schedule (CIS) (Bean, Nishisato, Rector, & Glancy, 1996)
	Hopemont capacity assessment interview (HCAI) (Edelstein, 1999; Edelstein, Nygren, Northrop, Staats, & Pool, 1993)
	MacArthur competence assessment tool — treatment (MacCAT-T) (Grisso & Appelbaum, 1998)

Some of the tools offer a semi-structured interview which guides the clinician through assessment of the person's appreciation, reasoning and understanding respectively, such as the MacArthur Competence Assessment Tool (MacCAT-T; Grisso and Applebaum, 1998). This assessment tool prompts the clinician to provide the patient with information concerning their condition and then ask the patient to describe their understanding of what they've been told. Incorrect or omitted information is addressed with prompting or cueing. A similar approach is undertaken when providing the patient with information regarding the treatment options and associated risk and benefits of each alternative. The patient is asked if they have any reason to doubt the information and they are requested to express a choice and their reasoning process is explored. Other assessments, such as the Capacity to Consent to Treatment Instrument (CCTI; Marson, Ingram, Cody and Harrell, 1995; Moye et al., 2007), use hypothetical clinical vignettes to assess decisional abilities in understanding, appreciation, reasoning and expression of choice.

While more detailed overviews of these assessments, and their limitations, are provided in many publications, (such as Hamilton et al., 2020; Lamont et al., 2013; Moberg and Rick, 2008; Moye et al., 2006; Palmer and Harmell, 2016), they are not discussed further here as they do not specifically address DMC for IL and thus may confuse the fundamental distinction that DMC is not global but specific to the issue at hand. Additionally, vignette-based instruments use information that is not specific to the patient's situation, thus while scores may provide insight into their decisional abilities, they do not measure the patient's ability to make the particular decision in question. Furthermore, many of the DMC assessment tools do not adequately address all four criteria (Hamilton et al., 2020; Vellinga et al., 2004). Webb et al. (2020a) observe that people do not typically discuss decision-making in terms of these four components and efforts to support DMC do not explicitly address these components of the assessment process. Even if these instruments are useful in prompting consideration of the person's four functional abilities of how they understand, appreciate, reason, and express a choice. they are designed to aid and enhance, rather than supplant, clinical judgment (Moye et al., 2006). A systematic literature review of assessment tools used to evaluate DMC among people with dementia reported that while structured assessment tools improve consistency between clinicians when assessing DMC, no assessment tool was sufficiently comprehensive or flexible to capture the complexities of DMC (Pennington et al., 2018). Due to the interactive and contextual nature of DMC, a test score alone cannot substitute for a HSCP's professional clinical judgment (Moye & Marson, 2007). A one-size fits all approach to assessing DMC has come to be recognised as inadequate due to the varying domains of DMC and the need to integrate multiple sources of data in complex clinical situations (ABA-APA, 2008).

2.5 Issues with DMC assessment in practice

As previously stated, DMC assessment is an essential and implicit part of every interaction between a HSPC and client, since capacity is required for valid informed consent (Applebaum, 2007). These clinical judgments of DMC are usually determined informally and implicitly through conversation and are underscored by the presumption of DMC. However, given that DMC assessment involves complex, subjective judgements and lacks an established gold standard method (Pennington et al., 2018), the literature shows that many HSCPs find this area of practice challenging. Many HSCPs report inadequate knowledge in understanding the concepts of DMC, insufficient awareness and skill in the required steps to undertake DMC assessment, and a need for education and supports to improve their practices (Donnelly et al., 2019; Donnelly et al., 2021; Ganzini et al., 2003; Jayes et al., 2017; Lamont et al., 2019; Mulally et al., 2007; Samsi et al., 2012; Willner et al., 2011a; 2011b; Willner et al., 2013; Young et al., 2018).

2.5.1 Understanding of the concept of DMC

Ongoing misunderstanding of DMC is recognised as a key pitfall in DMC assessment (Donnelly et al., 2021; Ganzini et al., 2003; Moye & Marson, 2007). It is frequently misunderstood by HSCPs as a global concept rather than specific to the time, issue and context which leads to issues in assessing DMC. Recent Irish research highlights challenges in adopting a functional approach to DMC, with some HSCPs over-relying on cognitive assessments which implies poor understanding of DMC (Donnelly et al., 2021). Even when a functional DMC assessment approach is adopted, this focus on the four abilities of understanding, appreciation, reasoning and expressing a choice has been criticised as this method emphasises cognitive aspects of decision-making and does not explicitly consider the decision in relation to a person's values (Palmer and Harmell, 2016). Narrow interpretation and strict application of these four criteria can result in overlooking other important clinical elements of DMC evaluation (Kontos et al., 2015). However, Wade (2019) argues that it is the people assessing DMC who focus on cognition, and in fact a more comprehensive interpretation of a person's appreciation and reasoning should consider their underlying values and priorities and how they use these during the reasoning process to reach a decision. Nonetheless, this tendency to focus on cognition reflects misunderstanding of DMC and that many HSCPs hold the presumption that people with cognitive difficulties, dementia and intellectual disability lack DMC suggests a status approach to DMC assessment pervades. Furthermore, suggestive of an outcome approach being adopted in practice, concerns have also been raised about HSCP's focus on perceived risk and how paternalistic practices among HSCPs has led to partiality in DMC assessments (Donnelly et al., 2019; 2021; Emmet et al., 2013) as HSCPs have difficulty separating their own beliefs and biases from the objective DMC assessment process (Moberg and Rick, 2008). A study in the UK found that newly appointed HSCPs had limited understanding on the principles of DMC assessment, with less than 30%

of respondents recognising that the outcome of decision is not relevant to an assessment of DMC (Willner et al., 2011a). Jayes et al. (2020) cited practice whereby DMC for IL was based on functional performance of a task rather than the person's ability to make an informed decision about where to live.

2.5.2 Inconsistencies in DMC practices

HSCPs across many studies report they find this area of practice challenging, irrespective of how experienced or how confident they are (Cliff & McGraw, 2016; Jayes et al., 2021; Williams et al., 2014). Across health and social care settings, many issues with DMC assessment appear to be common, relating to practice not being compliant with legal standards, the timely conduct of assessments, and effective interprofessional collaborations (Donnelly et al., 2019; 2021; Jayes et al., 2019; 2020; 2021; Hinsliff et al., 2017; Murrell and McCalla, 2016; Ní Shé et al., 2020; Scott et al., 2020). Overall, research suggests that HSCPs are inconsistent in their approach to identifying the relevant information required to assess DMC. Shreve-Neiger et al. (2008) found frequent disagreement in determining a person's DMC among physicians due to inconsistent use of DMC terminology, lack of awareness of current law relating to DMC and lack of uniform standards to assess DMC. These issues were found to persist in a more recent scoping review to examine physician's DMC training needs which found inconsistent approaches to DMC assessment among physicians due to suboptimal DMC training (Charles et al., 2017). A study of HSCPs in community teams for adults with learning disabilities (Willner et al., 2011b) found fewer than 20% could identify the criteria to determine DMC. Similarly, Emmett et al. (2013) found that while HSCPs claimed to be familiar with legal standards, they were not routinely being applied in practice. Murrell and McCalla (2016) found that although HSCPs' practice was informed by DMC principles, namely the assumption of DMC, their knowledge of DMC legislation was variable, and in some cases quite limited.

2.5.3 Implementation of DMC legislation

DMC legislation and policy differ across jurisdictions which limits any direct comparison, however, cross-jurisdictional experiences of implementation of similar DMC legislation may be instructive to the Irish context. Internationally, legislative reform to develop supported decision-making practice has been slow and is costly to implement, adding to the practice complexities relating to DMC assessment and support (Webb et al., 2020a). Despite recent legislative developments and reform in many Western countries, there has been limited empirical research published, outside of that from the UK and Canada, which are discussed below.

A systematic review of the experiences of adults lacking DMC, and their carers experiences, of capacity legislation in the UK was undertaken and found that while legislation provided useful mechanisms for substitute decision-making, HSCPs' awareness of legislation was limited, thus

decision-making was not always compliant with the legislative principles (Wilson, 2017). Most research in this review was drawn from carers' experiences, rather than the person whose DMC was being questioned and it mostly focused on financial and welfare DMC. Further DMC-related reviews focused on HSCPs in England and Wales, namely their knowledge and experience of capacity legislation (Scott et al., 2020) and how they assess capacity (Jayes et al., 2020). Similar to carers' experiences described by Wilson (2017), HSCPs experienced positive aspects of DMC-related legislation, whereby the underlying principles of legislation enabled the upholding of human rights in HSCP's practice (Scott et al., 2020). Efforts to support DMC and measures to enhance the assessment process were also identified, such as assessment timing, context and communication, echoing findings from Sinclair et al. (2021) that consideration of any functional or cognitive impairments and contextual factors that might influence the person's decision-making processes (e.g. familiar environments, typical best times of day and the presence of particular trusted people) leads to high-quality DMC assessment.

HSCPs' difficulties with this area of practice may be because the availability and nature of DMC training is often inadequate (Scott et al., 2020). A systematic literature review by Hinsliff-Smith et al. (2017) reported on the application of UK legislation on DMC assessment of older adults in health care and concluded that staff need more opportunities to engage with and learn about the legislation before they can implement it into their practice. Studies that have followed the implementation of the UK legislation show that there continues to be considerable variation on the understanding of DMC principles and legislation. Manthorpe et al. (2011; 2014) explored the knowledge and use of DMC legislation of care home staff working with people living with dementia in the UK and found that while staff knowledge increased over time, some staff remained unaware of their responsibilities under the legislation (Manthorpe & Samsi, 2016; Manthorpe et al., 2011). This is further demonstrated in a recent systematic review which suggested that staff working in extended care settings may not routinely involve people living with dementia in everyday decision-making because they lack tools and resources to help them to do so (Daly et al., 2018). DMC legislation takes time to be assimilated into practice, given the cultural shift required. A study conducted with specialist dementia community nurses in England revealed that although most held positive expectations of DMC legislation's potential, most had limited knowledge of and lacked confidence in using it (Samsi et al., 2012). A follow-up study exploring changes and developments in their views and practices found that two years after DMC legislation was implemented, it was better embedded into practice and there was greater understanding of principles of the law (Manthorpe et al., 2014). However, Ratcliff and Chapman (2016) observed that, in the UK, comprehensive training around their capacity legislation did not necessarily lead to high-quality application of requirements in practice, due to knowledge gaps among HSCPs.

In Canada, understanding and assessment of DMC as a socio-legal construct is informed by various provincial and national legislative acts which ensure the least restrictive and intrusive outcomes around DMC assessment (Brémault-Phillips et al., 2016; Charles et al., 2017), such as those in Ontario (Ministry of the Attorney General, 2005) the Yukon (Yukon Department of Justice, 2005) and Alberta (Government of Alberta (2013a, 2013b, 2013c). Similar to Ireland's legislation, the statutory frameworks in Canada also state it is the responsibility of the regulated HSCP proposing the intervention to determine whether the person has the capacity to decide about the intervention, though there is no specific assessment tool or recording format for this process. In Canada, occupational therapists are one of the many regulated HSCPs, accountable to the public through their regulatory colleges, who many undertake DMC evaluations according to legislation.

A DMC assessment model was initially developed in Alberta in order to implement DMC assessment practices that align with legislation (Pachet et al., 2007; Parmar et al., 2015). The purpose of this model was to provide well-defined, standardized best-practice processes and tools to conducting DMC assessments and reduce unnecessary declarations of incapacity. The development of the DMC assessment model coincided with the development of the province's Adult Guardian and Trusteeship Act (Government of Alberta, 2013c) which governs DMC assessment and thus, the two are closely aligned, with the model supporting operationalization of the DMC assessment process in the legislation. Implementation of the model has since been developed and adapted for use across the continuum of care and service sectors spread across Canada (Brémault-Phillips et al., 2018). In order to enhance implementation of the DMC assessment process as set out in legislation and policy, Charles et al. (2017; 2021) recommended that HSCPs be provided with appropriate education and tools as they found training opportunities led to less frequent conduct of inappropriate DMC assessments. However, in Davidson and colleague's (2016) international comparison of legal frameworks for supported decision-making, they noted that while Ontario in Canada has developed a comprehensive, progressive and influential legal framework, concerns remain about the standardisation of decision-making ability assessments and how the laws work together. Brémault-Phillips et al. (2016) reported that implementation of the best practice model for DMC assessment was more difficult in less supportive and under-resourced environments, without clear role descriptions and workload expectations, buy-in and accountability of HSCPs involved in DMC assessments. They recommended enhanced and sustained access to education and mentoring, allocation of dedicated DMC assessment resources and clearer organisational and system processes. Furthermore, they recommended co-ordination of services at a provincial systems level and across organisations to allow for greater integration of, and equitable access to DMC assessment. The body of research findings emerging from Canada supports the need to develop (and evaluate) DMC

assessment frameworks and toolkits to facilitate implementation of legislation, which is relevant to Ireland where practice frameworks and practice guidelines have yet to be developed. Furthermore, Brémault-Phillips et al. (2018) caution that not employing an implementation model can result in failure to implement or sustain the best-practice, demoralisation of staff, and loss of time and resources and they recommend access to a dedicated implementation team to further enable the uptake of best-practice DMC assessment, drive change and offer leadership.

In Ireland, professional concerns exist regarding the implementation of legislation which, due to its broad application, requires development of decision-making support services, codes of practice, training and advance care planning frameworks (Kelly, 2017; Ní Shé et al., 2020; Murphy et al., 2020; Usher & Stapleton, 2018). Donnelly et al. (2019) investigated social workers practice in Ireland in supporting people with dementia's involvement in decision-making and reported cultural, organisational and professional barriers to fully implementing the Act, such as lack of standardised practices and lack of awareness among HSCPs of their obligation to facilitate and support decision-making. Much work is required to discover how supported decision-making is best implemented, how to meaningfully and accurately discover an individual's will and preference and how that process can become part of service provision to ensure it truly fosters autonomy and wellbeing (Arstein-Kerslake et al., 2017).

2.5.4 Context of DMC assessments

Issues that influence the conduct and process of DMC assessments appear to manifest differently in different settings where HSCPs work. Numerous barriers have been identified as impacting on the promotion of assisted decision-making among older adults in acute settings in Ireland, such as the pressurised care environment and lack of interprofessional collaboration (Davies et al., 2019; Donnelly et al., 2019; 2021). This is similar to findings from the UK which highlighted that HSCPs' experiences of DMC practice were challenged by issues relating to time management, documentation standards and partnership working with other HSCPs and families (Jayes et al., 2021). Many studies completed in healthcare settings have reported that many staff lack confidence, and do not understand their legal responsibilities or how to exercise them (Emmett et al., 2013; Marshall & Sprung, 2016; Williams et al., 2014). By contrast, recent research by Jayes et al., (2021) found that staff in care homes that are involved directly in DMC assessment appeared confident about their practice which may reflect the evolving nature of HSCP knowledge and confidence, as DMC legislation becomes more embedded in practice. It may also reflect the impact of the context or setting of DMC assessments whereby, through prolonged relationships, staff in care homes develop

in-depth knowledge of residents compared to HSCPs in hospital settings, where the nature of healthcare delivery is more transient and time-pressured. However, in exploring DMC assessment in home health care settings, Cliff and McGraw (2016) report the influence of family members was more intense away from the hospital ward, and the long-term relationship between patients and HSCPs in community settings posed a potential threat to objectivity in DMC assessment.

Nonetheless, conducting assessments in a home environment was described as a measure to support people with dementia in decision-making (Cliff and McGraw, 2016; Jayes et al., 2020). MacDonald (2010) highlights that HSCPs' practices and beliefs are complex and ever-shifting, and thus lend themselves to different interpretations of how legislation ought to be applied, even within teams and organisations.

2.5.5 Professional roles in DMC assessment

There is also some debate regarding which HSCPs are best placed to undertake DMC assessment (Webb et al., 2020a). Despite growing understanding that the conduct of DMC assessments is the responsibility of all HSCPs and that it is appropriate for the HSCP most closely involved in the decision being made to undertake DMC assessment, ambiguity about whose role it is to complete DMC assessments was reported in many studies (Cliff and McGraw, 2016; Manthorpe et al., 2014). Most published studies discuss the role of physicians, psychiatrists and psychologists in determining DMC, which may reflect that most research on DMC related to medical treatment decision-making and may also reflect professional hierarchies which influence referrals pathways. Different HSCPs bring different competencies, knowledge and skills which allow the issue of ascertaining the individual's DMC to be comprehensively addressed, however limited awareness of HSCP's roles and skills can lead to suboptimal practice (Zusack et al., 2016). Williams et al. (2014) observe that the culture of HSCPs can lead to challenges and inconsistencies in DMC practices, with HSCPs in social care settings tending to adopt a MDT approach and HSCPs in healthcare settings tending to favour deferring responsibility for DMC assessment to a medical consultant. Irish research has found interprofessional collaboration and leadership styles within the MDT influences DMC practices in acute hospital settings, and where hierarchical cultures are embedded within healthcare organisations some HSCPs' skills and insights on DMC may be overlooked (Donnelly et al., 2021; Ní Shé et al., 2020). This is similar to many international studies which report findings that suggest the role of speech and language therapy in supporting the communication needs of people with dementia is not understood and their role in contributing to DMC assessment is not fully recognised (Jayes et al., 2021; McCormick et al., 2017; Suleman and Hopper, 2016). In order to progress implementation of legal and policy reform relating to DMC, enhanced understanding of inter-professional roles relating to the practice of supporting DMC is required (Sinclair et al., 2021). Reviews by Scott et al. (2020) and Jayes et al. (2020) recommended a collaborative assessment approach as DMC assessors should have

specialist knowledge and skills relevant to the nature of the decision being made. As previously discussed, occupational therapy research on their role and contribution to DMC assessment is lacking however, both reviews suggested occupational therapists led assessments related to discharge destination decisions.

2.6 DMC of older adults

Reflecting the increasing number of older adults and associated increase in cognitive impairment, DMC in older adults is emerging as a distinct area of research and practice (Moye & Marson, 2007; Moye et al., 2013). As discussed in Chapter 1, Moye and Marson (2007) identified eight categories of DMC requiring assessment among older adults. They also categorised these DMC domains of relevance to older adults according to cognitive and procedural skills (Table 2.1). Although DMC is no longer understood solely as a cognitive ability, given cognition affects so many DMC domains, cognitive impairment is a significant consideration in DMC of older adults and cognitive assessment remains one of the most prominent practice issues.

Older adults are recognised to be at risk of cognitive impairment due to chronic diseases, cognitive ageing, and delirium, and as any condition or treatment that affects cognition may potentially impair DMC, determining whether an older person has adequate DMC is a critical skill in the care of adults (Karlawish, 2021). While old age or cognitive impairment are not sufficient reasons to refute DMC, cognitive impairment is a relevant factor, since it is associated with impaired DMC (Kim, 2010). Thus, if cognitive impairment is present and other factors also exist, such as an abrupt change in mental state, refusal of recommended treatment or particularly risky behaviour, assessment of DMC may be warranted (Grisso and Appelbaum, 1998; Scholten and Gather, 2018).

Table 2.1

Capacity domains of relevance to older adults, scope of abilities and skills required (Moye & Marson, 2007)

Capacity domain	Scope	Abilities and skills required
Independent living	Broad	Cognitive and procedural
Financial management	Broad	Cognitive and procedural
Treatment consent	Broad	Cognitive
Testamentary capacity	Narrow	Cognitive
Research consent	Narrow	Cognitive
Sexual consent	Narrow	Cognitive
Voting	Narrow	Cognitive
Driving	Moderate	Procedural

2.6.1 DMC of older adults for IL

HSCPs need to consider and assess a broad range of possible factors that can affect an older person's ability to perform ADLs and IADLs and contribute to a decline in functional status and ability to live independently. Factors associated with decline in functional status include age, comorbidity, cognitive impairment, depression, social support, and activity (Dombrowsky, 2017). Predictors of nursing home placement among older adults are mainly based on underlying cognitive and/or functional impairment, and associated lack of support (Luppa et al., 2010).

2.6.2 Cognitive Underpinnings

In older adults, the most common disorder likely to affect the capacity to live independently is dementia. Persons with dementia become more dependent on others and with the progression of the disease, at some point in time, admission to a long-term care facility is often considered necessary (Joling et al., 2020). While living independently does not necessitate that an individual be cognitively intact, if cognitive deficits are present, the extent to which they will affect the person's ability to live alone and what, if any, adaptations should be considered to the individual's environment to enhance their cognitive strengths must be determined.

Cognition involves the interrelated processes of perceiving, organising, assimilating and manipulating information in order to process and generalise information (Salthouse, 2016). Normal ageing is often associated with a number of cognitive declines (Salthouse, 2012). Such age-related declines in

information processing speed, various types of memory, and executive functioning which can potentially influence a range of functional abilities supported by these cognitive abilities (Moye et al., 2013). Cognitive impairment may limit an individual's ability to engage in meaningful occupations, or potentially compromise a person's ability to recognise potential risk, anticipate consequences of actions, follow safety precautions or respond to emergencies (Toglia et al., 2019). Therefore, cognitive issues such as memory deficits, impulsivity, executive dysfunction and poor insight may trigger an assessment for DMC for living independently (APA-ABA, 2008).

2.6.3 Functional-cognition for IL

Functional-cognition incorporates metacognition, executive function, performance skills (e.g., motor skills), and performance patterns (e.g., habits, routines) (Wesson et al., 2016) in the context of everyday occupations and activities (Marks et al., 2021). Across many settings, occupational therapists evaluate cognitive and functional-cognitive abilities in order to complete an accurate occupational profile, to determine appropriate interventions, and to develop appropriate discharge recommendations. Functional-cognitive assessment aims to evaluate the individual's ability to perform complex and novel instrumental activities of daily living (IADL) tasks which integrate the whole of their abilities (Wesson et al., 2016), rather than separately focusing on impairment of specific cognitive domains such as attention, memory or executive functions. Occupational therapists assess the individual's functional-cognitive abilities and identify difficulties they might have performing real-life tasks (Wolf et al., 2019). They have developed performance-based assessments of functional-cognition that use dynamic enactment of IADL tasks (e.g. Fisher and Jones, 2010) to assess dimensions of performance incorporating cognitive load, self-monitoring, prospective memory, and ability to use strategies to adjust to changing environments and task complexity (Marks et al., 2021; Weiner et al., 2012). It is generally accepted and recommended that occupational therapists adopt a stepwise procedure for functional-cognition evaluations, using screening tests in domains of interest to occupational therapy followed by performance-based and more in-depth assessment to evaluate areas where screening indicates potential impairment (American Occupational Therapy & Association, 2020; Marks et al., 2021). However, in many clinical settings, occupational therapists have a relatively short time to complete assessments, and extensive evaluation may not be possible or practical. Therefore, they may tend to use screening assessments which are perceived to be more time efficient, and scores deemed to be more widely understood by MDT.

2.6.4 Values and preferences

A more recent focus of the literature and debate relating to decision-making has moved beyond identifying and describing the nature of cognitive deficits in decision-making to highlight that an individual's values and prior life experience need to be taken into account for DMC assessment (Knox et al., 2013). Many decisions people make are intuitive and based on emotions, experiences, values, preferences or habits, rather than logic and deliberation, and Smebye et al. (2012) highlights that the ability to hold values and preferences is independent of cognition and as many persons with mild to moderate dementia are able to state their preferences, they can still be involved in decision-making.

This consideration of individual values, interests and preferences reflects a broader recognition in healthcare that respecting and responding to the needs and preferences of clients and empowering them to make decisions to meet their needs is fundamental to high-quality, client-centred practice (Jayes et al., 2017; Stojan et al., 2016). It is specified in the Association of Occupational Therapists in Ireland (AOTI) Code of Ethics and Professional Conduct (AOTI, 2013, p. 4):

A member must ensure that the client has received all of the relevant information to allow the client or his/her representative to make informed choices or decisions about likely benefits and risks of the occupational therapy intervention options and to safeguard his/her dignity.

Understanding and assessment of the older person's preferences and values is considered key to their involvement in decision-making processes (Bunn et al., 2018). Preferences are shaped by past experiences, the characteristics of the context and environment, complexity of the decision, quality of options, how choice is elicited, and how options are presented (van Haitsma et al., 2020). A stated preference reflects an expression of the attractiveness of an option that serves to fulfil a person's needs, is generally based on one's values. Values generally reflect one's beliefs about self and life and are relatively stable over time and guide actions, while goals are desired outcomes of behaviours, based on values (Naik et al., 2016; van Haitsma et al., 2020). Approaches to discerning an individual's values include open-ended interviews, rating scales, narratives and decision analysis (Moye et al., 2021). Despite alignment of care with an individual's values being central to person-centred care and goal-setting (Kivelitz et al., 2021; Molnar et al., 2017; Moye et al., 2021; Tinetti et al., 2017; Van Haitsma et al., 2020), eliciting and documenting older people's personal values is not common in routine clinical care (Naik et al., 2016). Nonetheless, identification of older people's priorities using a structured process is both practical and feasible for HSCPs as part of routine clinical interactions (Naik et al., 2018). This aspect of the DMC assessment process is gaining more attention and Moye et al. (2021) suggest using structured tools, such as What Matters Most-Structured Tool (WMM-ST), to assess the priorities of older adults with multi-complexity, as it makes the process less abstract.

2.7 Clinical frameworks for DMC assessment for HSPCs

Hoptof (2005) argues that notwithstanding the varying definitions and complexities of DMC, it can be reliably assessed if the HSCP performing the assessment has clear guidelines to follow. The need to develop evidence-based tools to improve DMC practice was a key recommendation in the National Institute for Health Care and Excellence (NICE) guideline on decision-making and mental capacity in the UK (NG108; Institute and for Health and Care Excellence (NICE), 2018). Although “there is no equation, cookbook, or test battery for the assessment of capacity” (ABA-APA, 2008, p. 23), in recent years, a range of models and frameworks for DMC assessment have been developed in other jurisdictions to guide HSCPs in the assessment process, acknowledging the complex circumstances when a person’s DMC is being questioned (APA-APA, 2008; Bigby & Douglas, 2016; Brémault-Phillips et al., 2016; British Psychological Society (BPS), 2006; 2019; Parmar et al., 2015).

Moberg and Rick (2008) identified the need for evidence-based approaches to DMC assessment, suggesting a similar strategy could be adopted in various situations, though the DMC assessment only relates to a specific decision at a particular time. They suggest DMC assessment requires clarification of the referral question to determine if the HSCP receiving the referral is suitable to conduct the assessment. Then the assessment should be planned with consideration for cultural and ethical issues, including informed consent and confidentiality. The assessment is then undertaken, and findings from the DMC assessment interview should be integrated with additional patient-specific and decision-specific information, including the risks of the decision itself, to inform a clinical judgment about whether the individual has sufficient ability to make the decision at hand. Finally, the results should be communicated to the relevant person and any other assessments or interventions that may enhance the person’s DMC or address the limitations are recommended. The use of both standardised objective measures (e.g. cognitive assessments) along with subjective evaluation (e.g. emotional status) is recommended to inform clinical judgment regarding DMC (Mulally et al., 2007; Moberg and Rick, 2008).

2.7.1 Professional guidance for psychologists

Although they have not been empirically evaluated, recently developed frameworks and guidance documents for psychologists in the US and UK adopt similar stepped approaches to structure the comprehensive assessment of DMC.

2.7.1.1 American Psychological Association (APA) guidance

Drawing on Grisso's pioneering model for capacity assessment (2003) which suggested six elements: causal, functional, contextual, interactive, judgmental, and disposition; the American Bar Association (ABA) and the American Psychological Association (APA) Assessment of Capacity in Older Adults Project working group proposed a basic conceptual framework for assessing capacity based on six pillars: medical condition, cognitive functioning, everyday functioning, values, risk of harm, and means to enhance capacity (ABA-APA, 2008). They developed comprehensive best practice guidance for psychologists on conducting DMC assessments relating to their respective jurisdictions.

The APA-ABA (2008) framework consists of nine components set out below:

1. Legal standard – as a foundation to DMC assessment, the legal standard for the capacity in question must be verified as different capacities may have different legal requirements and standards vary across locations
2. Functional elements – assessment of everyday functioning in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) must be considered through interview and where possible direct observations and assessment of the individual's function in performing the specific task in question.
3. Diagnoses - the medical conditions causing impairment and/or disability must be documented, along with any information regarding prognosis and treatments.
4. Cognitive underpinnings – different domains of capacity demand different levels of cognitive functioning and impairment must be noted.
5. Psychiatric and emotional factors – any issues, temporary or permanent, which may impact on functioning and any treatment or timeframes must be recorded.
6. Value and preferences – these are fundamental to decision-making and are influenced by age and life experience, religion, culture, gender, ethnicity, sexual orientation etc.
7. Risk factors – assessment of potentials risk in the context of the above elements must be considered.
8. Steps to enhance capacity – identification of any actions that can be undertaken to maximise a person's DMC.
9. Clinical judgment – the core of DMC assessment is the HSCP's clinical judgment, which should clearly indicate whether the person has DMC.

2.7.1.2 British Psychological Society (BPS) guidance

The British Psychological Society (BPS) (2019) also developed a document which recommends adopting a similar approach and emphasises the importance of pre-assessment preparation to

ensure clarity on what is being asked in relation to DMC. They recommend the assessing psychologist should consider

- who the individual to be assessed is,
- what aspect of functioning and decision-making is being assessed,
- why the issue of DMC has been raised,
- what physical and/or psychological conditions may affect assessment,
- if relevant information regarding options is available,
- if previous assessments of DMC exist,
- if any other people (HSCPs, family, others) may need to be involved in assessment.

In completing the DMC assessment, they recommend interviewing the client with consideration for their abilities and needs, thus choosing a time, location, length of session, and communication approach that enhances the person's DMC and also documenting all aspects of the process in detail.

2.7.2 MDT clinical frameworks for DMC assessment

Although there is limited empirical research regarding use of clinical frameworks, available findings indicate that HSCPs feel more confident about their ability to assess DMC when they used frameworks or resources as they help structure the DMC assessment process, improve clarity of documentation and embed legislative requirements in clinical practice (Brémault-Phillips et al., 2016; Jayes et al., 2020; Ramasubramanian et al., 2011). These clinical frameworks are outlined below. Emmett et al. (2013) also reported that the recording of DMC assessments appeared to be more detailed and consistent with legislation when HSCPs used a documentation proforma with a patient with dementia. However, the authors unfortunately did not provide any information about the content of the documentation template.

2.7.2.1 Mental Capacity Assessment Support Toolkit (MCAST)

In recognition of the support needs of people with communication difficulties in assessing DMC, the Mental Capacity Assessment Support Toolkit (MCAST) was developed in the UK to provide guidance and practical resources to enable HSCPs working in acute hospital and intermediate care settings to engage in supported decision-making and DMC assessment, in line with UK legislation (Jayes et al., 2020). This toolkit offers HSCPs a structured proforma designed to support professionals to prepare, complete and document a DMC assessment. It prompts the assessing HSCP to clarify and document what decision is being made, whether it must be taken now and if a formal DMC assessment is warranted, including presence of impairment of mind or body, as this is a pre-requisite of UK legislation. It prompts the HSPC to prepare for DMC assessment by gathering relevant information from MDT, carers and family regarding decision options and consequences, and how cultural factors may influence decision-making. It prompts the HSPC to consider the individual's communication, cognitive, mental health and emotional needs and the set-up of the environment. The toolkit also

includes resources to enable HSCPs to identify and support the decision-making needs of individuals with communication difficulties, including a screening tool to prompt referral to a speech and language therapist (SLT) for specialist assessment and support. The toolkit has been shown to be usable and acceptable to staff in a range of hospital and homecare settings (Jayes et al., 2020; 2021).

2.7.2.2 Decision-Making Capacity Assessment Model

The DMC assessment model created in Alberta, Canada (Parmar et al., 2015; Brémault-Phillips et al., 2018) incorporated the development and trial of a standardised process, with supporting tools, to improve the quality of DMC assessments, reduce unnecessary declarations of incapacity and align with provincial legislation. After receiving DMC assessment education and training, HSCPs conduct or support DMC assessments utilising the 3-step process and associated documentation resources. The DMC assessment process begins with the identification and validation of reasons for the DMC assessment of a client, including identification of the specific DMC domain. The second step requires the relevant information pertaining to the decision is then collected, any reversible medical conditions are addressed, and in-depth social, cognitive, functional and/or psychological assessments are conducted by relevant HSCPs. Lastly, if the situation warrants a declaration of incapacity, a Capacity Assessment Interview is undertaken by the attending physician using proforma documentation. For more complex cases, experts (such as physicians, geriatricians, psychologists, psychiatrists, designated court-appointed capacity assessors with social work, nursing or occupational therapy backgrounds) and specialty services are consulted. This model was found to enhance the ability of HSCPs to assess DMC in a more confidently, competently, collaborative and standardised manner (Brémault-Phillips et al., 2016). Nonetheless, several barriers hampered implementation of the model such as HSCP role clarity, time and resource pressures, and education needs.

2.7.2.3 DMC assessment checklist

Ramasubramanian et al. (2011) developed a structured assessment framework, in the form of a 20-point checklist, to act as a prompt to help HSCPs adhere to the requirements of the UK legislation in a specialist learning disabilities unit. It prompts users of the checklist to reflect on their DMC assessment in terms of the quality and completeness of assessment and recording of capacity to consent and best interests. An audit of case notes following the introduction of the checklist indicated the checklist was useful for HSCPs to focus on DMC, consent and best interests for people with learning disabilities and mental health problems, in keeping with the UK legislation. However, the design of this small-scale study requires consideration as the initial audit only included six sets of case notes for patients who were assessed as lacking DMC and as it took place within six months of the legislation's implementation, the HSCPs' knowledge and practice relating to DMC assessment was likely still developing at this time.

Overall, the aforementioned clinical frameworks and resources are grounded in a functional approach to DMC assessment which emphasises that the assessment only deals with a person's DMC for a specific decision in the context of a specific situation and at a specific time. These frameworks also place the onus on the HSCP to maximise the person's abilities to demonstrate DMC and thereby assert the need for the HSCP to consider and provide additional supports or measures, such as simplifying information or presenting it in accessible format. Supported decision-making is a complex and dynamic process, centring on the subjective relationship between the individual, the supporter and the context (Knox, Douglas and Bigby, 2013; Webb et al., 2020b). Effective supported decision-making requires knowing the person well and respecting their wishes, in addition to open, honest and accessible communication, adherence to legislation, cultural sensitivity and provision of flexible strategies (Webb et al., 2020b).

2.7.3 Framework for Supporting Decision-making

In advancement of the view that DMC assessment extends to maximise DMC support, Bigby and Douglas (2016) present a process of support for decision-making that can be applied by supporters of people with cognitive disabilities within current legal frameworks in Australia. The seven steps in support for decision-making which they set out shifts the focus of the HSCP beyond establishing DMC to identifying the supports needed to maximise DMC:

1. Knowing the person - this usually encompasses knowing the person's attributes and style, their personal characteristics, likes and preferences, their skills, their understanding of their specific cognitive impairments in addition to knowing their social connections, history and personal story, which provides the conceptual context for understanding their will and preference.
2. Identifying and describing the decision – this helps illuminate the core features of the decision such as its scope (how much will it impact on a person's life and the other decisions that might flow from it); who should be involved in helping the person to make the decision; constraining factors that will help shape the decision and possible tensions that might arise; the time frame to make the decision, and; the potential consequences of choosing one option over another.
3. Understanding a person's will and preferences about the decision - all the possible options that need to be explored, the person's preferences about all the things that will be encompassed in the decision, and consequences of different options are identified. In this step, preferences and options considered should not be constrained by parameters imposed by things such as resources or risks.

4. Refining the decision and taking account of constraints – in order to make the decision implementable, preferences are then prioritised, refined and shaped by constraints such as time, money, impact on other people, and safety.
5. Deciding whether a self-generated, shared or substitute decision is to be made – based on the knowledge gained in earlier steps about the decision, preferences, priorities, constraints and consequences, the person’s own skills or the need for a more formal decision-making process or supports are identified.
6. Reaching the decision and associated decisions - the decision is made to reflect prioritised preferences. It may be formally recorded and communicated to others involved in the person’s life, in a formal or informal capacity, who will support its implementation.
7. Implementing a decision and seeking out advocates if necessary – in terms of executing the decision, additional advocates to support implementation of the decision may be sought to make sure the decision is followed through.

While this process is comprehensive and person-centred, it was developed in the learning disability sector, where HSCPs generally have more time and longer, more established relationships with clients. Evidence to date from acute hospital settings in Ireland, where many older people undergo DMC assessment, has highlighted the difficulty of implementing assisted decision-making processes due to the busy healthcare environment where staffing, time and resource shortages serve as barriers (Donnelly et al., 2021; Ní Shé et al., 2020). Therefore, any procedure that is perceived to be excessively bureaucratic, time-consuming or complicated from the perspective of the HSCP is unlikely to be used in clinical practice.

In practice, the stringency of the DMC assessment varies directly in relation to risk or the seriousness and likely consequences of the decision at hand (Applebaum, 2007). Therefore, the HSCP must reflect on the associated risks and consequences of the decision and as it is generally accepted that decisions associated with more serious consequences require a higher standard of DMC than low-risk decisions. Given the lasting consequences and ramifications of decisions relating to independent living, DMC assessment for IL decision requires much consideration. Chapter 3 will explore international literature pertaining to DMC assessment for IL.

2.8 Summary

This chapter has presented an overview of the evolving definition and conceptualisation of DMC. The three recognised approaches to DMC assessment have been examined and related issues regarding autonomy and supported decision-making are discussed. Although much of the empirical research

does not provide detailed information about DMC assessment processes, studies do indicate ways in which DMC assessments can be improved and frameworks which have been developed to help HSCPs to structure and document their assessments and to support DMC were identified and reviewed.

Though the functional approach to DMC assessment is widely accepted, and promoted in legislation and policy, many issues have been raised in the literature to suggest that a reductive approach to DMC assessment, which only considers the four components of understanding, appreciation, reasoning and expressing a choice, is inadequate. While the standardised DMC assessment instruments referred to in the literature are useful for research consent and medical treatment consent purposes, they have limited utility in clinical practice. Although the four-component assessment may contribute a useful structure towards establishing DMC, research indicates that assessing DMC is not a stand-alone assessment procedure. The final evaluation of DMC is a clinical judgment informed by standardised assessments of cognition and function, consideration of relevant risks in the context of the person's needs, values and circumstances. While there appears to be general acceptance in the literature that decision-making is largely a cognitive process, there is an emerging argument that the person's value and preferences need to be considered, as legislation and policy advocates. Moreover, emerging research in health and social care focuses on the appropriate resolution when DMC is found to be diminished and the importance of moving beyond assessing to supporting DMC is discussed. However, approaches to determining the person's will and preference are less clear. While there is limited research on the role of occupational therapy in DMC assessment, clinical frameworks developed for other HSCPs (namely psychology) and decision-making support models from other jurisdictions were reviewed.

On reviewing the literature, a policy-practice mismatch was found in DMC assessment, whereby national and international policies and legislation have provided for person-centred, human rights-based approaches which place the older person at the centre of all decision-making process, affirming their right to participate in care planning and decision-making, however this does not appear to happen in an appropriate or consistent manner in clinical practice. Published literature highlights the importance of DMC assessment for the growing older population with associated complex comorbidities, but also highlights issues relating to lack of expertise among HSCPs on how to assess DMC, time and resource barriers and extensive training and education needs for HSCPs, resulting in DMC assessment practices that are ad-hoc and non-standardised in nature.

As noted, DMC of older adults is an emerging area of research and practice. Limited Irish studies were found examining DMC assessment practices and no Irish studies examining occupational

therapy's contribution to the assessment process were found. Notwithstanding the limited empirical research, Moye and colleagues in the US and Jayes and colleagues in the UK make valuable contributions to understanding DMC for older adults, representing psychology and speech and language therapy respectively. Donnelly and colleagues in the PADMACs project have also generated multidisciplinary findings in the Irish context. However, DMC assessment and support remains an underdeveloped area of practice in Ireland and international literature appears to have limited impact on actual practice to date. It is evident therefore that further research is required to determine occupational therapy's contribution to DMC assessment of older adults and specifically in relation to IL.

At present, there is a lack of studies that document when, how, and the extent to which occupational therapists are being involved in DMC assessment in general, and specifically for older adults. Given that DMC legislation varies across jurisdictions and therefore training, resources, and clinical practices are often country specific, existing studies might not necessarily generalise to the Irish setting. It is, therefore, important to determine the current state of practice in Ireland to identify practice issues and to ensure optimal DMC assessment which is compliant with legislation. Moreover, the opportunity to identify training and resource needs for various HSCPs involved in DMC assessment may ensure that they have appropriate skill set to effectively assess and support DMC of older adults in relation to various DMC domains of relevance.

The overarching aim of the present study is to explore the current practices in Ireland regarding occupational therapists' involvement in supporting decision-making and DMC assessment for older adults. As the first phase of this study indicated that occupational therapists in Ireland who were involved in DMC assessment were most likely to work with older adults and to be involved in DMC assessment regarding IL, the need for a more focused review of the literature to focus on the assessment approaches of older adults' DMC, regarding decisions for IL was identified. The gaps in the literature, combined with findings from the survey conducted in the first phase of this research project, led to the development of a scoping review protocol (Usher and Stapleton, 2020a) to specifically review approaches to assessment of older adults' DMC for IL. The following chapter describe in detail the methodology and findings of the scoping review.

3.0 Assessment of older adults' decision-making capacity in relation to independent living: A scoping review

3.1 Chapter introduction

This chapter is a modified version of the scoping review published as an open access article in *Health and Social Care in the Community* (Usher and Stapleton, 2021; Appendix A) and has been reproduced here under the terms of the Creative Commons CC BY license of the copyright holder, John Wiley & Sons, Inc., which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

As outlined in previous chapters, due to increasing ageing populations, assessment of older adults' decision-making capacity is an important societal and health care issue. DMC assessment is challenging and issues with implementation of legislation have been identified internationally. This scoping review was conducted to specifically address Aim 3 of the research, to examine current international practice in the area of DMC assessment of older adults for independent living (IL).

While there is a growing body of research on older adults' DMC, to date, the literature has focussed on DMC for medical treatment, research participation, and financial decision-making. Most older people wish to remain living in the community for as long as possible, making DMC for IL an important domain of DMC to assess. However, despite its ubiquity in clinical practice, specific discussion of DMC for IL is less frequently addressed in the literature. Poole et al. (2014) observe that IL capacity is discussed theoretically in relation to ethical tensions between the principles of beneficence and autonomy. DMC assessment for IL is likely to become more pertinent as the number of people experiencing decision-making challenges increases. Older adults often face difficult decision-making situations regarding their ability to live independently, and it has been suggested that DMC assessment regarding IL requires a different approach to other DMC domains (Bourgeois et al., 2017; Schreiber et al., 2018) and can be more difficult to assess than the capacity to make medical decisions (Cooney et al., 2004). DMC for IL is multi-factorial and requires addressing the overlap between family, clinical, and judicial roles in responding to adults' changing capacities (Moye & Marson, 2007). A preliminary search of JBI Database of Systematic Reviews and Implementation Reports, Cochrane Database of Systematic Reviews and PROSPERO was completed in July and December 2018 and found no relevant completed or ongoing systematic or scoping reviews evaluating approaches to assessment of older adults' DMC for IL. Therefore, this review aimed to identify and map existing evidence to provide an overview of current approaches of assessing DMC for IL of older adults and details of who conducts assessments, what is measured and how, and in

what settings assessments occur. The outcome of the review includes a summary of available evidence and an identification of gaps in research.

3.2 Materials and methods

A scoping review design provides a systematic framework for searching, examining and summarising the literature and identifying gaps in the existing knowledge. This approach was deemed appropriate as it allows refinement of the search strategy and a deeper knowledge of the literature and the key concepts (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2017). The initial inclusion criteria, search strategy, approaches to study screening and data extraction were stipulated a priori in a published protocol (Usher & Stapleton, 2020a). However, due to the iterative nature of the research and findings from the survey in the first phase of the study, the focus of this review was refined to focus on the DMC domain of IL; therefore, the revised methods are described below.

The conduct of this scoping review was based on the framework and principles reported by Arksey and O'Malley (2005) and further recommendations provided by Levac et al. (2010) and Peters et al. (2017). Additional guidance on reporting in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA ScR) checklist (Tricco et al., 2018) was also used.

This framework recommends the following 5 key phases:

- Stage 1: Identifying the research question
- Stage 2: Identifying relevant studies
- Stage 3: Study selection
- Stage 4: Charting the data
- Stage 5: Collating, summarising and reporting the results

3.2.1 Stage 1: Identifying the research question

This review aimed at answering the following overall research question “What approaches to assessment of older adults’ DMC in relation to IL have been reported?”. This review also aimed to explore “Which HSCPs are involved in assessment of older adult’s DMC in relation to IL?”, as typically this is a multidisciplinary issue.

3.2.2 Stage 2: Identifying relevant studies

The search strategy and keywords were developed and refined in consultation with a university health sciences librarian. A preliminary search was conducted in Embase database to gain familiarity with the topic, an overview of the volume of the literature and to aid with the identification of key terms. The initial search terms for the scoping search reflected the key concept areas addressed by

the research question: ‘decision-making capacity assessment’, and ‘older adults’ and associated Medical Subject Headings (MeSH) terms. The final search strategy included ‘independent living’ and ‘discharge destination’ and was also applied to the remaining databases: CINAHL, PsychINFO, Web of Science and Scopus. The search strategy was tailored to the specific requirements of each database. See Appendix B for sample search strategy from the Embase database. These databases were searched for relevant literature from January 2000 – December 2020. Hand-searching of the reference lists of the publications identified was also conducted and authors were contacted to find additional papers. Electronic search results were exported into EndNote™ and then to Covidence™ and duplicates deleted. Studies were selected as per eligibility criteria (Table 3.1) based on the Population, Concept and Context (PCC) framework (Peters et al., 2017).

Table 3.1

Eligibility criteria

<i>Publication selection criteria</i>	
Population	older adults
Concept	described approaches and procedures used in assessment of DMC for IL
Context	included published data from any jurisdiction where DMC legislation requires functional assessment approaches

Note. Adapted from “Assessment of older adults' decision-making capacity in relation to independent living: A scoping review” by R. Usher and T. Stapleton, 2021, *Health & Social Care in the Community*, Advance online publication (<https://doi.org/10.1111/hsc.13487>). CC BY.

Publications regarding older people were of interest. Since there are various definitions of the age range of ‘older’ populations, a lower age limit was not specified as an inclusion criterion. Rather, publications were included which identified older people as their focus. Healthy older adults, and those with age-related cognitive impairment, mild cognitive impairment, dementia and neurodegenerative conditions were included. Publications that provided information on approaches and procedures used in assessment of older adults’ DMC for IL were considered in this review, including related cognitive, functional and proxy assessment. Publications relating to any clinical setting (acute hospital, community, long-term care) were included as DMC assessment is relevant in a variety of settings.

All types of qualitative and quantitative designs that verified or described current practices were considered eligible and expert opinions which provided enough detail were included. Studies were excluded if they did not describe the assessment process in sufficient detail or focused predominantly on other DMC domains (e.g. only on consent to research or medical treatment). The search was limited to reports published in English and published from January 2000 to December 2020 to ensure that findings reflect current clinical practice and recent changes in legislation.

3.2.3 Stage 3: Selecting the studies

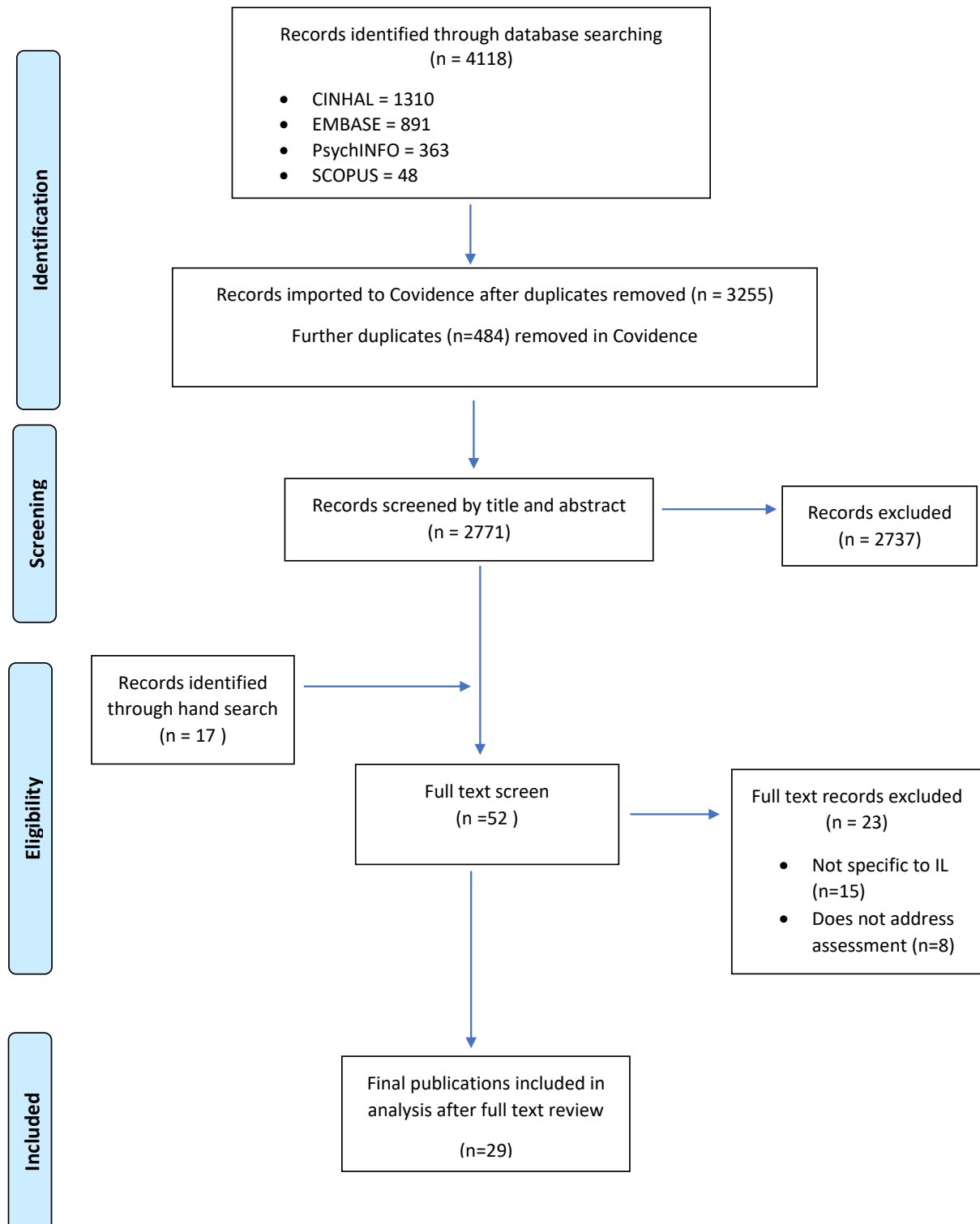
This stage involved selecting the articles in two steps: 1) title screening and abstract screening; and 2) full-article screening, as reported in a PRISMA flow diagram (Figure 3.1). Duplicate records were removed, and remaining records were screened by title, abstract and full text. Title and abstract screening was conducted by the researcher having refined inclusion and exclusion criteria with the research supervisor. The researcher read the full texts of publications corresponding with inclusion criteria. An opinion from the research supervisor was sought in case of uncertainty and consensus was reached through discussion.

3.2.4 Stage 4: Charting the data

Data from articles judged to have met all inclusion criteria was categorised, extracted and organised using Microsoft Excel. A data extraction form was developed by the researcher to capture information relevant to the research question and was piloted using five articles. The final data extraction form included the following information: Author(s), year of publication, study aim(s), study location, study design, population of interest/sample, assessment approaches, HSCPs involved, main findings and recommendations regarding the DMC assessment for IL among older adults (Appendix C). The researcher consulted the research supervisor regarding the development of the data extraction form and the data extraction process to ensure that all relevant data to answer research question were extracted from the publications.

Figure 3.1

PRISMA Flowchart of study selection and inclusion process



Note. Adapted from “Assessment of older adults’ decision-making capacity in relation to independent living: A scoping review” by R. Usher and T. Stapleton, 2021, *Health & Social Care in the Community*, Advance online publication (<https://doi.org/10.1111/hsc.13487>). CC BY.

3.2.5 Stage 5: Collating, summarising, and reporting results

Using the data extraction chart, data was collated and summarised. Numerical summaries described the data quantitatively and thematic analysis was conducted on all extracted data using Braun and Clarke's (2006) approach to provide a qualitative description of the findings. The researcher examined the data to identify codes representing sections of data with similar meaning. These were examined in relation to each other and sorted into preliminary groupings which were developed into sub-themes and themes. This iterative process required ongoing review and discussion between the researcher and research supervisor about the development of themes.

3.3 Results

3.3.1 Summary of the literature search/Study selection

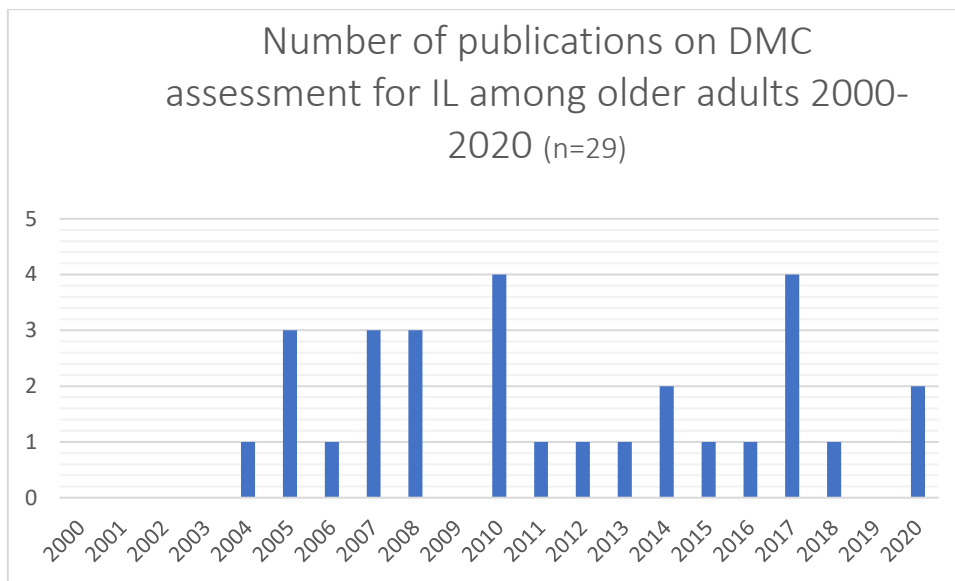
The electronic searches of databases resulted in 4118 records. After removing duplicates, 2771 titles were screened for eligibility. The screening of titles and abstracts resulted in identification of 35 publications relating to DMC assessment of older people for IL for full-text review. Additionally, 17 texts were identified from other sources. Following the exclusion of studies that did not meet the inclusion criteria, a total of 52 studies were included in the full text screen from which 29 publications were included in the final qualitative analysis.

3.3.2 Characteristics of publications

As the body of research regarding other DMC domains grows, there is increasing interest and research in DMC for IL among older adults. Subsequently, there were more frequent publications of literature on DMC for IL from 2004 onwards, with most publications since 2010, see Figure 3.2 displaying the number of publications over the years for the review period.

Figure 3.2

Number of publications on DMC assessment for IL among older adults 2000-2020



Note. Adapted from “Assessment of older adults' decision-making capacity in relation to independent living: A scoping review” by R. Usher and T. Stapleton, 2021, *Health & Social Care in the Community*, Advance online publication (<https://doi.org/10.1111/hsc.13487>). CC BY.

Most publications are commentary and discussion pieces rather than original research or review, reflecting how research in DMC of older adults relating to IL represents a new and emerging field. Most publications offer commentary on legal reform, discussing implications for clinical practice with suggestions for assessment approaches, and are based on expert opinion rather than empirical findings. A summary of the characteristics of the publications from the 29 records can be found in Table 3.2.

Table 3.2**Summary of characteristics of publications**

Publication characteristics	No. of records
Publication type	
• Original research	8
• Commentary/Case discussion	13
• Book chapter	3
• Review article	2
• Letter	1
• Validation of instrument	2
Country of origin	
• USA	17
• UK	7
• Canada	1
• Australia	3
• Ireland	1
Population of interest	
• Older adults	20
• People with dementia	6
• People with stroke*	2
• Non-specified age group (adults lifestyle choices)	2
Healthcare professionals who may contribute	
• Physician	12
• Psychiatrist	6
• Psychologist	9
• Social worker	10
• Nurse	9
• Occupational therapist	14
• Not specified/MDT approach	15
• Physiotherapist	7
• Case manager	3
• Speech and language therapist	2
• Other – family (2); Healthcare admin (1); adult protective services (1); Independent advocacy services (1); pharmacy (1); dietician (1) discharge planner (1)	
Context of assessment	
• Hospital	19
• Community**	6
• Not specified	5

*One study included people with dementia and people with stroke so was included in both categories

** One study reported assessments took place in both hospital and community settings so was included in both categories

Note. Adapted from “Assessment of older adults' decision-making capacity in relation to independent living: A scoping review” by R. Usher and T. Stapleton, 2021, *Health & Social Care in the Community*, Advance online publication (<https://doi.org/10.1111/hsc.13487>). CC BY.

3.3.3 Purpose and main findings or recommendations of publications

The purpose of the publication and a summary of assessment approaches and recommendations are presented in Table 3.3. Although many authors noted there is no gold standard for assessing DMC, the publications reviewed often recommended similar approaches and components to include in assessment, see later theme on Components of DMC assessment for IL (Section 3.3.4.3).

3.3.3.1 Population

Publications included in this review focused on older people, though very few defined this. Some publications specifically referred to people with dementia (Brindle & Holmes, 2004; Emmett et al., 2013; Hughes et al., 2015; Jayes et al., 2017; Poole et al., 2014; Stewart et al., 2005) and two specifically referred to people with stroke (Jayes et al., 2017; Mackenzie et al., 2008). Two papers did not specify an age group but referred to adults making lifestyle choices, so were included (Bastian et al., 2011; Darzins, 2010).

3.3.3.2 Context

Publications emerged from several countries – US, UK, Australia, Canada and Ireland, reflecting jurisdictions that have undergone legal reform regarding DMC assessment approaches. Most publications originated in the US. Publications referred to assessing DMC in a variety of contexts, with the majority referring to hospital and rehabilitation settings, however two publications advocated the benefits of assessment in the home environment where possible (John et al., 2020; Lai and Karlawish, 2007).

3.3.3.3 Concept

As the literature relating to DMC for IL is emerging, the terminology of this DMC domain varied across publications. While IL was frequently referred to as a DMC domain, other terminology included residence capacity, (Emmett et al., 2013; Hughes et al., 2015; Poole et al., 2014; Schreiber et al., 2018), dispositional capacity (Bourgeois et al., 2017), capacity for accommodation decisions (John et al., 2020) and capacity to make everyday decisions (Lai & Karlawish, 2007; Lai et al., 2008). IL was not always reported as primary domain of interest and approaches to its assessment were reported alongside other DMC domains such as financial capacity, medical consent and within general approaches to assessing DMC (Moye et al., 2005; Moye & Braun, 2010). Sometimes discussion of DMC assessment for IL related to vulnerability (Naik, 2017; Naik et al., 2010; Naik et al., 2008a) or was framed by concerns for guardianship (Moye & Braun, 2010; Moye et al., 2005).

Table 3.3

Purpose and main findings or recommendations of publications (n=29)

	Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
1.	Bourgeois et al. (2017)	Review clinical literature on assessment to determine the patient's 'dispositional capacity'	<p>Dispositional capacity is proposed as a new term with a separate meaning, which includes routine use of occupational therapy and social work. No definition or guidelines for determination of dispositional capacity was found</p> <p>Complex and multidimensional process – requires a different approach. Supplement DMC assessment with assessment of functional abilities in necessary self-management activities</p> <p>Consider:</p> <ul style="list-style-type: none"> • Demographic, medical and functional factors: age and stage of illness, understanding of illness, sensory capacities, mobility, and ability to perform activities of daily living and instrumental activities of daily living (e.g. Kohlman Evaluation of Living Skills and Assessment of Capacity for Everyday Decision Making, Texas Functional Living Scale) • Psychological factors: cognitive capacity (formal cognitive assessment) and other psychiatric disorders, including addictive disorders. • Social factors: housing status and status of the network of social support. <p>Modify assessment environmental and approaches to maximize performance</p> <p>Standardized guidelines for capacity determinations (both for informed consent and for disposition) would be helpful to clinicians, patients, and their caregivers.</p>
2.	Brindle and Holmes (2005)	Present issues in discharge planning of older people with dementia; outline DMC assessment to preserve personal choice	<p>Address:</p> <ul style="list-style-type: none"> • Cognitive status • Physical status • Functional abilities • Community resources available • Legal standards <p>Functional approach to DMC</p>

		and support people in their own homes.	<p>Consider person's social situation and cultural values along with their insight and awareness of their care needs and willingness to accept support.</p> <p>Recommends holistic and ongoing MDT approach and consultation with carers. Liaise with community support services, producing a flexible care package that mitigates risks, reduces readmission, preserves individual's autonomy and independence</p> <p>Advocate for participation of the older person and their families in assessment, care planning and evaluation, and seek regular feedback on appropriateness of care after discharge</p>
3.	Carrese (2006)	Discuss ethical dilemmas, approaches to assessing DMC, influence of physician values, and how to respond to patients' refusal of care.	<ul style="list-style-type: none"> • Communicate risks, concerns, options to individual • Consider their values, consistently stated preferences (eg, religious beliefs, cultural background, psychosocial factors, previous healthcare and personal experiences, preferences of family members/friends) • Assess cognition, insight • Functional approach to assess decision-making – 4 criteria – abilities to make and communicate a choice; understand relevant information about the situation; appreciate how relevant information applies to oneself in the situation at hand; and engage in rational deliberation about treatment options
4.	Clionsky et al. (2016)	Discuss ethical challenges for determining capacity regarding ability for self-care and independence in discharge planning	<ul style="list-style-type: none"> • Functional approach to DMC assessment and consideration and assessment of executive autonomy to implement plans • Consider affect and medical status • Assess cognitive function, specifically executive functioning abilities • Assess functional abilities, beyond the basic self-care needs. • Occupational therapy assessment of instrumental activities of daily living (IADLs) e.g paying bills, taking medications, and writing checks. • Reassess capacity and preferences over time, address reversible barriers to capacity
5.	Cooney et al. (2004)	Discuss issues related to assessment of independent	<p>Assess individual's ability to provide for his or her own care, nutrition, shelter, and safety needs, or direct others to meet those needs.</p> <p>Need to consider</p>

		living capacity of older adults	<ul style="list-style-type: none"> • risk • environment • individual's mental and physical capabilities, actions and behaviours in addition to condition/diagnosis <p>Incidental qualitative observations are important in addition to formal assessment of executive function</p> <p>Assess</p> <ol style="list-style-type: none"> (1) the person's ability to make a decision about where to live and understand the consequences of that decision; (functional approach – 4 criteria) (2) the person's actions that may put that individual or others in danger; and (3) the person's specific needs
6.	Darzens (2010)	Discuss DMC assessment process; assess and document personal-care participation restrictions as part of assessment	<ul style="list-style-type: none"> • Unsafe occupational performance/personal care restrictions causing risk to self or others is a valid trigger for DMC assessment • Occupational therapists contribute by suggesting physical environmental modifications or the provision of support from families, friends or community services to accommodate activity limitations <p>Refers to Six-Step Capacity Assessment process (Darzens et al., 2000)</p> <ul style="list-style-type: none"> • Explain assessment process to person • Information gathering using assessments e.g. Personal Care Participation Restriction and Resource Tool (PC-PART; Vertesi, Darzens, Edwards, Lowe & McEvoy, 2000; Turner, Fricke & Darzens, 2009) to structure assessment; document observations; gather information about the relevant choices, available supports • Inform person of relevant information • DMC assessment – functional approach • Act on findings – engage substitute decision makers
7.	Bastian et al. (2011)	Response to paper by Darzens (2010)	<ul style="list-style-type: none"> • Presumption of capacity is problematic because it is often used to avoid making an assessment • Use valid instruments to obtain a profile of the situation –include neuropsychological assessment. • Adopt a systematic approach, elements of assessments should be known by all members of the team • MDT approach
8.	Feng et al. (2017)	Discuss conducting independent living capacity	<p>In-home capacity evaluations are complex and challenging, yet results help family and HSCPs to support patients' preferences for staying in their own home as long as possible</p> <p>Typical independent living capacity evaluation includes:</p>

		assessments within the home.	<ul style="list-style-type: none"> • Assessment of the individual's cognition (e.g. neuropsychological testing) • Assessment of psychiatric symptoms • A functional measure e.g. Independent Living Scales • Observations of functioning in the home • Clinical interview with the patient that includes an assessment of their values and preferences for where and how they live <p>Collaborate with other providers, family</p> <p>Benefits of assessing in home:</p> <ul style="list-style-type: none"> • Directly assess the functional elements of independent living rather than relying solely on a report from the patient or other reporters. • Risks and benefits of the home situation to the patient are often evident by being in the patient's own space with them <p>Takes into account the patient's cultural background, preferences, and values</p>
9.	Hicks et al. (2012)	Examine autonomy, choice, options, and power in healthcare decision making for older people	<ul style="list-style-type: none"> • Assessment of risk and availability of resources often takes precedence over person's choice in determining discharge destination. • Inform person of options on available discharge destinations to allow person make choice • Listen to preferences and experiences of older person • Available options may not meet the needs of older adults who have diminished independence
10.	Jayes et al. (2017)	Explore approaches to assessment of capacity within acute hospital and intermediate care settings	<p>Need to assess</p> <ul style="list-style-type: none"> • Functional abilities • Communication • Cognitive skills <p>Assessment process includes potentially overlapping phases of information gathering and both formal and informal assessments of patients' decision-making abilities. HSCPs use informal approaches to collect information to help them plan more formalised assessments</p> <ol style="list-style-type: none"> 1. Gathering information before the assessment

			<p>Obtain information about patients' pre-admission functional abilities from their families, carers, community health and social care staff</p> <p>Use both formal and informal assessments to gain information about patients' current abilities, including their communication and cognitive skills. (e.g. cognitive screening assessments)</p> <p>2. Informal and formal assessments of decision-making ability</p> <p>Conversations with patients about their home lives and hospital admissions to establish rapport with patients and to gain information about their cognitive function (e.g., their orientation and insight) and provide an informal assessment of capacity.</p> <ul style="list-style-type: none"> • Use of locally developed proforma to structure assessments prompts staff to follow legal requirements of functional approach and can be used to document assessment. • Support patients with cognitive difficulties to learn information relevant to decision-making prior to the capacity assessment in order to enhance patients' capacity • Focus on information about risk and the long-term consequences of decisions when assessing patients' ability to make decisions about where to live on discharge • Assess patients' decision-making at different points in time. • MDT approach recommended, though not widespread due to availability of staffing resources • Assessment practice is variable and some staff would benefit from additional support in order to improve the quality of their capacity assessments. • DMCA of people with communication difficulties requires specialist support
11.	John et al. (2020)	Determine how clinicians in the hospital setting assess DMC in relation to consent to treatment, independent living and finances	<p>Collect detailed information concerning the person's cognitive status, functional abilities, mood, medical, social and environmental limitations</p> <p>Five domains of safe and independent living should be evaluated (Skelton et al): activities of daily living (ADLs); the home environment; instrumental ADLs (IADLs); medical self-care (including medication management); and basic financial affairs. A deficit in any one of these indicates safe independence is questionable.</p> <p>Incorporate both subjective (ie patient self-report) and objective (ie performance based or direct observation) assessments of functional abilities</p> <p>Multidisciplinary approach to decision-making capacity assessment and on-going training in DMC assessment recommended</p>

12.	Lai and Karlawish (2007)	Examine the current approaches to assessment of DMC regarding decisions about functional problems	<p>Current approaches to assessing decisional capacity for everyday activities in older people are incomplete; discussion of existing everyday decision-making tools</p> <p>Provides a template for a semi-structured interview to evaluate a person's ability to make an everyday decision, to supplement functional, cognitive, and medical assessments</p> <p>This assessment is one component, integrated into a multi-step assessment that incorporates knowledge of the patient's functional, psychological, socioeconomic, and medical state.</p> <p>Model for Assessing the Capacity to Make Decisions About How to Solve Functional Problems</p> <ul style="list-style-type: none"> • Function - Functional testing by an occupational therapist plus history from family members on prior level of functioning. • Cognition - Mini-Mental State Examination plus brief evaluation of executive function using an instrument such as the EXIT, delirium assessment • Psychological state - screen for depression • Use proposed template to characterize ability to make decisions about how to solve functional problems and then document decisional skills within the context of the common language of the decisional abilities (understanding, appreciation, reasoning, and choice). <ul style="list-style-type: none"> • Understanding the problem • Appreciating the problem • Understanding the solutions • Understanding the benefits and harms • Appreciating the benefits and harms • Initial choice • Comparative reasoning • Consequential reasoning • Expressing a choice
13.	Lai et al. (2008)	Demonstrate the reliability and validity of Assessment of Capacity for	<p>ACED instrument measures the capacity to make decisions about solving functional problems.</p> <p>ACED uses a semi-structured interview format to assess four decision-making abilities: understanding, appreciation, reasoning, and expressing a choice</p>

		Everyday Decision-Making (ACED), an instrument to evaluate everyday decision-making	<p>ACED is a reliable and valid measure to assess decision-making capacity. It may serve as an important addition to current methods used to assess everyday decision-making</p> <p>Based on its reliability, scoring pattern, and associations with measures of cognition and the MacCAT-T, the ACED is a valid measure of EDM ability.</p> <p>The unique content focus of the instrument allows it to be useful for assessing the capacity of older persons with very mild to moderate cognitive impairment to make decisions about how to manage their IADL disabilities</p>
14.	Mackenzie and Newby (2008)	Investigate the effect of cognitive problems and other factors on the DMC about discharge destination and to compare the impressions of multidisciplinary team	<ul style="list-style-type: none"> • Semi-structured interview to determine DMC regarding discharge destination, incorporates functional approach • Assesses insight to functional, cognitive, affective changes, risks in home environment, problem-solving and preferences • Also utilise standardised assessments such as MMSE, Barthel, MEAMS, BADS • Cognitive test scores, age and dysphasia are not good predictors of capacity to decide about discharge destination • MDT approach preferred (if trained in DMC) • MDT members' impressions of DMC should not be the only determinant of the need for formal assessment, as they are not closely related to the results of formal assessment.
15.	Moye et al. (2005)	5-step clinical framework presented for assessment of DMC	<p>DMC for independent living can be the most challenging domain to assess because the range of skills necessary for independent living is so broad.</p> <p>Tasks important to demonstrate the capacity for independent living have been described as instrumental activities of daily living (IADL), such as management of home, health, money, transportation, meals, and communication. However, assessment of these skills is not enough. Need to consider judgment in applying these skills in an organized and consistent manner</p> <p>Judgment involves insight, planning, and reasoning essential to independent living e.g. handle emergencies, compensate for areas of incapacitation, exhibit motivation for daily life, and minimize risk to self and others</p> <p>Process of assessment involves: referral clarification, assessment planning, assessment, synthesis of data and communication of findings, and follow-up</p> <p>Assessment includes a targeted clinical interview and mental health evaluation, cognitive testing, and specific capacity tests.</p>

			<p>Clinician must consider the diagnosis, cognitive abilities, functional abilities and skills, and context</p> <p>Utilise interviews, scales for depression, anxiety, and other psychiatric symptoms, standardized cognitive tests, IADL instruments e.g. Independent Living Scales (Loeb, 1996), DMC assessments such as MacArthur Competency Assessment Tool—Treatment (Grisso & Appelbaum, 1998b), the Hopemont Capacity Assessment Instrument (Edelstein, 1999), the Capacity to Consent to Treatment Instrument (Marson, Ingram, Cody, & Harrell, 1995),</p> <p>DMC assessment is clinical judgment that integrates the individual’s diagnosis and functional abilities and skills with sensitivity to the person’s circumstances, past experiences which may impact decision-making</p>
16.	Moye et al. (2007)	Develop a conceptual model and associated assessment template for conducting and documenting a capacity evaluation of older adults in guardianship proceedings.	<p>The model and template provide a structure for conducting and documenting a capacity evaluation in guardianship by using six assessment domains of interest to the courts</p> <p>Six assessment domains:</p> <ol style="list-style-type: none"> 1. Medical condition that produces functional disability 2. Cognitive functioning 3. Emotional and psychiatric functioning important to assess in a capacity evaluation 4. Components of everyday functioning relevant for adult guardianship 5. Values relevant for adult guardianship 6. Risk of harm and level of supervision needed 7. Means to enhance capacity - practical accommodations (such as vision aids, medication reminders), as well as medical, psychosocial, or educational interventions (such as physical or occupational therapy, counselling, medications, or training
17.	Moye and Braun (2007)	Discuss functional assessment of DMC within domain of independent living - specifically re. guardianship	<p>Consider the relevant legal standards</p> <p>Focus on the specific functional issues and related values</p> <p>Everyday functioning can be divided into two categories: activities of daily living (ADLs)(e.g. dressing, eating, toileting, bathing) and instrumental activities of daily living (IADLs) (e.g. health-care management, financial management, and functioning in the home and community).</p> <p>Everyday functioning can be assessed through formal means, informal means, or a combination of both. Informal methods include observing the individual or gathering information from the individual, family, and staff.</p>

			Formal assessments include ADL/IADL rating scales and occupational therapy (OT) instruments.
18.	Moye and Braun (2010)	Provide an overview of the theory and practice of assessing civil capacities (e.g., health care, finances, independent living) in older adults	<p>Summarises the framework and process from the ABA-APA Handbook for Psychologists (American Bar Association and American Psychological Association, 2008).</p> <p>Outlines components necessary for clinical capacity assessment:</p> <ol style="list-style-type: none"> 1. Understanding of the legal standard; 2. Discern the functional elements; Which tasks appear to be most challenging for the individual (managing medications, keeping the home clean, maintaining adequate hygiene, exercising judgment in staying safe in the community)? How have functional concerns caused problems? Are these problems new or longstanding? Have these problems happened or are others afraid they may happen? Activities of daily living (ADLs) (e.g., grooming, toileting, eating, transferring, dressing) and instrumental activities of daily living (IADLs) (e.g., abilities to manage finances, health, and functioning in the home and community) may be areas to evaluate. 3. Determine the diagnosis 4. Assess underpinning cognitive processes 5. Identify psychiatric or emotional factors which may influence function 6. Consider person's values and preferences for care, where or how they live; evaluate the decision-making process 7. Risk in in the context of the supports available 8. Maximizing capacity both during the evaluation and in the future - compensate for sensory, cognitive, and physical deficits <p>Provide a clear, concise, clinical judgment; integrate historical information, interview data, and test data, in the context of a diagnosis and functional considerations to reach conclusion.</p> <p>Includes comprehensive clinical interview, standardized assessments of cognition and standardized assessments of function.</p> <p>Tests may include:</p> <ul style="list-style-type: none"> • Independent Living Scales (ILS) • Mini-Mental Status Examination (MMSE) • Repeatable Battery for the Assessment of Neuropsychological Status (RBANS-A) • Trail Making Tests A and B • Clock Drawing

19.	Naik et al. (2008)	Discuss assessment of capacity to make and execute decisions regarding safe and independent living;	<p>Conceptualizing and assessing autonomy solely in terms of DMC is inadequate and must be expanded to include decisional <i>and</i> executive dimensions.</p> <ul style="list-style-type: none"> • Assess cognition using standardised screens • Assess DMC using functional approach, using standardised case scenarios • Assess executive capacity using self-report and observation of performance of activities associated with independent living. <p>Five domains of functioning related to self-care and placement:</p> <ol style="list-style-type: none"> (1) activities for personal care, (2) activities for independent living, (3) maintenance of the living environment, (4) basic medical self-management, (5) and activities related to daily financial affairs. <p>Consider insight to limitations and awareness of supports</p>
20.	Naik et al. (2010)	Describe HSCPs' perceptions of and screening of vulnerability among older adults living in community settings	<p>Evaluate</p> <ul style="list-style-type: none"> • Cognitive abilities such as memory, attention, and orientation • Decision-making processes (including reasoning or judgment) • Ability to plan and safely perform everyday tasks (Functional Independence Measure; KELS) <p>Consider physical environment and social supports, safety, personal appearance and grooming</p> <p>Interdisciplinary team approach in the home setting</p> <p>Vulnerability to risks associated with independent living is characterised by:</p> <ol style="list-style-type: none"> 1) Inability to routinely perform activities of daily living across 5 domains: maintenance of personal finances, medical self-management, mobility, personal care and hygiene, and maintenance of a safe living environment 2) Inadequate social support 3) Social and demographic factors. 4) Neuropsychiatric conditions such as depression and dementia
21.	Naik (2017)	Discuss assessment of capacity to	<p>Decision-making capacity is “the process of making decisions for oneself or extending that power to another individual when it is impaired” and executive capacity is the “process of carrying one’s decision into effect either alone or by delegating those responsibilities to another individual.”</p>

		<p>make and execute decisions for safe and independent living. Present clinical model</p>	<p>Decision-making and executive capacity should be evaluated independent of one another across five broad functional domains for independent living:</p> <ul style="list-style-type: none"> • maintaining personal needs and hygiene • condition of the home environment • maintaining activities for independent living • health-care self-management • managing financial affairs. <p>DMC assessed using functional approach Executional capacity assessment – does person have a plan to person implement decision, they can adapt plan and delegate as required</p> <p>Recommend use of MED-SAIL Comprehensive and standardised approaches to assess cognition, mood, ADL abilities, mobility and nutrition</p>
22.	Mills et al. (2014)	<p>Describe the development and validation of MED-SAIL, a brief screening tool for capacity to live safely and independently in the community</p>	<ul style="list-style-type: none"> • Commonly used tools do not address the overlap of function, cognition, and judgment required to assess DMC for independent living • Use of MED-SAIL to differentiate between no capacity and partial/full capacity for independent living in community-dwelling older adults and identify older adults who may be at risk for losing their independence • Functional approach to DMC assessment applied to case scenarios related to independent living • Cognition assessed using St. Louis University Mental Status Examination (SLUMS); • Functioning and judgment assessed through Independent Living Scales (ILS) to determine the respondent's knowledge of information, ability to perform self-care tasks, and care for property • MED-SAIL was significantly correlated with the Independent Living Scales. • MED-SAIL is an effective screening tool to differentiate between no capacity and partial/full capacity in community-dwelling older adults for the purposes of referral for comprehensive further evaluation and service planning. • MED-SAIL allows HSCPs in the community to identify older adults at risk for losing their independence, potentially requiring transitions into long-term care settings. <p>Responses to the MED-SAIL scenarios can be shared with family members or caregivers to contextualize capacity impairments in a manner that is meaningful to everyday living</p>
23.	Skelton et al. (2010)	<p>Describe interdisciplinary</p>	<p>Cognitive function, affect and judgment are important for safe and independent living, and deficits in these domains are linked to impaired executive control function</p>

		<p>capacity assessment and intervention (CAI) model for home-based independent living capacity assessments with older adults.</p>	<p>Developed CAI Model as comprehensive approach to assessment of DMC for independent living, at a community outpatient geriatrics clinic to address gaps in training and consistency. Includes an in-home geriatrics assessment followed by an interdisciplinary team meeting to develop a plan of care to support the individual in their homes whenever possible</p> <p>Consider executive capacity as well as decisional capacity</p> <p>Ideally, assessments are performed in the patient’s home but may also occur in the clinic or skilled nursing facility. 5 domains of safe and independent living (Naik et al. 2008) should be evaluated: (1) personal needs e.g. bathing, toileting, dressing, feeding; (2) condition of home environment; (3) activities for independent living, e.g. shopping, cooking, laundry, using telephone and transportation; (4) medical self-care, e.g. medication management, wound care; (5) financial affairs, e.g. daily transactions, paying bills</p> <p>Assessment process 1) History, social and physical exam 2) Battery of standardized screening tools to assess cognition; affect and functional abilities (e.g. MMSE, GDS, KELS) 3) MDT meeting to examine all aspects of case history, assessments and recommend appropriate interventions. 4) Meeting with the older adult and family members and social services professionals to discuss assessments and recommendations 5) Follow-up assessment to ensure that intervention recommendations have been implemented and are effective</p>
24.	Poole et al. (2014)	<p>Explore how judgements about capacity regarding going home are made for people with dementia on medical wards and how they</p>	<p>Assessments of residence capacity, judgements about ‘best interests’ and subsequent discharge decisions are complex from every perspective: HSCPs, people with dementia and for their families.</p> <p>Multiple formal and informal assessments, often entails second opinions e.g. from old age psychiatry.</p> <p>Complex decisions require planning meetings and case conferences to seek the views of relatives.</p> <p>Clarity about the information to be imparted to the person concerned is required</p> <p>Allow sufficient time and consider timing of assessment</p>

		might be improved	<p>Need more support and training for practitioners, as well as support and advocacy for patients and families</p> <p>Need properly resourced step-down or rehabilitation units to facilitate timely and good decision-making</p>
25.	Emmett et al. (2013)	Discuss how assessments of residence capacity are performed on general hospital wards, compared with legal standards	<ul style="list-style-type: none"> • Functional approach to capacity assessment • Informal assessments of capacity occur over time - involve gleaning information from various sources, which then feeds into the overall capacity assessment E.g OT home visit – could inform judgements about the patient's functional ability to weigh things up • Formal assessment - Gather information on person's past and current living arrangements; current and future care needs; supports available to meet these needs. • Present relevant information regarding various options, alternatives and risks associated with a particular choice of residence to a patient • Assess if they can understand and weigh those factors in order to demonstrate decisional capacity and make an informed choice – functional approach • Use of a pilot proforma led to lengthy, well documented formal assessments which closely followed the statutory requirements • Legal standards governing DMC assessment are not routinely applied in practice in general hospital settings; wide inconsistency of approach amongst professionals and between cases • More specific legal standards are required when assessing capacity to decide place of residence on discharge from hospital
26.	Hughes et al. (2015)	Discuss the importance of residence capacity and how it should be assessed	<p>Functional assessment approach</p> <p>Assessment takes time and effort, physical environment should be quiet and private.</p> <p>Focus on information required by person with dementia to make such decision:</p> <ul style="list-style-type: none"> • Why a change of residence is being proposed: problems, concerns, reason for admission • What is being proposed (e.g. move into a care home) • Available options (e.g. if they go home, help is recommended because of the risks identified) <p>Consequences of making any decision, including a decision not to follow the advice being given, or making no decision at all</p>
27.	Schreiber et al. (2018)	Discuss decisional capacity of older patients	<p>Residence capacity evaluations are fundamentally different from standard capacity evaluation</p> <p>MDT approach required to access the breadth of information necessary for an informed discussion of the discharge options</p>

		with cognitive impairment who refuse a safe discharge	<p>Functional observation is essential in addition to self-report due to lack of insight regarding risks or capabilities E.g. Hospital-based occupational therapy assessment, such as the Kohlman Evaluation of Living Skills, used to characterize functional deficits. (Bourgeois et al. 2017)</p> <p>Comprehensive holistic assessment – consider risks, person’s values - must consider all possible risks and benefits to going home</p>
28.	Stewart et al. (2005)	Discuss uncertainties and conflicts around place of discharge of older people	<ul style="list-style-type: none"> • Functional approach to DMC • Explain process, law and rights to person with dementia and family (including the right to take risks and make unwise decisions) • Use trial home discharges to assess insight, functional abilities, risks and sustainability • Liaise with multidisciplinary community mental health teams and services to assess and monitor person with dementia’s ability to cope at home • Open involvement and communication with both patients and families. Need for patient advocacy for people with dementia
29.	Usher and Stapleton (2020b)	Explore occupational therapy practices regarding DMC assessment	<p>Highlights role of occupational therapists within multidisciplinary assessment of DMC.</p> <p>Need to assess</p> <ul style="list-style-type: none"> • functional performance abilities • cognitive skills. • environment <p>OT assessment often includes gathering information about the person's past and present living arrangements, their current and future care needs, and supports available to meet those needs so the person can understand and weigh various options and risks, to demonstrate decisional capacity and make an informed choice</p> <p>Adopt strengths-based approach – focus on what client can do</p> <p>Typical assessment approaches included:</p> <ul style="list-style-type: none"> • performance-based assessments; • interview-based assessments • professional judgment.

			<p>Includes standardised assessments and structured observations of performance of daily tasks</p> <p>Structured observations of the person's ability to complete functional tasks informs assessment of DMC, e.g. kitchen task assessments; home visits; washing and dressing assessments; community access and money management tasks. Standardised observations of function such as Assessment of Motor and Process Skills (AMPS) and Kettle Test.</p> <p>Cognitive screening assessments e.g. Montreal Cognitive assessment (MoCA), Addenbrooke's Cognitive Examination (ACE-III), Mini Mental State Examination (MMSE) and Rivermead Behavioural Memory Test (RMBT) to inform DMC assessments.</p> <p>Seek collateral information from family, other HSCPs</p> <p>Assessment occurs in clinical setting, home and community</p>
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Note. Adapted from “Assessment of older adults' decision-making capacity in relation to independent living: A scoping review” by R. Usher and T. Stapleton, 2021, *Health & Social Care in the Community*, Advance online publication (<https://doi.org/10.1111/hsc.13487>). CC BY.

3.3.4 Themes identified from the review

Six themes were identified from the data extracted through thematic analysis (Figure 3.3). The first five themes describe the approaches to DMC assessment for IL and the last theme outlines the multidisciplinary approach and highlights the HSCPs involved.

Figure 3.3

Summary of themes from review

<i>Theme 1</i>	<i>Functional approach to DMC assessment for IL</i>
<i>Theme 2</i>	<i>Values and preferences</i>
<i>Theme 3</i>	<i>Components of DMC assessment for IL</i> <ul style="list-style-type: none">• Cognitive assessment• Functional performance assessment• Environmental assessment• Risk assessment
<i>Theme 4</i>	<i>Maximising and supporting DMC</i>
<i>Theme 5</i>	<i>Specific assessments for IL DMC</i>
<i>Theme 6</i>	<i>HSCPs involved in assessment</i>

Note. Adapted from “Assessment of older adults' decision-making capacity in relation to independent living: A scoping review” by R. Usher and T. Stapleton, 2021, *Health & Social Care in the Community*, Advance online publication (<https://doi.org/10.1111/hsc.13487>). CC BY.

3.3.4.1 Theme 1: Functional approach to DMC assessment for IL

Though legal definitions of DMC vary internationally, most legislation and literature pertaining to DMC generally defines DMC for any domain in terms of four widely accepted criteria: understanding, appreciation, reasoning and expression of choice (Grisso & Appelbaum, 1998). In relation to DMC for IL, the majority of publications in this review advocate for a functional approach to DMC assessment, incorporating these four dimensions, namely the assessment of the person’s abilities to: understand relevant information about the situation; appreciate how relevant information applies to oneself in the situation; engage in rational deliberation about available options; and to make and communicate a choice (Brindle & Holmes, 2004; Carrese, 2006; Clionsky et al., 2016; Cooney et al., 2004; Darzins, 2010; Emmett et al., 2013; Hughes et al., 2015; Jayes et al., 2017; Mackenzie et al., 2008; Mills et al., 2014; Naik, 2017; Naik et al., 2008a; Stewart et al., 2005; Usher & Stapleton, 2020b).

Some authors argued that capacity assessments for IL must be expanded beyond decision-making to include executorial dimensions (Clionsky et al., 2016; Naik, 2017; Naik et al., 2008a; Skelton et al.,

2010). While DMC can be assessed using the above functional approach criteria, executional capacity assessment is concerned with the person's ability to carry out the decision and includes the additional opportunity to consider the person's ability to develop a plan, adapt the plan and delegate as required. Naik et al. (2008a) argues that disabilities or physical limitations do not affect executional capacity, as long as the older adult is aware of the limitations and cites potential supports.

3.3.4.2 Theme 2: Values and preferences

Many publications highlighted the need to ascertain the person's preferences and values (Brindle & Holmes, 2004; Carrese, 2006; Clionsky et al., 2016; Feng et al., 2017; Mackenzie et al., 2008; Moye & Braun, 2010; Schreiber et al., 2018), which may reflect increasing awareness of the impact of social and cultural factors, beliefs and attitudes on decision-making. A history of a consistently stated preferences should be considered as this may reflect the person's values, religious beliefs, cultural background, previous healthcare and personal experiences (Carrese, 2006), as these long-held values, preferences, and patterns lay the personal foundation for decisions (Naik et al., 2010). The importance of listening to the person's preferences is stressed, particularly when the options available may not suit the person's needs (Hicks et al., 2012). The need to adopt a functional approach to DMC assessment and to evaluate the *process* of decision-making, rather than the outcome, is important, given the individual has the right to make decisions that HSCPs may think unwise, therefore the HSCPs' own values must be held in-check (Carrese, 2006; Hicks et al., 2012). However, while the importance of considering the older person's values and preferences for IL is highlighted, there is little information on how to gather this information, except for Feng et al. (2017) who suggest the clinical interview should include asking questions such as, "What makes your home a home?" in order to ensure HSCPs recommendations are consistent with the person's wishes.

3.3.4.3 Theme 3: Components of DMC assessment for IL

Capacity for IL lies at the confluence of function, cognition, and judgment (Mills et al., 2014). Unlike other domains of DMC, such as DMC for medical consent, which is largely a cognitive task, DMC for IL is a broad domain encompassing multiple everyday life functions and skills (Naik et al., 2008b). Thus, most publications recommended a multi-component approach which includes assessment of the person's cognitive and functional abilities, their values and preferences, risks, and the environment in question.

3.3.4.3.1 Cognitive assessment

The majority of publications referred to assessment of cognition as part of a comprehensive DMC assessment for independent living (Bastian et al., 2011; Bourgeois et al., 2017; Brindle & Holmes, 2004; Carrese, 2006; Cooney et al., 2004; Feng et al., 2017; Jayes et al., 2017; John et al., 2020; Moye & Braun, 2010; Naik, 2017; Naik et al., 2010; Naik et al., 2008a; Skelton et al., 2010; Usher & Stapleton, 2020b). In assessing cognitive function for this particular domain, some authors specifically refer to the need to assess memory, attention and orientation (Naik et al., 2010) and others emphasise executive functioning abilities (Clionsky et al., 2016).

Specific standardised cognitive screens are referred to in many publications (Mackenzie et al., 2008; Naik et al., 2008b; Skelton et al., 2010; Usher & Stapleton, 2020b) such as Montreal Cognitive assessment (MoCA), Addenbrooke's Cognitive Examination (ACE-III), Mini Mental State Examination (MMSE), and Rivermead Behavioural Memory Test (RMBT). In utilising cognitive screens, consideration of the individuals' educational, socioeconomic background, and the need to use assessments normed for older adults is stressed (Moye & Braun, 2010). However, while cognition was deemed a critical component of the DMC assessment process, some publications argued that reliance on cognitive screening is not sufficient to predict capacity to make decisions regarding IL (Mackenzie et al., 2008; Usher & Stapleton, 2020b).

3.3.4.3.2 Functional performance assessment

Given the skills required for IL, the majority of publications refer to the need for assessment of functional skills and abilities to perform daily living tasks. Both subjective (i.e. self-report) and objective (i.e. performance based or direct observation) assessments of functional abilities are recommended (Bourgeois et al., 2017; Cooney et al., 2004; John et al., 2020; Skelton et al., 2010; Usher & Stapleton, 2020b). Both approaches are required as there can be significant difference between self-report and performance-based observations (John et al., 2020). Older people with cognitive impairment may lack insight into their deficits and may have a tendency to over-report capabilities or downplay risks (Schreiber et al., 2018).

Many authors recommend that assessment of functional abilities go beyond evaluation of basic activities of daily living (ADLs) (e.g., grooming, toileting, eating, transferring, dressing) (Clionsky et al., 2016; Moye & Braun, 2010; Moye & Braun, 2007; Naik, 2017; Naik et al., 2010; Naik, et al., 2008b). They suggest assessment should address instrumental activities of daily living (IADLs) relevant to IL, such as maintenance of the living environment, medical self-management, management of daily financial affairs and recommend using self-report and observation of performance of these activities that are associated with IL.

Functional performance of everyday tasks may be assessed using observations and standardised assessments, and articles reviewed highlighted assessment tools such as Independent Living Scales (ILS); Functional Independence Measure; Kohlman Evaluation of Living Skills (KELS); Personal Care Participation Restriction and Resource Tool (PC-PART); Assessment of Motor and Process Skills (AMPS) and Kettle Test (Bourgeois et al., 2017; Darzins, 2010; Feng et al., 2017; Mills et al., 2014; Naik et al., 2010; Schreiber et al., 2018; Skelton et al., 2010; Usher & Stapleton, 2020b). Occupational therapy assessments of function and performance, including home visits were highlighted in some publications (Darzins, 2010; Emmett et al., 2013; Moye and Braun, 2007; Usher & Stapleton, 2020b) as a component of multidisciplinary assessment.

3.3.4.3.3 Environmental assessment

Some of the publications reviewed refer to the person's home environment, recommending consideration of both the physical and/or social environment in the IL DMC assessment process (Bourgeois et al., 2017; Cooney et al., 2004; John et al., 2020; Usher & Stapleton, 2020b). As previously stated, a home-based assessment, taking cognisance of the person's ability to maintain a safe and accessible living environment, may provide some estimation of any level of vulnerability to risk associated with IL (Naik, 2017; Naik et al., 2010; Naik et al., 2008b; Skelton et al., 2010).

Darzins (2010) suggests physical environmental modifications or provision of support to accommodate activity limitations contributes to decision-making for discharge planning as by minimising participation restrictions and associated risks, the older person can make informed decisions about their ability to manage at home and to accept recommended IL supports. Feng et al. (2017) advocate the benefits of observing the older person's functioning in the home, not only in relation to risk but in terms of understanding of the person's cultural background, preferences, and values. However, Emmett et al. (2013) report that while occupational therapy home assessment may contribute to DMC assessment by informing judgements about the patient's functional ability to weigh things up, conversely it may encourage an outcome approach to DMC assessment, whereby HSCPs attribute capacity on the basis of the consequences of the older person's decision-making choices. Therefore, evaluation of the person's environment, or their functioning within their environment, must be carefully integrated into the DMC assessment process to ensure it does not detract from the recommended functional approach to DMC assessment. Rather, environmental assessment is part of the relevant information that applies to the person's situation, which they must show ability to understand, appreciate and weigh-up in making a decision.

3.3.4.3.4 Risk assessment

Consideration of risk is referred to as part of the overall assessment process or as a trigger for DMC assessment for IL within numerous publications (Carrese, 2006; Cooney et al., 2004; Darzins, 2010; Hicks et al., 2012; Jayes et al., 2017; Mackenzie et al., 2008; Moye & Braun, 2010; Schreiber et al., 2018; Stewart et al., 2005) though there are no recommendations on how to undertake this. Emmett et al. (2013) and Moye and Braun (2010) report concepts of risk assessment and management play a particularly important role in the DMC assessment process regarding IL. Schreiber et al. (2018) argue that assessment must consider all possible risks and benefits to going home and Feng et al. (2017) suggest these risks and benefits are often evident when DMC assessments are conducted within the home. Identified risks and subsequent concerns must be communicated to the person in order to evaluate if they can weigh up the risks and benefits (Cooney et al., 2004; Usher & Stapleton, 2020b). Stewart et al. (2005) recommend that the person is advised of their right to take risks and make unwise decisions.

3.3.4.4 Theme 4: Maximising and supporting DMC

In effort to support and optimise DMC, many publications highlighted consideration of assessment timing, given that DMC may fluctuate, and emphasised the importance of modifying the assessment setting and the approach taken to compensate for any physical, sensory or cognitive deficits and thus maximise DMC (Bourgeois et al., 2017; Clionsky et al., 2016; Hughes et al., 2015; Moye & Braun, 2010). Clionsky et al. (2016) recommend addressing reversible barriers to DMC (such as delirium) and reassessing the person's DMC and their preferences over time. Informal assessments of DMC occur over time as HSCPs utilise formal and informal approaches to gather information (Emmett et al., 2013; Jayes et al., 2017). A strengths-based approach, emphasising the person's abilities, is recommended (Usher & Stapleton, 2020b). Many publications recommended providing the person with sufficient information relevant to the decision, in an accessible format, so they can make an informed choice (Emmett et al., 2013; Jayes et al., 2017; Poole et al., 2014). Clarity about the information to be imparted to the person concerned is required (Poole et al., 2014) and only then can the person's level of insight be considered (Brindle & Holmes, 2004; Carrese, 2006; Stewart et al., 2005). Stewart et al. (2005) also recommend 'trial discharges' be instigated more routinely to determine a person's insight into their ability to manage at home and subsequently to make an informed decision regarding IL.

3.3.4.5 Theme 5: Specific assessments for IL DMC

This review included publications describing the validation of three instruments specifically concerned with DMC assessment of IL. Mills et al. (2014) describe the development and validation of the Making and Executing Decisions for Safe and Independent Living (MED-SAIL) screening tool for identifying community-dwelling older adults at risk for losing their independence. Naik (2017) recommends its use in assessment of capacity to make and execute decisions for safe and independent living. Mills and Naik (2017) describe its use in the context of self-neglect in older adults. Lai et al. (2008) present the reliability and validity of Assessment of Capacity for Everyday Decision-Making (ACED), which uses semi-structured interview to evaluate the person's capacity to make everyday decisions about solving functional and IADL problems. Lai and Karlawish (2007) recommend this assessment be integrated into a multi-step assessment that includes the person's functional, psychological, socioeconomic, and medical status. The Communication Aid to Capacity Evaluation (CACE) was developed and validated as an accessible tool, providing structure through pictorial and written choices, to allow HSCPs to evaluate capacity of people with aphasia to consent to be admitted to long-term care (Carling-Rowland et al., 2014). Although these tools were developed in the United States (MED-SAIL and ACED) and Canada (CACE), the issues that arise regarding the preservation of an individual's rights to decide where and how to live have relevance in other jurisdictions.

3.3.4.6 Theme 6: HSCPs involved in assessment

A multidisciplinary approach was recommended in many publications (Jayes et al., 2017; John et al., 2020; Usher & Stapleton, 2020b) and a range of HSCPs were mentioned as having a potential role in contribution to the assessment process. Schreiber et al. (2018) note that no one discipline could have access to the breadth of information relevant to IL. Most publications pertained to the work of physicians and psychologists, though they often referred to the involvement of nurses, social workers, occupational therapists and mental health providers, or used generic terms such a clinician or healthcare professional. As reported by Jayes et al. (2017), the involvement of HSCPs might depend on who has relevant skills and knowledge about the person's home situation or functional abilities. For example, many publications highlighted the contribution of occupational therapy in functional performance assessments and home assessments, which is often pertinent for decisions relating to IL.

3.4 Discussion

This scoping review aimed to synthesise knowledge about approaches to assessing DMC for IL of older adults. This review was motivated by the need to identify ways of implementing recently commenced DMC legislation in Ireland and to improve DMC assessment practices among HSCPs who work with older adults. Twenty-nine records were identified for inclusion in this review which relate to current approaches to assessing older adults' DMC for IL, including which HSCPs contribute to assessments, what is measured and how, and in what settings.

Given IL is a broad domain, it is not surprising that many publications recommended a multi-pronged approach to assessment. While this review has identified key components of DMC assessment for IL, there is much overlap between these areas and assessments of cognition, function, environment and risk often occur simultaneously. The lack of clear distinction between certain concepts can lead to difficulties implementing the functional approach as outlined in legislation. Emmett et al. (2013) highlighted how conflation of perceived risk with DMC can lead to adoption of an outcome approach. This review also highlights that a person's value and preferences may not be as consistently or easily assessed as more concrete components of assessment, and therefore may be overlooked as HSCPs focus on objective assessment of areas such as cognition or function. This is an issue that requires further attention given recent legislation emphasises the person's will and preference as a core principle. By considering underlying beliefs, attitudes and expectations, HSCPs may be able to support and promote DMC of older adults for IL. Reflective of legislative and policy changes, many publications emphasise the importance of supporting people in decision-making and maximising DMC as part of the assessment process.

A multidisciplinary approach is highlighted in this review. Successful collaboration among HSCPs requires a shared and consistent understanding of DMC, however a lack of standardised approach is reported (John et al., 2020). This reinforces the need for training and education on DMC which has been widely acknowledged (Jayes et al., 2017; Usher & Stapleton, 2020b; Young et al., 2018). Additionally, lack of inter-professional collaboration and 'perceived' professional isolation have been identified as clinical practice issues, with medical practitioners predominantly taking responsibility for assessing DMC (Davies et al., 2019). Addressing training and education gaps may also enhance confidence and address practice issues relating to professional hierarchy, reluctance to assess and deferral to others. Multidisciplinary collaboration may also allow HSCPs share the responsibility associated with assessment and consequences of assessment outcomes.

Three specific assessment tools of DMC for IL were identified in this review, which may be useful when incorporated into a comprehensive multi-stage approach. Given the complexity of DMC for IL, it is unlikely any one assessment tool could consider all the individual and contextual factors that

contribute to decision-making for IL. Nonetheless, there is growing awareness of variables in clinical judgment and discrepancy between structured assessment and expert opinions in under and over-estimating DMC (Pennington et al., 2018). Therefore, in borderline or challenging cases, using structured assessment tools may be useful, if considered as part of a comprehensive multi-disciplinary approach, which includes open discussion with the older person and their relevant caregivers.

3.4.1 Recommendations for future research

A broad variety of literature was examined, encompassing scientific evidence, reviews, clinical experience and judgment and expert opinion. However, no records were found on older people's views (or their relatives) regarding what approaches they find appropriate for assessment of their DMC for IL status, which limits the interpretation of results. There is clear need for research which captures perspectives of older people and caregivers on their preferences and concerns regarding DMC assessment for IL and to better understand their experiences of the process and to ensure adequate attention is given to their will and preference. Additionally, to create best practices in this area, more research is needed to expand understanding of barriers and facilitators to comprehensive assessment and provide more detailed descriptions of outcomes.

This review highlights the emerging literature regarding approaches to DMC assessment of older adults for IL. However, the paucity of empirical research is evident, especially given the international context and the significance of DMC for IL assessment outcomes for older adults. Limited literature on assessment of DMC for IL may reflect conceptual confusion and variance in terminology used to describe this domain. Much literature exists on multidisciplinary practice in discharge planning which often relates to the DMC domain of IL, though it may not be explicitly addressed. Previous research identified that DMC assessments in acute hospitals mainly relate to discharge decisions, which require patients to make choices about returning to their usual residence, with or without a package of care (Jayes et al., 2017). However, while discharge planning research may overlap with DMC research, publications which did not explicitly refer to assessment of DMC were not included within the review. This may explain the lack of literature from disciplines such as occupational therapy, which despite often being involved in DMC assessment may publish research framed as discharge planning and may not specifically address DMC issues, and therefore were beyond the parameters of this review. Previous research found that people with dementia are excluded from care-planning meetings on the assumption they lack DMC (Donnelly et al., 2018), however the process of determining DMC was not described. Nonetheless, discharge and care planning should incorporate aspects of DMC, and therefore knowledge on approaches to assessment is required for HSCPs

involved in discharge planning (such as occupational therapists, social workers, public health nurses and community services), to ensure decision-making is compliant with legislation, promotes the rights of the older person and grounded in the underpinning principles of enablement, least restriction and participation.

Furthermore, another conceptual issue in the broader DMC assessment literature is highlighted by Moyer and Braun (2010), whereby the legal use of the term “functional” in discussing DMC assessment approaches refers to one of three approaches to determining DMC. A functional approach to DMC assessment recognises DMC as issue specific and time specific and emphasises the *process* of making a decision, rather than the outcome of the decision itself. In gerontology and wider healthcare practice, the term “functional assessment” or “functional capacity evaluation” is typically used in reference to a person’s ability to perform ADLs and IADLs (Quinn et al., 2011). While this conceptual discrepancy did not limit this review, the potential misinterpretation of a core concept has implications for the implementation of legal guidance in clinical practice.

While this review was conducted systematically and rigorously, there are several acknowledged limitations. A single researcher was primarily responsible for study selection, data extraction and data synthesis. The researcher consulted the research supervisor throughout the review process, to ensure consistency in application of the search strategy and the results obtained. This review followed the framework outlined by Arksey and O’Malley (2005) and further recommendations provided by Levac et al. (2010) and Peters et al. (2017). Due to disparate study designs and the descriptive nature of the publications included in the review, systematic quality assessments of the final included results as suggested by Levac et al. (2010) was not conducted. However, the discussion includes directions for future research and the utility of the research in practice.

The review offers a systematic overview of the existing literature regarding the assessment of older adult’s DMC for IL. Both quantitative and qualitative data were sought but most publications presented were commentaries and case discussions. As the review was limited to publication in the English language, papers published in other languages many have been missed. Additionally, most publications originated in the US which indicates further research from other jurisdictions is required. As the approach to DMC assessment is framed by the context, variance in legal standards between jurisdictions must be considered. For example, the legislation in Ireland does not consider a ‘best interest’ approach as exists in the UK. Equally, there is no prerequisite for an impairment of the mind or brain, whether as a result of an illness or external factors, such as alcohol or drug use, as there is in UK and US. The prevalence of psychiatry and psychology related publications may reflect some jurisdictions legislative requirements for a diagnosis that may impair DMC in initiating DMC assessment. As legal reform increasingly places emphasis on the person’s will and preference, research will need to address how this is best assessed and addressed as part of DMC assessment.

Despite these acknowledged limitations, the body of knowledge presented in this review provides a broad understanding of how DMC of older adults regarding IL is assessed.

3.5 Conclusion

This review identified and mapped existing literature on approaches to assessing older adults' DMC in relation to IL and highlights current gaps in research. Despite increasing literature on this topic in recent years, the need for further research to expand understanding of the complexity of DMC for IL assessment and to explore the barriers and facilitators influencing the assessment process was identified. As older people should be involved in deciding where they live, future research gaining insights into their perspectives regarding assessment of DMC for IL is recommended. Overall, findings indicate a comprehensive and multidisciplinary approach, using validated screening instruments for assessing cognition and functional performance and clear communication of outcomes is required when assessing older people's DMC for IL.

4.0 Methodology

4.1 Introduction

An overview of the methods used to address the aims of the study will be presented in this chapter. An overall mixed method approach was utilised and justification of the choice of this methodology will be provided. The study was conducted via three sequential phases of data collection, in conjunction with the scoping review reported in the previous chapter. The aims, sampling procedures, data collection and data analysis methods of each empirical phase will be outlined.

4.1.1 Research aims and objectives

The overall aim of this research study was to explore the role of occupational therapy in the assessment of decision-making capacity of older people in relation to independent living, within an Irish context of practice. The study sought to explore how occupational therapists currently contribute to DMC assessment practice, to examine factors that impact on their current practices, including recent legislation, and to identify core assessment components and procedures that clinicians should consider when engaging in this area of practice. To achieve this aim, a four-phased sequential mixed methods design, using a combination of qualitative and quantitative approaches, was utilised and the methods and objectives of each phase of the study are outlined below in Figure 4.1.

Figure 4.1

Study phases, methods and objectives

Phase 1: A national survey of current occupational therapy practice in assessing decision-making capacity.
<ul style="list-style-type: none">• To examine if occupational therapists in Ireland are currently involved in the formal assessment of decision-making capacity, and if so, to what extent are they involved in this component of practice• To explore occupational therapists' awareness of and attitudes towards recent Irish legislation regarding decision-making capacity and the potential implications of this legislation for their practice
Phase 2: A scoping review of the literature regarding multidisciplinary assessment approaches used to evaluate decision-making capacity of older adults, in relation to independent living decisions.
<ul style="list-style-type: none">• To identify and map current knowledge on assessment of older adults' decision-making capacity in relation to independent living.
Phase 3: Focus groups interviews to explore occupational therapists decision-making capacity assessment practices with older adults, in relation to independent living.
<ul style="list-style-type: none">• To explore how occupational therapists in Ireland are currently involved in the assessment of decision-making capacity of older adults in relation to independent living• To explore issues that impact on the current decision-making capacity assessment practices of occupational therapists who work with older adults• To explore occupational therapists' attitudes towards and experiences of implementing recent legislation regarding decision-making capacity within their practices
Phase 4: Nominal group technique to form consensus on assessment components and procedures in addressing decision-making capacity assessment of older adults, in relation to independent living.
<ul style="list-style-type: none">• To identify key dimensions of occupational therapy assessment practices to guide occupational therapy's contribution to practice in decision-making capacity assessment of older adults, particularly in relation to independent living

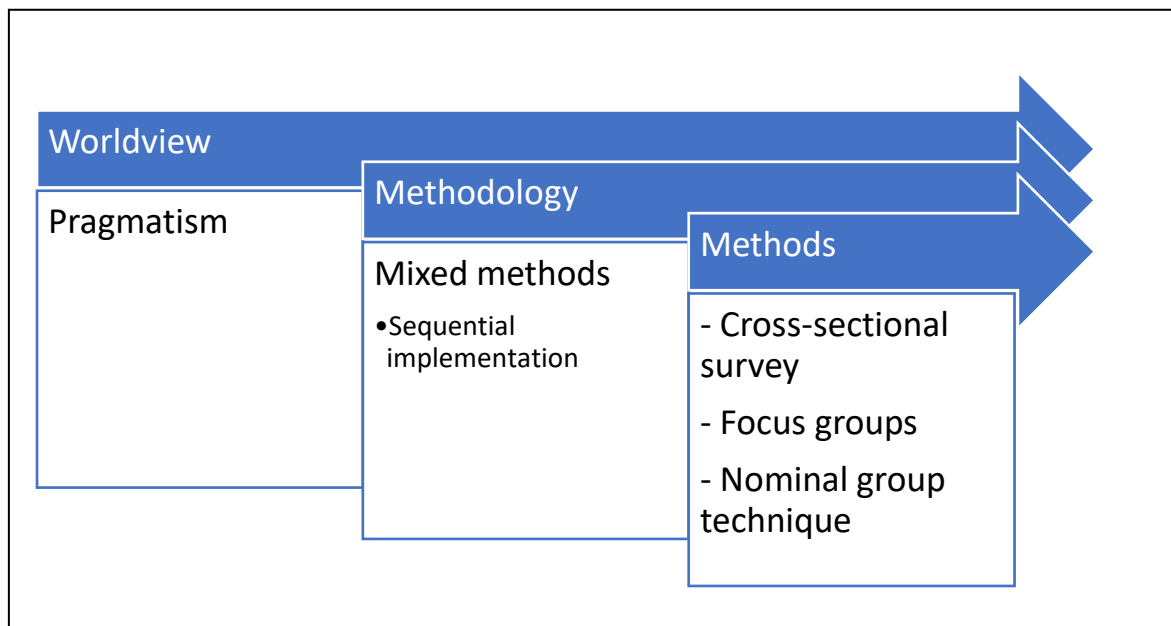
4.2 Overview of the methodology

An overall mixed methods design was chosen to address the specific objectives of this study. A brief overview of mixed methods research will be presented in this section, and the appropriateness of this approach to the current study will be discussed. Sequential mixed methods research and the specific structure and design of the current study will be presented, followed by a detailed description of each of the phases of the current study.

Creswell and Plano Clark (2018) argue that researchers should articulate the philosophical assumptions underpinning a mixed methods study and recommend the use of Crotty's conceptualisation (1998). The design of this current study was informed by the pragmatist worldview, using a sequential mixed methods approach. The specific procedures for the mixed methods of data collection in the study include survey, focus groups and nominal group technique (see Figure 4.2)

Figure 4.2

Philosophical underpinnings of the research



Traditionally, qualitative and quantitative research were regarded as the two main approaches to research. These approaches were viewed dichotomously, as being based on opposing and incompatible assumptions, in what was termed the 'paradigm debate' (Creswell and Plano Clark, 2018). The dominant positivist paradigm and quantitative approach emphasised scientific objectivity, in contrast to the constructivist, interpretivist paradigm and qualitative approach, which rejected objectivity and theory testing (Creswell and Plano Clark, 2018; Teddlie and Tashakkori, 2009). Many

scholars question the value of engaging in the paradigm debate, and instead advanced a view of qualitative and quantitative research paradigms and their associated methods as two ends of a continuum, whereby mixed methods research designs, containing elements of both quantitative and qualitative elements, can be placed in the middle of the continuum (Johnson and Onwuegbuzie, 2004; Creswell and Creswell, 2018). Others have recognised mixed methods as the 'third paradigm' of research (Bazeley, 2018; Doyle et al., 2009; McBride et al., 2018).

4.2.1 Pragmatism

In selecting which methodology best suited the nature of the current study, careful consideration was given to the philosophical assumptions underpinning the research. Creswell and Plano Clark (2018) assert that in designing and conducting mixed methods research, researchers need to know alternative worldviews, articulate their own philosophical position and how it informs the conduct of their research. They advocate for flexible use of the worldview that best fits with the context of the particular study. As this study seeks to explore the role of occupational therapy in an emerging and complex practice area, a paradigm of pragmatism was adopted, as this orientation is considered appropriate for addressing real world, practice-orientated research (Creswell and Plano Clark, 2018), including health services research (Adamson, 2005). Pragmatism is strongly associated with mixed methods research as it combines and integrates both qualitative and quantitative methodologies to address the issue under examination, using both inductive and deductive reasoning and thinking to inform the exploration of the research question (Creswell & Plano Clarke 2018). Pragmatism employs diverse approaches, giving primacy to the importance of the research problem and question, and valuing both objective and subjective knowledge (Morgan, 2007).

While there has been recent development in adopting transformative (Mertens, 2003; 2009) and critical realist (Maxwell, 2012) perspectives in mixed methods research, most researchers embrace pragmatism as the optimal worldview for mixed methods research (Johnson et al., 2007; Creswell and Plano-Clark, 2018; Morgan, 2007, 2014; Tashakkori and Teddlie, 2003; 2010). Consistent with mixed methods research where researchers pursue both qualitative and quantitative approaches within one study, pragmatism is not committed to any one system of philosophy and reality (Creswell, 2009; Morgan, 2014). Pragmatism holds that research methods should follow the research questions, using the 'what works' approach, that gives the best possibility of obtaining worthwhile answers, rather than being based on a particular philosophical alignment (Johnson and Onwuegbuzie, 2004; Onwuegbuzie et al., 2009; Teddlie and Tashakkori, 2009). Thus, a pragmatic standpoint is led by practicality and offers epistemological justification and logic for combining

multiple sources of knowledge with the objective of establishing a comprehensive understanding of people and the world in which we live and practice (Morgan, 2014).

Denscombe (2008) cautions that the philosophical meaning of pragmatism has the potential to be associated with the common-sense use of the word 'pragmatic' which implies a certain lack of principle underlying a course of action or the notion that 'anything goes' and warns this should not be linked with the mixed methods research approach. Within the current study, the mixed methods research design allowed the researcher the freedom to choose the most appropriate procedures to answer the study question. However, this does not imply that the researcher discarded logic and rigour or adopted an unprincipled approach; instead, it required that the researcher moved away from rigid principles to deal appropriately with the emerging facts concerning the research problem (Florczak, 2014). The philosophical assumptions pertinent to both quantitative and qualitative paradigms were explored and used to inform the choice of a mixed methods research approach within the current study.

The pragmatic approach to mixed methods research recognises the epistemological differences between qualitative and quantitative paradigms but does not view these forms of inquiry as incompatible, instead advocating a shared aim for all research (Johnson and Onwuegbuzie, 2004). This pragmatic approach offered a foundation for combining quantitative and qualitative methods in the current study. As Morgan (2007) states, a pragmatic approach serves as a way to redirect our attention to methodological concerns rather than metaphysical or abstract matters. This allowed the aim of the current study, to examine a complex multifaceted area of practice, to be realised in a way which could not have been achieved by relying on one single research paradigm.

4.2.2 Mixed methods research

Mixed methods research is a growing approach to research design and is increasingly used in diverse fields such as education, management, sociology and health sciences (Creswell and Plano Clark, 2018). It has evolved from its emergence in the late 1980s to its current form, having gone through several periods of development and growth (Creswell and Plano Clark, 2018). Many different terms are used for this approach including integrated or combined research, multimethod, mixed research and mixed methodology but recent scholars use the term mixed methods (Bryman, 2006; Creswell and Creswell, 2018; Tashakkori and Teddlie, 2010). Mixed methods inquiry intentionally and systematically connects qualitative and quantitative methods to address complex research questions (Meixner and Hathcoat, 2019). It involves the rigorous collection, analysis and interpretation of both qualitative and quantitative data to investigate the same core issue within one study (Creswell and

Creswell, 2018; McBride et al., 2018). It draws on the strength of both quantitative and qualitative approaches and minimises the limitations of both approaches (Creswell and Creswell, 2018). Research questions that are broad and complex, with multiple facets, tend to benefit most from a mixed methods design (Tariq and Woodman, 2013).

Within health and social sciences, mixed methods research is becoming increasingly popular, as it allows deeper and broader understanding of complex issues and synergistic utilisation of both quantitative and qualitative approaches to address different aspects of the overall research question and produce a rigorous, comprehensive and credible source of data (Doyle et al., 2019; McBride et al., 2018; Meixner and Hathcoat, 2019; O’Cathain et al., 2007; Tritter, 2019). Mixed methods researchers seek to view problems from multiple perspectives to enhance and enrich the meaning, to contextualize information, to develop a more complete understanding of a problem, or to examine processes/experiences along with outcomes (Creswell and Plano Clark, 2018). O’Cathain et al. (2007) observe that justifications for using a mixed methods approach are usually grounded in the applied nature of health research, such as the need to engage with the real world and to address policy related issues, where quantitative components in mixed methods studies describe a phenomenon and qualitative components explore an issue and give a voice to key stakeholders. The validity of the findings is enhanced as multiple forms of data derived from different methods are analysed and interpreted in an integrated manner (Tritter, 2019).

Combining mixed methods approaches provides new knowledge and insights that go beyond separate quantitative and qualitative results (Bazeley, 2018; Creswell and Plano Clark, 2018; Pope and Maysa, 1995). The rise of mixed methods reflects recognition that collecting and combining both qualitative and quantitative data provides the most complete analysis of research problems, which is of particular relevance in healthcare research which examines complex issues or explores emerging areas of practice. Moreover, mixed method research findings in these complex areas have the potential to provide policymakers and practitioners in applied areas with the multiple forms of evidence that are required to document and inform research problems (Creswell and Plano Clark, 2018).

Previous occupational therapy research studies have incorporated mixed methods to explore complex practice issues, such as the emerging role of occupational therapists in adult critical care (Algeo and Aitken, 2019), the perspectives of and experiences of occupational therapists in the use of occupation-based practice (Kaunnil et al., 2021), and to identify the key factors that contributed to the implementation process of a new complex intervention by occupational therapists (Eriksson et al., 2020). In these studies, mixed methods design was successfully used to provide a both a broad

description of the role of occupational therapy, as well as in-depth understanding of facilitators and barriers that impact on occupational therapy service delivery, and the potential future role of occupational therapy in assessment and treatment in different practice areas. Gathering both qualitative and quantitative data on these studies enabled deeper understanding and enhanced knowledge of occupational therapists' experiences across these varied areas of occupational therapy practice.

While the use of mixed methods is relatively common in occupational therapy research, Mortenson and Oliffe (2009) caution that there are several methodological issues to be considered and emphasise the need to justify use of mixed methods. As this current study aims to explore a complex, multifaceted and emerging area of occupational therapy practice, a mixed methods design was deemed an appropriate approach to adopt. As outlined in preceding chapters, the international research and literature in the area of DMC of older adults is emerging and reflects a context of practice without clear guidelines or frameworks and subsequent difficulties in implementing policy and legislation. Furthermore, findings from emerging international research in this area have not been translated to practice in Ireland, due to differing legal definitions between jurisdictions and complexity of this multidisciplinary practice area. This justifies the need to explore the assessment process that is embedded within the Irish context of service provision, resulting in findings that may be more transferable to practice. In the current study, the depth of insight gained from mixed methods offers a distinctive occupational therapy perspective on current DMC assessment practice, describes the role and practices of occupational therapists in assessment of older adults' DMC for IL and explores the challenges of implementing legislation for this particular client group. By integrating both quantitative and qualitative methods and findings into the current study design, this research aims to gain deeper understanding of the practitioners' experiences and real-world insights into a complex and multifaceted practice area. The mixed method approach allows for more holistic understanding of practice and contextual factors influencing assessment approaches, which is of particular importance in this study, as DMC assessment practices are changing in response to recent legislation and emerging policy.

4.2.3 Structure and design of the current study

Several approaches to the design of mixed methods research are discussed in the literature, with most scholars focusing on the relative sequencing of when quantitative and qualitative strands are implemented relative to each other, when data are integrated, and relative priority or weighting of quantitative or qualitative strands in addressing the study's aims. Greene et al. (1989) identified five purposes of mixed-methods studies from their theoretical review of mixed methods research,

presented in Table 4.1, and this system of classification is still relevant (Schoonenboom and Johnson, 2017).

Table 4.1

Purposes of mixed-methods studies from Greene et al. (1989)

<i>Triangulation</i>	seeks convergence, corroboration of results from different methods
<i>Complementarity</i>	seeks elaboration, enhancement of results from one method with results from other method
<i>Development</i>	uses results from one method to inform other methods
<i>Initiation</i>	exploratory discovery
<i>Expansion</i>	extends the depth and scope of inquiry

The current study reflects aspects of *triangulation* and *development*, however as it aims to elaborate, enhance and clarify results from one method with results of another and to expand the scope and breath of inquiry by using different methods for different inquiry elements, the study purpose also corresponds with *complementarity* and *expansion* approaches (Greene et al., 1989). Using quantitative and qualitative methods brings about greater understanding of the findings about the role of occupational therapy in assessing older adults' DMC in relation to independent living. The complementarity approach uses strengths of one method to augment the other (Morgan, 2014), with each phase in the current study bringing further explanation, elaboration and enhancement of the data collected in preceding phases.

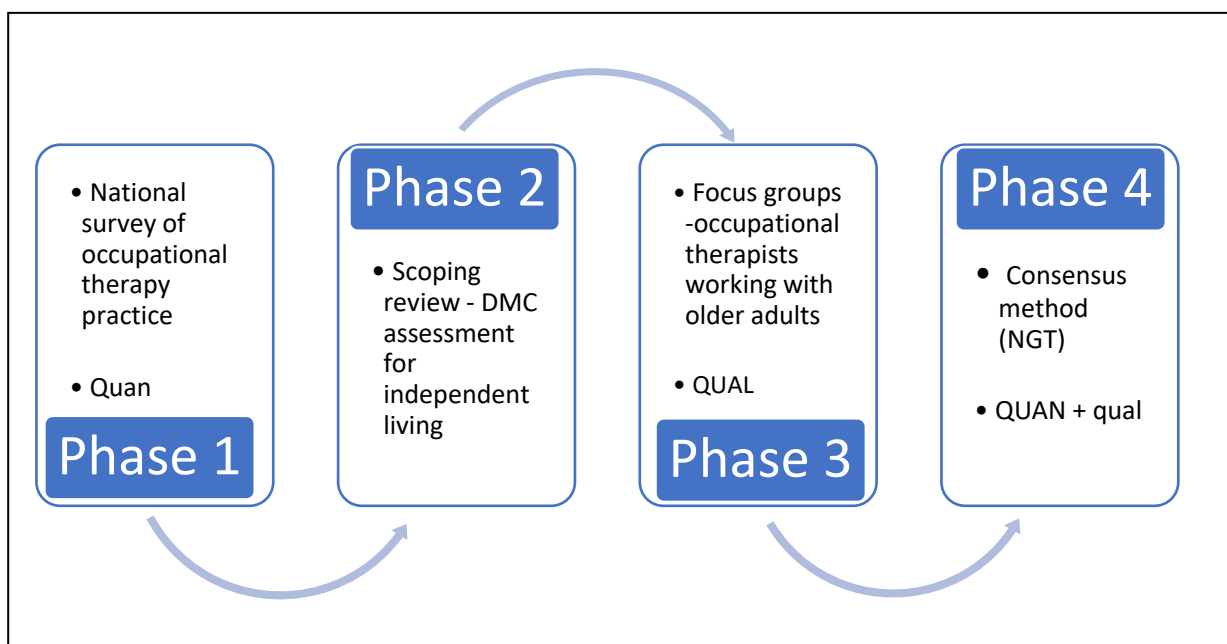
Creswell and Plano Clark (2018) recommend a typology-based approach in designed mixed methods research, as this addresses the 'point of interface', where the mixing or integration of the methods occurs. There are a range of mixed methods classification systems drawn from fields of nursing, health and education research and for the purpose of clarifying the substantial overlap in typologies, Creswell and Plano Clark (2018) identify three core designs of mixed methods studies: convergent, explanatory sequential and exploratory sequential mixed methods. *Convergent* design typically involves collection of quantitative and qualitative data at the same time and integrating the information in the interpretation of the overall results. In *explanatory sequential* designs, an initial quantitative phase is followed by a qualitative phase as a means of further explaining the quantitative data. Conversely, *exploratory sequential* design begins with a qualitative phase to explore participants' views and then develops a second quantitative phase, to build or identify appropriate instruments or interventions. However, rather than focus on the timing or ordering of the qualitative and quantitative components in designing and conducting mixed methods studies,

Creswell and Plano Clark (2018) suggest that the focus should be on the outcome sought in mixing the data, i.e. whether the intent is to explain, explore or converge.

The overall approach of the current study is exploratory in nature as it sought to explore the experiences of occupational therapists and establish their informed opinions as contributors to DMC assessment, to inform the development of practice that is culturally relevant and sensitive. An exploratory approach is deemed suitable when the research concept has not been previously researched and there is a lack of theory (Morse, 1991; Creswell, 2009), as is the case in this current study where the focus is on an emerging area of practice in DMC assessment approaches in relation to IL. However, the present study does not comply with the specific structure of either exploratory sequential design or explanatory sequential design as outlined by Creswell and Plano Clark (2018), which typically involves two phases. Instead, the current study utilises a sequential approach which encompasses four distinct interacting phases of data collection and analyses, combining quantitative and qualitative methods. Data were gathered sequentially, with findings from earlier phases of the study informing the design and analysis of subsequent phases that were undertaken to explore, explain and extend the findings from the earlier phases. The flow of research activities in this design is illustrated in Figure 4.3.

Figure 4.3

Overview of procedures of iterative sequential study design (with notation to indicate relative priority)



It is recognised that not every mixed methods study fits into the major typologies and in such cases a combination of existing approaches may be needed (Meixner and Hathcoat, 2019; Teddlie and Tashakkori, 2009). Thus, in adopting the pragmatic 'what works' approach advocated by Creswell and Plano Clark (2018), a multiphase approach was adopted in the current study to address the research questions. As such, the overall study design fits well with the *iterative sequential mixed methods design* framework as outlined by Teddlie and Tashakkori (2009), whereby collection of quantitative and qualitative data occurs sequentially, with more than two chronological phases, with the design of each phase emerging as a result of the findings of the previous phase and findings from all phases are combined in drawing inferences from the overall study (McBride et al., 2018). Teddlie and Tashakkori (2009) describe three stages within each phase of a sequential mixed methods study:

- the conceptualisation stage, where research purposes and question are formulated
- the experiential stage, where methodological and analytical operations occur as data is generated and analysed, and
- the inferential stage where explanations and inferences are drawn.

In an iterative sequential mixed methods design such as the current study, the final meta-inference is a conclusion based on the integration of the inferences that have been generated from the findings of all phases of the study.

Data integration involves connecting the data where earlier phases guide subsequent phases but there is no direct comparison of results (McBride et al., 2018). While integration of quantitative and qualitative data can add rigour and depth to mixed methods studies, there is little consensus on approaches to this complex process (Creswell, 2015; Doyle et al., 2019; McBride et al., 2018). Teddlie and Yu (2007) assert that data collected sequentially is related rather than independent, as each type of data informs collection of the other. Multiple points of interface are possible within mixed methods projects, as integration can occur at design, methods, interpretation and reporting levels (Bazeley, 2018; Fetters et al., 2013).

Designing research questions that require both quantitative and qualitative methodologies is an often-overlooked point of integration (Creswell, 2015; Doyle et al., 2019), however this study was conceived and planned as a multi-phased mixed methods study from the outset, requiring consideration of data integration from the initial planning of the project and at each conceptualisation stage of the various phases, where the research aims and questions were formulated. At methods level, there are numerous points of integration in this sequential design, whereby the first quantitative phase informed the focus of the scoping review in the second phase. Both of these phases influenced the overall development of the third phase, including the sampling frame and the topic guide for focus groups. These findings subsequently informed the development

of the NGT consensus meeting in the fourth phase. The final point of integration at methods level is the data analysis. Most mixed methods studies analyse quantitative and qualitative data separately using appropriate methods and then merge findings to yield 'a whole greater than the sum of its parts' (Doyle et al., 2019, p.11). As the current study was conducted sequentially, data were analysed following each phase of data collection. The analysis and findings from each phase informed the next phase of the study, including design components, data collection and sampling (Teddlie and Tashakkori, 2009). While the findings for each phase are presented separately, integration occurs again at discussion level where integrated understanding of both quantitative and qualitative data is used to develop meta-inferences and an overall sense of the findings (Doyle et al., 2019; Teddlie and Tashakkori, 2009). Figure 4.4 provides a graphic illustration of data integration within the overall study, demonstrating each of the phases, procedures and stages.

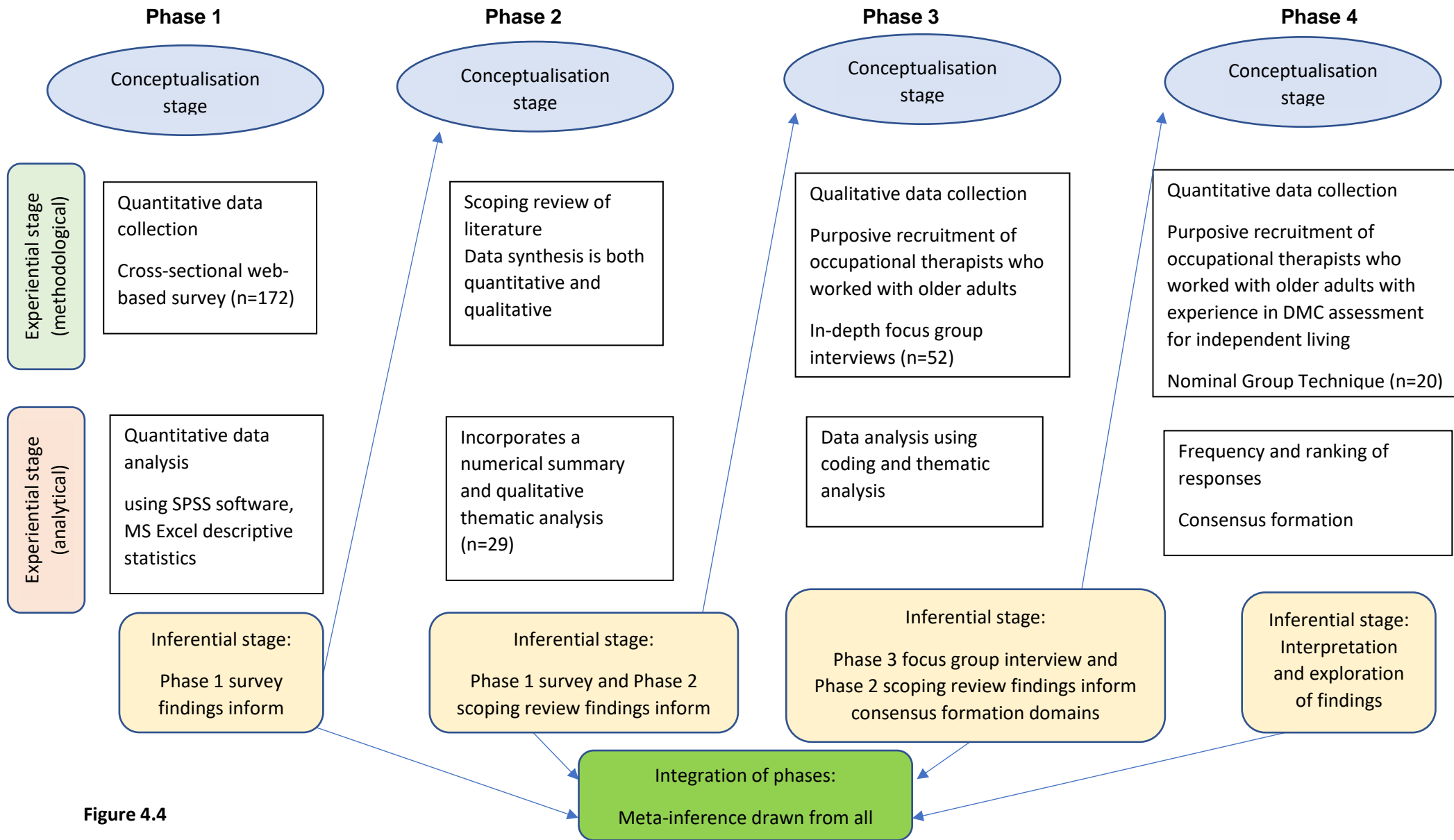


Figure 4.4

Overview of current sequential mixed method design, demonstrating phases, procedures and stages and overall data integration

The rationale for this approach is that the quantitative data and subsequent analysis from the first phase provided a general understanding of the issues faced by occupational therapists in assessment of DMC. Phase 1 commenced with a quantitative study, a cross-sectional web-based survey to examine if and to what extent occupational therapists are involved in DMC assessment in Ireland. Its purpose was exploratory in nature, and the survey method was used in an attempt to provide an overview of current occupational therapy practices in DMC assessment within an Irish context. This initial phase of data collection yielded information which was used to build the next phase of the study. Specifically, the results from Phase 1 indicated that occupational therapists who work with older adults were most likely to be involved in DMC assessment and they were most concerned with the DMC domain of IL. The findings of Phase 1 also highlighted that assessment of DMC for IL was a major area for concern among occupational therapists who worked with older adults, but the data collection in this phase was limited by the survey method which did not allow for in-depth exploration of this issue. Therefore, these findings were used to inform subsequent phases of the study.

In Phase 2, the scoping review focused on DMC assessment approaches for IL among older adults and explored international and multidisciplinary approaches for this particular domain of DMC. In line with the rationale for adopting a sequential approach in mixed methods research as outlined by scholars (Creswell and Plano-Clark, 2018; Teddlie and Tashakkori, 2009), the findings from Phase 1 and Phase 2 informed and shaped the design and data collection methods in Phase 3 to further refine the research focus.

Findings from Phase 1 and Phase 2 indicated the need for further in-depth exploration of occupational therapists' views on assessment of DMC among older adults, specifically in the domain of IL. Therefore, Phase 3 utilised qualitative focus group interviews with occupational therapists who were actively involved in DMC assessment with older adults, to explore their practices when assessing DMC for IL in more detail and to identify the challenges encountered by occupational therapists in addressing this area.

Finally, informed by these earlier phases of exploration, a fourth and final phase was designed to agree consensus on recommended approaches for occupational therapists in Ireland who contribute to the assessment of DMC for IL among older adults. Phase 4 used nominal group technique (NGT) as a structured approach to obtaining consensus from occupational therapists on critical dimensions of assessment of older adults' DMC, specifically for IL, as the findings from the survey and focus groups indicated that this was the domain occupational therapists contributed to most. Some authors consider consensus group methods, such as NGT, to be straddling both qualitative and quantitative

methodologies (Humphrey-Murto et al., 2017a; Perry and Linsley, 2006; Potter et al., 2004), adding further substantiation to the adoption of the pragmatic worldview. Overall, this is a multiphase design, as it involves the iterative sequence of connected quantitative and qualitative studies (McBride et al., 2018) where each individual phase builds on the previous phase and together, they aim to answer the overarching research question concerned with exploring the role of occupational therapy in decision-making capacity assessment of older people.

In a single researcher study, such as this current PhD study, Creswell and Creswell (2018) recommend adopting a sequential approach to conducting mixed methods research as the preferred approach. Rather than engaging in multiple data collection and analysis procedures simultaneously, adopting this consecutive sequential phased approach allowed the current study to be divided into manageable phases projected over a period of time. While there are challenges to mixed methods research design given the extensive data collection and time-intensive nature of analysing both qualitative and quantitative data, the current study capitalises on the inherent strengths in each method, the sequential timing of implementation of different methods allows development and by using different methods for different inquiry components, a deeper understanding is sought. As mixed methods research provides a complex and comprehensive approach to research that leads to a better contextualised understanding of practices, processes and changes needed (Creswell and Creswell, 2018; McBride et al., 2018), it is suitable for the current study which aims to answer the complex and increasingly salient clinical question of how to address DMC for IL amongst older adults.

4.3 Phase 1: National Survey of Occupational Therapy Practice

Phase 1 of the study was conducted to examine current occupational therapy practice in Ireland in relation to DMC assessment. It specifically addresses the first two objectives of the overall study, to examine if and to what extent occupational therapists are involved in DMC assessment and to explore their awareness of legislation regarding DMC and how it has impacted their practice.

4.3.1 Study design

An online cross-sectional survey was designed to gain opinions and a wide range of responses among occupational therapists in Ireland. Surveys are frequently utilised to accurately collect information that measures attitudes, knowledge and behaviours of respondents (Bowling, 2014; Creswell & Creswell 2018). An online survey was chosen as this method of data collection was deemed the most efficient approach to gather responses from occupational therapists across a wide geographical spread and variety of practice settings. Bryman (2012) notes that self-completion questionnaires are one of the main instruments for gathering survey data as they offer many advantages: they are time-efficient and cost-effective, especially for gathering data from a sample that is geographically widely dispersed. Additionally, self-completion questionnaires offer more convenience for respondents who can complete the questionnaire when they want and at the speed that they want to go. Online survey platforms enhance survey distribution and facilitate convenient and efficient data collection and analysis from a defined population sample (Couper et al., 2001; Fox et al., 2003; Fricker and Schonlau, 2002). They also allow for anonymous completion thereby reducing, and possibly eliminating, interviewer effects and potentially reducing social desirability bias among respondents (Bryman 2012).

Surveys are frequently used in occupational therapy research, nationally and internationally. They have been used to gather data descriptive on clinical practice, such as describing practice approaches used by paediatric occupational therapists (Moore and Lynch, 2018), evaluation approaches used in occupational therapy practice (Stack et al., 2018), and application of research in clinical practice (Wressle and Samuelsson, 2015). They have also been used to gather information about occupational therapy provision across different areas of practice such as dementia (McGrath and O'Callaghan, 2014) and mental health (Craik et al., 1998). International studies examining healthcare practitioners' knowledge and practices of assessing DMC in the acute general setting (Lamont et al., 2019) and psychiatry (Schofield, 2008) have been executed using online surveys. The aims of Phase 1 of this current study to examine current practice among occupational therapists in the assessment of DMC were similar to the aims of the studies completed by Lamont et al. (2019) and Schofield (2008), thus a similar methodology using an online survey was used in this phase of the current study.

4.3.2 Questionnaire design

An anonymous online questionnaire was developed specifically for the purposes of this study by the researcher to explore the practices of occupational therapists in Ireland regarding DMC assessment. The questionnaire development was informed by surveys used in previous studies that investigated the assessment of DMC by other professional groups such as lawyers (Helmes et al., 2004), neuropsychologists (Mullaly et al., 2007), speech-language pathologists (Aldhous et al., 2014; Jayes et al., 2017; McCormick et al., 2017), psychiatrists (Schofield, 2008) and non-specified healthcare practitioners (Lamont et al., 2019). The relevant items from these questionnaires were contextualised to fit within Irish occupational therapy practice and addressed the domains of DMC assessment defined by Moye and Marson (2007) and the recent Irish legislation, the Assisted Decision-Making (Capacity) Act (2015).

Various approaches were incorporated into the design and operationalisation of the survey to enhance content validity and face validity. Consideration was given to the construction, revision and refinement of the questionnaire as recommended by Oppenheim (1992). The development of initial drafts of the questionnaire followed an iterative process based on a review of the literature on DMC, review of other questionnaires and the current legislation, and discussions between the researcher and supervisor to ensure the survey was presented in an unambiguous clear format and measured the concepts under investigation (Bowling, 2014). The content of earlier drafts of the questionnaire was reviewed by the researcher and supervisor and the phrasing, order and construction of questions along with types of responses required was carefully considered. As it is not possible to prompt or probe survey respondents when they are completing the questionnaire, the self-completion questionnaire must be clear, unambiguous, and easy to complete to ensure questions are not misunderstood or inadvertently omitted (Bryman, 2012). Closed questions in the survey were structured in various formats to promote responses. These included dichotomous (yes/no) responses and the use of filter questions requiring respondents to answer only if they answered a previous question in a certain way. Additionally, the final question had 19 statements that required rating on a five-point Likert scale to indicate participants' level of agreement or disagreement with statements in relation to their confidence, attitudes and beliefs in relation to DMC assessment. Open ended options were also included, providing opportunities for respondents to explain their responses and provide additional information. The length, layout, presentation, comprehension of questions and ease of progression through the survey may impact on response and completion rates (Couper et al., 2001; Dillman et al., 2009), therefore the structure of the survey was carefully considered in effort to ensure respondents completed the survey.

The questionnaire consisted of 25 questions, divided into four sections:

- (1) Demographic information (six questions)
- (2) Context of decision-making assessment (eight questions)
- (3) Assessment process (nine questions)
- (4) Beliefs and attitudes regarding decision-making assessment (two questions).

In order to confirm the face and content validity of a data collection instrument, the instrument should be piloted (Cohen et al., 2011; Mertens, 2015; Robson, 2011). Oppenheim (1992) suggests that when piloting a questionnaire that the pilot should focus on the questions, the sequence of the questions, and the rating scales used within the questionnaire. Following review and revisions of the questionnaire by the researcher and the research supervisor, the initial final draft of the questionnaire was piloted on six senior practicing occupational therapists with a range of practice experience. The pilot participants were requested to provide feedback regarding questionnaire content, clarity of the questions and comprehensibility of the language used, the ease of navigation and sequence of the questions, and time required to complete. Feedback from the pilot informed the final questionnaire design to ensure the structure and flow was coherent. In relation to the content, no major changes were suggested. Feedback from the pilot participants highlighted the need for clarification of wording of some items and correction of minor grammatical errors. The questionnaire was modified based on the feedback to improve clarity and presentation of the questionnaire prior to final dissemination of the survey (Appendix D). Ethical approval from School of Medicine Research Ethics Committee (SOMREC), Trinity College Dublin was granted prior to commencement of data collection (Appendix E).

4.3.3 Participants

Occupational therapists working in Ireland were invited to participate in this research. As this study aimed to explore current practices across a range of settings and client groups, inclusion criteria were deliberately kept broad. Participants were required to be currently working as occupational therapists in Ireland in any area of clinical practice where they may need to be involved in the completion of DMC assessment. Participants needed to be sufficiently proficient in English to complete the questionnaire.

4.3.4 Recruitment process

A convenience sampling approach was used in that participants of interest were occupational therapists currently practicing in Ireland. In order to reach this target group, recruitment was conducted via the Association of Occupational Therapists of Ireland (AOTI) in effort to recruit from a

cross-section of practicing therapists across a wide variety of public and private settings, reflecting current occupational therapy practice in Ireland. The questionnaire was distributed by the AOTI via email to its members who agreed to be contacted for research studies. This email included information regarding the survey, a participant information leaflet (Appendix F) and a hyperlink to the SurveyMonkey® website, allowing members to access the questionnaire online.

In effort to maximise the response rate, a reminder email to participate in the study was sent on two occasions. Additionally, snowball sampling techniques were used whereby AOTI occupational therapy special interest groups were contacted and asked to distribute the invitation through email and recipients were asked to share the email with other occupational therapists who met the inclusion criteria but may not be members of AOTI. The questionnaire was completed anonymously, with no identifying information sought. Informed consent was implied if the participant completed and submitted the questionnaire. The survey was live over a three-month period, from July to September 2018 and was administered through SurveyMonkey®.

4.3.5 Data analysis

Completed questionnaires were analysed descriptively to measure categorical variables (including frequencies and percentages). Open ended responses were analysed using basic content analysis. SurveyMonkey® and Microsoft Excel were used to complete the descriptive analysis and generate graphical outputs.

4.4: Phase 3: Focus groups with occupational therapists with experience of working with older adults

As is typical in sequential mixed methods research, the research questions evolve as an iterative process as the study progresses and questions and procedures from one phase emerge from the findings of the previous phase. Thus, the Phase 1 survey results along with the scoping review findings from Phase 2 (discussed in Chapter 2) informed the development and focus of Phase 3 of the study. The findings from the survey of therapists in Phase 1 indicated assessment of DMC was a challenging area of practice for occupational therapists and highlighted the need for an approach to DMC assessment that is specifically tailored to individual client groups. The majority of respondents in the Phase 1 survey worked with older adults, indicating the need to look at DMC assessment for this particular client group and the specific domain of IL was identified as the domain most frequently assessed by occupational therapists. The scoping review findings indicated that assessment of DMC in relation to IL requires a multi-component approach, including cognitive, functional, environmental and risk assessments. Hence the specific focus and objectives of Phase 3 of the study evolved from the findings emerging from the Phase 1 survey and (Phase 2) scoping review.

Focus group discussions with occupational therapists were used to address the aims of this phase of the study:

- To explore the current involvement of occupational therapists in Ireland in the assessment of decision-making capacity of older adults, specifically in relation to assessment of DMC for independent living.
- To explore factors that facilitate or hinder the engagement of occupational therapists who work with older adults in assessment of DMC for independent living.
- To explore occupational therapists' attitudes towards recent legislation regarding decision-making capacity and how it shapes their practice in this area.

4.4.1 Study design

A qualitative approach was adopted for this phase of the study as the aim was to explore the perspectives and experiences of occupational therapists in undertaking DMC assessments for IL and to explore issues stemming from these experiences. Focus groups were undertaken to gain a deeper understanding of occupational therapist's views of their current and potential future role in contributing to DMC assessments of older adults for IL decisions, and to share ideas and advance discussion on the factors that facilitate and hinder their engagement in this area of practice.

4.4.2 Theoretical framework guiding the qualitative design: Interpretive description

An interpretive descriptive (ID) methodology (Thorne, 2016) guided this phase as it allows the subjective experience of participants be examined, to understand and generate knowledge that could inform clinical practice (Hunt, 2009; Thorne, 2016). ID is increasingly used within qualitative healthcare research as it offers an accessible and theoretically flexible approach to address complex experiential questions while producing practical outcomes (Burdine et al., 2020). ID allows researchers to examine disciplinary knowledge and explore a phenomenon with the goal of identifying recurrent patterns or shared realities among individuals, while also accounting for variations between subjective perspectives (Thorne et al., 1997). Practical applications can be derived from the understanding and knowledge generated from the perceptions and experiences of the group under study (Burdine et al., 2020; Thorne, 2016). ID was designed to explore how individuals and groups make meaning and act in real-world healthcare situations and the understanding and knowledge generated from the perceptions and experiences of the group under study can be applied to practice (Burdine et al., 2020; Thorne, 2016). Therefore, ID fits with this phase of the study's aim to explore the perspectives and experiences of occupational therapists in undertaking DMC assessments with older adults in relation to IL, to explore issues stemming from these experiences and the need to understand and generate knowledge that could inform practice.

4.4.2 Method

Focus group discussions were the specific qualitative method utilised to allow in-depth exploration of the practices of occupational therapists working with older adults in DMC assessment for IL. Focus groups entail bringing a group of people with specific characteristics or experiences together, using open-ended questions to generate ideas, share differing experiences and insights in order to explore specific issues and to enhance understanding of a topic. The optimal number of participants in focus group discussions to maximise contributions from all participants varies from four to nine participants, according to best practice (Bryman, 2012; Carpenter and Suto, 2008; Freeman, 2006). Focus groups usually last one to two hours and are guided by a topic guide to maintain the flow of the group's discussion (Carpenter and Suto, 2008). The group dynamic allows participants to explore their views, generate questions and reflect on and discuss taken-for-granted behaviours and assumptions in ways that may have been more difficult in face-to-face interviews (Barbour, 2010; Bowling, 2014). Focus groups were relevant to the aims of this phase of the study as they are effective in assessing experiences, attitudes, opinions, and concerns of participants about practice issues (Carpenter and Suto, 2008) and are time and cost effective (Green and Thorogood, 2018).

Bowling (2014) reports that when addressing issues of difficulty, the focus group format is less inhibiting for respondents than one-to-one interviews as the group situation allows participants to see that others may find the same issue challenging and that this enables them to share their experiences. Given DMC assessment was highlighted as a challenging area of occupational therapy practice in Phase 1, the focus group technique was deemed appropriate to explore participants' perspectives of these challenges in ways that may not be possible through individual interviews. Focus groups allow different perspectives to be examined and highlight cultural values, social norms and groups practices relative to a specific context or practice issue (Carpenter and Suto, 2008; Green, 2019) and therefore were considered an appropriate method in this phase of the current study to explore the perspectives and experiences of occupational therapists in undertaking DMC assessment for IL, in an Irish context.

The group dynamic aspect of focus group discussion is particularly useful to elicit a wide variety of different views in relation to a particular issue and it allows the researcher to develop an understanding of why people hold certain views (Bryman, 2012). During the discussion, focus group participants respond to others' views and may qualify or modify their expressed view; or present an idea that they may not have thought of without the opportunity of hearing the views of others. Compared to individual interviews, focus group discussions allow new/unanticipated ideas to be shared and explored from different perspectives which advances exploration of the topic. Focus

groups provide more and different information about participant's experiences, attitudes and ideas as group interaction stimulates and motivates participants to actively contribute with responses and clarifications (Gronmo, 2020). Focus groups can prevent the researcher exerting undue influence on the shape of the discussion as participants frame their experiences and concerns in their own terms, rather than those of the researcher, and also participants may raise issues that the researcher may not have otherwise considered (Green, 2019).

In order to function at their optimum, focus groups tend to be small in size to manage group dynamics and ensure each participant has ample opportunity to contribute to the topic (Bowling, 2014; Carpenter and Suto, 2008; Green, 2019). There are mixed recommendations in the literature in relation to the selection of group participants who are unknown to each other or whether to use natural groupings, such as colleagues (Bryman, 2012). Some authors recommend using groups made up of people who know each other to ensure discussions are as natural as possible (Kitzinger, 1994) while others argue that recruiting people entirely from natural groups is not always feasible (Fenton, 1998) and people who know each other well may hold implicit assumptions that they do not feel need to be brought to the fore (Morgan, 1998). In the current study, participants from a variety of settings and with a range of practice experience in working with older people were included to encourage different perspectives and to prompt participants to discuss taken for granted issues that they may have otherwise considered too common sense to mention. Sampling participants for heterogeneity can allow contrasting views to be captured within each group (Green, 2019), however, for logistical reasons, some focus groups included occupational therapists from within one organisation. This homogeneity around shared experiences can provide a supportive environment for discussing a difficult or complex issue (Green, 2019) and as this study sought to gather a group of professionals with specific knowledge and experience on a particular and complex professional issue, this was deemed appropriate. Ethical approval for this phase of the study was granted by the School of Medicine Research Ethics Committee (SOMREC), Trinity College Dublin prior to commencement of recruitment and data collection (Appendix G).

4.4.3 Participants and recruitment

Interpretative description methodology aims to enable researchers to develop a better understanding of the subjective reality of a specific population and therefore requires a careful sampling technique, to ensure selected participants are especially knowledgeable about or experienced with the phenomenon of interest, in order to yield sufficient in-depth data to answer the research questions (Burdine et al., 2020). Purposive sampling was used to recruit practicing occupational therapists with experience of contributing to DMC assessment of older adults, particularly in relation to IL. Participants were required to be currently working as occupational

therapists in Ireland and they needed to have had experience of being involved in the completion DMC assessments for older people. Participants were also required to be sufficiently proficient in English to participate in the focus group discussion.

Three strategies have been recommended to maximise recruitment of participants to focus groups (Peek and Fothergill, 2009):

- Researcher-driven recruitment
- Key informant recruitment
- Spontaneous recruitment

All three recruitment strategies were employed in this study. *Researcher-driven recruitment* typically involves the researcher finding a way to contact participants (typically through telephone calls, emails and flyers), communicate with them, and schedule the focus group meeting time and location. In the current study, the researcher enlisted the support of Association of Occupational Therapists of Ireland (AOTI), the professional body for occupational therapists, to facilitate recruitment. An introductory email about the study was distributed by AOTI via email, to members who agreed to be contacted for research studies (Appendix H). *Key informant recruitment*, which entails stakeholder organisations actively assisting in the recruitment of participants, was utilised whereby the AOTI Older Person Advisory Group shared the study information with its members to solicit information in participation. Targeted approaches such as using platforms utilised by the community of interest are effective in recruiting relevant participants (Green, 2019). These recruitment strategies were further enhanced by utilising snowball sampling techniques whereby occupational therapists who received the notification of the research were asked to share the email with other occupational therapists who met the inclusion criteria and who may be interested in this topic but may not be members of AOTI. *Spontaneous recruitment* arises in settings where participants colleagues or friends move in and out of public spaces where focus groups may occur. In the current study this occurred when individuals volunteered to participate having heard about the focus group occurring in their place of work through their colleagues.

Participants who received the notification of the study and who were interested in participating sent expressions of interest directly to the researcher by email. The researcher followed up with these interested participants to further explain the study and answer any questions they may have. Following this information sharing, those who indicated definite interest in participating in the study were emailed a detailed participant information leaflet (Appendix I) and focus group preparation guide (Appendix J). Having allowed at least a seven-day period for reflection, a follow-up telephone call or email was sent to confirm that the participant was still willing to participate and subsequently to agree a suitable time and place for the focus group. A range of options were offered regarding the

location and timing of focus groups in order to provide convenience to participants, including online options and the researcher travelling to the participants place of work to complete the focus group. In addition to verbal consent already indicated, written informed consent was also obtained by the researcher at the commencement of each focus group and participants in the online focus group emailed their consent to the researcher in advance of the focus group (Appendix K).

4.4.4 Data collection

Focus groups are typically conducted face-to-face, however recent research has shown that online focus groups can generate a considerable amount of relevant data for the researcher although they tend to be shorter than comparable face-to-face focus groups, (Reid and Reid, 2005). Online video conferencing technology, such as Zoom®, has been shown to be a viable and cost-effective tool for conducting focus groups, allowing participants from different geographic areas to contribute (Archibald et al., 2019). In addition to face-to-face focus groups, this online option was offered in the current study to facilitate participation that allowed for geographical spread and representation of occupational therapists across Ireland.

Determining the number of focus group discussions to be held is a core consideration of research design, as it influences multiple study components such as sample size and scheduling (Hennink et al., 2019). However, in interpretive descriptive research, data collection and analysis occur concurrently, each procedure informing the other in an iterative process (Thorne, 2016). Thus, the number of focus groups held was not determined in advance as this requires review of the study data and data collection continued until saturation was achieved. This is the point in data collection when issues begin to be repeated and further data collection becomes redundant (Barbour, 2007). While there is no set number of focus groups that have to be completed before data saturation is achieved, Hennick et al. (2019) suggest that at least four focus groups would usually be required to identify a range of new issues and meet code saturation and to fully understand these issues and achieve meaning saturation. Following an extension of the issues that were raised in the focus group sessions, when comments and patterns began to repeat and little new material was generated, the data collection process was terminated (Bryman, 2012).

The researcher was acting in the role of moderator and conducted each interview guided by the recommendation for the conduct of focus groups as outlined by Bryman (2012). Each focus group session began with an introduction, whereby the researcher thanked participants for coming and invited participants to introduce themselves, and then the researcher outlined the goals of the research and the format of the focus group session. The researcher outlined the conventions of focus group participation i.e. only one person should speak at a time; that all data will be treated

confidentially and anonymized; that everyone's views are important and contrasting views and experiences were expected and encouraged. To ensure that the discussion flowed well and to ensure dominant participants did not monopolise discussions, participants who were reticent about talking were encouraged to contribute by the researcher (Bryman, 2012). Each focus group was audio-recorded to allow accurate transcription and subsequent data analysis.

Demographic information regarding each participant's background and experience was gathered at the beginning of each focus group session. The focus groups were conducted using a semi-structured topic guide which employed open-ended questions to explore participants' experiences and views regarding DMC assessment practices for older adults and factors affecting their practice. The topic guide was derived from a review of literature relating to DMC assessment approaches and was also informed by the findings from the survey of occupational therapy practice in DMC assessment conducted in Phase 1 of this study. Consideration was given to the development, formulation and sequencing of appropriate questions and the use of different categories of questions, as suggested by Krueger and Casey (2014), was used throughout the focus group discussion to yield rich data. The topics and issues for discussion were specified to the participants in advance of the focus group through the provision of a focus group preparation guide which was sent to each participant, outlining the main areas that would be addressed in the focus group in order to allow participants to consider key issues and reflect on their experiences of DMC assessment in advance of the meeting.

There is some debate regarding how much structure should be involved in the interview questions for focus groups. Some researchers prefer to use just one or two very general questions to stimulate discussion, with the moderator intervening as necessary, while other researchers prefer to add more structure in the organization of the focus group sessions and develop 'guiding questions' which offer main headings with several more specific elements (Bryman, 2012). The topic guide employed for this study (Appendix J) grouped the topics to be covered into three main areas of discussion:

- the DMC assessment process
- participants' attitudes towards DMC assessment and their beliefs regarding their expertise and their role in this area of practice
- participants' awareness of DMC legislation and how has it influenced their practice.

The researcher had a number of prompt questions, designed to ensure that there was some consistency between the focus group sessions. Early questions were designed to generate initial reactions in a relatively open-ended way (Krueger and Casey, 2014). Whilst generally adopting a more structured approach to questioning, the researcher was also prepared to allow discussion that departed from the interview guide, since such debate may provide new and unexpected insights.

According to Bryman (2012), this approach to questioning allows the researcher to address the research questions and ensure comparability between sessions whilst simultaneously allowing participants to raise issues they see as significant, in their own terms. During the focus group, the researcher restated and summarised information to validate and verify participants' answers, to determine accuracy of understanding and interpretation, and to act as a probe to generate further discussion on the topic. After each focus group, the researcher listened back to the audio recording and reviewed field notes to inform the approach adopted in subsequent focus group sessions.

4.4.5 Data analysis

Interpretive description requires data analysis processes that extend beyond merely collecting and reporting data but transforming raw data into findings that are coherent and credible, with applicability to the discipline's practice (Thorne et al., 2004). ID orients data analysis toward the development of findings that will contribute to the understanding of the complexities of healthcare issues, and moreover, the generation of knowledge to advance practice (Burdine et al., 2020). ID is a 'non-categorical' approach in that it remains amenable to the introduction of analytical frameworks (Thorne, 2016; Thorne et al., 2004). Furthermore, ID favours analysis frameworks which progress via a process of inductive reasoning, as analysis and interpretation deepen, a more complex picture is constructed from the data (Burdine et al., 2020).

Thematic analysis is a method for identifying, analysing, organizing, describing, and reporting themes found within a data set (Braun & Clarke, 2006) and was used in this phase of the current study as it provides a rich and detailed, yet complex account of data. Thematic analysis is a useful method for examining different perspectives, highlighting similarities and differences, and generating unanticipated insights (Braun & Clarke, 2006; King, 2004). It is also suitable for summarising key features of a large data set, as it requires a well-structured approach to handling data (King, 2004). There is limited discussion in the literature about how to conduct rigorous and relevant thematic analysis (Nowell et al., 2017). Therefore, data analysis for this phase was undertaken using the six-phase thematic analysis approach described by Braun et al. (2018; 2006), see Table 4.2. The model of thematic analysis advocated by Braun and Clarke (2006) constitutes a foundational method for qualitative data analysis and as it is not specific to any particular philosophical approach such as grounded theory or discourse analysis, it can be pragmatically applied across a range of epistemological and theoretical approaches. Thus, it is compatible with the flexibility of mixed methods research design as used within the current study and with interpretive description, yielding a detailed and rich account of the data.

Table 4.2**Six phase approach to qualitative thematic analysis (Braun and Clarke, 2006; Braun et al. 2018)**

Phase	Description of the process
1. Familiarisation with the data	Transcribing data, reading and re-reading the data, noting initial ideas
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating relevant data for each code
3. Searching for themes	Collating codes into potential themes, gathering relevant data for each potential theme
4. Reviewing themes	Checking if themes work in relation to the coded extracts and entire data set, generating a thematic map of analysis
5. Defining and naming themes	Ongoing analysis to refine each theme and the overall story the analysis tells, generating clear definition and names for each theme
6. Producing the report	Final analysis of selected extracts, relating analysis back to the research questions and literature, producing a scholarly report of the analysis

The first five phases of the thematic analysis approach undertaken are presented below.

4.4.5.1 Phase 1: Familiarisation with the data.

Data familiarisation was achieved by listening back to each focus group recording immediately after each session and by making notes to inform subsequent focus group sessions. Focus group recordings were transcribed and read whilst listening to the audio recording to ensure accuracy of the transcripts. Following these initial steps, the researcher engaged in multiple readings of the transcripts to gain an overview of the breadth of its content. Field notes were made to detail points of interest in the data, identifying patterns and potential codes and themes. The researcher was immersed in the data, repeatedly reading the transcripts with a view to identify codes. This prolonged engagement with the data and documentation of theoretical and reflective thoughts and potential codes contributes to establishing trustworthiness of the current study (Nowell et al., 2017).

4.4.5.2 Phase 2: Generating initial codes

The second phase of analysis involved the systematic production of and comparison of preliminary codes of emergent patterns in the data. Coding is an important part of analysis that enables the

researcher to organise data into relevant categories (Braun and Clarke, 2006; 2012; Cohen et al., 2011; Miles and Huberman, 1994). A code is most often a word or short phrase that represents and captures a datum's primary content and essence (Saldaña, 2009). The coding strategy utilised within Braun and Clarke's framework was influenced by Saldaña (2009) who ascribes to the pragmatist paradigm and promotes 'choosing the right tool for the right job'. He recommends use of elemental coding approaches as a primary data analysis method, using basic but focussed filters when reviewing the corpus datum which then build the foundation for future coding cycles (Saldaña, 2009). Initially, coding was completed by hand, as the researcher read and re-read each transcript and noted the categories along the margins. Based on the preliminary reading and labelling of groups of words from the transcripts, a tentative list of codes was developed (Miles and Huberman, 1994). The first cycle coding used structural coding primarily as a labelling method to code and organise the data corpus into broad topics. It was guided by the research aims and the focus group topic guide, which was informed by the earlier phases of the study and existing literature. This method of first cycle coding is considered appropriate for exploratory investigation and when semi-structured data gathering protocols have been used (Saldaña, 2009). 'Line by-line' (Bryman, 2016) analysis was conducted to ensure that the researcher did not lose contact with the participants' responses and the contextual settings. Thorne et al. (2004) recommend disciplined reflexivity in the earliest coding and organizing processes, to avoid holding onto assumptions held from the outset of the study or to avoid premature closure, by affixing an existing structure onto the findings early in the analytic process and then seek only to confirm it. Thus, the researcher engaged reflexive journaling and in peer debriefing with the research supervisor. Groups of data were examined and reviewed for a range of alternative codes. Preliminary codes were discussed with the research supervisor who also read sections of transcripts. This led to the identification of a number of additional codes. Then, more in-depth descriptive or topic coding within each of these broad areas followed.

Transcripts were re-read by the researcher to check for consistency in the allocations of text within each category, using a basic constant comparative approach (Lincoln and Guba, 1985). Areas of overlap and similarities in the categories were highlighted, categories were reviewed, refined, amalgamated or moved to another topic area. The coding strategy and progress was reviewed with the research supervisor. Then all transcripts were imported into NVivo 12 computer software package to aid data organisation and management. The researcher re-coded all transcripts using the NVivo software, according to the categories identified during the hand coding. Intra-coder reliability was demonstrated through this process and additional new codes and categories (referred to as 'nodes' in NVivo) were identified as appropriate. At regular intervals throughout the coding process, the researcher checked each category/node with corresponding sections of text for consistency.

4.4.5.3 Phase 3: Searching for themes

Once the initial coding was completed, the codes were examined in relation to each other and then collated into potential themes by clustering all data on a particular code under one heading, thus making the study of source material more manageable for analytical purposes (Franklin and Bloor, 1999). Provisional themes were then developed into sub-themes and themes. The researcher kept notes about the development and hierarchies of concepts and themes and discussed the process with the research supervisor.

4.4.5.4 Phase 4: Reviewing themes

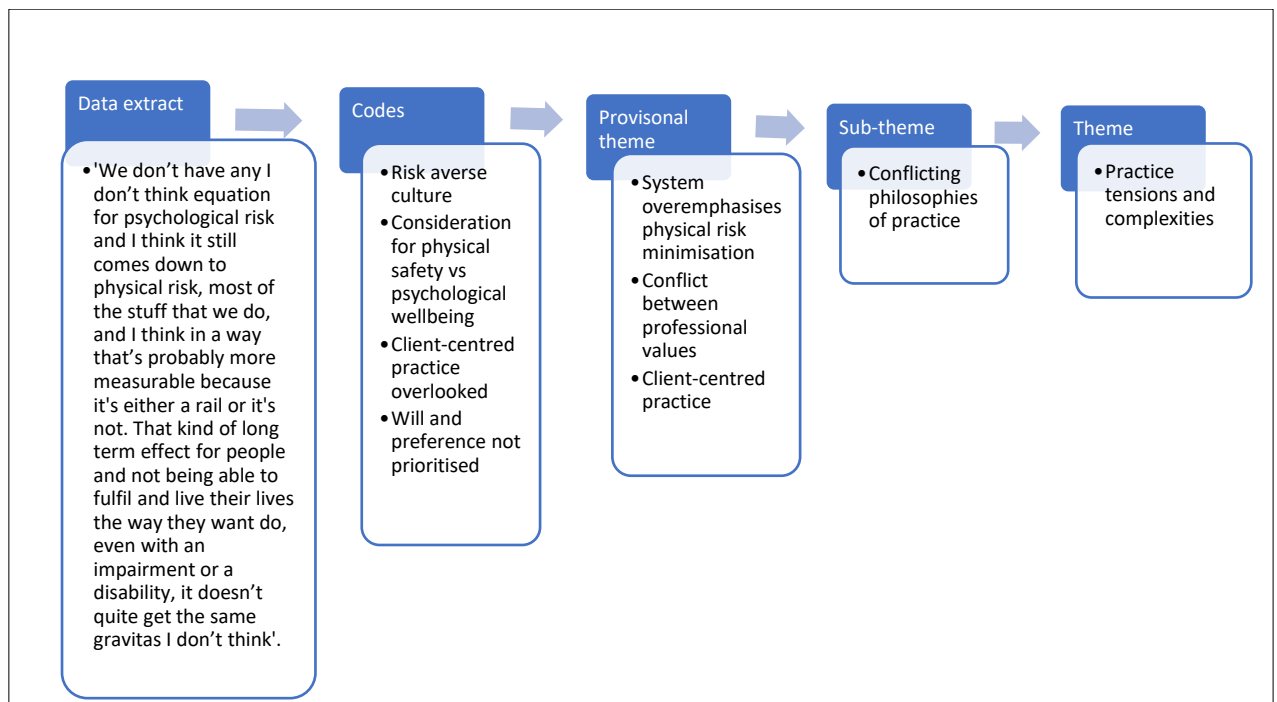
In this phase, the preliminary themes were then reviewed and refined in a cyclical process of reviewing coding and checking themes. This process continued until the categories and definitions were considered acceptable and the coding decisions were found to be reliable. NVivo enabled comparisons to be made between cases highlighting similarities, differences and variations (Cohen et al., 2007; Gibbs, 2007). Concept maps were drafted and re-worked to help organise and refine themes. The process of drafting diagrams helped the researcher make sense of theme connections (Nowell et al., 2017). The themes and subthemes were also reviewed and agreed with the research supervisor to confirm the accuracy of their development, as recommended by Myles and Huberman (1994). Themes were also tested for referential adequacy by returning to raw data (Nowell et al., 2017).

4.4.5.4 Phase 5: Defining and naming themes

The fifth stage of defining and naming themes required ongoing analysis to refine each theme within the overall story the analysis tells, generating clear definition and names for each theme. In order to synthesise meanings and recontextualise data into findings, Thorne et al. (2004) recommend the researcher must constantly explore such questions as: Why is this here? Why not something else? What does it mean? A narrative for each theme was written, outlining the aspect of interest within the theme in order to refine the theme to ensure it reflects the content and implicit meanings. Themes were reviewed to ensure that data extracts for each code coherently expressed the theme and to ensure themes were distinct from each other. This process required considerable reworking of codes and themes to move from explicit (semantic) themes to conceptual (latent) themes. This process was undertaken with peer discussion with the research supervisor who provided peer review and inter-coder agreement. Figure 4.5 represents an example of analysis steps with data extract, codes, provisional theme which were developed into sub-themes and themes.

Figure 4.5

Thematic analysis example from data extract



Although presented in linear manner, thematic analysis is a reflexive and recursive process that requires the researcher moves back and forth between steps when analysing the data and reviewing findings (King et al., 2018; Robson, 2011). The aim of coding and theme development in both reflexive thematic analysis and interpretive description is not to summarise the data or minimise the researcher subjectivity but to provide a coherent interpretation of the data, grounded in the data (Braun et al., 2018; Thorne, 2016). In line with recommendations from Nowell et al. (2017), data analysis was conducted in a precise, consistent, and exhaustive manner through recording, systematizing, and disclosing the methods of analysis with enough detail to enable the reader to determine whether the process is credible. Thorne et al. (2004) argue that within every data set there will be numerous interpretive possibilities and elements of interest and therefore she emphasises the relevance of the research question. While some findings may deviate from the original question, which was inevitably based on limited understanding, presenting the patterns and themes within the data in a professional narrative allows the most important ideas to be conveyed and their meaning accessed in a new manner. Thorne (2016) cautions against 'overdetermination of pattern' caused by paying attention only to that which is common in the data set, which can lead to recreating the self-evident or obvious rather than uncovering new insights and richer and more nuanced understandings of complexity which may be hidden.

4.4.6 Methods to Increase Rigour in this phase of study

Qualitative research must be conducted in a rigorous and methodical manner to yield meaningful results that will be accepted as trustworthy (Nowell et al., 2017). This section outlines the efforts made to increase rigor in the execution and analysis of this qualitative phase of the research. The rigour of the overall study will be discussed further at the end of the chapter.

Thorne (2016) argues that health science research has responsibility and obligation to establish credibility that extends beyond adherence to methodological rules and traditional evaluative criteria as research findings should hold meaning and benefit individuals and society. As this research aims to use the knowledge created through the research process to inform practice, it is important that the research is recognized as credible and legitimate by researchers, clinicians, policy makers, and the public. Therefore, the trustworthiness of the research (Lincoln & Guba, 1985) must be demonstrated. The original, widely accepted and recognized criteria introduced by Lincoln and Guba (1985) of credibility, transferability, dependability, and confirmability will be briefly defined and then discussed in how the study was conducted. Nowell et al. (2017) argue the trustworthiness criteria developed by Lincoln and Guba (1985) are pragmatic choices for researchers concerned about the acceptability and usefulness of their research for a variety of stakeholders.

4.4.6.1 Credibility

Lincoln and Guba (1985) argued that the credibility of a study is determined when readers can recognize the experience. It addresses the “fit” between participants’ views and the researcher’s representation of them (Tobin & Begley, 2004). A number of techniques to address credibility have been suggested, such as prolonged engagement with research data, data collection triangulation, and researcher triangulation (Lincoln and Guba, 1985). Data from multiple sources was used as focus group participants worked in a variety of settings, across a diverse geographical area and had a range of practice experience. Thorne (2016) reports that ‘representative credibility’ is achieved through use of multiple data sources, therefore the large and varied sample may have allowed a more substantive understanding of DMC assessment practice issues. The researcher kept a reflective log to record initial impressions after each focus group and peer debriefing was conducted regularly with the researcher’s supervisor. Peer debriefing is recommended to provide an external check on the research process (Bryman, 2012) and it was used to address ambiguous statements and to check preliminary findings and interpretations against the raw data, to aid the development of codes and themes. The process of coding and analysis was described in detail to demonstrate theoretical, methodological and analytical choices throughout this phase of the study (Nowell et al., 2017).

The process of member checking to confirm the findings and interpretations with the participants also enhances credibility (Lincoln & Guba, 1985). In addition to the conduct of within-interview member checking as previously discussed, participant validation was also sought through a synthesised member-checking process (Birt et al., 2016). Creswell (2009) recommended member-checking with interpreted themes and patterns of the data, rather than transcripts. Birt et al. (2016) argue that if studies aim to understand experiences and behaviours and to potentially change practice, participants should be able to recognise their experiences in the results, otherwise findings cannot be transferable to the wider community or viewed as evidence to change practice. Therefore, participants were sent preliminary interpretations of the data for review and invited to provide further perspectives and feedback on the provisional themes. As credibility of member-checking lies not in the undertaking of the process but in the reporting of the procedure outcomes, Table 4.3 provides information on response rates from the sample.

Table 4.3
Engagement in member checking process

	Sent member checking document	Returned with substantive annotation	Returned with minimal annotation	Returned with no annotation	Did not return
Number of participants	52	0	3	16	33

19 participants replied and confirmed that interpretations reflected discussions from the focus group in which they had participated. Of the 33 who did not respond to member checking, six were no longer contactable due to leave. That people did not respond may suggest that the researcher's findings and impressions were congruent with the views of participants, though this cannot be assumed as participants may be reluctant to be critical (Bryman, 2012).

In ID, the researcher is a valuable instrument of the research and the researcher's knowledge, research background, and personal experiences are major sources of insight (Thorne, 2016). The researcher has previous experience in occupational therapy practice with older people and some understanding of how occupational therapists contribute to DMC assessment. This experiential knowledge analytical framework was used to aid inquiry of DMC practices, components of assessment approaches, instruments used, and interpretation of assessment findings to support decision-making. As this experience may also lead to potential bias, the researcher shared her ideas and experiences with the research supervisor and engaged in peer debriefing. This also included

presenting research findings at various gerontological and occupational therapy conferences and engaging in discussion with peers.

4.4.6.2 Transferability

Transferability refers to the generalizability of findings as they apply to other contexts. Because qualitative research typically entails the intensive study of a small group, it is concerned with depth rather than breadth (Bryman, 2012). By generating thick descriptions of the participants and in verbatim reports, and by providing detailed accounts of the design structure and the research process, those who seek to transfer the findings to their own context can judge transferability (Lincoln & Guba, 1985).

4.4.6.3 Dependability

To establish dependability, researchers must ensure that all phases of the research process research process are clearly documented in a logical, transparent manner, allowing readers to judge the dependability of the research (Bryman, 2012; Lincoln & Guba, 1985; Tobin & Begley, 2004). When readers are able to examine the research process, they are better able to judge the dependability of the research. Thorne (2016) proposed an agile and continuous relationship between data collection and analysis which the researcher endeavoured to achieve by using field notes made during focus groups to contextualise transcripts and maintain the integrity of participants' accounts. Though the researcher did not undertake audit, the phases of the research process from problem formulation, selection of research participants, fieldwork notes, interview transcripts, data analysis decisions were discussed and reviewed by the research supervisor to ensure proper procedures were followed.

4.4.6.4 Confirmability

While recognizing that objectivity is impossible in qualitative research, confirmability is concerned with ensuring that the researcher's interpretations and findings are clearly derived from the data, rather than allowing personal values or theoretical inclinations overtly influence the findings (Bryman, 2012; Nowell et al., 2017). This requires the researcher to demonstrate how conclusions and interpretations have been reached (Tobin & Begley, 2004). According to Lincoln and Guba (1985), confirmability is established when credibility, transferability, and dependability are all achieved. The researcher has attempted to provide rationale for theoretical, methodological, and analytical choices throughout the entire study, so that others can understand how and why decisions were made. ID methodology acknowledges the biases inherent in research, held by individuals and by disciplinary groups. Acknowledgement and discussion of the disciplinary biases and assumptions held by occupational therapists allowed the researcher to reflect on how such professional biases

impact on how this topic is understood, by the researcher and by participants. In order to account for such bias, the researcher maintained a reflective log and engaged in debriefing with research supervisor. ID acknowledges the researcher's theoretical and practical foreknowledge of the phenomenon. The researcher is a qualified occupational therapist with clinical experience in working with older adults. In previous clinical employment, the researcher was asked to contribute to decision-making capacity assessments. Therefore, the views and clinical experience of the researcher are acknowledged rather than attempting to bracket or suspend the experience and beliefs. In order to minimise bias, the researcher was reflexive and critically aware of interviewer influence during the focus groups and when reviewing the recordings. The researcher was cautious about attributing her own opinions to the group, especially in cases where the researcher introduced an idea to the group. The researcher has engaged in reflexive writing and peer discussion to examine her own bias and experiences, in addition to considering the social and disciplinary context the research is directed towards.

Rather than rigidly adhere to what Thorne et al. (2004, p. 8) term the 'gamesmanship of rigour', credibility of ID research is achieved by maintaining integrity in the interpretive process where findings simultaneously confirm hunches of clinicians while also illuminating new relationships and understandings. Thorne (2016) argues that health science research must show moral defensibility to justify why the knowledge created is necessary and how it may be used and also disciplinary relevance in how it may advance the profession's knowledge. Hunt (2009) notes the clinical orientation which ID provides and how the explicit relationship with clinical practice leads data analysis towards development of findings that will influence HSCP's practice. As ID is intended to illuminate a phenomenon that HSCP's need to understand, findings should contribute to making sense of the complexities of healthcare practice as ID reveals patterns and variations of common experiences. From the outset the researcher has acknowledged that findings from the current study may guide clinical practice and future training and education needs of occupational therapists and potentially wider multidisciplinary colleagues. The finding may also have potential impact on the experiences of older people and the assessment approaches they are subjected to and how they participate in the process. Pragmatic obligation requires researchers to consider the findings may be applied to practice despite limits to generalizability and therefore the researcher has acknowledged the practice mandate and considered potential practice implications based on knowledge gained through this research. The researcher has attempted to demonstrate contextual awareness in acknowledging that disciplinary and social contexts which influence the assumptions and interpretations of the researcher and indeed the participants.

4.5: Phase 4: Consensus formation using nominal group technique (NGT)

The findings from the scoping review (Phase 2) identified and described existing current multidisciplinary approaches used to determine DMC for IL among older adults internationally. The focus group findings (Phase 3) provided insight to DMC assessment issues affecting occupational therapy practice in Ireland, particularly in relation to IL for older adults. While the potential contribution of occupational therapy to this multidisciplinary practice was highlighted, so was the and the need for more guidance on this area. Findings from Phase 1 and Phase 3 highlighted a gap between awareness of DMC legislation and its subsequent application into everyday practice in Ireland, which was also reflected internationally in the scoping review findings. Thus, the fourth and final phase aimed to identify assessment approaches for occupational therapists in Ireland that address DMC assessment of older adults in relation to IL, from a client-centred, occupation-based perspective, that aligns with recent legislative changes.

Consensus development in healthcare practice and research allows for a group approach with multiple experts sharing ideas to form consensus on topics ranging from appropriateness of procedures to development for both clinical practice guidelines and research agendas (Kea and Sun, 2015; World Health Organization [WHO], 2014). A consensus formation approach was adopted in Phase 4 of this study which sought to define the role of occupational therapy in this practice area, by involving occupational therapists with experience in assessing and supporting older adults' DMC for IL in Ireland. Consensus methods are increasingly being used within mixed-method research projects (Humphrey-Murto et al., 2017) as they allow information that cannot be obtained through statistical methods to be synthesized (Jones and Hunter, 1995) and they enable decision making in grey areas of healthcare (Foth et al., 2016). Consensus methods provide a valuable way to identify, measure and clarify issues in health services organisation, such as defining professional roles, design of educational programmes and projections of care needs for particular client groups (Jones and Hunter, 1995). Consensus methods are extensively used in many fields including healthcare research because of their presumed capacity to extract collective and tacit knowledge from a profession (Foth et al., 2016; Steward, 2001) and therefore are useful in this study which seeks to explore the role of occupational therapy in DMC assessment in relation to IL, which has been acknowledged in multidisciplinary international literature and assumed in practice but with limited research to support it.

Three main formal methods are used to achieve consensus in the health sector: the Delphi method, the nominal group technique and the consensus development conference (WHO, 2014). Nominal group technique (NGT) (Delbeq et al., 1975) was the method used to arrive at consensus in this phase of the study. NGT has been used for consensus formation concerning clinical practice issues

such as recommended approaches for dementia (Trickey et al., 1998), intensive care (Rolls and Elliot, 2008) and pressure care management (Rycroft-Malone, 2001). In situations where there is a dearth of evidence and evaluative research, ways of improving clinical processes such as assessment and management practices are more likely to be found in the experiences of professionals themselves, thus justifying use of consensus methods such as NGT (Trickey et al., 1998). Advantages of the NGT include the generation of a large number of ideas and the potential for discussion and debate followed by a structured ranking process (Humphrey-Murto et al., 2017). Søndergaard et al. (2018) found NGT proved to be a useful method for reaching consensus on identifying key quality markers for use in daily clinical practice and they recommended the method to address complex questions in clinical practice. Therefore, NGT was deemed useful for this study to agree consensus on assessment components and approaches to guide occupational therapists in Ireland in addressing DMC assessment of older adults in relation to IL.

In this phase of the study, the nominal group technique meeting aimed to agree consensus on:

- Factors that trigger the need for assessment of decision-making capacity of older adults regarding independent living
- Key components of occupational therapy assessment that may inform the assessment of, and the support of, older adults' decision-making regarding independent living
- Methods to ensure that the older person's will and preference is included and supported in the assessment of their decision-making for independent living
- Practical strategies occupational therapists should employ in their practice to facilitate an optimal and thorough assessment of decision-making capacity for independent living

4.5.1 Participants and Recruitment

A purposive sampling approach was used to recruit practicing occupational therapists with experience in contributing to DMC assessment of older adults, specifically regarding IL. Participants were required to be currently working as occupational therapists in Ireland, who had experience of being involved in the completion DMC assessments for older people in relation to IL. Participants needed to be sufficiently proficient in English to participate in the NGT consensus meeting. In effort to recruit a cross-section of practicing therapists across a variety of public and private settings, reflecting current occupational therapy practice in Ireland, a general introductory email (Appendix L) and a flyer, with details of the NGT meeting along with the researchers contact details (Appendix M), was distributed via AOTI to its membership. Additionally, occupational therapists who participated in the focus group discussions in the earlier phase of the study and who had consented to further contact were also invited to participate in the consensus meeting. Snowball sampling was also encouraged, where recipients of the invitation email were asked to distribute the consensus meeting

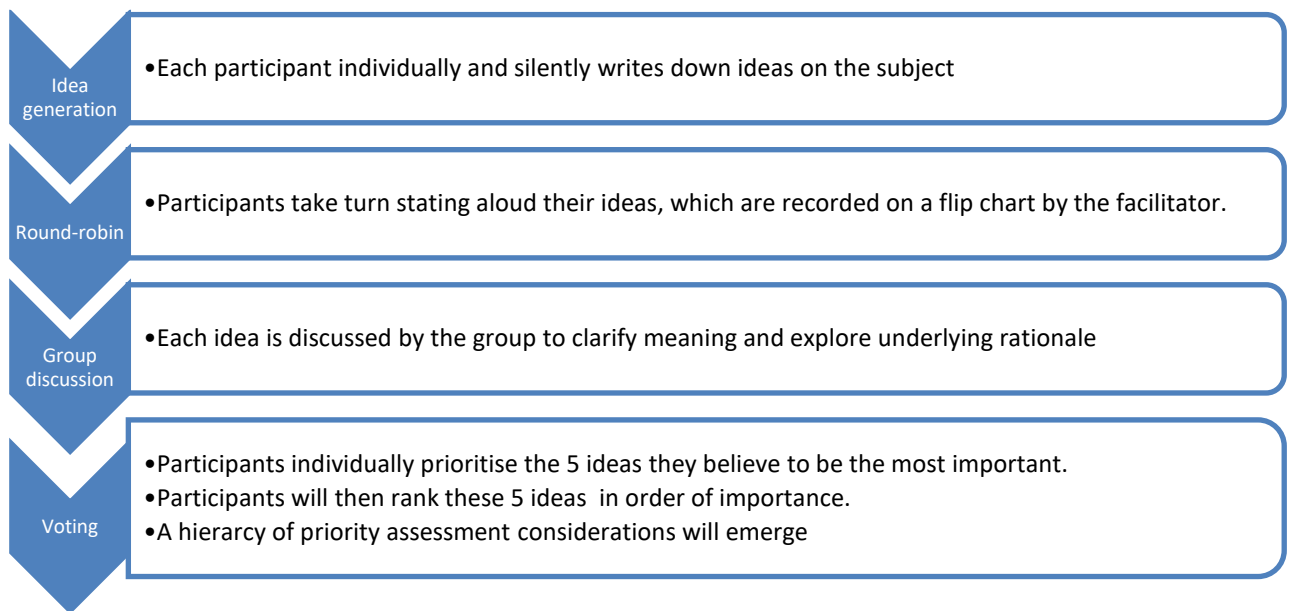
information to other occupational therapists that met inclusion criteria and may be interested in participating in the study. Once participants indicated their intention to attend the NGT meeting, a separate detailed participant information leaflet (Appendix N) and NGT preparation document which provided information on the NGT meeting process, the aims and objectives of the NGT meeting, and questions for participants to reflect on before the meeting, were sent out to all participants (Appendix O). Ethical approval was obtained from School of Medicine Research Ethics Committee (SOMREC), Trinity College Dublin prior to recruitment (See Appendix P).

4.5.2 Process of NGT

The NGT process employed in this study followed the guidelines as set out by Delbecq et al. (1975). It allowed participants to identify, rank and rate critical DMC assessment dimensions linked to the individual aims of the phase. The NGT as set out by Delbecq et al. (1975) is a 4-stage process, comprised of the following four steps:

Figure 4.6

NGT Process (Delbecq, Van de Van and Gustafson, 1975).



4.5.2.1 Step 1: Idea generation

At the beginning of each NGT session, a question is read out and presented to the participants. Each participant is instructed to generate a list of ideas, individually and silently, in response to the question under discussion. Participants are encouraged to generate as many ideas as they deem relevant to the question.

4.5.2.2 Step 2: Round robin recording

The individual ideas are then fed back among the whole group, each participant sharing one idea at a time in a round-robin fashion. The facilitator records each idea onto a flip-chart, the round robin recording continues until all ideas are exhausted. This approach to round robin recording of ideas limits the ownership of the ideas among group members as each person only provides one idea from their list at a time. At their turn, each participant provided any additional ideas from their list that are not already included on the master list.

4.5.2.3 Step 3: Group Discussion

The next step involves group discussion and clarification of ideas and statements to ensure participants understand the meaning of each individual item. As described in some papers, the grouping of duplicate items occurs at this stage, to ensure a more succinct and clear list to allow easier ranking by participants (McMillan et al., 2014; Tuffrey-Wijne et al., 2016). It is important prior

to voting that there is shared understanding among the participant as to what exactly each idea on the list encompasses.

4.5.2.4 Step 4: Voting

The final stage in a NGT session is the voting. Each participant individually selects the five statements they consider the most important from the ideas generated in the master list. They write each statement on a separate index card. Then each of the five selected priority statements are ranked by each individual participant, assigning a rank of 5 for the most important statement through to a rank of 1 for their least important statement. The facilitator collects the five index cards from each participant and records the number of participants who voted for each statement and the ranks that they assigned to each statement. Vander Laenen (2015) suggests that typically an NGT session should last on average between 60 and 75 minutes.

4.5.3: *Process of NGT within the current study*

For the purpose of this NGT meeting, there were four individual NGT sessions held to address each of the four questions. As NGT is a single-purpose technique (Delbecq et al., 1975), it can only address a limited number of issues. Therefore, in order to address the research aims of this phase of the study, that is, to form consensus on assessment components and procedures to guide occupational therapists in Ireland in addressing DMC assessment of older adults in relation to IL, four separate questions were identified to be addressed at the NGT meeting. For each question, the four steps of the NGT process were followed as a separate process.

The question posed for each NGT session is critical in determining the quality of the ideas generated (Tuffrey-Wijne et al., 2007; Vander Laenen, 2015). Thus, much consideration was given to the formulation and phrasing of the questions for each NGT session to ensure they were unambiguous and in language appropriate to the participants. Manera et al. (2018) recommend that the facilitator has sufficient knowledge of the topic under investigation and understands what information is sought as the way questions are framed by the facilitator impacts on the quality and range of responses. Following refinement of the questions with the research supervisor, the researcher piloted the four questions with two senior occupational therapists with experience in this practice area but who could not attend the NGT consensus meeting. They completed the first stage of the NGT process, the silent generation of ideas, for each question, in effort to ensure the questions promoted detailed and realistic responses. This confirmed that the questions were suitably phrased and understood by participants and that the order of the questions was appropriate. As there were no difficulties identified in the pilot, the content and order of the questions was deemed suitable.

The questions for exploration within each session were:

- Question 1: *As an occupational therapist, what are the factors that trigger your consideration that an assessment of decision-making capacity is indicated for an older adult, regarding independent living?*
- Question 2: *What are the key components of occupational therapy assessment that may inform the assessment of, and the support of, older adults' decision-making regarding independent living?*
- Question 3: *Will and preference is considered an integral component in the assessment of decision-making capacity. As an occupational therapist, how should you ensure that the person's will and preference is factored into your assessment and support of their decision making for independent living?*
- Question 4: *'How' a decision-making capacity assessment is conducted is crucial in ensuring a fully considerate and fair process. What practical strategies should occupational therapists employ to facilitate an optimal and thorough assessment of decision-making capacity?*

The meeting was conducted according to a predetermined schedule, which included a short presentation by the researcher on current DMC assessment legislation and research. Provisional findings of research undertaken as part of this overall study prior to this phase of data collection were presented, to contextualise the purpose of the NGT within the overall study for the participants. The purpose and procedures of the NGT were also explained. The participants signed consent forms (Appendix Q) and completed a demographic questionnaire relating to their professional experience. The researcher and research supervisor acted as group facilitators for all four sessions. Feedback on the NGT process was sought from participants after the meeting by a short questionnaire to evaluate participant satisfaction with the NGT process (Appendix R).

4.5.4 Data analysis

There is much variance in the reporting of how consensus is reached following the data collection method of NGT. McMillan et al. (2014) argue that consideration should be given to the voting frequency (i.e., the popularity of the idea among participants) as well as the strength (i.e., the sum of votes and relative importance of the priority). Some research presents the complete list of items voted upon and the total rank score assigned to each item (Denning et al., 2012; Miller et al., 2000; Sanderson et al., 2012; Stapleton and Connolly, 2010; Steward, 2001). A similar approach is adopted in this study, where the scores for each statement were summed and findings are presented based on the number of people voting on each item and the sum of votes or ranks assigned to each item. A total group rank score was calculated for each statement by summing individual ranks assigned by

participants to that statement. The highest possible rank score was 100 (the number of participants multiplied by highest possible individual rank score i.e., 20 multiplied by five). For each separate NGT session, the rank scores allocated to each item, the number of participants who voted for each statement and the total sum of votes for each statement were collated.

4.5.5 Rigour

Humphrey-Murto et al. (2017) set out recommendations for demonstrating methodological rigor for consensus group methods which have been adhered to in this current study in order to add credibility to the research process and ensuing results (see Table 4.4). The purpose of this phase of the study was clearly defined and this guided the subsequent selection of the appropriate consensus group method and the targeting of expert participants through purposive sampling. Careful consideration was given to the development of questions for each NGT session, and these were piloted on practicing occupational therapists with relevant practice experience to ensure clarity of the questions, comprehensibility of the language used and cohesion in the sequence of the questions. In order to increase the relevance of the findings, prior to the NGT meeting, each participant was sent detailed information to ensure participants were prepared and informed. Each NGT session was co-facilitated by the researcher and research supervisor, who has experience in this method.

Table 4.4

Recommendations to Ensure Methodological Rigour when using Consensus Group Methods

Recommendations to Ensure Methodological Rigour (Humphrey-Murto et al., 2017)	
1	Define the purpose or objective of the study
2	Outline each step of the process.
3	Describe the selection and preparation of material for the participants.
4	Describe the process of how items were selected for in sufficient detail.
5	Describe how the participants were selected and their qualifications. Describe NGT facilitators credentials.
6	Describe the number of rounds planned.
7	Clearly describe how consensus was defined.
8	Report response rates and results after each round
9	Describe the type of feedback provided after each round.
10	Describe how anonymity was maintained
11	Address potential methodological issues in the discussion

4.6 Validity of overall mixed methods study

In order for healthcare research to impact policy, practice or the thinking of HSCPs, the findings must be credible (Tritter, 2019). In order to ensure credibility, the researcher gave much consideration to the logic of the design, the methods used to collect data and how they related to the research question, and the overall management and process of the research. The order and combination of each phase was carefully planned to ensure maximum benefit and research validity as concerns about validity and rigour in mixed methods research have been identified as one of the major issues and important aspects of research (Creswell and Plano Clark, 2018; Teddlie and Tashakkori, 2009).

Discussion and debate about the different terms used to describe and apply this concept within mixed methods research have occurred in the literature, though Creswell and Plano Clark (2018) recommend use of the term validity because of its acceptance and common understanding by both quantitative and qualitative researchers. Validity using a mixed methods methodology should be based on establishing both quantitative validity and qualitative validity pertaining to the data for each phase of the study, in addition to validity considerations unique to mixed methods.

Methodological triangulation is achieved through the use of different data collection methods which ensures that the most comprehensive approach is taken to address a research question when a single research method is inadequate (Morse, 1991). Tritter (2019) asserts the intended relationship between the data collected is an important consideration in mixed methods research design. In the current study, sequential triangulation is used as the results of one method are used to plan the next method. For example, unexpected quantitative results from the survey regarding the assessment process were further explored in the qualitative focus groups to probe into practice issues relating to DMC assessment. In explaining the quantitative results in more depth, it made sense to purposively select the qualitative sample from individuals who may be able to provide the best explanations. Within mixed methods studies, each of the qualitative and quantitative methods must be complete in itself and must meet criteria for rigour, therefore each phase of this study was conducted as if the method stands alone, adhering to the rules and assumptions inherent in each method. Overall, this study utilises appropriate strategies for maintaining validity of each method and also to ensure accurate inferences from the integrated data.

Quality in mixed methods research is debated and while a number of quality frameworks have been developed, there is no agreed criteria to evaluate mixed methods studies (Doyle et al., 2019; Ivankova, 2014; O’Cathain, 2010; Onwuegbuzie and Johnson, 2006). In reporting the mixed methods procedures of this study, the recommendations of standards to address quality proposed by Creswell and Creswell (2018) were adhered to: the nature of mixed methods research was discussed, the basic intent and definition of mixed methods as well as the rationale and the value it lends the study

were provided. The data collection, analysis and interpretation procedures were also discussed. For each of the individual phases within the study, where available, specific reporting guidelines were followed for the method adopted: STROBE guidance (von Elm et al., 2007) was used to report on the Phase 1 survey; PRISMA-ScR guidance (Tricco et al., 2018) was used to report the Phase 2 scoping review; COREQ guidance (Tong et al., 2007) was used to report focus groups of Phase 3; and recommendations for consensus methods from Humphrey-Murto et al. (2017) were followed for the reporting of the NGT meeting in Phase 4.

4.7 Chapter summary

This chapter provided an overview of the methodological approach employed in this study. The philosophical underpinnings of pragmatism guided the mixed-methods research design which was dictated by the research questions. In-depth descriptions of the quantitative and qualitative data collection methods were provided. This multiphase sequential mixed-methods design involved collecting and analysing the qualitative and quantitative data separately, however the findings from each phase informed the development and execution of subsequent phases. Although the current study commenced with quantitative data collection, the overall approach adopted was exploratory. By undertaking a national survey of practice, results of this first phase yield key dimensions which were used to frame later stages of the study. The national survey established that occupational therapists were involved in DMC assessment for IL, and in particular those who worked with older adults were more frequently engaged in this area of practice. This data was used to provide a sampling frame to identify a sub-sample for further investigation. Therefore, the second phase of the study examined current international guidelines and practice in the area of DMC assessment of older adults in relation to IL. The third phase explored the DMC assessment practices of occupational therapists who worked with older adults. This qualitative phase explored their practice experiences, which was a different type of research question than establishing prevalence or frequency. This phase confirmed that the domain of DMC assessment occupational therapists were most concerned with was IL and highlighted emerging concerns in this area of practice. The fourth phase of this study then utilised consensus methods to agree core occupational therapy practice issues relating to the assessment of DMC of older adults in relation to IL, and this method ensured the research is grounded in the experiences of those who are the object of the study. Each strategy yielded different information, but all approaches provided a way of identifying key issues for research participants. The chapter also outlined considerations in relation to validity, credibility and quality. The following chapters will provide analysis and discussion of the research findings.

5.0 Survey findings

5.1 Introduction

This chapter is a modified version of the results section of the article published in the *Australian Occupational Therapy Journal* (Usher and Stapleton, 2020b; Appendix S) and has been reproduced here with the permission of the copyright holder John Wiley & Sons, Inc. (Appendix T).

In this chapter, findings from the national survey of occupational therapists will be presented. Occupational therapists in Ireland were invited to participate in a cross-sectional online questionnaire to explore occupational therapy practices regarding DMC assessment and to examine factors that impact on occupational therapists' engagement in this area. In particular, the survey aimed to:

- Explore the current practices of occupational therapists in the assessment of DMC
- Examine the factors that impact on occupational therapists' engagement in the assessment of DMC

5.1.1 Structure of the presentation of the findings

The response rate of the survey is discussed, followed by the presentation of the participant profile of the occupational therapists involved in this phase of the study. This will be followed by presentation of the findings on the context of DMC assessment, the DMC assessment process and the beliefs and attitudes of occupational therapists regarding DMC assessment, which corresponds to the sections of survey.

5.2 Survey findings

In total, one hundred and seventy-two questionnaires were returned. As snowball recruitment was encouraged by third parties, subsequently the researcher was unable to obtain the exact number of clinicians who were invited to participate and therefore cannot calculate a response rate. All submitted questionnaires (n=172) were included in the analysis; 121 (70.35%) were completed in their entirety. The demographic section of the questionnaire was completed by all participants (n=172). The majority of respondents (86.63%, n=149) completed the assessment context section and most respondents (73.26%, n=126) completed the attitudes and beliefs section. The lowest response (51.74%, n=89) was to the assessment process section. As a result, the sample was varied between 89 and 172 participants for each survey section. The survey took an average time of 10 minutes to complete.

5.2.1 Participant profile

A nationwide geographical spread was noted in the responses. The majority of therapists responding to the survey had more than seven years of practice experience (67.44%, n=116). Many respondents indicated that they worked with multiple client groups and the largest subgroup of respondents worked with older adults (66.28%, n=114). Socio-demographic and professional profiles are provided in Table 5.1.

Table 5.1

Demographic Profile of Survey Participants

<i>Demographic profile</i>	%	(n)
Total number of respondents		172
Female	96.5	166
Years of work experience		
- Less than 3 years	17.44	30
- 4-6 years	15.12	26
- 7-10 years	25	43
- 11-15 years	18.6	32
- 16-20 years	9.3	16
- More than 20 years	14.53	25
Highest level of education completed		
- BSc.	55.81	96
- MSc.	41.86	72
- PhD.	2.33	4
Typical client group		
- Older adults	66.28	114
- Persons with stroke	31.98	55
- Persons with traumatic brain injury	20.93	36
- Persons with progressive neurological conditions (e.g. MS, MND etc)	36.05	62
- Persons with psychiatric disorders/mental health difficulties	29.07	50
- Persons with dementia	54.65	94
- Persons with unspecified cognitive dysfunction	30.81	53
- Persons with developmental/intellectual disabilities	15.12	26
- Other (including palliative care n=6 and/or oncology n=2)	13.95	24
Practice setting		
- Hospital-based	53.49	92
- Community-based	44.77	77
- Private practice	5.81	10
- Research-based	1.16	2
- Academic	2.91	5
- Other	7.56	13

Note. Adapted from “Occupational therapy and decision-making capacity assessment: A survey of practice in Ireland” by R. Usher and T. Stapleton, 2020, *Australian Occupational Therapy Journal* 67(2), p.112

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5.2.2 Context of DMC Assessment

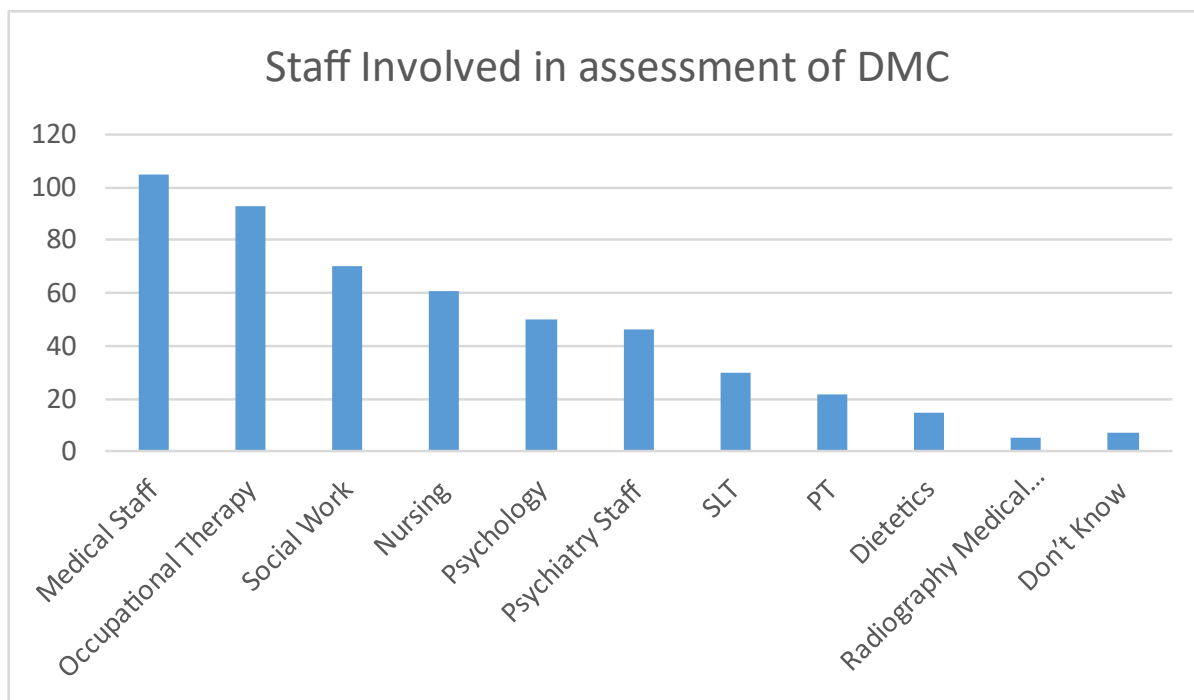
This study findings confirmed that occupational therapists were aware of DMC legislation and most respondents reported occupational therapists as having a significant role to play in the assessment of DMC in their work setting (65.77%, n=98). Most respondents were aware of the Assisted Decision

Making (Capacity) Act 2015: 22.15% (n=33) regarded themselves as ‘very familiar’ and 68.46% (n=102) reported ‘some familiarity’ with the legislation. The majority of respondents, 63.09% (n=94) reported that the Act has implications for their practice.

The findings highlighted a collaborative approach involving occupational therapists working alongside other multi-disciplinary team (MDT) members in the assessment of DMC. In terms of which HSCPs were most likely to be involved in the assessment of DMC, most respondents indicated medical staff had a significant role in DMC assessment (73.15%, n=109). Respondents also identified other HSCPs as having a role in DMC assessment, such as social workers (51.01%, n=76), nursing staff (42.28%, n=63) and psychologists (36.24%, n=54).

Figure 5.1

HSCPs involved in Assessment of DMC

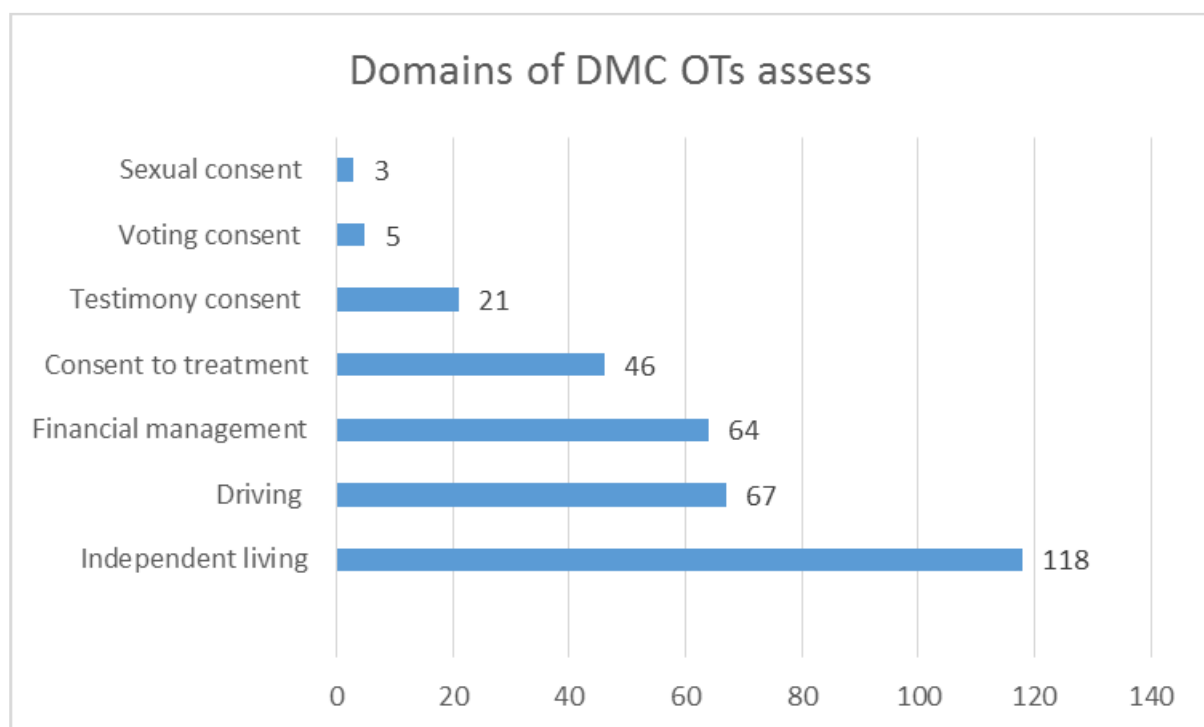


As DMC assessments occur within a multidisciplinary context, the survey also found that occupational therapists engaged with their colleagues from other healthcare disciplines when assessing DMC. Most respondents reported discussing DMC assessments with other MDT colleagues (78.86%, n=97), primarily liaising with physicians, nurses and social workers. The majority of respondents (69.80%, n=104) reported receiving MDT requests to contribute to DMC assessment. These requests for occupational therapy’s involvement in DMC assessment typically came from medical staff (60.40%), nursing (35.57%), social work (30.20%) and psychology staff (12.08%).

While most respondents (86.51%, n=109) reported that occupational therapy is ideally suited to contribute to DMC assessments within a multidisciplinary context, a smaller number of respondents (65.77%, n=98) reported occupational therapy plays a significant role in DMC assessment in their workplace. Furthermore, the frequency of engagement in DMC assessment tended to be low, with 77.85% (n=96) contributing to DMC assessments less frequently than monthly. Of the 114 respondents who reported working with older adults, the majority of this subgroup of occupational therapists reported to be involved in DMC assessments (65.8%, n=75), however most reported involvement on an occasional or ad-hoc basis (51.7%, n=59).

In the survey, occupational therapists were also asked to identify in which areas of DMC assessment they were typically involved. Of the categories of DMC outlined by Moye and Marson (2007), occupational therapists were more likely to be involved in DMC assessment of independent living (79.19%, n=118), driving (45.89%, n=67), financial management (44.44%, n=64) and consent to treatment (31.94%, n=46). Occupational therapists were rarely involved in assessment of DMC for testimony (14.58%, n=21), voting (3.50%, n=5) or sexual consent (2.11%, n=3) (Figure 5.2).

Figure 5.2
Domains of DMC Assessed by Occupational Therapists



Note. Adapted from “Occupational therapy and decision-making capacity assessment: A survey of practice in Ireland” by R. Usher and T. Stapleton, 2020, *Australian Occupational Therapy Journal* 67(2), p.113 (<https://doi.org/10.1111/1440-1630.12629>). Copyright 2020 by John Wiley & Sons, Inc

Involvement in assessment of the various DMC domains tended to be linked to the area of practice of the occupational therapists. Occupational therapists working with older adults, persons with dementia and cognitive dysfunction, persons with stroke, neurological conditions and traumatic brain injury (TBI), and in psychiatry, were regularly involved in DMC assessments relating to independent living (Table 5.2). By contrast, only 27% (n=7) of occupational therapists working with intellectual disabilities (ID) client groups reported frequent involvement in DMC assessments for independent living.

Table 5.2
Frequency of DMC Assessment for Independent Living

	Never		Sometimes		Frequently	
	%	n	%	n	%	n
Older adults	8.8%	10	28.9%	33	52.6%	60
Stroke	5.5%	3	25.5%	14	58.12%	32
TBI	8.3%	3	33.3%	12	55.6%	20
Neurological	6.5%	4	32.3%	20	54.8%	34
Psychiatric	12.0%	6	38.0%	19	34.0%	17
Dementia	8.5%	8	24.5%	23	56.4%	53
Cognitive dysfunction	7.5%	4	34.0%	18	49.1%	26
ID	34.6%	9	30.8%	8	11.5%	3

Note. Adapted from “Occupational therapy and decision-making capacity assessment: A survey of practice in Ireland” by R. Usher and T. Stapleton, 2020, *Australian Occupational Therapy Journal* 67(2), p.115

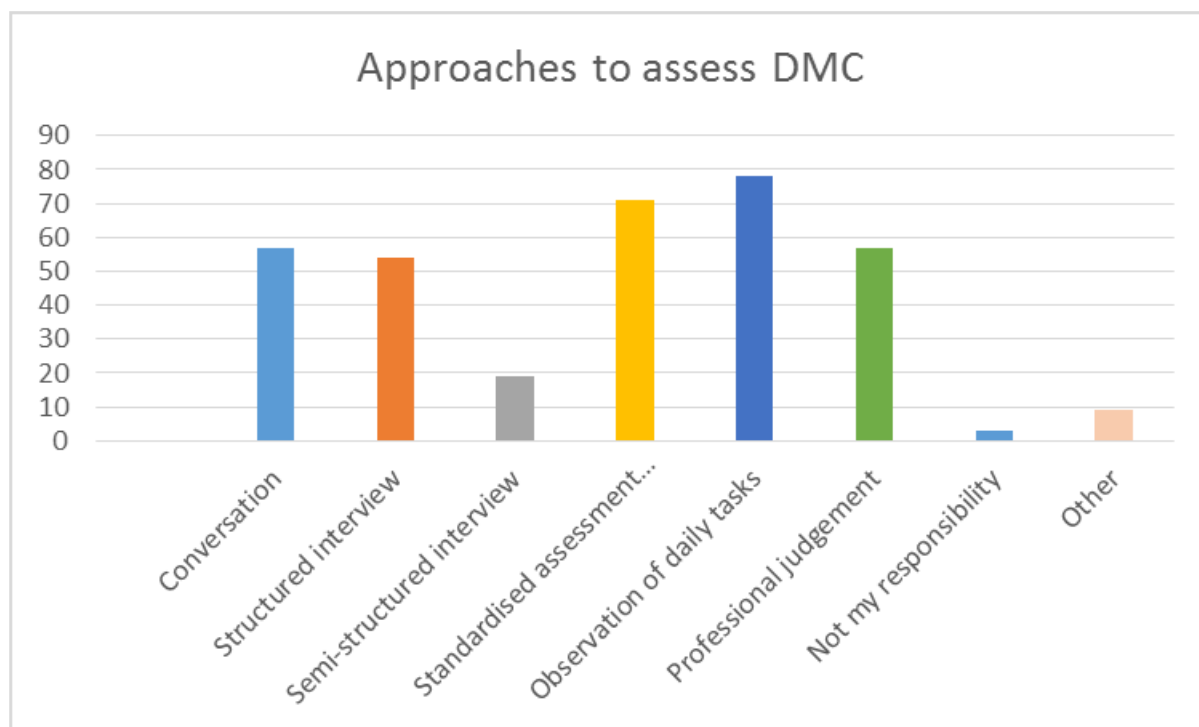
(<https://doi.org/10.1111/1440-1630.12629>). Copyright 2020 by John Wiley & Sons, Inc

5.2.3 DMC assessment process

The assessment process section was answered by 89 respondents, with occupational therapists reporting they typically using multiple approaches to assess DMC, including performance-based assessments and interview-based assessments. Usual assessment approaches included objective approaches, such as use of structured observations of the person’s performance of daily tasks (n=78) and use of standardised assessments (n=71). Occupational therapists also reported using subjective approaches, such as semi-structured and structured interviews (n=73). Lastly, many occupational therapists reported their assessment was informed by professional judgment (n=57) (see Figure 5.3).

Figure 5.3

Approaches to Assess DMC



Note. Adapted from “Occupational therapy and decision-making capacity assessment: A survey of practice in Ireland” by R. Usher and T. Stapleton, 2020, *Australian Occupational Therapy Journal* 67(2), p.115 (<https://doi.org/10.1111/1440-1630.12629>). Copyright 2020 by John Wiley & Sons, Inc.

Performance-based assessment included both standardised assessments and structured observations of performance of daily tasks to gain information about the persons’ current abilities, including their functional performance and underlying cognitive skills. Many occupational therapists reported using a range of structured observations of the person’s ability to complete functional tasks as methods to inform the assessment of DMC, such as kitchen task assessments (80.39%; n=72), home visits (70.79%, n=63); washing and dressing assessments (64.04%, n=57); community access (43.82%, n=39) and money management tasks (41.57%, n=37). Some respondents also reported using standardised observations of function such as Assessment of Motor and Process Skills (AMPS; Fisher and Jones, 2010) (19.10%, n=17) and the Kettle Test (Hartman-Maeir, Armon, & Katz, 2005) (16.85%, n=15).

Participants also reported using information from cognitive screening assessments such as the Montreal Cognitive assessment (MoCA; Nasreddine et al., 2005) (83.15%, n=74); Addenbrooke’s Cognitive Examination (ACE-III; So et al., 2018) (70.79%, n=63); Mini Mental State Examination (MMSE; Folstein et al., 1975) (47.19%, n=42) and Rivermead Behavioural Memory Test (RBMT;

Wilson et al., 1989) (42.70%, n=38) to inform DMC assessments. Respondents reported that cognitive screening tools are used as part of typical practice and the scores can be useful in informing the assessment of DMC (66.29%, n=59). Additionally, respondents reported that other MDT members specifically request a particular standardised assessment or screening tool be carried out to inform the overall assessment of the client's DMC (50.56%; n=45). However, many respondents (76.40%; n=68) reported that they felt that scores on standardised cognitive screening tools do not always reflect the person's functional ability or DMC and were uncomfortable with this aspect of their occupational therapy assessment being used to inform DMC assessment.

The majority of respondents (73.98%, n=91) favoured a strengths-based approach to DMC assessment and reported it is important to focus on what clients can do rather than what they cannot do in assessments of DMC. Subsequently many therapists used functional based assessments of performance. Only 18.55% (n=23) reported basing their recommendations primarily on formal assessment data. Over half of the respondents (54.84%, n=68) reported that they rely on qualitative aspects of the client's performance more than test scores themselves. Rather than only using objective assessment, occupational therapists also reported using less 'invasive' methods of determining DMC and reported direct engagement and discussion with person. In order to understand the person's subjective experience and perspective, 64.04% (n=57) of occupational therapists reported gathering information through conversation with the person and 60.67% (n=54) reported using semi-structured interviews with the person to assess DMC. Reflective of the services most occupational therapists work in, respondents reported that most assessments typically take place in the clinical setting (82.02%, n=73). However, occupational therapists also reported that they conduct assessments in the client's home (48.31%, n=43) and in the community (20.22%, n=26). An overwhelming majority (98.88%, n=88) also reported that they typically obtain collateral information from the client's carer/family or other staff, through conversation, semi-structured interviews and standardised assessments.

5.2.4 Beliefs and attitudes regarding DMC assessment

The attitudes and beliefs section of the survey was completed by 73.26% (n=126) of the whole survey sample. Of those who responded to this section of the survey, over half of respondents (54.76%, n=69) reported that contributing to DMC assessment is more difficult than other aspects of occupational therapy practice and many respondents (52.07%, n=63) did not agree that their training prepared them well for this area of practice. Respondents reported engaging in various modes of further education in relation to DMC assessment. Self-directed methods to learn more about DMC assessment were reported by many respondents: 64.29% (n=81) reported engaging in discussions with colleagues, 30.16% (n=38) reported engaging in peer education and 38.89% (n=49) reported

reading research, journal articles and books related to the topic. Formal education such as attending seminars and conferences was reported by 42.86% (n=54) of respondents. The majority of respondents to this section (91.86%, n=113) reported that occupational therapists would benefit from additional training in the area of assessment of DMC. Additionally, high proportions of the occupational therapist respondents (88.71%, n=110) reported it would be beneficial if there were general guidelines available to direct occupational therapists in their involvement in DMC assessment and 81.45% (n=101) felt that guidelines specific to different client groups and practice areas was required.

Difficulties with implementation of DMC assessment into practice were reported by the participants and only a very small proportion of occupational therapists (13.71%, n=17) reported that they were satisfied with DMC assessment procedures in their workplace. Just over half (50.80%, n=63) of respondents to this section described the assessment of DMC as a time-consuming process. About half of respondents (53.23%, n=66) reported the role and contribution of occupational therapy as a key contributor to the establishment of DMC is valued by other MDT colleagues in their workplace. While most respondents (65.32%, n=81) reported they were confident in the contribution made by occupational therapy to DMC assessment, only 45.24% (n=57) would be confident in assuming a leadership responsibility in determining DMC.

5.3 Summary

The findings from this survey of a cross-section of occupational therapists provide insight on how DMC assessment is currently addressed within occupational therapy practice in Ireland and set the context for this research. Most occupational therapists who responded to the survey were aware of Irish DMC legislation, and a high proportion of respondents worked with older adults indicating DMC assessment is of particular relevance to this client group. Most respondents regard occupational therapists as having a role in DMC assessment, addressing multiple DMC domains. In particular, occupational therapists reported significant involvement in DMC assessment regarding independent living, and less so in other areas, such as sexual consent. Most respondents reported adopting varied assessment approaches when contributing to the determination of a person's DMC, gathering subjective and objective information and addressing both cognitive and functional skills. However, findings highlight a gap that exists between awareness of DMC legislation and its subsequent application into everyday practice. While occupational therapists recognise their role in contributing to DMC assessments, only a minority are satisfied with DMC practices in their workplace. The survey has highlighted that an overwhelming majority of occupational therapists reported a need for further education and training as many occupational therapists find DMC assessment challenging.

6.0 Focus Group findings

6.1 Introduction

In this chapter, the findings from the qualitative focus group discussions will be presented. Focus groups were utilised to explore occupational therapists' processes regarding decision-making capacity (DMC) assessment, in relation to independent living (IL) among older adults. In particular, focus groups aimed to explore:

- current DMC assessment practice experiences of occupational therapists
- DMC assessment education and training needs of occupational therapists
- awareness of and attitudes towards recent legislation regarding DMC
- factors that impact on occupational therapists' engagement in the assessment of DMC.

Focus group discussions allowed participants frame their experiences in their own terms rather than that of the researcher and raise issues that the researcher may not have otherwise considered (Green, 2019). The group dynamic allowed participants to reflect on and discuss taken-for-granted behaviours and assumptions (Barbour, 2012).

The chosen interpretive descriptive (ID) methodology (Thorne, 2016) fits with this phase of the study's aim to explore the perspectives and experiences of occupational therapists in undertaking DMC assessment for IL, issues stemming from these experiences and the need to understand and generate knowledge that could inform practice. The presentation of the findings is based on interpretive description and thematic analysis of the focus group data. Principles guiding interpretive description and thematic analysis outlined in the methodology chapter were followed. Participants quotes will be used throughout to support the description and interpretation of findings.

6.1.1 Structure of the presentation of the findings

The participant profile of the occupational therapists involved in this phase of the study will be presented. This will be followed by presentation of the themes identified in the analysis process.

6.2 Participant profile

Fifty-two occupational therapists, practicing across seven counties in the Republic of Ireland participated in the focus group discussions. Nine focus groups were conducted with between four and eight participants in each session. Socio-demographic and professional profiles are provided in Table 6.1. Participants were employed across a range of hospital and community settings, including primary care and private practice. The vast majority of focus group participants were female, which is reflective of the gender profile of the profession nationally and internationally. Participants had an average of 9.5 years of experience, with the majority of participants having seven years or more experience (57.69%, n=30). Most participants described their practice area as working with older

adults (82.69%; n=43), within this some specifically reported working with people with dementia or cognitive disabilities and with older adults with psychiatric difficulties.

Table 6.1
Focus group participant characteristics (n=52)

	Overall sample (n)	%
<i>Demographic profile</i>		
Total number of participants	52	100
Female	51	98.08
<i>Current position grade</i>		
- Staff grade	22	42.31
- Senior grade	25	48.08
- Clinical Specialist	1	1.92
- Manager	4	7.69
<i>Years of work experience</i>		
- Less than 3 years	10	19.23
- 4-6 years	12	23.08
- 7-10 years	12	23.08
- 11-15 years	9	17.31
- 16-20 years	3	5.77
- More than 20 years	6	11.54
- Mean years' experience (standard deviation)	9.5 (SD 6.6708)	
<i>Highest level of education completed</i>		
- Diploma	1	1.92
- BSc.	28	53.85
- PG Certificate	1	1.92
- PG Diploma	1	1.92
- MSc.	20	38.46
- PhD.	1	1.92
<i>Predominant client group currently work with</i>		
- Older adults	43	82.69
- Persons with stroke	6	11.54
- Persons with dementia	1	1.92
- Persons with developmental/intellectual disabilities	2	3.85
<i>Practice setting</i>		
- Hospital-based	31	59.62
- Community-based	20	38.46
- Private practice	1	1.92
<i>Geographical location/county currently work in</i>		
- Dublin	39	75
- Louth	6	11.54
- Mayo	1	1.92
- Kerry	1	1.92
- Meath	1	1.92
- Westmeath	3	5.77
- Longford	1	1.92

6.3 Focus Group Themes

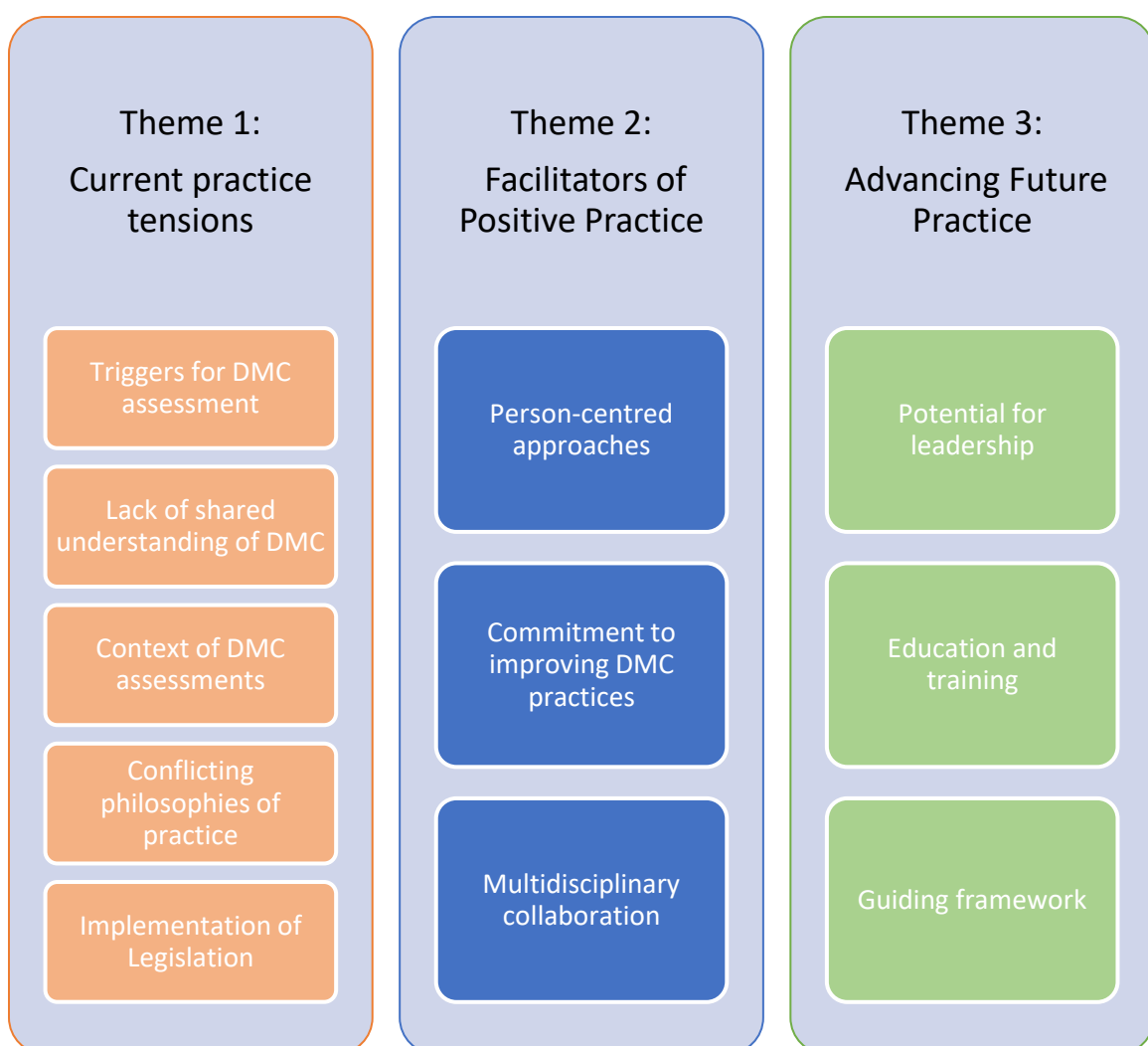
Participants in all focus groups unanimously reported that the domain of DMC they were most frequently involved in assessing for older adult's related almost exclusively to independent living. This was evident for occupational therapists who worked both in hospital and community settings.

Decisions around IL typically focussed on issues of place of residence, essentially this related to continuing to live at home or admission to a nursing home or other long-term care service. It also included decisions regarding care packages such as acceptance of equipment or support services to enable the older person to remain living in their home. Focus group discussions allowed participants confirm and elaborate on each other’s experiences and ideas.

Following analysis of the focus group data, three overarching themes and a total of eleven related subthemes were identified. They are presented in Figure 6.1 and are described below.

Figure 6.1

Visual Descriptor of Overarching Themes Identified

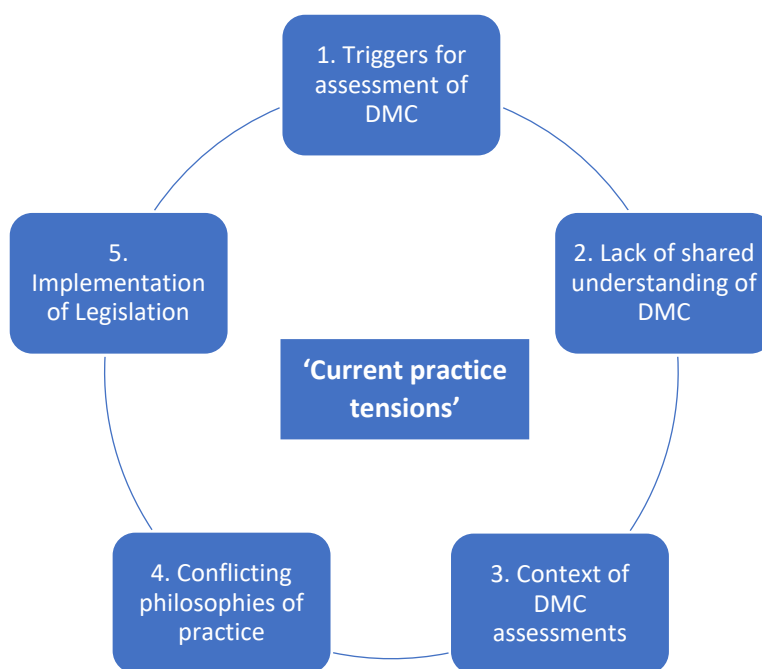


6.3.1 Theme 1: ‘Current practice tensions’

Given the ethical, legal and social considerations that arise in relation to the assessment of older adults DMC for IL, participants described many tensions and complexities within current practice. Within this theme, five subordinate themes were identified, as presented in Figure 6.2.

Figure 6.2

Theme 1 ‘Current practice tensions’ and related sub-themes



6.3.1.1 Triggers for assessment of decision-making capacity for independent living

While participants broadly understood that as a fundamental principle the DMC of the older person was to be presumed, participants identified a range of triggers related to issues of risk and safety that might indicate the need for DMC assessment for IL. The most common triggers reported were when an older person presented with cognitive impairment, reduced insight into their functional abilities or support needs, and concern regarding self-neglect. Overall, participants recognised that the trigger or indication for assessing DMC was often due to concerns for the older person’s safety, whether this risk was observed behaviour or reported by key stakeholders such as family members or other HSCPs.

If there’s a particularly risky incident that would normally trigger for us, if somebody has had, you know, hadn’t been taking their medication or has had an accident in the home or the family are particularly concerned or the neighbours are concerned or the GP or somebody. And that might trigger it. FG7P1

Ultimately, doubt over DMC was likely to be raised when there was a discrepancy between the views of the older person and their family, and/or the recommendations of HSCPs. Participants described an approach where if the older person complied with the advice from the HSCPs or did not voice any objections to the suggested plan for their care or place of residence, this ‘compliance’ was generally and perhaps falsely assumed to indicate DMC, rather than completing any formal assessment.

However, if the older person's preferred options for IL were not supported by their family or key stakeholders, or not in line with the recommendations of HSCPs, this was often viewed as an 'unwise' decision and typically led to the older person's DMC for IL to be questioned which would subsequently trigger an assessment of their DMC.

I think it's when there's a conflict between what the patient wants and what the family want. So what happens is the family say 'Oh they can't go home and go to long term care', if the patient doesn't question it generally, I think they go to long term care but if they stand up and say 'Actually, I don't want to', that's when it kind of starts to become more of an issue. FG7P3

The tendency to interpret this disagreement between the HSCPs and/or family with the older person's wishes as evidence of the older person lacking DMC was further compounded when cognitive impairment was present. While participants demonstrated awareness that cognitive impairment itself was not enough to warrant an assessment of DMC, they acknowledged that if the older person had a cognitive impairment, it was more likely to lead to questioning of the person's DMC. Given the magnitude of risk involved in decisions regarding IL and residential options, there was a tendency towards no longer presuming their capacity to make these decisions if a cognitive impairment was present.

There's inherently a disagreement, so one person is 'wrong' in making the decision, so then if the person has a cognitive impairment, they're nearly automatically the one that's making the 'wrong' or the 'unwise' decision and the family, or the assumption is the family are making the 'good' decision. FG6P4

It's not that everybody who has a cognitive impairment automatically gets a capacity assessment, it's more when there's that query about whether they can go home or not, whether they're actually understanding what the risk or insight as to how they are. FG4P1

DMC was also likely to be questioned when the older person was demonstrating a functional decline, particularly when behaviours suggested a risk of self-neglect. Of particular concern was when there was evidence of inability to manage conditions, non-compliance with medication management and advice, or evidence of risk-taking behaviour:

If somebody isn't, I suppose, in line with the normative behaviours, and if they're not, you know, they don't want to take the medication for some reason or they, you know, are drinking alcohol or doing other things then that definitely can be more of an impediment for the team to have that assessment done... So, for most of the assessments I do, there would be a particular concern, whether that be: are they able to manage, you know, cooking by themselves? Or are they at risk of self-neglect and not doing personal care tasks? Or are they isolating themselves and their ability to kind of maintain social contacts? That type of thing. FG7P1

I think sometimes in hospital, as well, you see people come in and maybe they're very unkempt, they're living alone at home and people start to question 'Are they ok at home?' and that kind of triggers a bit of a discussion with the team. FG5P2

While all of the above were identified as common triggers that led to a questioning of the person's DMC, there was a general awareness that these were not necessarily valid reasons to trigger a DMC assessment. Overall, practice tensions occur because these triggers tended to outweigh the principle of presumed capacity. While these triggers may prompt concern, participants acknowledged that such issues often require further exploration and discussion to clarify personal values and choices. The role of the HSCP was in establishing if the issues were as a result of decreased cognitive or functional abilities, or availability and acceptance of supports or if they were, in fact, evidence of lack of capacity.

It's their decision, they're not getting washed and dressed every morning because they don't want to. We can't force them into that... If somebody comes in and they're not clean, you know its automatic referral to us and 'Why are they not doing it, are they confused, do they need care?', when actually instead of looking at it, maybe that's just the way that they've always lived. FG4P6

Although focus group participants clarified they understood that making 'unwise' choices did not mean the person did not have capacity, they still reported this concern was often what caused the MDT to discuss the person's DMC in relation to independent living. Participants were aware that if the decision was out of character from what they knew of the person, this may indicate the need to consider their DMC abilities and IL support needs.

If the family or us think it's an unwise decision, that can catch all of us, I think, in practice. And it's very important that if the person is making, you're allowed make unwise decisions. I make unwise decisions all the time. But I suppose it's deciphering that, that generally is what triggers it, I would find. That you think 'Well, this is 'unwise' based on what we have seen of the person'. FG8P5

6.3.1.2 Lack of shared understanding of decision-making capacity

Many participants reported that a universal understanding of DMC, as is set out in recent legislation and policy, is not widely shared among the MDT. This was a source of frustration for many participants who reported that this lack of common understanding of the concept among various stakeholders ultimately led to variance in practice between different organisations, within services, and even within teams. Lack of awareness of the key concepts underpinning recent legislation hampered approaches adopted for DMC assessment. Some participants reported that not all members of the wider MDT had undertaken DMC awareness training and subsequently were not familiar with recent legislation and how DMC is conceptualised within the legislation. Given this lack of awareness of the constructs of what constitutes DMC, and unfamiliarity with the guidance on DMC assessment, the actual assessment of DMC in practice can often be less than optimal.

The challenge is obviously they're not aware of it. So you're kind of the only one who has that awareness. And you're the only one trying to push that FG2P4

Recent legislation and policy guidance states that DMC is time and issue specific. However, participants report that this is not always understood in practice and DMC is treated as a global, all-or-nothing trait, rather than something that is considered for specific decisions.

People talk about capacity like it's this big global concept, you've got it or you don't. Not 'Do you have the capacity to decide you want to go home?', 'Do you have the capacity to decide you want to go to rehab?'... I don't even know that I've had a client that has been deemed to have capacity for one element and not another FG4P3

This lack of awareness that DMC is time and issues specific was a concern for occupational therapists who felt the DMC is not understood as something that is fluid and may fluctuate, leading to concern that the outcome of one DMC assessment at one point in time may be inappropriately applied to all future situations or DMC assessments, with detrimental effect for the older person.

I think a lot of people lack that understanding that it's decision specific. I think that even at wider MD team or on ward level, that understanding isn't there with everyone. And I think that causes a lot of problems. FG8P4

The other challenge is that as much as we all know in here like in the OT department, that it's very much time specific and decision specific. If you were to do an assessment and you document that yes 'Mary doesn't have capacity to make this specific decision, at the specific time'. You don't know where that's going to go, or how that's going to be picked up once they leave here. Because if it's documented wrongly somewhere else to say, 'Oh Mary doesn't have any capacity'. Then you know that follows them. FG2P4

The other major issue participants identified is that, among the wider team, DMC is often conflated with cognition. Participants reported that the terms 'cognition' and 'capacity' may be used interchangeably. This has consequences for the approach taken to DMC assessment and perpetuates the misunderstanding that those with cognitive impairment do not have DMC. It can also lead to inappropriate use or over-reliance on scores of cognitive screens to inform DMC assessment and a dilemma for occupational therapists, where they were concerned that cognitive assessments they conducted might be used by other HSCPs as demonstration of DMC or more likely, to infer lack of DMC.

There's a lot of confusion now as well on the wards between cognition and capacity. So like you know, a capacity assessment, a cognitive assessment, people are thinking of them as the same things. FG4P5

I would previously have worked in an acute hospital and I would've found that you do a cognitive assessment on somebody and that was nearly being used like that was the capacity assessment. And the amount of times we were having to document 'This is not a capacity assessment'. FG9P2

Participants reported trying to address this misconception among the MDT and how they continuously try to differentiate between cognitive impairment and DMC. Participants described how within their occupational therapy practice, they tried to shift the MDT emphasis away from cognitive

screening scores by emphasising the importance of functional performance assessments. They reported the importance of using functional assessments to supplement and contextualise information gleaned from cognitive screens and how functional performance can outweigh poor scores on the standardised cognitive screens.

As soon as there is any kind of a diagnosis of even a mild cognitive impairment. It's straight away, 'Oh well, they haven't got capacity because they've a cognitive impairment'. Sometimes you kind of have to try and rein it back in and be like, 'Well no, hold on, people can still have capacity with a cognitive impairment'. FG9P2

A lot of time you hear, they're like 'Oh, a poor score in the cognitive assessment, that means they don't have capacity, done'. Whereas at least if we're involved in that we can say that 'Oh no, they scored poorly on assessment, but their functional cognition is higher than that, here's what they're actually doing'. We can kind of have that information and that information will be considered. FG4P6

An important issue also emerged where participants discussed how there is often a lack of clear distinction between the concepts of assessing *functional capacity* for independent living or assessing *capacity to make a decision* about independent living. Participants recognised the interrelatedness of these issues but emphasised the importance of differentiating between the distinct aspects of these concepts to ensure assessment focuses on DMC, rather than functional ability.

We are confusing it a little bit sometimes, the functional ability, like the performance component, like they can do X, Y and Z, functional tasks, with the fact that... maybe they can't manage their medication, but they can decide who they want to help them manage their medication. Or you know, that kind of subtle difference that's there, they physically can't do a task but they still have the actual capacity to decide how. FG5P2

6.3.1.3 Context of DMC assessments

The context of the DMC assessment presented many challenges for participants who often described the settings and circumstances of where, when and how DMC assessments took place as problematic and inappropriate. This was further compounded by involvement of family members, whom many older people are reliant on to facilitate their decisions around place of residence and yet are experiencing burden of care. The overall culture and philosophy of care within organisations also influenced the approach taken to assessment and support of DMC for IL.

Participants recognised the significant implications of DMC IL assessment outcomes for the older person. They recognised the profound impact of decisions around independent living and the life-changing consequences of not upholding the person's wishes to continue living at home. However, some participants felt the significance or the complexities of such decisions are often not appreciated by the MDT and this was reflected in the approach taken to assessment.

It's generally a bed side assessment on a ward round...we have them as these casual conversations, you know, rather than giving people the time and the space to actually consider things and weigh things up... FG3P3

This may be due to the pressures that exist in many of the resource-constrained settings where DMC assessments occur. Participants frequently cited staffing shortages, time shortages, and lack of resources, such as access to appropriate functional assessments or opportunity to complete home visits, as negatively impacting on their input in this area of practice. This was particularly pertinent in some acute hospitals where limited time and administrative pressures to discharge and maintain 'patient flow' did not allow for a considered decision-making process. The hospital setting was not seen as an optimal place to consider such significant decisions relating to IL. This setting was seen as not conducive to the completion of a thorough DMC assessment and the person is not given enough time to consider the available IL options:

We're making a decision with someone who's away from home. Who's been through a traumatic event. A lot of the time they've come from the acute hospital to another setting and they're out of sorts and we have made those decisions about those people while they're in here. FG1P4

There isn't time to make that decision, they are not even given time or privacy to make a decision. Like the conversations are held at bedsides with the curtain pulled, you know other patients around, people listening, people running in and out of the ward, for a decision like where you're going to go, you're not going home again, that has massive consequences and they can't, it's very difficult for them to make that decision, there's pressure on them to make that decision. FG5P3

It's never a good setting for any decision to be made...like how can you expect someone to perform in like a completely brand new environment, like you probably wouldn't be able to do it yourself. FG4P3

Participants felt assessments of DMC would be better in the person's own environment where they were more comfortable and '*balance of power is in their favour*' (FG1P3). Participants described how being in their home and their environment can shift the dynamic because '*people are more empowered in their own home*' (FG1P3). The notion of power imbalance is significant within the assessment context, as participants described incidents of coercion where the older person may be pressured into accepting an IL option that is not their preferred choice or incidents of deception, where the older person is not given accurate or sufficient information:

I've often seen them really try to coerce the person, you know 'You'll go to a nursing home, sure you'll be safe there, there's lots to do there'... Or telling them, 'You're only going for a few days to the nursing home, it's not forever'...It's a bare faced lie, that's very uncomfortable, terrible. FG4P6

Participants shared other examples of practice which made them feel very uncomfortable and which demonstrates that the will and preference of the person is not always considered, such as incidents where the older person was excluded from the decision-making process or from care-planning meetings.

Nobody asked the patient questions, nobody asked about where they wanted to go. Like as a rule our patients weren't invited into the family meetings. FG7P4

In the hospital the decision for long term care is often already made on behalf of the patient. Before we ever ask the patient about it FG9P2

Some participants attributed this to underlying ageism and negative attitudes that tended to underestimate and undervalue the view of the older person. Others viewed it as an attitude of professional arrogance whereby HSCPs assert their expertise without due consideration for the older person:

I think it does come back to a little bit of 'we know best, we're the professionals and we know what's best for you, and we have this for you, and a nursing home is for you, and we are all safe'. FG4P3

Sometimes this position of expertise or authority is granted by the older person who, perhaps due to feeling vulnerable because of their circumstances, is willing to take advice of HSCPs, even if it is not what they wanted. This may reflect the culture of paternalism which is pervasive in wider society and influences the approaches adopted by healthcare organisations, HSCPs and families. It often prompts both HSCPs and family members to act in protective, but often restrictive ways in their effort to minimise risk and promote safety.

I think also in the older generation is that culture of listening to what the doctor says or what someone in authority says. So perhaps they're not as free to speak what they actually believe, you know. So I think that colours it a little bit. People don't speak up for themselves as naturally as they might otherwise. FG9P1

I think also families and with the best will in the world, but because of the circumstances, just 'What if, what if, what if?' and I think we have in general become quite paternalistic about trying to be in control and be responsible FG3P4

Families do always want the best, but they're clearly paternalistic and wanting to be safe and well. So they clearly will want you in a nursing home FG4P3

The notion of interdependence between the older person and the family caregivers was recognised as complicating issues related to independent living, particularly where the outcomes of such decision affect the lives of family members. Participants acknowledged the complexity of the situation when older adult's preferences regarding their living situations are dependent on the support or assistance of family members, and the inherent conflict as the concerns and needs of the family cannot be simply dismissed in the name of considering the older person's autonomy:

That's one of the difficulties. We don't necessarily have one client, one person that is making a decision and it's kind of their own decision to make but they're living with family members and it's affecting other people and so sometimes you might have a conflict where there's one decision to be made and two different perspectives and it's not necessarily clear whose decision it is to make. FG6P2

Participants did recognise that, in the absence of community support services, family members are often under immense pressure to provide care themselves or fund services to fill the gaps.

Participants recognised how as HSCPs, they were often dependent on family members to facilitate the living preferences of the older person. Therefore, the interests and concerns of the family could not be precluded. There was empathy for families who tried to support the IL preferences of the older person and understanding that sometimes these situations became unsustainable, when it impacts on the family caregiver's wellbeing. Nonetheless, participants expressed frustration at the dominance of the family's voice over the patient's will and preference and this was seen as a barrier to good practice:

I think they've way too much power. It's like the family's preference take precedence over the patient preference, you know. If they're willing to support the risky discharge, they go in your favour. But if they're not, even if the discharge isn't that risky, but they don't fill the gaps in carers and it's just not a reality. FG1P8

Families who were not prepared or able to support the older person's preferences for independent living were reported to frequently threaten litigation. Fear of litigation and public condemnation was a significant concern, raised at all focus group discussions. Participants reported that it is the main reason for the focus on risk minimisation and safety promotion, rather than fulfilling the older person's will and preference.

Family are shouting and going 'this person can't come home or we're not, we're going to take you to court or you know if something goes wrong'. FG3P1

I feel and it's been said before at MDTs, the fear of litigation, family members saying 'You're sending my mum home, I will sue you if she falls or anything happens to her' and that frequently does happen in family meetings. The cases where I probably disagreed with the consultant's decision are the cases where there's been a very strong family there who have wanted the person to go into long term care... So I feel the family certainly have a big influence on the consultant's fear of litigation. FG4P2

Participants described that many HSCPs, including occupational therapists, are concerned about being responsible for an incident where a person was at risk and the subsequent professional repercussions. This fear of blame and litigation can lead HSCPs to become more concerned with protecting themselves, by choosing restrictive practices, rather than considering the consequences for the person.

It's very risk averse here. When they're going home, there's nearly always a panic and it's all the outcome for ourselves, rather than the patient. Like the whole litigation thing, people are really vulnerable with it. FG5P1

I think there's this worry that if anything happens them at home that it can end up coming back on where they discharged from. And I think that's the concern that people have when they're discharging someone. Because they're afraid of the risks, it could be despite the person having capacity. FG2P4

The culture of practice varies in different settings and organisations and is strongly influenced by the team dynamic: *'It is got to do with the culture of the team and the members of the team. And the experiences that they have'* (FG8P6). In settings and organisations where the MDT were not seen to share the same views towards supporting DMC or supporting positive risk-taking, occupational therapists reported feeling isolated on the MDT. Participants did not want to go against the team or feel like they were alone in their approach.

You don't want to be the only one from the team, then that you're steering this boat and you're then the only one in the boat, do you know what I mean, like you're just navigating the choppy waters yourself. FG6P3

There's that kind of feeling a bit alone and really feeling like you have to like, strongly advocate for somebody. So sometimes that can be kind of hard if they don't share the same kind of values as you and it's almost like you think, 'How can you not know about this person's rights', do you know?... Sometimes you can feel like you're swimming against the current in terms of your mindset FG3P3

Overall, participants from both hospital and community settings reported there was a dominant risk averse culture, reflecting a wider paternalistic trend in society. However, one participant reflected on her different experiences in working in primary care and in a hospital setting, and how the organisational culture can influence that approach to risk. In hospital settings, there was a stronger tendency towards risk reduction.

In an institutional setting, we can become so protective of the person. And really, we have people with the very similar functional status, similar cognitive abilities, living at home alone and actually managing fine. FG8P7

Participants acknowledged that supporting someone's DMC required more effort and also that it required the team's support. In time-pressured, resource constrained environments, the MDT can perceive promoting the person's will and preference or supporting their DMC as effortful and sometimes inconvenient. In situations when occupational therapists were the ones to draw attention to the need to adopt a different approach, they risked being perceived as delaying the discharge process. If the wider team does not share the same attitude towards enabling choice or allowing risk, it can be a source of interdisciplinary conflict.

It takes more energy, it takes so much longer to support somebody. Whatever information we, however, whatever reading we need, to break it down to support the person to understand. To be able to make the correct decision. That takes a lot of time, a lot of energy and belief from your team members. FG8P4

I find there's a little bit of impatience sometimes from some colleagues when we're discussing complex clients and it's like 'If they just accept the help that they've been offered and do it the way we've told them then we wouldn't have to have this conversation'. FG6P1

And the teams who almost roll their eyes when they see you coming because they know you might be the one to go, 'Well actually, step back for a second'. FGP1

Where I'm working at the moment, it's so risk averse and the amount of nearly stand-up arguments I've had at this point with nurses and doctors and everyone. FG9P3

Participants discussed professional hierarchies within MDTs which impacted on their involvement. Sometimes, their viewpoints were not heard and they reported seeking support from more senior colleagues.

I try the best I can, but unfortunately when you're one person, like I'm one OT working in a setting that I'm the only person advocating for this, my voice does get lost and it can get ignored unfortunately. Even though you are shouting sometimes...I've had to bring the senior in. I actually at one point had to bring the manager in and get the manager to assess and get him to document and even at that they were still being ignored. It takes strong professional identity FG9P4

The notion of strong professional identity and confidence to challenge the MDT was shared by many participants who reported 'You have to be very confident to say well actually no, I don't think that they're going to struggle when they go home because of X, Y or Z' (FG5P3).

Therapists who were confident in their professional philosophy were more inclined to advocate for the client involved. For many respondents, this confidence had only come with experience and they had become more comfortable with calculated risk-taking as they progressed through their careers.

Sometimes when I think about maybe recommendations I have made in the past, and I shudder and think 'Wow'. How many people's lives have I had a major impact on based on maybe my own fears as a therapist about what may happen to the patient, if I was more vocal about advocating for them to do something that might be risky. FG3P3.

When I started out in my career, when I look back now, I was much more risk adverse, 'of course they need to go to a nursing home, they need to be safe'. Living is far more important, but I would have veered much more towards this kind of paternalistic, we need to care for them and look after them and they need our protection and that's my job. FG4P3

6.3.1.4 Conflicting philosophies of practice

Participants reflected on the predominant culture of risk aversion within healthcare settings and reported that this culture and subsequent restrictive practices were 'a total conflict of interest with your professional values' (FG3P5). They reported risk was presented as barrier to allowing a person to pursue their preferred IL choices, rather than using risk assessment as a means to enhance fulfilment of a person's IL preferences by ensuring accountability and transparency in the decision-making process.

Participants described the dominant focus within healthcare as adherence to risk management which may be in conflict with the principles of DMC assessment. In some cases, the organisational philosophy dictates the scope and nature of occupational therapist's practice, which was a source of ethical tension for many participants. Participants reported being very conflicted as although occupational therapy's professional philosophy regarding enablement and empowerment aligns with principles of DMC assessment, participants sometimes relinquished these professional values, which were deemed to be in direct conflict with the culture of the organisation:

I think we're coming from more of a risk side of things, and there's lots of risks... rather than enablement for them. As OTs, we should be more working with risk... like we all say that we'd like empower patients, but what it actually comes down to, is risks FG1P3

We have been advised to always err on the side of caution in terms of scoring the risk up as opposed to down. And for me, even if I'm writing an intervention plan and my goals are quite occupation-focused, but yet my outcome measure is around risk FG3P2

If you've got somebody who wants to take a risk that's at odds with the organization often that we represent and sometimes it mightn't be at odds with actually what OTs believe inherently that people should be able to do but I think when you're employed within a setting and then you still always have that fear yourself, you've your own professional responsibility, that I think they're inherently at odds actually FG6P4

Some participants reflected on how occupational therapists were engaging in the DMC assessment process in ways that were contradictory with professional values, because they did not exercise their professional autonomy and yielded to the prevalent culture of the team or organisation within which they worked.

If we think back to our training and what we learnt in college, the way it's gone in practice goes against everything we believe as OTs. But I think because it's the overriding attitude, it kind of, we're very isolated in the way we feel about it sometimes and our background and how we're trained to think about it. FG8P6

Participants felt that occupational therapists lose sight of their core professional values and on the principles of DMC assessment as set out in legislation by adhering to the prominent focus on safety and risk prevention. Some participants recognised that recommendations from HSCPs were often focused solely on minimising risk. With such emphasis on safety, risk reduction is given more consideration than the client's will and preference, thereby compromising the older person's choice and autonomy, and potentially denying rights and opportunities to engage in valued occupations.

We've gotten so caught up in risk that we negate human rights. FG1P7.

I do think the safe word is something we shouldn't really be using, I just think unsafe, safe, its very subjective, you know to use as a globalised sort of term, a way of restricting...I think as OTs we have to be very aware of, that we're not disabling, that we are actually enabling and advocating... Like that balance of say autonomy and beneficence and that kind of safeguarding becomes a negative thing when it's about risk and restriction, you know, rather than letting someone actually engage in whatever it is that they want to do. FG3P4

I suppose you're not factoring in what their wishes are, you know, essentially you're giving them options and they're saying 'No, I don't want that' but you're kind of going 'I think you need that' and then their wishes are aren't probably being given as much a point. FG6P3

This idea of conflicting philosophies can result in competing priorities that are not always aligned, as illustrated by one participant who described how falls prevention takes precedence over other aspects of IL, as the primary concern is risk reduction:

The issue is not about 'how can we make so-and-so have the best quality of life or be more independent'. It's about 'we've got to bring that risk of falls down'. So the idea of quality of life is kind of gone, and falls management is in its place. FG9 P1.

This reluctance to engage in positive risk-taking described by participants may be due to a narrow understanding of risk. In decisions around independent living, preventing physical risk may incur psychological harm where valued aspects of life relating to home, community and privacy are overlooked. Participants felt that attention is paid to physical risk as it is easier to quantify and measure, therefore there is a tendency to address these issues, such as falls risk. Conversely, risk to the older adult's well-being is rarely considered. Participants recognised this was an equally significant, if not greater risk, when older persons were denied opportunities to make choices that would allow them to engage in meaningful and valued occupations.

We predominantly kind of focus on physical risk anyway and we don't really look at psychological risk to somebody's health and wellbeing to their overall occupational identity... We don't have any equation for psychological risk and that long term effect for people, of not being able to fulfil and live their lives the way they want do, even with an impairment or a disability, it doesn't quite get the same gravitas I don't think. FG6P3

It's almost like the language of say 'patient safety' needs to change, in terms of yes, consider patient safety, but also consider their risk of occupational deprivation FG8P6.

6.3.1.5 Implementation of Legislation

Participants largely welcomed legislation and felt there was increasing awareness among occupational therapists on the need to support older people to make their own decisions around independent living. However, they felt this increased awareness was not operationalised into practice and had not progressed beyond a general acceptance that this is an important practice issue due to the lag between the enactment and implementation of the legislation. There was general agreement that practice was lagging behind as the Act has not yet been fully commenced. Many therapists reported it has led to confusion where people are still working of the 'old system' and some are attempting to use the new legislation. They also reported that momentum to implement the legislation was subsequently eroded.

They just introduce it and there's no training support or additional thought going into it and it's just landed and you're like ahh, you know. FG6P3

There's been such a delay... That's frustrating, that doesn't help us. And I think that maybe it impacts on everyone's confidence. FG8P6

People are waiting for the legislation and they keep saying they're waiting, they're waiting, they're waiting... I think in terms of the Act there is a bit of a vacuum or a disconnect between the legal part and the actual practical application and there seems to be a massive gap. FG3P3

This lag between enactment and implementation of legislation and subsequent confusion may have undermined how readily people are adopting the Act into their practice as participants reported:

There's also this kind of attitude like, well nationally no one know what's happening so why address it now, let's wait till we get more directive (FG5P3).

Lack of guidance on implementation has led to reluctance to engage in the DMC assessment process and this is further hindered by competing policies and projects which may be given higher priority and regarded as more urgent. One participant spoke of how it was difficult to reconcile various policy directives which can seem contradict each other, such as a focus on errorless practice which does little to promote positive risk-taking:

I feel as a manager, all I hear about is and in the healthcare environment in general is about quality improvement, patient safety, errorless practice. What can we do to reduce errors? We're meant to be supporting people in terms of making decisions. And enabling them to make the best decisions. But that fear of people being put at risk... it is a real challenge from legislation, from an administrative perspective, in terms of supporting clinicians. FG8P3

Another key factor related to perceived challenges in implementing the Act is the lack of community support services to facilitate older people to live independently. Participants regarded this as a fundamental issue, because it greatly impacts on choices for independent living available to the older person. If the older person's preferred choices for independent living cannot be supported by community services, participants felt that the dominant focus on safety generally leads to restrictive practice, which is about risk minimisation and does not align with the principles of DMC as set out in the legislation:

Safety is a core value, and that you need to be safe at home and all of that is influencing my decision over whether or not you have capacity. And it shouldn't. You know the true capacity is your ability to weigh up your decision. It shouldn't matter what supports you have in place, it really shouldn't. FG4P3

This lack of variety and availability of community support services and accessible home-based options can lead to early admission of older people to nursing homes, despite this not being their preference. Participants expressed frustration at the availability of funding for nursing home care, but that there is no statutory entitlement to home support services in the community setting.

It's just a shame we don't have any options and there isn't really even options for, I suppose, sheltered accommodation or transition accommodation, it's all or nothing. You know you can

have a home care package, or 24-hour care, there is nothing in between for the most part. FG3P1

We would very often see people who, do you know, they go into nursing homes before they need to because the package of care isn't there for them in the community - we can't give you 7-hours of care a week in the community, so here have 168-hours instead. FG7P2

That's a systematic flaw, that funding is available for nursing homes but not for home care or even assistive technology and it needs to be funded. FG3P5.

These structural, systematic flaws are widely recognised and yet widely accepted. Participants reported they do not always document that the person's IL choice is not fulfilled due to lack of available services. However, they recognised that if there were adequate community support services available, to facilitate safer discharges or support continued community living, participants reported that DMC for IL would not be such a contentious issue:

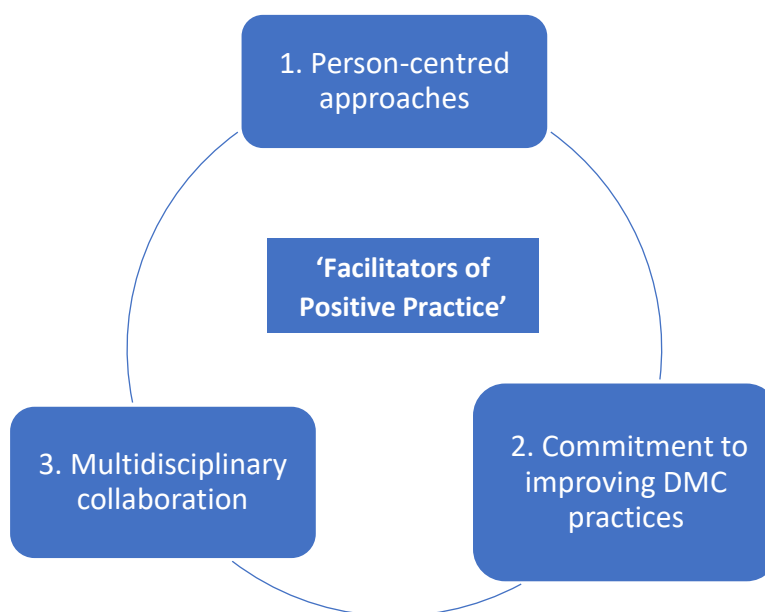
I don't feel like it would be as big of an issue if we could facilitate safer home discharges... If you increase community service, you'd probably find the capacity tests in this hospital might halve - that's not right either, that tells you something is wrong. Capacity wouldn't be as much of a question because there wouldn't be as many risks, it shouldn't be that the services available are determining the capacity assessment... It's confusing capacity and safety... And we are all about safety, we must keep you safe and if you're saying if you're safe, I'll let you have capacity. FG4P3

6.3.2: Theme 2: 'Facilitators of Positive Practice'

Participants described how occupational therapy made many positive contributions to this area of practice and had much potential to offer. A number of facilitating factors were identified, which occupational therapists felt led to positive practice and enhanced outcomes for the older person regarding IL decisions. Occupational therapists reported that they try to embed enablement strategies in their approach to DMC assessment to support people to make IL choices in accordance with their will and preference and promote person-centred approaches among the wider MDT. Participants described a strong commitment to improving their practice in this area, having engaged in education and introduced various practice initiatives. Participants highlighted the need to collaborate with MDT colleagues in order to maximise the effectiveness of the DMC assessment process which they recognised as requiring multi-disciplinary team involvement. Participants reported that core components of occupational therapy practice, such as client-centredness and occupation-based approaches, not only enhanced the DMC for IL assessment process but enabled occupational therapists to extend the scope of practice beyond mere assessment of DMC for IL but to maximising and supporting older adult's DMC in relation to independent living.

Figure 6.3

Theme 2 'Facilitators of Positive Practice' and related sub-themes



6.3.2.1 Person-centred approaches

Occupational therapists described many positive aspects of person-centred practice in the multi-disciplinary context of DMC assessment, whereby the older person's will and preference for IL is to the fore and the older person is supported to participate in the decision-making process. Participants cited examples of good practice where the whole MDT focus is on the person's quality of life, with specific consideration given to the person's values, will and preference.

It's all about quality of life and every member of the MDT is very like conscious of the person's quality of life. What do they want? And like, it's everybody's role like and especially as an OT, we talk through their values. What really, what do they want to do in and how can we support that. FG8P7

More specifically, many participants highlighted the particular contribution of occupation therapy to the MDT process of DMC assessment. Participants described a holistic approach adopted by occupational therapists, which they regarded as different to other MDT members and felt this was of particular value in the area of DMC for IL given the complexities of decisions to be made. Participants reported that they use a wide range of assessments tools and approaches, and they could often assimilate various assessment findings to give a more holistic, comprehensive picture. They reported typically exploring the person's values and goals at initial interview, as well as undertaking assessments of function, cognition and the person's living environment.

We see beyond just the person, we consider their environments that they're in, and obviously their everyday occupations or activities. I mean nobody else looks at all those things as a general picture, not to mind their kind of cognitive considerations around function. So I think a lot of those types of issues are what you're looking at in relation to capacity, to make an informed decision. From our knowledge and from our working, from our training, how we would have more of a skill set of those kind FG3P4.

OTs look at the full picture really, because like you're looking at somebody's functional ability, their cognitive ability, functional mobility I suppose as well. If it's about going home, it's about going out and doing those home visits and seeing what the person is like in their own home. So I think as OTs we're hugely valuable for this part of the capacity assessment, because we're kind of looking at a whole person, rather than just individual items FG9P2.

We think about the bigger picture, I think, because we have so much knowledge around the function, but also the environment, their cognitive status and all that as well. So, we can always link on further FG2P4.

I think we're good at kind of unpicking everything as well as OTs. In every area of practice, we actually look at a situation in great detail and kind of pick everything apart and say well why is that happening. Its more the application of sometimes what that means is where we differ in terms of, we're actually applying what we see to, I suppose, how this person will practically manage. FG3P3

Participants felt the assessments occupational therapists conduct are thorough and comprehensive, and their interpretation of assessment findings was crucial to understanding the person's current circumstances for independent living and how their current abilities and needs matched those.

Following these baseline assessments, the available options could be identified which would allow the person to engage in the process of informed decision-making and allow the therapists to assess the older person's ability to appreciate the information relevant to their situation and deliberate IL options.

Many participants felt that occupational therapists were skilled in using enablement strategies and that because of this focus on the benefits of the older person's continued occupational engagement, occupational therapists tend to be less risk adverse than some MDT colleagues and more inclined to consider balance of risk. Participants reported that occupational therapists are trained to use strengths-based approaches to enable occupational participation and engagement, which can then be extended to maximise DMC and participation in decision-making.

We are used to looking from a strengths approach in terms of what they can do and what we can help them on. I mean there's so many compensation strategies and skills training that we can do in order to enhance a person to be able to make those decisions in their day-to-day life. So, I definitely think we're in a very strong position to be able to lead on that. FG7P1

We really look at what makes people tick and what their occupational identity is, and how they want to pursue that in their lives and that's what our kind of core philosophy is really – meeting people where they're at and figuring out, well, how can you continue to live as good

a life as possible? And the fallout from that is, well then, what decisions need to be made, you know, to help you to do that and then, how can we help you make those decisions FG6P4.

I think that OTs are probably less risk adverse because client-centredness is so much to the centre our philosophy of our profession that we're able to rationalise why we're making the decision, that's what the client wants and it's in line with what we're observing FG7P3

Where do their abilities and strengths lie, do you know, because sometimes it is all very, like they've a physical impairment and these are the impacts that then you've totally found the other side, you know, that balance of what are their strengths and, you know, how can we play to those strengths and use those strengths as opposed to just like say you're left with a significant impairment FG6P3.

Participants suggested the role for occupational therapy should go beyond mere assessment of DMC to supporting DMC. Maximising DMC requires HSCPs know the person and understand what supports they may need to make a decision and use practical strategies to maximise their participation. Participants spoke of the need to present relevant information in a way that is accessible to the older person to allow them to participate in the decision-making process. As occupational therapists commonly complete cognitive assessment, they can use findings from these cognitive assessments to ensure they present relevant information to the older person in an accessible format. By offering the appropriate decision-supports or accommodations that the older person may need, the occupational therapist ensures the older person can be supported as much as possible in the decision-making process.

If someone does have a cognition difficulty, if you're going to give them ten pieces of information, they're not going to be able to take that on, so it can that be broken up. Or if they've difficulty with attention, we'll give short sessions in terms of giving them a break or whatever it might be. In that you're supporting the person to get the information first of all. FG8P5

Participants reported that occupational therapists need to explain the purpose of the assessment and then provide clear accessible feedback on cognitive, functional and environmental assessment findings, in an accessible manner, so as to enable the older person gain insight into their abilities and needs and thereby participate in the decision-making process more fully and make informed IL choices. Participants reported occupational therapists often facilitate the older person to problem-solve and weigh-up their potential options. By using these problem-solving approaches, providing accessible information, and giving clear feedback to the older person enables the older person to participate in decision-making and also gives therapists a marker of their levels of insight, and therefore their DMC.

Sometimes it's a bigger client wish that they want to stay at home and you're kind of helping breaking it down, 'What's the barrier to that or what are the challenges of you staying at home?' and 'How can we remove or lessen some of those barriers?'. FG5P1.

You're trying to translate and put that back to them and say, 'Okay, well Mary, you know you're needing help with this, this and this. And you know, on the home visit there was this issue, that issue, or this was really good. You managed to get into your house but you had trouble getting up and down the stairs, what about bringing the bed downstairs? Or you know, you need a hand with the shower, what about getting a carer in for showering?' And just kind of, you've to present all the information to them FG1P6

You're saying, 'From our perspective, having met you and having spoken to you and having observed you at home, these are the difficulties that are coming up at the moment. These are the things that we could do to help. If that doesn't happen, these are the potential consequences and then what would you like, what would you like the next step to be?' FG5P1.

Many participants viewed occupational therapy theories and practices as well-aligned with the legislation and the approach to DMC it sets out. Participants reported that due to their training, occupational therapists are well-placed to embrace the challenges arising in this area of practice. Participants regarded occupational therapists as having a strong role to play in advocating for the client and feel their training emphasised this. They felt the person-centred approach to care was integral to both their occupational therapy practice and to the process of assessing and supporting DMC.

I think it is that we've been trained to think in a certain way. It's with our models and frames of reference and the client centred approach - it is very different to what some of the other disciplines have and we all just take it for granted because that's the way we think. You do want to know what their values and their beliefs are, and what's important to them or else you can't really do your job. FG1P3.

It's in line with the theory and conceptual models and the way that we think as people, everything that we learn in college, the theory supports that enabling choice, enabling occupation. We look at the environment and the impact that it has on the person's ability to make decisions. I think that we're so well fitted to this FG8P6.

We're person-centred, person-centred care is the core of what we do, which is at the core of the assisted decision-making FG6P4

The principles of DMC assessment which place value on the person's will and preference fit well with occupational therapy theory, in which supporting and enabling the person to engage in valued occupations is central. Therefore, participants felt they could readily embrace the theoretical underpinnings of the legislation around assessing and supporting DMC within a supportive MDT approach.

The OT team here, once they meet somebody, they look at why is the person here, why does that person feel that they're here at the service. What would they like out of it? And conversations and treatments fall out of that. You know, whether it is around a decision that they want to go home... we will look at the fit of that person's abilities or if there is an issue with regards them understanding that. We will have the skills to breakdown that information in a way that it can be assimilated appropriately by that person. We will take that time to do that. FG8P3

6.3.2.2 Commitment to improving DMC practices

Although many participants described how their DMC assessment practice had changed and how they had engaged in quality improvement projects and efforts to improve practice, there was still a general feeling of dissatisfaction with current DMC assessment practices. Many participants reported assessment and support of DMC had been identified as a learning priority in their professional development plans and many participants had attended information seminars and education sessions. Participants reported some implementation strategies they were using to develop this area of practice. Some participants had focussed on DMC-related practice at journal clubs and had team discussions to explore ways to implement the legislation and improve practice within their service. This included being involved in initiatives such as establishing an MDT working party to raise awareness of the legislation and how to implement it across an organisation. Participants gave examples of occupational therapy leading this area of practice, such as developing a pathway for occupational therapists to guide their clinical reasoning and providing education sessions within their teams.

In our service, we've been trying to really raise the profile and the awareness, because it's one of our OT goals for the year, to really define what our role is in supported decision making. We've organised things like journal clubs and we've had like MDT coming and we all identified what our role is and things like that. FG3P3

Other participants described service developments whereby they made a conscious effort to involve family caregivers at an earlier stage in the assessment process, so they could collaboratively work with families on a discharge plan from the outset, rather than at the end of the occupational therapy process. This increased awareness and insight of the older person and their family members to the current needs and abilities of the older person, which allowed the older person, family members and occupational therapists to agree realistic goals and encourage the family caregivers to utilise enabling rather than restrictive strategies with the older person.

Participants emphasised the need to first of all have good awareness of the legislation and underpinning principles. This then prompted participants to reflect on practice and many reported they had changed their practice. Participants reported the recent legislation had given them more confidence to advocate for client's wishes and it often gave validation for their clinical reasoning, specifically for supporting client IL decisions which involved risks. Participants described how the legislation enabled them to be less risk adverse and reminded them of the importance of ensuring the older person's voice was heard throughout the process. Though participants were seeking more guidance in terms of how to implement the Act, some felt the legislation gave some protection against the threat of litigation.

When people are being risk averse, you can point out to them that that's contrary to policy and its contrary to legal requirements. And you will go a long way with that. And I suppose that's made me brave FG7P4

I have found since this has come in and we're being so explicit in what the actual care needs are and kind of where you can minimise risk and where risk has to be accepted. FG3P1

I definitely personally have changed my practice and feel a lot more comfortable with decisions that I probably wouldn't have been comfortable with before. FG7P3

Once we've done our job properly and followed the process, we are actually being as responsible as we could be. Because we're supporting the patient and their preference. FG1P8

Some participants felt the recent legislation had supported a cultural shift towards positive risk-taking behaviour. In some cases, participants reported this change in attitude and approach to assessing and supporting DMC in relation to independent living was shared among the wider team. One participant described an example where the general medicine team had changed their approach: *they're doing like gradual discharge home, which would have been unheard of before.* FG3P1

6.3.2.3 Multidisciplinary Collaboration

While participants felt occupational therapists were well-suited to this area of practice, they also advocated for an MDT approach, and they felt they had better outcomes when occupational therapists worked within supportive MDTs:

I am very lucky in that I'm not swimming upstream in that, you know, my philosophy would be very much the philosophy of the rest of the team (FG7P4).

A multidisciplinary approach ensures those who know the person are involved and ultimately this leads to more comprehensive assessment.

Linking in with your colleagues, say like the GP or the public health nurse or people who know the patients for years and have a better history. Because we only know them for a month, you know what I mean. So it's really good to work as a team and the wider team I think you know. FG5P4

Participants felt multidisciplinary collaboration is required in complex decisions around issues of independent living where the magnitude of risk is high. Participants emphasised that occupational therapists had a role in contributing to this area of practice, yet because of *'the weight associated with whatever you arrived at'* (FG2P1), many participants were also relieved to share the burden of responsibility with MDT colleagues. The reluctance to assume responsibility for DMC assessment is

not only held by occupational therapists, but also the wider MDT, possibly because the consequences of decisions relating to independent living are so significant. Some participants reported that when more people who were involved in sharing the decision-making, this led to sharing the responsibility and risk, ultimately leading to improved outcomes for the person.

I think we do have a place in terms of gathering information and providing and contributing. But I think sole responsibility or making a final decision, I would feel it's good to have maybe a team. FG2P4

No wonder no one wants the responsibility of that then because it could be so damning... honestly because its massive and people think nothing of saying 'You have no capacity, you need to go to a nursing home', that is just so big, they're 80 years in the one house and overnight, I'm uprooting you. FG4P3

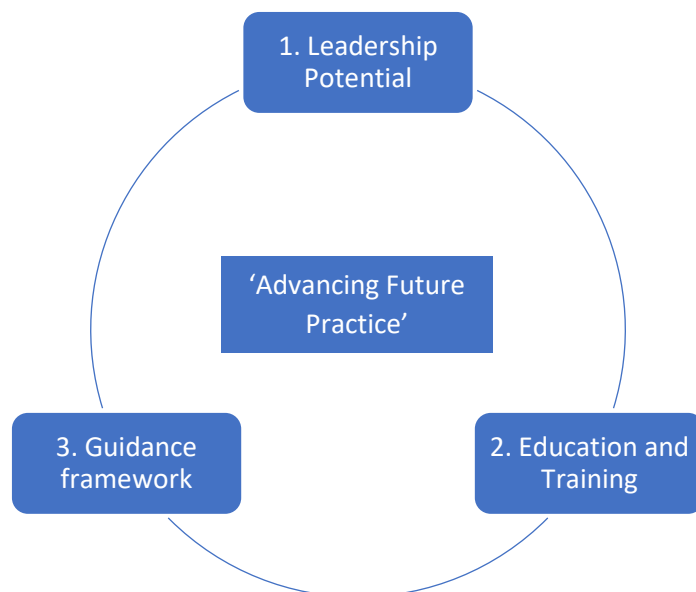
There is that concept though of the kind of 'risky shift' that sort of the more people involved in making a decision the least restrictive practice is put in place but then it depends on who the people are who are making the decision, you know what I mean, so if you've got everyone within the same culture and the same training it's easier. FG6P4

6.3.3: Theme 3: 'Advancing future practice'

In addition to the challenges and complexities of current practice, participants identified a number of opportunities for the profession of occupational therapy to contribute to DMC assessment and support. They recognised potential for leadership in issues of DMC that relate to independent living. However, to fulfil this potential, they also identified gaps in education and training and the needs for resources such as a guidance framework to enhance their confidence in engaging with this area of practice.

Figure 6.4

Theme 3 'Advancing future practice' and related subthemes



6.3.3.1 Leadership Potential

In relation to DMC for independent living, participants largely agreed that, based on their professional philosophy and training, and their degree of involvement in assessments that are relevant to independent living, occupational therapists have a strong role to play in this particular area. Participants reported that occupational therapists had embraced this evolving area of practice more than other disciplines. Occupational therapists were doing groundwork to prepare themselves and their teams to implement the new legislation and that they were well-suited to this role.

I do think OTs are very well positioned to contribute to the decision making. I think we've lots of skills to offer. I think we're very well placed in the team. FG2P2

I think the OT department here are very advanced in terms of the whole decision capacity making. I think you wouldn't hear any other discipline bringing up the words, you know decision making capacity FG2P4

I know in other hospitals they have working groups that OTs are leading out on educating and supporting the whole of the organisation. I think as OTs we do tend to take a lead on things like that. Like we're talking about capacity and the capacity Act a lot, whereas I don't see the same chat around the rest of the team, even though it affects whoever is on the team. FG8P4

Many participants also held the view that occupational therapists had potential to demonstrate some leadership and develop practice, building on current knowledge and experience.

There does need to be a sense of leadership and there will be some cases where we might be the leaders, but that's depending on the decision FG8P6.

It's something that maybe is OTs time to sort of own it a bit more, like I think we're well placed with our skill set FG3P4

This is definitely an area that I think we could lead in and it's something that we really have to step up and step into. Because we have a responsibility, you know what I mean, as a profession, that this is definitely an area that we have so many skills that we can apply. There is a lot of work being done already and a lot of people in this room have a great understanding of the Act and of practice and application and advocating for people, so I think we have all of the necessary skills. So we should be pressing ahead with that, you know FG3P3.

Nonetheless, much work is needed in order to advance this area of practice, in considering how to implement the Act and to ensure practices are aligned to organisational and professional philosophies. Some participants were concerned about what it would mean for occupational therapists if their responsibility increases without clear guidance.

It's gonna really fit with how we view and think about people but I think there's gonna be an awful lot of support needed in order to be able to really do that in a way that's going to not compromise you from your organization's perspective FG6P4

I think that we're so well fitted to this, but at the same time I'd be afraid, with us, that we would take on a lot with this. And I think there's a fear amongst all OTs that you know, how is this going to impact us and it will mean a lot more things falling on us as well. What will our role be within it? You'd want to be very clear as to what, how we contribute to this and what our role is within it FG8P6.

I can understand why, without having clarity about what is best practice and the questions you need to be asking, that people aren't going to put themselves forward and it's very hard to influence change without it coming from top down FG3P2

6.3.3.2 Education and training

Invariably, participants discussed the need for more training and education on the legislation itself and its implications for practice. It was suggested that this training needed to happen at undergraduate level and also as a continuous professional development course for all clinicians. Participants argued training should be mandatory for all members of the MDT within organisations. Participants reported that as it was a complex area, training would need to be face-to-face to ensure reflection on current practices and suggested use of case-studies to stimulate MDT discussion and application.

We need more knowledge on this, you know we don't have a huge amount of knowledge on this. There's nothing guiding us FG4P4

It would be great to have nurses, speech and language, physio, social worker, all making that decision. So, they're the people who need the education. I think the teams, and that, need education as well... any of those people who are going to be talking to people about what the discharge plan is or what their decisions are. They all need to be trained because all of us need to be, all of the MDT needs to be trained in what is the actual capacity assessment.
FG4P5

It's so complicated, I just think the next step is education. It's too early, legislation came out but it didn't have the guidance, it didn't have the support. There wasn't the education, there was no plan on how to implement that. And there had to be a plan before that comes into place. FG4P3

In order to rise to the challenge of leading practice in this area, some participants felt there was a role for occupational therapy in education of the wider public about the Act and its implications for older people and their lives. Some participants also felt a public awareness campaign would be helpful to empower older adults to demand a more rights-based approach and so family members were aware of the limits of their influence. Some participants suggested that this was an opportunity for promotion of the occupational therapy role to wider teams and society.

We should be involved at a national level then in terms of the education to the general public around that, enablement piece and maximising decision making or optimising decision making and things like that FG5P2.

Highlighting our role, the OT role, not only to our local team but I know nationally we really need to be on working groups and giving education sessions to the needs of a families or whatever it is...highlighting OTs have a role in this area FG5P3

I think in general there needs to be like a lot more education, training out there for all people, not even just health professionals, people in the public service, like in banks, things like that
FG5P1

6.3.3.3 Guiding framework

In terms of specific occupational therapy resources, participants also discussed the need for an occupational therapy guidance framework on the approach to DMC assessment. Participants stated this was required to improve quality of practice and ensure wider understanding of issues and more consistent practice within and across services. With a guidance document, participants felt occupational therapists would be at least '*Singing from the same sheet*' (FG9P2). Many participants had overseas experience and often described proforma documents which they felt ensured some consistency of practice and development of such templates was generally seen as favourable.

We need a framework, we need a process. There has to be paperwork and guidance so that it's documented FG8P4

Having something formal in place as in looking at the person as a whole, breaking their areas down, see their functional tasks, their cognitive ability, their mobility, their safety. Having

something in place that we you know we could all, you could nearly standardise and have it as one. So we'd all be on the same page. FG9P2

Overall, while participants were willing to engage more in this area of practice, having a framework and training would increase confidence in their ability to engage in this complex area of practice.

Just from an OT point of view it might be good for us to look at OTs, like our own pathway, what we need to follow in terms of supporting, what we need to follow, I suppose in terms of our assessment and our feedback and what we need to be considering. FG5P4

Even that little bit of training gave me more confidence in capacity awareness. And even doing that gives you more confidence because you talk about it more, you're more aware. And you feel you're able to question things FG5P1

6.4 Summary

The focus group discussions provide rich insights to the current practice experiences of occupational therapists in Ireland in assessment of DMC of older adults for independent living. They confirmed DMC regarding independent living as the domain of most relevance to occupational therapy practice with older adults. Participants described various factors that both challenge and facilitate occupational therapists' engagement in the assessment and support of DMC of older adults. Many practice tensions were identified as occupational therapists perceived the healthcare system and organisations, they work within to present barriers to assessing and supporting DMC in a client-centred, occupation-based manner. Nonetheless, occupational therapists were motivated to engage in this area of practice and saw occupational therapy as having potential to make an important contribution. They also provided insight to occupational therapists' attitudes towards recent legislation regarding DMC and highlighted directions for development to enhance practice in this area. Overall, the focus group discussions addressed the tensions and issues within current practice which make DMC assessment for IL so complex. They also highlighted many positive aspects of occupational therapy practice and the benefit of a multidisciplinary approach, which form a foundation for further advancements in this area, with the potential for occupational therapy to take a lead in assessing and supporting decision-making capacity for independent living.

7.0 Findings from consensus meeting

7.1 Introduction

The findings from the fourth phase of this study will be presented in this chapter. The overall aim of this phase of the study was to form a consensus on recommended approaches for occupational therapists in Ireland that address DMC for independent living of older adults. The focus was on establishing a consensus that was embedded within occupational therapy practice and encompassed a client-centred, occupation-based perspective that aligns with recent legislative changes.

This phase of the study consisted of a consensus meeting of occupational therapists with experience in assessing and supporting older adults' decision-making capacity for independent living in Ireland. Consensus was sought through use of the Nominal Group Technique (NGT) (Delbecq, Van de Van and Gustafson, 1975).

The aims of the NGT meeting were to agree consensus on:

- Triggers that indicate that an assessment of decision-making capacity is required for an older adult, regarding independent living.
- Key components of occupational therapy assessment that may inform the assessment of, and the support of, older adults' decision-making in relation to independent living.
- Methods to ensure the person's will and preference is central in the assessment of their decision-making for independent living.
- Practical strategies occupational therapists should employ to facilitate an optimal and thorough assessment of decision-making capacity.

7.1.1 Structure of the presentation of the findings

The participant profile of the occupational therapists involved in this phase of the study will be presented first. This will be followed by presentation of the consensus reached through the analysis process for each of the NGT questions.

7.2 NGT Participant Profile

Twenty occupational therapists, including the researcher and research supervisor, contributed to the NGT meeting and consensus formation. The NGT process allows for the facilitator to be an active participant in the group and to actively contribute to the process and consensus formation (Delbecq et al., 1975). The researcher and research supervisor are both qualified occupational therapists with previous clinical experience working with older adults and had experience of contributing to assessment of decision-making capacity and were aware of the recent legislative changes. Therefore, they both contributed to the process.

Socio-demographic and professional profiles of the NGT participants are provided in Table 7.1. Occupational therapists practicing across seven counties participated in the consensus meeting, representing nationwide geographical spread. Participants were employed across a range of hospital settings (including acute hospitals, rehabilitation, day hospital and memory clinic services), community settings (including primary care and long-term care services), and academia. Therapists who took part in the consensus meeting had a range of five to 34 years' experience, with the majority of participants having more than seven years of practice experience (85%, n=17). All participants had practice experience that predominantly involved working with older adults, including one participant specifically reported working with older people with mental health issues and two participants reported working in stroke rehabilitation. Participants had an average of 16 years work experience, and 10.2 years of experience of working with older adults. Ten participants had completed formal postgraduate education. Six participants reported having completed no further training in relation to DMC assessment, whereas the majority (n=14, 70%) reported having attended seminars or presentations at conferences that specifically discussed DMC assessment.

All of the consensus meeting participants (n=20, 100%) had experience of contributing to DMC assessments of older people. Of the 17 participants who were currently working in clinical practice, some were very frequently involved in DMC assessments relating to independent living; five participants reported to be involved in DMC assessment at least weekly, one reported to be involved at least fortnightly. Four participants reported they contributed to DMC assessment on a monthly basis and seven were involved more occasionally. All participants had sufficient exposure and experience to draw on in generating and ranking recommendations.

Table 7.1**Consensus meeting participant characteristics (n=20)**

	Overall sample (n)	%
<i>Demographic profile</i>		
Total number of participants	20	100
Female	19	95
Current position grade		
• Staff grade	2	10
• Senior grade	12	60
• Clinical Specialist	2	10
• Manager	1	5
• Academic	3	15
Highest level of education completed		
• Diploma	2	10
• BSc.	8	40
• PG Certificate	1	5
• MSc.	8	40
• PhD.	1	5
Years of work experience		
• Less than 5 years	0	0
• 5-6 years	3	15
• 7-10 years	3	15
• 11-15 years	5	25
• 16-20 years	3	15
• More than 20 years	3	15
• More than 30 years	3	15
Years of experience working with older adults		
• 3 years	2	10
• 4-6 years	5	25
• 7-10 years	5	25
• 11-15 years	3	15
• 16-20 years	0	0
• More than 20 years	3	15
• More than 30 years	1	5
Practice setting		
• Hospital-based (12)		
○ Rehabilitation	8	40
○ Acute	4	20
• Community-based (5)		
○ Primary care	3	15
○ Community mental health	1	5
○ Long-term care facility	1	5
• Academia	3	15
Geographical location/county currently work in		
• Dublin	14	70
• Louth	1	5
• Kerry	1	5
• Longford	1	5
• Clare	1	5
• Westmeath	1	5
• Tipperary	1	5
Frequency of contribution to DMCA		

• Weekly	4	20
• Fortnightly	2	10
• Monthly	4	20
• Occasionally	7	35

7.3 Consensus reached following NGT

For the purpose of this consensus meeting, there were four individual NGT sessions held to address each of the four questions. For each question, the four steps of the NGT process were followed as a separate process (as outlined in Chapter 4). The researcher and research supervisor acted as group facilitators for all four sessions. Participants were divided into two separate groups of ten participants, who simultaneously worked on the same questions, but merged for the round robin recording in order to generate one master list of statements and thus ensuring all participants took part in the same discussion and clarification of items and were voting on the same list of items.

7.3.1 Interpretation of votes

The forced selection component of NGT allows participants to only select and vote for five items from each generated list. In the voting phase of the NGT process, each participant individually selects the five items they consider to be most important from the list generated by the group in previous NGT steps of generation, round-robin recording and discussion of ideas. They write each of the five prioritised items on a separate index card and then rank each of their five selected items according to importance. The most important item was given a rank score of five by the individual, the second most important item was assigned a rank score of four, and so on to the least important item among those five prioritised items was assigned a rank score of one.

For each NGT question, a hierarchy of ranked items emerged, as each participant had to assign a rank to each of their five selected items and rank the importance of each item relevant to the other four items they had prioritised from the list. A total group rank score was calculated for each item by summing the individual ranks assigned by the participants to that statement. The highest possible rank score that could be achieved by any one item was 100. i.e. the total number of participants in the group (n=20) multiplied by five, the highest possible individual rank score. This maximum total group rank score could be achieved by one item only within each voting category and would indicate absolute consensus on that particular item. Therefore, the number of participants voting for an item along with the total rank scores (sum of rankings) are considered when looking at the strength of the consensus.

7.3.2 Establishing consensus

There are several approaches to defining consensus, which does not need to be defined as full agreement among participants but can be a pre-determined range, specified by the researchers (Nair et al., 2011). However, most consensus methods studies do not provide a definition of consensus at the start of the study and when they do, consensus agreement definitions range widely from more than 20% agreement to 90-100% agreement (Humphrey-Murto et al., 2017b). Typically, when a definition of percent agreement among participants is discussed, it is in relation to Delphi methods rather than NGT, such as that from Singer et al. (2019). Nonetheless, classification of the strength of consensus can be useful and for this study, a definition that agreement of 50% of participants indicated consensus was obtained on that item. In addition to the number of votes or percentage of participants voting on an item, the rank score must also be considered, as many participants may have voted for an item but have assigned it overall lower rank scores. Nair et al. (2011) caution that the purpose of NGT is to establish a prioritization of ideas and issues, and while the use of numerical voting can assist in this, the numbers should not be used for further quantitative analysis or interpretation. The recommendations were classified according to the strength of consensus within the nominal group according to Table 7.2 (from strong consensus to no consensus).

Table 7.2

Classification of the strength of consensus (based on Singer et al., 2019)

Strong consensus	Agreement of >90% of the participants
Consensus	Agreement of >75-90% of the participants
Majority agreement	Agreement of >50-75% of the participants
No consensus	Agreement of <50% of the participants

7.4 NGT Session 1: Factors that trigger assessment of decision-making capacity regarding independent living

- NGT Question 1: *As an occupational therapist, what are the factors that trigger your consideration that an assessment of decision-making capacity is indicated for an older adult, regarding independent living?*

During the initial silent generation of ideas, 33 factors were identified as triggers that prompt occupational therapists to consider decision-making capacity assessment. During discussion, all the 33 factors were considered to ensure consistency in their interpretation. Similarity and overlap

between factors were discussed and it was agreed to amalgamate some of these subcomponents, resulting in nine agreed categories going forward for voting (Table 7.3).

Following voting, very strong consensus emerged that risk was a key factor in triggering DMC assessment with 19 out of the 20 participants (95%) ranking this factor, and seven participants indicating that it was the most influential trigger for DMC assessment, giving it their highest-ranking score of five. Discrepancy or disagreement between the older person's perceptions of their abilities and needs and that of other stakeholders, such as family members or members of the MDT, was the next highest ranked trigger for DMC assessment. A large majority of participants (n=18, 90%) voted that this conflict frequently triggered DMC assessment, with nine participants indicating it was the most influential trigger, giving it their highest rank score of five. There was also strong consensus that decreased insight and awareness was a factor that triggered the possible need for DMC assessment with the majority of participants (n=17, 85%) voting for this item, however participants generally ranked this factor lower.

Resistance to accepting recommended assistance or situations where the older person declined supports was also a factor that had moderately strong consensus as a trigger for a DMC assessment (n=14, 70%), but generally received lower rankings overall. Moderate consensus was also reached regarding an unsupportive living environment without adequate social or care support as a trigger for DMC assessment (n=12, 60%). There was less consensus that the carer context and cognitive difficulties would indicate DMC assessment. Both items received ranks scores of 16 but carer context received a higher number of votes (n=10, 50%) indicating majority agreement. Other components which were considered but on which no overall consensus was agreed included mood and mental health (two votes, rank score 4) and medical history (one vote, rank score 2).

Table 7.3**Triggers for DMC assessment, ranked in order of importance**

Item/statement	Individual rank scores	Total number of votes	Total rank score
Person is at risk , safety concerns, risk-taking behaviour, e.g. getting lost, vulnerable to fire, food safety concerns, evidence of personal neglect, repeated admission for same reason	2,4,2,2,3,5,5,5,4,5,4,5,3,3,5,5,4,3,4	19	73
Conflict regarding needs of older person, discrepancy between older person's perspective and that of other stakeholders (e.g. family, MDT)	5,5,5,1,2,3,5,2,5,4,5,5,2,4,5,4,5, 5	18	72
Decreased insight and awareness , executive deficits, poor judgements, unrealistic appraisal of self, problem solving difficulties	4,5,4,4,4,5,4,3,2,3,4,1,1,1,3,1,3	17	52
Resistance to assistance , declining support services or input, poor help-seeking behaviour, refusing services deemed essential	2,3,2,3,4,4,1,2,3,4,2,4,2,2	14	38
Unsupportive living environment , lack of social support, lack of care package availability, risky home environment, change in circumstances	3,1,1,3,3,2,2,4,3,3,1,1	12	27
Carer context , carer strain (physical and emotional), subjective concerns identified by family, carers, MDT, community sources	1,1,1,1,2,4,1,2, 1,2	10	16
Cognitive difficulties , reduced memory or recall, poor historian	3,3,1,1,2,1,5	7	16
Mood and mental health	3,1	2	4
Medical history , diagnosis, prognosis	2	1	2

7.5 NGT Session 2: Components of occupational therapy assessment that inform the assessment and support of older adults' decision-making regarding independent living

- NGT Question 2: *What are the key components of occupational therapy assessment that may inform the assessment of, and the support of, older adults' decision-making regarding independent living?*

In the generation phase of this NGT session, 20 ideas were identified by participants as components of occupational therapy assessment that may inform DMC assessment of older adults' regarding independent living. In discussing the various components of occupational therapy assessment, participants strongly emphasised the need to use a combined approach of standardised assessments

and functional observations, and to include self-report and collateral reports. They described how the unique contribution of occupational therapy came from this holistic, client-centred and occupation-focused assessment which was strength-based, emphasising the older person's abilities. They also discussed the importance of the assessment environment and how conducting assessment in a familiar environment can empower the older person. Following the discussion phase, these 20 ideas were condensed down to 12 agreed items which were put forward for voting (Table 7.4).

Very strong consensus emerged that occupational therapist's contribution to overall DMC assessment should include an assessment of function (n=20, 100%). All participants voted for this item and predominantly assigned it rank scores of 4 and 5, yielding a total rank score of 90. There was also very strong consensus that cognitive assessment was a key component of occupational therapy assessment which informs DMC assessment and support, though it received slightly lower individual ranks scores (n=18, 90%). Assessment of the home environment also gained strong consensus with the majority of participants (n=16, 80%) indicating they thought it was a key component of occupational therapy assessment which contributes to overall DMC assessment for independent living. Participants also regarded interview-based assessment such as the initial interview and self-report from the older person as an important component to inform DMC assessment (n=12, 60%) though this received overall lower rank scores.

Only six participants (30%) voted on consideration of the older person's goals and wishes as a key component of occupational therapy assessment that may inform DMC assessment, however this item received a higher rank score than the collateral information gathered from other sources, which got nine votes (45%) but lower individual rank scores. There was weaker consensus on considering social structures (n=6, 30%) or adopting a prolonged approach to assessment (n=5, 25%). Other components were considered but no overall consensus was agreed for items such as physical and sensory assessment which received one vote (rank score 2), and items such as roles and routines, and mood and motivation did not receive any votes when participants were forced to rank these against the other factors.

Table 7.4

Components of occupational therapy assessment that may inform DMC assessment and support

Item/statement	Individual rank scores	Total number of votes	Total rank score
Assessment of function – observation of performance in tasks relevant to person (in variety of environments), basic and instrumental activities of daily living, community and home related functional activities considering physical and cognitive elements	4,5,4,4,4,5,3,2,4,5,5,2,5,4,4,4,1,5,3,4	20	90
Cognitive assessment – combined approach, cognitive functional evaluation; standardised screens executive function (including insight and awareness, planning, judgement, safety awareness)	5,3,3,1,1,3,2,1,3,1,4,3,5,4,4,5,1,5	18	54
Assessment of home environment – assessment of physical home environment, home-based functional assessment, pre-discharge, social set-up, safety issues	2,4,2,5,4,5,3,1,2,4,3,2,2,1,4,3	16	47
Interview-based assessment Initial interview – self report or perspective on reason for admission, current living situation, supports in situ/available	1,3,1,1,5,5,4,1,3,5,1,5	12	35
Identification of the person’s goals, and wishes – will and preference, include self-rated performance and satisfaction, ongoing gathering of goals and preferences	3,5,2,4,5,3	6	22
Collateral information - reports from various sources such as family, MDT, community agencies Ongoing collaboration with MDT	2,3,2,5,1,3,2,2,1	9	21
Social structures – social environment, availability of services and supports in community and at home	1,5,2,4,1,3	6	16
Prolonged assessment approach , compliance, carry over, learning, response to intervention, problem-solving, multiple sessions, optimal setting	1,2,4,3,2	5	12
Risk-benefit assessment of specific task performance	3, 3	2	6
Physical, sensory assessment	2	1	2
Roles, routines (previous and present)	0	0	0
Mood, motivation	0	0	0

7.6 NGT Session 3: Methods to ensure that the older person's will and preference is privileged in the assessment and support of the older person's decision-making capacity for independent living

- NGT Question 3: *Will and preference is considered an integral component in the assessment of decision-making capacity. As an occupational therapist, how should you ensure that the person's will and preference is factored into your assessment and support of their decision making for independent living?*

Twenty-three ideas were initially generated for discussion on how to ensure the older persons' will and preference is considered in DMC assessment and support and following discussion these ideas were condensed into ten items that were voted on (Table 7.5). Strong consensus was achieved on exploring will and preference explicitly through interview, with specific emphasis on discussing the person's reasoning for their expressed preferences (n=17, 85%) and eleven participants assigned it the highest rank score of 5 to this item. Participants recommended asking the older person direct questions about what is most important about their current living situation, what activities and occupations are important for the person to do at home, and what works well about their current living situation and what their priorities are for living arrangements. Participants also reached strong consensus on the importance of involving the person throughout the assessment process (n=16, 80%). Approaches such as establishing the person's occupational profile, allowing time to establish will and preference, and presenting the person's will and preference to family and MDT all received 12 votes (60%), though occupational profile received a higher rank score of 36 compared to 31 for the other items. Establishing an occupational profile typically includes identifying meaningful occupations the person engages in along with previous and current roles and routines which may be seen to reflect the persons values and preferences. There was some agreement on the utilisation of advocates or relevant supports to identify will and preference (n=9, 45%) and on the provision of education and experimental opportunities of available options (n=7, 35%). There was less agreement on using advanced care directives (n=5, 25%), collateral information from others (n=3, 15%) or in using assessment tools such as Canadian Occupational Performance Measure (COPM; Law et al., 2014) (n=3, 15%).

Table 7.5

Approaches to ensuring the person's will and preference is included in assessment process

Statement	Individual rank scores	Total number of votes	Total rank score
Exploration via interview with explicit reference to will and preference, and specific emphasis is on reasoning/why they hold such preferences, conversation using variety of techniques	5,5,5,5,2,5,5,5,1,1,3,4,5,3,2,5,5,5	17	70
Involve the person throughout the process, highlight strengths to person and team, explain relevance of the assessments and feedback results	4,4,4,5,4,3,4,1,3,5,4,1,3,3,4,2	16	54
Occupational profile , previous and current roles, habits, routines, previous engagement prior to admission, listen to narrative/life story, values and beliefs	3,2,3,3,1,1,1,5,5,3,4,5	12	36
Allow time to establish will and preference, ongoing process based on feedback/discussion, acknowledge that will and preference might change, allow opportunity for self-appraisal	2,1,2,4,3,4,2,2,3,1,3,4	12	31
Present the person's will and preference to MDT and family, awareness of external influences on person – financial pressures	1,3,3,4,4,3,5,2,2,2,1,1	12	31
Utilisation of advocates, relevant others (including other appropriate MDT members) and other necessary supports	3,2,1,5,4,5,4,1,3	9	28
Education on available options , experiential exploration opportunities	2,2,3,4,2,2,2	7	17
Advance Health Care Directive , previous will and preference and any changes,	1,1,2,4,2	5	10
Collateral information and history from carers, family, MDT	4,3,2	3	9
Use client-centred tools e.g. COPM	5,1,1	3	7

7.7 NGT Session 4: Practical strategies occupational therapists should employ to facilitate an optimal and thorough assessment of decision-making capacity

- Question 4: *'How' a decision-making capacity assessment is conducted is crucial in ensuring a fully considerate and fair process. What practical strategies should occupational therapists employ to facilitate an optimal and thorough assessment of decision-making capacity?*

Twenty ideas were initially generated for discussion on practical strategies to facilitate optimal and thorough DMC assessment and support. Following discussion, these ideas were condensed to eleven items that were put forward for voting (Table 7.6). Strong consensus was reached on both the need for a consistent approach to DMC assessment among the MDT and use of compensatory techniques, such as communication aids, as practical strategies occupational therapists could use to enhance the DMC assessment process. Adopting a consistent approach received sixteen votes (80%) and a rank score of 60, whereas adopting compensatory strategies received nineteen votes (95%) but a slightly lower rank score of 59. In terms of compensatory approaches, occupational therapists discussed many general strategies. In relation to the set-up of the assessment environment, they highlighted the need to ensure it is quiet and private, with minimal distractions and interruptions. In preparing for DMC assessment, they drew attention to the need to consider the older person's values, experiences, cultural and religious traditions. When presenting the older person with information pertaining to the decision, they identified the need to consider the older person's education and literacy levels and to offer additional information in an accessible format. Employing good communication skills, such as speaking slowly, clearly, loudly and providing written and/or pictorial aids to enhance understanding and ensuring the older person has access to necessary communication aids and services, such as interpreter, was seen as a basic requirement for effective DMC assessment. Participants stressed the importance of providing information in simple language and breaking down complex ideas into chunks of separate information. Strategies such as use of clarifying questions to ensure the older person's understanding of information, along with repeating, rephrasing and summarising information as necessary was seen to improve their participation. Lastly the need to allow the older person sufficient time for responses and to consider their options and weigh up their preferences was highlighted.

Participants also regarded education on DMC legislation and on DMC assessment protocols to be an important factor in optimising occupational therapy practice in this area and this item also reached strong consensus (n=17, 85%). Some consensus emerged for person-centred collaboration, which although it received only 11 votes (55%), eight participants assigned higher individual ranks scores of 4 and 5 to this item indicating its importance. Similarly, nine participants (45%) recommended adopting an individualised approach and four participants assigned this a rank score of 5. Nine

participants (45%) also voted on using clear and explicit documentation as a means to enhance the DMC assessment process. There was much discussion but less clear agreement regarding other items such as the use of a broad range of assessments, focusing more on supporting rather than assessing the older person's DMC, aiming for the best outcome for the client and consideration for timing of the assessment and allowing sufficient time. The person's wellness and mood did not receive any votes, though it was identified as a point of consideration and may relate to other higher ranked items such as to the need adopt a person-centred, individualised approach, taking into account the person's abilities and circumstances at the time of assessment.

Table 7.6

Practical strategies recommended for occupational therapists to facilitate an optimal and thorough assessment of decision-making capacity

Statement	Individual rank scores	Total number of votes	Total rank score
Consistent approach across MDT , agreed local policies/procedures, avoid mixed messages to the person, joint training/workshops with the whole MDT, promote a less 'risk adverse' approach among the MDT and family	4,2,5,5,3,4,4,5,5,3,5,2,4,5,3,1	16	60
Compensatory strategies to maximise the person's participation in the process – communication supports, SLT involvement, alternative presentation of materials/information, presence of advocate/trusted representative, quiet environment	4,5,2,4,3,4,4,4,1,1,5,3,3,1,5,2, 2,3,5	19	59
DMC specific education – occupational therapists must become more informed/expert in the process, increase their awareness of legislation, best practice, rights-based approach etc so that occupational therapists could better promote the will and preference of the client	2,3,2,1,4,4,2,3,2,2,2,3,5,4,2,2,4	17	47
Person-centred collaborative approach ensuring the person themselves are included in the process, reassurance provided to person throughout	5,3,5,5,2,1,4,4,4,4,5	11	42
Individualised approach , not a one-size-fits all, take all factors into account, customised to person, considers sociocultural, education factors	1,5,5,1,5,2,2,3,5	9	29
Documentation – explicit reference to person's expressed will and preference in occupational therapy documentation, information on locally available services/supports	3,1,1,1,2,2,1,1,3	9	15
Broad range of assessments available to select from, select the appropriate assessment, incorporating more use of self-rating tools	3,5,3,1,1	5	13
Emphasis on supporting DMC rather than assessing DMC occupational therapists have a role to support DMC rather than merely assess DMC	3,2,3,3,1	5	12
Ensure the person's will and preference is recognised/documented , despite impact of limited resources or external constraints which may hamper its execution	1,4,1,1,4	5	11
Timing of assessment – ensure optimum timing of the process, allow sufficient time	3,1,2,1	4	7
Person's wellness and mood		0	0

7.8 Participant satisfaction with NGT process

A participant satisfaction questionnaire was completed by most of the NGT participants (n=18, 90%) on completion of the NGT meeting. Participants rated their satisfaction with the NGT process as a development tool by rating their agreement with six statements on a Likert scale. All respondents (n=18, 100%) strongly agreed that they were satisfied with the items chosen in each of the NGT question areas. Most respondents (n=17, 94.4%) to the questionnaire strongly agreed that their opinions were represented in the items put forward for voting and none felt their opinions or ideas were excluded. The majority of questionnaire respondents (n=17, 94.4%) strongly agreed that the NGT was a useful process in consensus development regarding practice recommendations. Respondents also provided additional feedback reporting that the NGT method ensured all group members were represented, that they were satisfied with the facilitation, that the research was important and timely for occupational therapy practice, and that participation in the NGT meeting had prompted reflection on practice and sharing of ideas to improve practice.

7.9 Summary

This phase of the study followed the process for the execution of NGT meetings as set out by the original authors (Delbecq et al., 1975). Using this method, participants selected the five most important components within various areas of interest regarding DMC assessment of older adults for independent living. The consensus formation meeting was divided into four separate rounds of NGT where participants selected and voted on:

1. the factors most likely to trigger an assessment of DMC for independent living,
2. the most important components of occupational therapy assessment that may inform DMC assessment for independent living,
3. considerations for ensuring the person's will and preference is addressed in the assessment process and
4. practical strategies occupational therapists could utilise to ensure an optimal and thorough assessment process.

The findings represent a hierarchical organisation of key components to be considered in DMC assessment for IL, based on informed clinical opinions of participants. The forced choice and ranking inherent in this method avoids the possibility of all the items within each domain being highly recommended and as such, allowed for the prioritisation of items that are highly recommended. Thus, the recommendations that reached consensus are potentially reflective of and more applicable to practices among occupational therapists in Ireland.

8.0 Discussion

8.1 Introduction

This study was conducted to explore occupational therapists' role in DMC assessment practice in Ireland. The purpose of this chapter is to provide a discussion of the combined findings from all phases of the current study. The findings from the four phases are integrated as outlined in chapter four and will be discussed, explored and compared with the relevant national and international literature. The strengths of the mixed methods design will be clearly illustrated as the data gleaned from the various phases of the study serve to corroborate and strengthen the findings. The discussion reflects the overall aim of this research study, which was to explore the role of occupational therapy in the assessment of older adults' decision-making capacity for independent living, within an Irish context of practice.

The study gathered information pertaining to occupational therapists' views and experiences of involvement in DMC assessment. The study identified factors influencing occupational therapist's practices in this area, including how recently enacted legislation was being adopted and integrated into practice. The study also aimed to provide an overview of current international practice in this area, and to explore a consensus on assessment protocol and procedures occupational therapy should incorporate into their assessment of DMC. The study was completed over four phases to address the study objectives which were:

1. To examine the extent to which occupational therapists in Ireland are currently involved in the formal assessment of DMC within their practice
2. To explore occupational therapists' awareness of, and attitudes towards recent legislation regarding DMC and the potential implications of this legislation for their practice
3. To examine current international practice in the area of DMC assessment of older adults for independent living through a scoping review
4. To explore factors influencing occupational therapist's practices in DMC assessment of older adults in relation to independent living
5. To identify assessment protocol and procedures for occupational therapists in Ireland that address DMC for independent living of older adults

The study was designed as a mixed methods study, with an exploratory focus, and involved three phases of empirical data collection and a scoping review to effectively address the study aims. Phase

one was an online survey to gather an overview of occupational therapists' current engagement in DMC assessment in clinical practice. The second phase of research involved a scoping review which focused on international and multidisciplinary DMC assessment practices concerning older adults' DMC for IL. Phase three comprised focus groups with occupational therapists who work with older adults in Ireland, to explore their experiences of assessment of DMC for IL and to explore their perceptions of the impact of recently enacted Irish DMC legislation. Phase four entailed a consensus formation meeting with occupational therapists with relevant experience in working with older adults and contributing to the assessment of their DMC for IL in an Irish context. The aim of this phase of the study was to form a consensus on occupational therapy involvement in DMC assessment, specifically to outline triggers that would indicate a DMC assessment was warranted; relevant components that should be included in an occupational therapy assessment to inform DMC assessment for IL; assessment methods to incorporate the person's will and preference into the assessment process and what practical strategies occupational therapists should employ to enhance DMC assessment. The main findings from all three empirical data collection phases will be discussed collectively in this chapter within the context of the study objectives outlined above and in relation to existing research and scholarly debate as presented in both the literature review and the scoping review.

Although the process of assessing DMC has attracted recent attention in practice and research, this is the first piece of comprehensive research exploring how occupational therapists contribute to DMC assessment in Ireland. This area of occupational therapy practice has received little attention in the research to date internationally, and this study was designed with the intent of gaining insight to this developing practice area in a manner that was appropriate and sensitive to the context of current occupational therapy practice in Ireland. While the findings are reflective of the Irish context of practice, they also have international implications and provide some insights and findings that further expand issues identified in the emerging international literature on DMC for IL.

The study findings regarding the clinical context of occupational therapy's contribution to DMC assessment, which gives the rationale for the study's focus on older adults and IL, will be discussed first. The role of occupational therapy in assessing and supporting DMC will then be discussed and study findings will be situated within the existing knowledge base. Factors affecting occupational therapy's input in this multidisciplinary area will be discussed. Study findings will then be considered with regard to the potential future contribution and scope of the role of occupational therapy within this new multidisciplinary area of practice. The strengths and limitations of the overall study will be discussed. Finally, the study findings will be considered in terms of practice implications for occupational therapists as well as their significance for future research.

8.2 Clinical context of occupational therapy's contribution to DMC assessment

An initial aim of the current study was to establish if occupational therapists were involved in DMC assessment and if so, to ascertain which client groups' DMC they assessed and what domains of DMC they assessed. In addressing this aim, the study findings provide the clinical context of current occupational therapy practice relating to DMC in Ireland.

8.2.1 Client group

Findings from the first phase of this study indicated that the occupational therapists surveyed were more likely to be involved in DMC assessments if they worked with older adults. Typically, this older adult client group included persons who have a diagnosis of stroke or who have cognitive impairment, such as dementia. Previous studies on HSCPs' experiences of and involvement in DMC assessment have focused on assessments for people with learning disabilities and those with mental health conditions (e.g., Curley et al., 2019a; 2019b; Ramasubramanian et al., 2011). However, in the first phase of the current study involving occupational therapists only, it was the occupational therapists who were working with older adults that were more likely to be involved in DMC assessment, whereas the therapists working with people with intellectual disability and people with mental health conditions were less likely to be carry out DMC assessments. This finding may be reflective of the professional roles of the majority of occupational therapists who responded to this study, who were mainly employed in hospital and community-based settings. This finding, along with the demographic trends of an increasing older population, provided the rationale for this study's focus on the DMC assessment process with older people in subsequent phases of the study.

8.2.2 Domain of DMC occupational therapists assess: Independent living

As previously discussed, Moye and Marson (2007) identified at least eight categories of DMC requiring assessment among older adults: independent living, financial management, driving, consent to treatment, sexual consent, research consent, voting and testamentary consent. To date, most published research on older adult's DMC has predominantly focussed on DMC assessment for medical treatment, research participation and financial decision making among older adults (e.g. Evans et al., 2020; Gilbert et al., 2017; Marson et al., 2000; Moye et al., 2004). However, the occupational therapists in this study who worked with older adults, regardless of whether they worked in hospital or community settings, overwhelmingly identified IL as the domain of DMC they were most likely to assess and reported they were less likely to be involved in these other domains as identified by Moye and Marson. They reported frequently contributing to DMC assessment of older adults for decisions relating to older persons' discharge destinations following treatment or rehabilitation, including decisions relating to options for continuing to live at home, transitioning to

residential care and acceptance of recommended care packages, including adaptive equipment and/or support services. This finding is consistent with previous studies in other jurisdictions that recognised occupational therapists as HSCPs who have a remit in the assessment of DMC for IL (e.g., Emmett et al., 2013; Jayes et al., 2017; 2020; Scott et al., 2020). However, in the existing literature little detail regarding the role or practice of occupational therapists is provided, other than acknowledgment of occupational therapists' involvement in assessment of DMC for IL.

Occupational therapists in this study spoke about how their philosophy of practice and training in occupational theories and models aligns well with DMC legislation and best practice approaches to DMC assessment in the literature. As occupational therapists seek to understand who the older person is; what occupations or activities the older person wants, needs or is expected to do; and where the older person does these activities (AOTA, 2016), participants reported that a thorough and comprehensive occupational therapy assessment is congruent with a DMC assessment for IL. Given occupational therapists have a key role to play in the assessment of, and provision of treatment interventions to facilitate, continued or enhanced performance in activities of daily living (AOTA, 2016; Darzins, 2010), it is not surprising that occupational therapists would consider themselves as having a role to play in assessment of DMC for IL. Supporting functional ability and promoting continued participation in valued daily activities and life roles associated with IL is a key domain of occupational therapy practice, therefore it is also not surprising that other HSCPs would recognise the occupational therapist's role in DMC assessment for IL. However, assessment of functional performance of IL tasks is not the same as assessing DMC for IL. A person's functional ability to execute IL tasks is different to their DMC for IL (Naik et al., 2008a). Information gathered by occupational therapists in their assessment of and intervention with clients typically includes information about the person's past and present living arrangements, their current and future care needs, and supports available to meet those needs. These same issues have also been identified as underlying requirements in DMC assessment for IL (Emmett et al., 2013). Therefore, the domain of DMC for IL was focus of the current study not only as there is a paucity of research but because it is most relevant to occupational therapy practice.

8.3 Occupational therapy's multicomponent approach to DMC assessment for IL

Having established that occupational therapists are involved in DMC assessment of older adults for IL, findings from this study provide insights into the domain and purview of occupational therapy practice in this area. As DMC for IL is a broad domain encompassing multiple life skills and everyday tasks (Naik et al., 2008b), occupational therapists in this study were aware of the multifaceted nature of DMC for IL and advocated for a multicomponent approach to ensure a comprehensive assessment of the various and complex issues which must be considered in decision-making for IL.

A multipronged approach to DMC assessment was consistently advocated by occupational therapists who participated in the survey, focus groups and NGT meeting, in line with the findings from the previous research cited in the scoping review. Similar to previous recommendations (Brindles and Holmes, 2005; Moberg and Rick, 2008; Sinclair et al., 2019), occupational therapists in this study recommended this multicomponent assessment process include a detailed clinical interview, assessments of the older person's cognitive and functional performance, the physical and social environment in question, along with values and preferences of the person. In the current study, participants reported that a well-constructed initial occupational therapy assessment could provide much of the relevant information required to build a picture of the older person's DMC for IL, such as the older person's previous or current living arrangements, their understanding of their present and future care needs, and their goals and preferences regarding IL.

In many ways, the approach to assessing DMC as set out in legislation might appear to be quite straightforward, in that it requires the person is able to understand, retain and use relevant information and communicate their decision by whatever means. However, while participants did not dispute this, they reported that DMC assessment was a much more nuanced and complex process and difficulties frequently arise due to the delicate balance of minimising risk and maximising autonomy of the older person. Additionally, the unique needs and values of the person must be addressed alongside concerns from other stakeholders, making determination of DMC for IL a very complex task. Decision-making about which occupations to engage in involves more than a weighing up of available or pre-existing options, but is a complex process encompassing personal motivations, personality and environmental factors (Parnell et al., 2019). By extension, decision-making for IL requires consideration of how well the person can meet the everyday demands associated with living in their physical and social environment, along with less easily defined preferences and values. Therefore, occupational therapists in the current study stressed that accurate DMC assessment requires more than a brief interview, in order to ascertain knowledge of the person, their social situation and cultural values, similar to recommendations from Brindles and Holmes (2005). They recommended a multicomponent approach, with consultation with caregivers or family members and other key stakeholders.

Occupational therapists in this study reported employing a variety of formal and informal assessment methods to inform DMC assessment for IL, as has been advocated in the literature (Aldhous et al., 2014; Jayes et al., 2017). Occupational therapists in this study advocated for a strengths-based approach to DMC assessment, emphasising a focus on what the person can do, rather than what the person cannot do, when assessing DMC. They also asserted that DMC assessments should empower older people to participate to their ability rather than be used to remove decision-making opportunities from older people with DMC difficulties. This approach to DMC assessment and

support is aligned with the call for DMC assessments to move beyond measurement of impaired abilities and focus on the supports needed to enhance individual's strengths rather than deficits (Flynn and Arstein-Kerslake, 2014; Seyfried et al., 2013). A pre-requisite to supporting a person in making a decision is to ensure the availability of accessible, appropriate and accurate information on their options (Darzins and Browne, 2018). Occupational therapists in this study offered a range of practical strategies to optimise DMC assessment of older people, similar to previously identified suggestions in the interprofessional literature (BPS, 2019; Moye et al., 2006). Many of these are generic strategies, that any HSCP would typically employ when assessing an older person and include setting up a quiet, private assessment environment, employing clear and accessible communication approaches and allowing sufficient time. However, in providing older people with opportunities to meaningfully engage in the decision-making process for IL, occupational therapists in this study recommended older people may need individualised information specific to the options available to enable them to understand the relevance and consequences for their life or situation, similar to the literature (Alzheimer's Europe, 2020).

Wade (2019) asserts that in any particular situation, a person's DMC will vary as their strengths and weaknesses will vary, which makes it impossible that any one standardised test could determine a person's DMC, meaning that ultimately DMC assessment is a professional judgement. Therefore, for decisions relating to IL, the thorough and comprehensive assessment and information-gathering approach that occupational therapists adopt is important to inform that clinical judgement and also to enable the person to engage in the decision-making process. As recognised in the literature, IL is a broad domain of DMC, requiring more than cognitive skills (Moye and Marson, 2007; Naik et al., 2008a), and it encompasses multiple activities of daily living (ADLs), thus this clear recommendation from occupational therapists in the current study for a multipronged approach to assessment is not surprising. Occupational therapists in the NGT agreed consensus on many components of occupational therapy assessments and interventions that should be used to inform DMC assessment of older people for IL, which include assessing the older person's cognition, their function and the environment in question. They also agreed consensus on how to establish and include the older person's will and preference in the DMC assessment process. Each of these components will be discussed in line with relevant literature, along with consideration for how to enhance this process.

8.3.1 Assessment of cognition

Decision-making is underpinned by a range of cognitive skills that enable the person to consider available options, the possible consequences of different options, and to plan a course of action accordingly (Suleman and Kim, 2015; Ganzini et al., 2004). Additionally, impairment of cognition is associated with difficulties performing daily activities and thus is frequently assessed by occupational

therapists (Toth et al., 2021). Therefore, it is not surprising that in this study, participants agreed strong consensus on cognitive assessment as a key component of occupational therapy practice that may inform assessment of and support of older adults' DMC for IL, as cognition is an underlying component in functional performance of ADL tasks and also an important underlying component of DMC. Occupational therapists participating in all three phases of data collection referred to cognitive assessment as a critical component of DMC assessment for IL, similar to as has been suggested in the literature (Bourgeois et al., 2017; Brindle & Holmes, 2005; Carrese, 2006; Cooney et al., 2004; Feng et al., 2017; Jayes et al., 2017; John et al., 2020; Mills & Naik, 2017; Moye & Braun, 2010; Naik, 2017; Naik et al., 2010; Naik et al., 2008a; Skelton et al., 2010).

Occupational therapists in the current study identified the assessment of several components of cognition as relevant during the process of trying to establish a person's DMC for IL. Areas of cognition such as memory, attention and orientation have been highlighted as relevant when assessing DMC (Naik et al., 2010), and it is evident from the reported assessment tools used by therapists in the current study that these components of cognition are incorporated into their practice and contribute to the establishment of the person's DMC. Therapists reported frequent use of standardised cognitive screening tools such as the Montreal Cognitive assessment (MoCA; Nasreddine et al., 2005), Addenbrooke's Cognitive Examination (ACE-III; So et al., 2018), Mini Mental State Examination (MMSE; Folstein et al., 1975) and Rivermead Behavioural Memory Test (RMBT; Wilson et al., 1989) to assess these cognitive skills and inform DMC assessments. In addition, occupational therapists in the current study specifically identified the importance of executive function (including insight, judgment, planning and self-awareness) as a key consideration in assessing cognitive function when trying to establish the person's DMC for IL. Similar emphasis on executive function as a component of DMC assessment has been identified in the literature (Clionsky et al., 2016). However, it is perhaps more challenging to assess elements of executive function in clinical practice and standardised screening tools to assess executive functions in relation to DMC are less well developed, requiring a more holistic approach to this assessment. Concern has been raised about occupational therapists' tendency to use impairment-focused standardised assessments rather than consider occupational performance when assessing DMC (Usher and Stapleton, 2018). However, a more holistic approach to DMC assessment was highlighted in the current study, where occupational therapists reporting using standardised cognitive screening tools alongside functional observation, interviews with the patient and relevant informants, and discussion among relevant members of the MDT. While most occupational therapists in the current study reported the inclusion of standardised cognitive screening tools as part of their DMC assessment, at each phase of data collection, occupational therapists in this study consistently emphasised that reliance on standardised cognitive screens was not sufficient to determine DMC for IL and they would not base

their judgment regarding the older person's DMC on scores from standardised cognitive screening tools.

Occupational therapists in this study strongly recommended a functional-cognitive evaluation approach, which is indicative of practice that has evolved in line with a growing criticism that standard cognitive assessments lack ecological validity and do not adequately address the dynamic interaction between cognitive, motor and social skills, activity demands and activity contexts (Ossher et al., 2013; Romero-Ayuso et al., 2021), as is required when considering the impact of cognition on DMC for IL. Occupational therapists believe that cognitive function is best understood within the context of performing activities of daily living, as people with cognitive impairment often compensate for deficits by utilising other skills or aids. Models of cognitive-functional evaluation have been proposed by occupational therapy scholars and such approaches typically include patient report, collateral report, occupation-based assessment and cognitive screening, allowing the occupational therapist to make objective clinical judgment about function, cognition and safety (Erez and Katz, 2018; Giles et al., 2020; Zilbershlag and Josman, 2019). Many occupational therapists have incorporated these existing models into practice as evidenced in the current study and the approach to DMC assessment that occupational therapists reported adopting. However, occupational therapists in this study also reported that other HSCPs have a tendency to request and over-rely on cognitive screening results to inform DMC assessment and discharge recommendations, reflective of prevalent models of care in many clinical settings which emphasise efficiency and rapid discharge.

Occupational therapists in this study were keen to stress that they understood cognition and capacity as distinct, though related, concepts. Although cognition was understood as an important underlying component that may potentially impact on the older person's DMC, scores on cognitive tests do not equate to the presence or absence of DMC. Occupational therapists conveyed understanding that the standardised cognitive screening tools used to assess underlying cognitive components were not designed to assess DMC and therefore should not be used in isolation to determine DMC. While cognitive screening tools are used to monitor changes in cognitive status and identify cognitive strengths and weaknesses affecting occupational performance (Radomski and Morrison, 2014), occupational therapists in this study asserted that DMC cannot be determined solely on the basis of cognitive assessments which do not capture whether the person can understand, reason, appreciate and make and communicate a particular decision in a given situation, as required in the recent Irish DMC legislation. Some participants expressed concern that the results from cognitive screens they had completed may sometimes be improperly used as a determination of the older person's DMC and reported emphasising findings from the cognitive functional evaluation to their MDT colleagues.

8.3.2 Assessment of function

There was unanimous agreement among occupational therapists that overall DMC assessment for IL should include assessment of the older person's functional skills and abilities to perform daily living tasks, relevant to the person and their home and community living circumstances. Occupational therapists discussed the importance of assessing performance of basic ADLs, such as washing, dressing, grooming and eating, and more complex, instrumental ADLs, such as management of the living environment, shopping, medication management and paying bills. They recommended the use of standardised functional assessments, structured observations and gathering self-report and collateral reports in order to build a comprehensive picture of the older person's DMC for IL.

The contribution of occupational therapists to assessing functional performance as part of DMC assessment was previously acknowledged in some multidisciplinary DMC literature (Emmett et al., 2013; Jayes et al., 2017; 2020; Scott et al., 2020), however this research provided limited detail of their input. Occupational therapists in this study provided more detailed accounts of how they utilise functional assessments to inform DMC assessment. Occupational therapists in this study strongly emphasised need for functional assessments which are more ecologically valid. Participants reported they routinely assess older adults' functional skills and that they draw on a range of standardised assessment tools such as the Assessment of Motor and Process Skills (AMPS; Fisher and Jones, 2010) and Kettle Test (Hartman-Maeir, Armon, & Katz, 2005). Occupational therapists in this study reported that involving the older person in these functional evaluations allows the older person opportunity to self-evaluate their own abilities and challenges. By using functional tasks, the occupational therapist can provide concrete, tangible information to enable the older person build insight to their capabilities, highlight areas of difficulty and problem solve around potential risks through discussion and feedback. Occupational therapists in this study described how this process allows the older person's DMC to be supported, as they have better understanding of their own situation and needs and therefore can make more informed decisions about their IL preferences.

Findings from this study recommend incorporating a subjective and objective approach to functional assessment, whereby the occupational therapist seeks self-report accounts through interview and functional observations of relevant ADLs. This is consistent with recommendations drawn from the scoping review literature (John et al., 2020; Skelton et al., 2010) and recognises that older people may not accurately account for their own skills and needs (Schreiber et al., 2018). Research suggests that older people with cognitive decline and executive dysfunction often lack the metacognitive skills or awareness of their deficits which further compromises their functional abilities and decision-making (Zilbershlag and Josman, 2019). Equally, as highlighted by occupational therapists in this study, the use of direct observation in combination with structured interviews and self-report and

informant scales, allows the older people with cognitive impairment to demonstrate how they compensate for deficits in executive functional and memory with other intact cognitive skills and by utilising compensatory aids. Participants in this study also reported that clients may be reluctant to admit anxiety about their changed abilities or about returning home for fear they will not be allowed to return home, which can then be perceived as them having reduced insight. This tendency to underreport concerns was also observed by Durocher and Gibson (2010), who attribute it to the power differential between clients and HSCPs. This reluctance to openly discuss abilities and anxieties can further complicate the balancing of safety concerns and respect for autonomous choice. It highlights the need for clear and open communication around DMC assessment processes and potential implications to allow optimal participation by the older person.

8.3.3 Assessment of the home environment

All contemporary occupational therapy models draw attention to the social and physical environment as the context for occupational performance and as a factor that can influence peoples' experiences of health and participation (Law et al., 1996; Polatajko et al., 2013; Taylor, 2017). Therefore, where possible, occupational therapists may conduct their assessments in the person's home or relevant community setting in order to identify facilitators and barriers in the person's environment. Accordingly, pre-discharge home visits have become an important part of hospital-based occupational therapy practice internationally, to allow comprehensive assessment and to optimise function, participation and safety (Davis and McClure, 2019; Godfrey et al., 2019). Home assessment can lead to greater adherence to recommendations and reduced hospital readmissions (Lockwood et al., 2020). Beyond discharge-planning, home-based assessments of older people can be used to identify risks such as falls, malnutrition, polypharmacy and cognitive impairment (Fjell et al., 2018). Occupational therapists in primary care and community-based services usually base their work in the client's own environment, so they usually conduct their assessments and interventions in the older person's home (Bolt et al., 2019).

Occupational therapists in this study strongly agreed that assessment of the older person's home, as the IL environment, is a key component of occupational therapy assessment which contributes crucial and unique insights to overall DMC assessment for IL. Occupational therapists reported that their assessment of the physical and social aspects of the home environment, alongside the older person's functional performance within their own environment, allowed the older person's abilities to be more accurately evaluated. Similarly, occupational therapists reported that using home-based assessments can be used to increase the older person's own awareness of their abilities and potential risks. The older person can also trial aids, equipment and environmental modifications to enhance their functional abilities and address risks in their home environment.

Findings from the scoping review highlighted the integration of home environment assessment into DMC assessment requires some care to ensure that it does not prompt HSCPs to adopt an outcome-based approach to DMC assessment. This is particularly important where a person may perform poorly in a home-based assessment or where the occupational therapist judged the home environment to be unsuitable to the older person's needs. Both of these issues could lead to an outcome approach in evaluating DMC, whereby the older person's desire to remain at home as their preferred IL choice could be deemed to be 'unwise'. Rather, as highlighted by participants in this study, the information gleaned from a home-based assessment should enhance understanding of the older person's values, habits and preferences and allow all possible risks *and* benefits of IL be considered. Assessment of the home environment is part of the relevant information that applies to the person's situation, which they must show ability to understand, appreciate and weigh up in making a decision. Stewart et al. (2005) proposed routine use of 'trial discharges', to enhance a person's insight into their ability to manage at home and subsequently to make an informed decision regarding IL. Occupational therapists in the current study highlighted how a home-based assessment may allow the older person to reflect on their ability and performance which may enable them to explore seemingly abstract IL options, and the therapist then uses this information to support the older person to make informed IL decisions.

However, as highlighted in focus group discussions, due to time constraints and staffing pressures, hospital-based occupational therapists do not always have sufficient time to conduct home-based assessments. This sub-optimal reality of practice requires further attention as the participants in this study recognised home-based assessment as a significant and unique contribution occupational therapy offers to DMC assessment for IL. Occupational therapists are the only HSCPs trained in assessment of both the physical and social environment. Additionally, they have a range of assessment tools to draw on to help them identify aspects of the environment which support and inhibit the person's occupational engagement (Chui et al., 2006; Letts et al., 1998; Stark et al., 2010). Some of the publications in the scoping review supported this view that occupational therapist's evaluation of the older person's environment, or their functioning within their environment, provides valuable insight to informing judgments about the older person's functional ability to weigh things up, their cultural background, preferences and values and their potential vulnerability to risks associated with IL (Emmett et al., 2013; Feng et al., 2017; Naik, 2017). Occupational therapists' understanding of how the environment restricts or supports occupational performance and their skills in systematically evaluating the physical, social and cultural environment affords the profession an opportunity to offer a distinct contribution to DMC assessment for IL.

8.3.4 Establishing will and preference

Despite its centrality in legislation and policy, commentary in the literature suggests poor interdisciplinary understandings of will and preference (Carney et al., 2019). They suggest the concept of will and preference is not fully understood as a guiding principle for DMC assessment and this lack of understanding may undermine its execution in practice. Contrary to these concerns, occupational therapists in this study were aware that the older person's will and preferences should be central in assessing and supporting DMC for IL and they considered that they had a good understanding of the meaning of will and preference. They also reported a strong commitment to person-centred care and participants in the focus groups and NGT spoke of the importance of exploring the older person's values and goals at initial interview and throughout the occupational therapy process, which would inform assessment of DMC for IL.

Participants were in agreement about the need to ascertain the older person's values and preferences in DMC assessment, similar to findings from the scoping review (Clionsky et al., 2016; Feng et al., 2017; Moye & Braun, 2010; Schreiber et al., 2018). However, as observed in the scoping review, despite growing appreciation for considering the person's values and preferences, there is little information available in the literature on how to gather this information. A novel finding of this study is the consensus achieved on how to ensure the older persons' will and preference is established and integrated into the DMC assessment process.

Person-centred care principles are intrinsically linked to human rights, autonomy and self-determination (Phelan and Rickard-Clarke, 2019). Therefore, person-centred care is central to DMC assessment and support. Person-centred care, or client-centred practice as it is frequently referred to in occupational therapy literature, is long considered a key component of occupational therapy practice. With its emphasis on collaborative approaches, shared decision-making, respecting and valuing client's contributions (Mroz et al., 2015), it is not surprising that in adopting a person-centred approach, occupational therapy practice encompasses examination of the person's will and preferences. Occupational therapists who participated in the NGT strongly recommended explicit exploration of the older person's will and preference through interview to tease out the values that underlie the older person's preferences for specific living arrangements. Occupational therapists in this study recommended asking direct questions about what is most important about where the person lives, what personal activities are important for the person to do at home, and what works well about their current living situation. This is similar to the recommendation from Feng et al. (2017) that the DMC assessment for IL should include asking questions such as 'What makes your home a home?' in order to ensure that HSCPs' recommendations are consistent with the person's wishes.

Alignment of care with an individual's values is central to person-centred care and goal-setting practices, which are widely subscribed to in healthcare (Kivelitz et al., 2021; Molnar et al., 2017;

Moye et al., 2021; Tinetti et al., 2017; van Haitsma et al., 2020). However, research suggests that eliciting and documenting older people's personal values as part of routine clinical interactions is not commonly undertaken by HSCPs, despite it being both practical and feasible (Naik et al., 2016). Nonetheless, identification of older people's priorities as part of the DMC assessment process is gaining more attention and the use of structured tools is recommended (Moye et al., 2021; Naik et al., 2018). There was majority agreement among occupational therapists in the NGT about use of an occupational profile to ensure the older persons' will and preference is considered in the DMC assessment for IL. An occupational profile is a summary of a client's life history and experiences, their values and interests, their roles and patterns of daily living, and relevant contexts (AOTA, 2020). Occupational therapists may use an established template, such as the AOTA's Occupational Profile (AOTA, 2017) or a locally developed service-specific template to collect the information and document the client's priorities and desired outcomes. There was also majority agreement among occupational therapists at the NGT about the need to allow time to establish the older person's will and preference. The occupational profile information is routinely collected by the occupational therapist over multiple sessions, through both formal and informal interview techniques and conversations to ensure a person-centred approach in the occupational therapists' evaluation, intervention planning, intervention implementation, and discharge planning. Thus, a well-constructed and thorough occupational therapy process of assessment, intervention, feedback and discussion should address the older person's will and preference for IL. That occupational therapists are explicitly identifying and documenting their clients' will and preference as part of routine practice is of importance in ensuring DMC assessment for IL is consistent with legislation. This also suggests that the implementation of recent Irish DMC legislation, which places central importance on the person's will and preference, may not present acute challenges to occupational therapists who, in gathering information about the older person's priorities and desired outcomes, are already practicing in a manner that aligns with a key principle of the Assisted Decision Making (Capacity) Act. However, while person-centred care has become dominant in healthcare, it is not always operationalised in practice. Although it is generally easy for occupational therapists to agree with 'respecting' and 'enabling' clients, and supporting 'patient autonomy', the interpretation and commitment to these values in real-world situations varies (Thomas et al., 2019). Exclusion of older people from decision-making processes is a significant finding from this study. Although it may not be surprising, as it has been reported in the literature as an issue (Donnelly et al., 2018; Ekdahl et al., 2012; Rhynas et al., 2018), it does require urgent attention and change in HSCPs' practices in order to ensure compliance with recent DMC legislation. During focus group discussions, some occupational therapists reported that older people were not involved in care planning meetings and some also described incidents of coercion where older people were purposely misinformed about their admission to long-term care facilities. These accounts imply that current DMC practices may be

incongruent with previously espoused beliefs in person-centred care. This finding also supports the concern that despite professional rhetoric about commitment to person-centred care, older people's priorities and preferences are frequently overlooked or not incorporated into routine clinical practice (Naik et al., 2016; 2018). Occupational therapists in this study achieved strong consensus about the importance of involving the older person through the whole DMC assessment process. Irrespective of the person's DMC, participants recommended older adults should be included in the decision-making process and have their views heard and options explained.

Furthermore, participants in this study also raised concerns about the limited IL options available to older people in Ireland which do not support person-centred approaches and are inflexible and insufficient to support the older person's will and preferences. Similarly, Manthorpe and Samsi (2016) criticised services for older people which reduce, rather than promote, independence, reduce the older person's community connections and potentially stigmatise older people. Hicks et al. (2012) argued that respecting the older person's experiential expertise is crucial, especially when the limited available options do not meet the range of needs of the older person. Therefore, in an Irish context of limited IL options, occupational therapists highlighted the importance of engaging older adults and their families in decision-making. They advocated for a relational approach by recognising the older person's values, preferences and life circumstances and considering the wider social contexts in which decisions are made. There was also majority agreement among occupational therapists at the NGT about presenting the older person's expressed preferences to their family and the wider MDT.

Although there are concerns highlighted in the literature that the meaning of 'will and preference' in relation to DMC can seem abstract and difficult to establish, occupational therapists in this study describe making explicit efforts to purposively establish the persons will and preference throughout their interviews, assessments and interventions. Their occupational therapy philosophy of enabling the persons interests and values aligns well with the emphasis on will and preference in recent DMC legislation, and therefore occupational therapists may be well-positioned for a potential leadership role in establishing the older person's will and preference in DMC assessments for IL.

8.3.5 Risk-benefit assessment

Concepts of risk assessment and management were identified in this study and in the scoping review as part of the DMC assessment process regarding IL (Emmett et al., 2013; Moye and Braun, 2010). However, in the NGT no overall consensus was agreed among occupational therapists on its importance and there was no recommendation on how to undertake risk assessment arising from the scoping review. This may relate to other components such as function, cognition and

environmental assessment requiring more attention in clinical practice, thus being higher ranked items in NGT and also because risk assessment is an integral part of the assessment of these other components. There is no doubt that concern for risk is a major point of contention in occupational therapists' practice in this area. In the focus groups, occupational therapists identified HSCPs' concerns for risk as the primary trigger for DMC assessment, as is also acknowledged in the literature (Carrese, 2006; Cooney et al., 2004; Darzins, 2010; Hicks et al., 2012; Jayes et al., 2017; Mackenzie et al., 2008; Moye & Braun, 2010; Schreiber et al., 2018; Stewart et al., 2005). Findings from this study confer findings from the literature that report the concept of risk is pervasive in discourse around discharge decisions for older adults (Rhynas et al., 2018; Stockwell-Smith et al., 2018).

Occupational therapists report that in practice, the dominant view of older person's decision-making about IL among HSCPs involves objective and rational evaluation of risks and consequences. Because there is potential for adverse outcomes, IL choices which entail risk-taking are viewed negatively and discouraged, often without much consideration for the values, meanings, motivations and benefits of allowing older people pursue IL options which support their engagement in personally relevant activities. Previous research highlights that HSCPs, older people and their families often hold diverse views about risk-taking which may not necessarily align (Li et al., 2021) and therefore, decisions about discharge and long-term care can be distressing for older people, their families and HSCPs, due to their different views (Denson et al., 2013). Occupational therapists in this study highlighted that having multiple perspectives on IL, from the person, family and various HSCPs, can lead to more responsive and less restrictive risk management. Furthermore, exploration of the older person's life experiences, occupational patterns, values and preferences can inform the evaluation of risk. This finding is in keeping with the literature on supporting shared decision-making, which has highlighted the importance of considering how to best manage these divergent perspectives between HSCPs, family members and older people, to ensure the views of those stakeholders with the least power (often the older person) are not disregarded (Durocher et al., 2017; Ibrahim & Davis, 2013; Marsh and Kelly, 2018).

However, occupational therapists highlighted how the conceptualisation of risk as debated by MDTs and families is often very narrow and they were very frustrated by the current dominance of risk management culture within healthcare settings and its impact on the assessment of the older person's DMC for IL. Occupational therapists in this study described paternalistic approaches where consideration for the older adult's physical safety outweighed any other aspect of wellbeing. Similar to findings from Rhynas et al. (2018), occupational therapists reported there is limited, if any, consideration for the quality-of-life risks posed by admission to nursing homes where there are potential limitations on older person's independence and lifestyle. Occupational therapists in this

study reported that the overriding focus in healthcare is to ensure patient safety through risk elimination, such as reducing risk of physical injury associated with falling. Participants recognised that this risk avoidance approach leads to presenting the older person with limited IL decision options and HSCPs' recommendations, which privilege safety rather than the person's will and preference. This can lead to increased risks to the older person's wellbeing through loss of other valued aspects of IL, whereby older adults may no longer participate in occupations from which they derive meaning, identity and self-worth. Occupational therapists stressed the importance of considering this psychological risk in addition to physical risk and safety, however, they acknowledged that this risk is not as easy to quantify or measure.

Hunt et al. (2021) highlight HSCP's tendency to emphasise the identified risk rather than the associated value, meaning or other social considerations and caution HSCPs not to overstate risk. Findings from this study highlight the need to go beyond measuring and minimising proximal and physical risk associated with IL preferences but to consider broader implications of psychological risk on wellbeing and quality of life. The need to attribute positive value to risk-taking in order to allow people exercise choice has also been highlighted in literature (Gooding, 2013; Knox et al., 2013). Findings from this study suggest occupational therapists must re-examine their values and perceptions of risk management and its integration into their DMC assessments for IL. Participants raised concerns that focus on risk avoidance and elimination in DMC assessment may lead to restrictive, disempowering IL options.

Adopting a relational approach allows all stakeholder's concerns and hopes to be explored, and for the nuances of risks and abilities to be clarified (Marsh and Kelly, 2018). However, in practice occupational therapists find this aspect of DMC assessment challenging. They highlighted that a person-centred approach to DMC assessment invariably required more time and effort, and therefore is sometimes resisted by MDT colleagues as it disrupts workflow and does not easily fit within existing service delivery models. This is similar to observations in the literature that alternative approaches to risk management may not be compatible with the models of discharge planning commonly practiced, which do not seek the older person's participation (Durocher et al., 2015; Huby et al., 2004). Participants were not satisfied with the presentation of risk as a barrier to fulfilling the IL preferences and wishes of the older person. Some occupational therapists cited use of practice resources, such as the 'Risk Enablement Process' (Royal College of Occupational Therapists [RCOT], 2018) as useful tools to guide this complex aspect of occupational therapy practice and also to influence the wider MDT's perception of risk. This guidance document prompts occupational therapists to consider the degree, nature and likelihood of risk occurring as well as the value and benefit of the person's choice, and what will be gained occupationally, physically, psychologically and socially. Occupational therapists reported it allowed the MDT to consider the strengths and skills of

the older person, and any others involved in their care, and how these might counter-balance identified risks to allow the older person to pursue their preferred IL option. Occupational therapist's utilisation of existing tools such as this allows for a more nuanced and contextualised understanding of risks and benefits in assessing and supporting older person's DMC for IL. Such approaches to framing risk within DMC assessments for IL are required if occupational therapy is to fully embrace its role and potential in this area of practice.

8.4 Factors that affect occupational therapists' engagement in assessment of DMC for IL

Within this study, occupational therapists identified a range of factors which impact on their implementation of optimal DMC assessment and support practices, as set out in legislation and policy. Many contextual influences impacted on occupational therapists' efforts to operationalise best practice in DMC assessment, including the assessment setting, interprofessional collaboration and the MDT's understanding of a functional approach to DMC assessment, the recent DMC legislation, involvement of the older person and their family in the assessment process and the availability of services. Findings also demonstrate discord between the ideal DMC assessment approaches set out in legislation and policies and the reality of undertaking this complex task in practice. The contextual factors identified in this study are important considerations for all HSCPs, who will have to develop codes of practice that align with legislation and fulfil their responsibility to enable older people to maximise and demonstrate their DMC, within the constraints of pressured health and social care settings.

8.4.1 The assessment setting

Occupational therapists working in a range of settings were involved in this study, including acute hospitals, rehabilitation settings, primary care, long-term care and community care services. Findings from this study demonstrate the impact of the care setting where occupational therapists typically work on the DMC assessment process. As assessments of older adults' DMC for IL are often triggered following an episode of illness or injury, or due to health or functional decline, they frequently occur in acute healthcare settings. Participants who worked in these settings identified a range of factors which impact on their DMC assessment practices. Occupational therapists reported experiencing time pressures due to staffing shortages and high occupancy levels, which were further compounded by administrative pressures to discharge patients. These factors undermined their DMC assessment practices, similar to barriers to DMC assessment that have been reported in previous research (Charles et al., 2017; Davies et al., 2019; Donnelly et al., 2021; Jayes et al., 2020; Sinclair et al., 2019). Furthermore, participants reported these settings may not have suitable resources to enable a thorough assessment of DMC for IL.

Occupational therapists reported that DMC assessment requires a prolonged assessment approach, preferably conducted over multiple sessions, and including home-based assessment, to enhance the older person's participation in the DMC assessment process and lead to more comprehensive assessment. Therefore, in order to adequately assess DMC for such a broad domain as IL and considering IL decision outcomes have such far reaching consequences for the older person., this study highlights the importance of allowing adequate time to complete DMC assessments, and the potential need to carry out successive assessments, if necessary. Alongside recognition of the need to allow sufficient time for information gathering to inform establishment of DMC, participants also highlighted the need to consider assessment timing, given that a person's DMC may fluctuate over the course of a day. These considerations for both time and timing have also been raised in the literature (Bourgeois et al., 2017; Clionsky et al., 2016; Hughes et al., 2015; Moye & Braun, 2010). Similar to findings from Donnelly et al. (2021), occupational therapists in the current study indicated that due to time constraints and pressures, the typical high-occupancy acute hospital environment in Ireland, where many DMC assessments often occur, is not conducive to conducting a timely and comprehensive assessment of DMC, as set out in policy, legislation and literature.

Prevalent medical models of care which underpin service delivery in these settings where DMC assessments frequently occur emphasise efficiency and rapid discharge, which can impede holistic assessment approaches. The occupational therapy practice environment in acute hospitals is often constrained by time pressures, funding shortages, high caseloads, staffing issues and delays in access to services. Occupational therapists report that owing to these factors, the assessment settings often require an efficient decision-making process. However, in circumstances where the older person's DMC must be established, more time may be required to undertake the multicomponent assessment. Yet, the ethos in acute hospital type settings may not be conducive to a comprehensive and holistic DMC assessment approach as set out in legislation, which would ideally allow the older person to explore various options for IL available to them before deciding their preferred choice or appreciating which supports best match their needs and values.

Acute hospital-based occupational therapists in this study described sub-optimal practices, where assessments often take place in a rushed manner in busy, noisy wards, where older people were not given adequate privacy, quiet space or supports to enable their decision-making. These issues identified by the occupational therapists in this study are consistent with findings emerging from other Irish research among other HSCPs (Donnelly et al., 2021; Ní Shé et al., 2020). Further issues with the physical space available in acute hospitals were identified by some occupational therapists who reported they did not have access to a functional assessment suite in their setting, where they could observe the older person perform ADLs relevant to IL, such as a meal preparation task in a kitchen environment. This inevitably limited their assessment process and hampered addressing a

significant component of DMC for IL. Nonetheless, some participants described creative approaches to overcome challenges the assessment setting posed by using facilities available within the setting, such as assessing the person undertake a shopping and money management task in the hospital shop. Overall, findings from this study add to concerns raised in other research about lack of time as a significant barrier to supporting decision-making for older people with dementia (Tarzia et al., 2015) and about the general suitability of hospital settings for DMC assessment and discussions (Donnelly et al., 2021).

However, despite these pressures, Shotwell (2019) argues that the evaluation process in hospital settings is not incompatible with occupational therapy philosophy, and occupational therapists should still focus on what the client wants to and needs to do. They assert a comprehensive occupational therapy assessment in a hospital setting should consist of an occupational profile, address performance patterns such as habits, roles and routines, assess physical, social, cultural context and environments in addition to analysis of occupational performance, and draw on cognitive and functional assessments. However, as previously discussed, many occupational therapists in this study described how, though they recognise they have a role to play, due to time and staffing pressures, it was not always feasible to undertake a comprehensive and multicomponent DMC assessment.

Therefore, participants suggested that settings with a slower pace of patient throughput, such as slow-stream rehabilitation or community-based services, allow occupational therapists and other HSCPs sufficient time to build rapport with the older person and gather information over multiple sessions and this enables more person-centred, enabling DMC assessment approaches. Occupational therapists who worked in community settings or on primary care teams and integrated care teams reported that decision-making about IL options should be addressed by HSCPs who worked in these settings, and preferably when they visited the older person at home. Participants in this study discussed the value of home-based assessment to facilitate their understanding of the older person's abilities, acknowledging that a familiar environment not only tends to facilitate improved occupational performance, but also that conducting assessments in the older person's home also shifts the power dynamic in favour of the older person. They also suggested that conducting assessments in the person's home allows better understanding of the older person's identity and life roles. This understanding is relevant to DMC assessment for IL because, as observed by Feng et al. (2017), the person's values and cultural background inform their will and preference for IL. Therefore, conducting DMC assessments in less pressurised settings and more familiar environment to the older person may allow more meaningful consideration of their will and preference in relation to IL by relevant stakeholders.

8.4.2 Interprofessional collaboration

Assessment of DMC is a complex multicomponent process involving input from several stakeholders. Traditionally the treating physician, psychiatrist, or psychologist assessed a person's DMC, and this clinical judgment may have been informed by input from the multidisciplinary team (MDT). However, recent Irish and international legislative developments, and commentary in multidisciplinary literature (e.g. Murrell and McCalla, 2016; Zuscak et al., 2016), have emphasised that DMC is a complex area and should not be viewed as the sole remit of any one healthcare profession but benefits from the knowledge and skills of various HSCPs. Irish legislation states that DMC assessment should be carried out by the HSCP with relevant expertise specific to the area of DMC under question. Reflective of this, recent national and international literature refers to nurses, occupational therapists, physicians, physiotherapists, psychiatrists, psychologists, social workers and speech and language therapists being involved in DMC assessment (Jayes et al., 2020; Donnelly et al., 2021). Some HSCPs, have emphasised their role in DMC assessment, such as speech and language pathologists who demonstrated their specialist skills in supporting people with communication difficulties like aphasia to engage in DMC assessment (Aldhous et al., 2014; McCormick et al., 2017; Suleman and Kim, 2015). While the focus of this study was on the role of occupational therapy in DMC assessment, the participants in this study emphasised that they worked as part of a multidisciplinary team, primarily engaging with physicians, nurses and social workers when assessing DMC. Similar to recommendations from literature identified in the scoping review (Jayes et al., 2017; John et al., 2020), occupational therapists in the focus groups reported that cohesive interprofessional working among HSCPs enhanced DMC assessment for IL.

Participants recognised the benefit of interprofessional collaboration among the MDT specifically in relation to DMC for IL because it is such broad and complex area. They reported it allows sharing of complementary knowledge and skills and a more comprehensive assessment, aligning with the argument from Schreiber et al. (2018), that no one HSCP could have access to the breadth of information required in relation to DMC assessment for IL. Additionally, given the complexity and weight of IL decisions, occupational therapists in this study also advocated MDT collaboration as a means to share the burden of responsibility in assessing DMC. This view is consistent with literature which promotes the importance of an MDT approach to share the burden of supporting the older person's will and preference where there are concerns about risk (Donnelly et al., 2021; Sinclair et al., 2021).

However, MDT working also raised many challenges for occupational therapists in this study. They reported that interprofessional collaboration was difficult due to lack of awareness and utilisation of occupational therapists' skills and knowledge, professional hierarchies and leadership issues, similar to other research findings (e.g. Donnelly et al., 2021). Limited understanding of the broad scope of

occupational therapy practice within health care systems has led to many occupational therapists being pigeonholed into narrow roles, such as bathing-and-dressing experts (Richards and Vallee, 2020). Although participants reported occupational therapy input was frequently sought by MDT colleagues to inform DMC assessments for IL, they indicated that some HSCPs only requested occupational therapy input in relation to the cognitive assessments they had conducted with the older person. Therefore, a limited view of occupational therapists' contributions to DMC assessment may be implied as other aspects of occupational therapy evaluations were not sought by the wider MDT.

This under-utilisation of occupational therapists' skills in DMC assessment may reflect a lack of role clarity and limited understanding of the potential scope of occupational therapy to this area of practice, which may be due to limited research and/or occupational therapy's poor professional status in medically dominated professional hierarchies. Similar to findings from this study, recent international research indicates that despite DMC legislation applying to all HSCPs and stipulating that the HSCP with relevant skills and experience conducts the DMC assessment, lack of clarity persists regarding whose role it is to complete DMC assessments (Cliff and McGraw, 2016; Manthorpe et al., 2014). Participants reported that they attempted to assert their professional contribution to DMC assessment for IL by providing further information on the older person's functional ability and physical and social environment in effort identify issues pertinent to IL to be considered by the MDT when establishing a person's DMC. Nonetheless, the findings suggest that occupational therapists currently play a more supportive role in DMC assessment rather than assuming responsibility for the determination of the older person's DMC. This is in line with findings from a recent Irish study, whereby geriatricians reported they were often the final decision-makers in assessing DMC, despite MDT input (O'Brien and Clyne, 2021). Other research findings have suggested that the choice of which HSCPs assess DMC is often be decided or assumed based on perceptions of professional hierarchy and responsibility, rather than on the basis of which HSCP has more knowledge, skill or information about the decision and the patient (Jayes et al., 2017; Ní Shé et al., 2020). If the role and remit of occupational therapists is not fully understood or recognised as suggested in this study, other HSCPs may be reluctant to relinquish DMC assessment responsibilities. This description of occupational therapists not adopting a more significant role in DMC assessment, despite recognising their own apparent skills and suitability, raises questions about their potential for leadership in this area of practice.

Previous literature suggests that occupational therapists sometimes have poor professional identity and difficulty asserting their role, particularly when there are conflicting priorities within the MDT, leading to reduced confidence and over-ruling by colleagues (Murray et al., 2015). International research has shown that occupational therapists are sometimes reluctant to express alternative

opinions to the MDT or to be seen as obstructing the discharge process and therefore conform to MDT views (Atwal and Caldwell, 2003; Hazelwood et al., 2019). Participants in this study spoke of the 'lonely place' of occupational therapy on the MDT when their views differed from those of the team, and occupational therapists did not appear to be assertive in advocating for the client's wishes. Despite reporting that their professional philosophy and practice is well-aligned with DMC legislation and that they have the requisite skills for assessment of DMC for IL, some occupational therapists in this study appeared to be reluctant to adopt a position of leadership or even to promote their own role within their teams. Additionally, participants reported that the significance and complexities of IL decisions were not always appreciated by the MDT and that the occupational therapists' efforts to promote the older person's will and preference or support their DMC was perceived by their colleagues as delaying the discharge process. A negative repercussion of this perception was reported whereby some MDT colleagues avoided involving occupational therapy in the DMC assessment process when it was perceived they would slow the process or delay discharge by promoting a more thorough and therefore time-consuming assessment process. These findings suggest the value of offering an occupational perspective of the older person in evaluating their DMC for IL is not always recognised by other HSCPs, who may inadvertently overlook the skills of occupational therapists or more concerningly, deliberately not seek their input. These issues with interprofessional collaboration precipitate ethical tensions for occupational therapists in how they approach DMC assessment for IL. Also of concern is how disempowered occupational therapists are in asserting their role and expressing their professional autonomy. MDT environments should be safe and supportive, where ethical challenges can be openly discussed, rather than where input from HSCPs is seen as slowing progress.

However, despite these challenges, some examples of cohesive MDTs which valued the role of occupational therapy and other HSCPs in the DMC assessment process were also identified in this study, across various practice settings. Some focus group participants spoke of interprofessional collaboration from initial goal-setting with the older person, right through to their discharge, and in these situations DMC assessment was seen to be optimal and person-centred. Participants described how the MDT worked together and with community services to facilitate the older person's will and preference for IL living. They reported that organisations which were committed to a person-centred care ethos were more supportive of honouring the older person's values, will and preference and ensuring the older person's participation in the decision-making process. When the MDT have a shared and holistic focus on the older person's quality of life, it is easier to undertake DMC assessment in manner that protects the rights and preferences of the older person. Some occupational therapists described how the introduction of new legislation had given them opportunity to demonstrate the increased role of occupational therapy in DMC assessment for IL. They reported the legislation had helped raise awareness of MDT input in DMC assessment and thus

supported a cultural shift among the wider MDT in their DMC assessment practices and occupational therapists felt there was more recognition and respect for their contributions. Some participants cited MDT practice initiatives that had been recently introduced, such a gradual discharge to allow the older person trial strategies and supports for IL, which would not have been considered standard practice prior to the recent enactment of DMC legislation. Some occupational therapists reported they had engaged in MDT education and others reported they had set up interprofessional working groups to review DMC assessment, which allowed HSCPs explore and communicate their relative discipline's roles.

Although legislation has highlighted that all HSCPs have a role to play in DMC assessment, tensions exist within the MDT and the role of occupational therapy in the area is not fully established. Despite occupational therapists reporting that they have significant contributions to make, they do not appear confident enough to consistently assert their role within the MDT context. Occupational therapists recognised that their philosophy is aligned to the spirit of the legislation and that recent DMC legislation affords them opportunity to promote and expand their role beyond merely contributing to DMC assessment for IL but potentially developing leadership roles in this area of practice.

8.4.3 Understanding of functional approach to DMC assessment among MDT

In terms of enhancing DMC assessment for IL, strong consensus was achieved in this study regarding the need for a consistent approach to DMC assessment across the various MDT members, and the need for locally agreed policies and procedures to be in place to guide the assessment process. However, one of the challenges encountered by occupational therapists in engaging in interprofessional collaboration in this area of practice was a lack of shared and consistent understanding of DMC as a concept and of the key principles of a functional approach to DMC assessment as set out in the legislation. This lack of a shared understanding of these concepts underlying DMC assessment among the MDT was a major barrier in adopting a collaborative approach to DMC assessment in practice.

The functional approach to assessment of decision-making requires an assessor to establish whether a person is able to understand, retain, and use or weigh relevant information in order to make a decision and then communicate a choice. Occupational therapists reported that they understood that DMC was to be assessed using a functional approach which reflected that DMC is time, issue and context specific. However, they expressed frustration that this understanding was not necessarily shared by all HSCPs across the MDT, and many of their colleagues still perceived DMC as a global, all-or-nothing concept which led to subsequent concerns among occupational therapists that if an older person was judged not to have DMC for one decision, this judgment would then be extended to many other situations. As previously discussed, the issue of conflation of cognition and DMC among

some MDT members was described as a pervasive practice issue which negatively impacted on DMC assessment practices. This persistent conflation of cognition and DMC as reported in this study reflects practice where the approach to DMC assessment is more aligned with the outdated status approach and is not aligned with the requirements of the legislation, which sets out the need to adopt a functional approach to the assessment of DMC. Furthermore, this approach to DMC perpetuates discriminatory beliefs that those with cognitive impairment do not have DMC and cannot participate in decision-making and may be why older people are sometimes excluded from care planning discussions, as reported in this study and recent Irish literature (Donnelly et al., 2018) and thus requires further attention as HSCPs attempt to implement the legislation and empower and support the older person's DMC.

The other triggers that occupational therapists identified as prompting initiation of DMC assessment may also indicate that, despite occupational therapists reporting awareness of the need to adopt a functional approach, this knowledge has not yet become embedded in practice. Occupational therapists agreed that risk was the most crucial factor in triggering DMC assessment. Safety concerns regarding an older person's IL decisions and discrepancies between the older person's perspectives and that of family members or HSCPs were reported as the most common reasons to initiate an assessment of DMC. This may imply that an outcome approach to DMC assessment prevails in practice, whereby the possible negative consequences of the older person's decision influence the judgement of whether the older person has DMC. Equally, that compliance with HSCPs' advice or recommendations was seen to indicate DMC also implies an outcome approach to evaluating DMC is frequently adopted by HSCPs, whereby an older person opting to make an 'unwise' choice may be construed as lacking DMC.

Findings from this study indicate that in order to advance DMC assessment and support older people's decision-making and practice in accordance with legislation, all HSCPs involved in their care must be aware of the principles and concepts of DMC as a starting point. A shared and robust understanding of what a functional approach to DMC assessment entails is fundamental to this. This will allow MDTs engage in critical reflection on their current practices and identification of potential strategies to enhance practice and ensure it aligns with legislation and policy, moving away from the now outdated status and outcome approaches to DMC.

8.4.4 Implementation of DMC legislation

Although findings from this study indicate an awareness among occupational therapists of recent developments in DMC legislation in Ireland, participants reported difficulties in operationalising the provisions and the spirit of the legislation into practice. Occupational therapists reported that the lag

between the enactment of the Irish legislation (in December 2015) and its anticipated full commencement (in June 2022) has led to delays in its implementation to practice. Furthermore, they reported the absence of clinical guidance on how to operationalise the legislation had led to confusion and inconsistent practice among HSCPs. This is consistent with international research which reports that implementation of legislation in other jurisdictions has been challenging for HSCPs. International literature regarding the application of legislative reform on practice in other jurisdictions has consistently found there was slow uptake of legislative implications among HSCPs and that introduction of legislation had a variable impact on practice (Hinsliff-Smith et al., 2017; Jayes et al., 2017; Scott et al., 2020; Wade and Kitzinger, 2019). In the UK, a review of the Mental Capacity Act concluded that despite mandatory training, understanding of and implementation of the Act was generally poor, and it had not been embedded into everyday practice (Hinsliff et al., 2017). Wade and Kitzinger (2019) suggest one reason for poor application of DMC legislation to practice is the lack of practical guidance. Decisions related to IL, such as moving to a nursing home, have significant and long-term consequences and require a different approach to minor day-to-day decisions and may require specific guidelines. Additionally, IL decisions would benefit from an early care-planning meeting with key stakeholders to start a process of sharing information about the person's situation and to determine the person's choices, wishes and values.

MacDonald (2010) reports that while DMC legislation makes the decision-making process more explicit, it is not sufficient in itself to produce the required changes in practice. Structural and organisational barriers to adopting a rights-based approach to work with older people, such as resource rationing, pressure from other agencies, and proceduralisation of practice, constrain development of person-centred approaches as set out in DMC legislation. This is similar to what occupational therapists in this study reported regarding the impact of contextual barriers on implementing legislation, such as the pressure to measure and manage risk and the ambivalence towards the rights of older people to participate in decision-making. Therapists reported that these issues hamper the implementation of the legislation and do not support older people's exercise of their will and preference.

In reviewing application of legislation in the UK, Boyle (2011) found some HSCPs regarded the legislation with apathy and did not regard compliance with it as a priority, which may have been due to insufficient or inadequate training to bring about change in practice. Conversely, occupational therapists in the current study demonstrated a strong commitment to enhancing their practice in this area. Participants across all phases of the study reported that they had engaged in education and training on DMC legislation where available, in effort to align their DMC assessment practices with current legislation. Some participants reported facilitating journal club discussions in effort to enhance their own and their colleagues understanding of DMC and the practical implications of the

legislative changes. Others reported they had introduced quality improvement initiatives relating to DMC in their workplaces, such as development of care pathways and flowcharts of the DMC assessment process, in effort to improve their practice in this area and to ensure it conformed with legislative requirements. While the impact of self-initiated training and education on DMC may not have translated into widespread change, it did lead to greater awareness amongst occupational therapist and a recognition of the need to change current DMC practices

Given the challenges occupational therapists experienced in asserting their professional role and influencing practice as previously discussed, such efforts to translate the legislation to practice will require careful consideration and resourcing. Factors such as HSCPs' motivation and commitment to enhance their practice in this area have not been previously explored in the DMC literature. As methods and approaches to enhance DMC assessment practices are increasingly sought, it is important to highlight that in this study occupational therapists' enthusiasm and efforts appeared to be an enabling factor which had positive influences on their DMC assessment practices. As legislation is fully commenced, HSCPs' insights to real-life practice initiatives, such those reported by occupational therapists in this study, will be crucial in addressing the cultural shift that the new DMC legislation requires and may allow more relevant and effective DMC assessment resources and tools be developed and implemented in practice.

Although the mere existence of legislation is not sufficient in itself to impact on practice changes, occupational therapists did identify emergent benefits of the enactment of DMC legislation on their approaches to DMC assessment. Some occupational therapists in this study reported that their experience of implementing the legislation was empowering, similar to reports from some HSCPs in the UK (Hinsliff et al., 2017; McDonald, 2010; Manthorpe et al., 2012). They reported that the legislation has enabled them to prioritise supporting older people to exercise their rights and therefore, it can be used to support broader cultural shifts towards rights-based care. Participants described using legislation to challenge sub-optimal DMC assessment practices among the MDT and to validate their support of positive risk-taking and advocate for the older person's wishes. Participants also reported referencing the legislation when they negotiated with family members who disagreed with HSCPs plans to support an older person's IL preferences. They used the legislation to justify discharge decisions that encompassed risk and to educate the family members on the boundaries of their influence and the rights of the older person.

8.4.5 Influence of family members

Decision-making about IL is a complex process and involves many stakeholders with a range of experiences and views. Involvement of family is key to the collaborative planning and coordination

processes of client-centred occupational therapy practice (Mroz, Pitonyak, Fogelberg, and Leland, 2015). As this study highlights, multiple perspectives from the person, family and various HSCPs are required for more responsive and less restrictive decision-making.

Provision of informal care by family members is a growing phenomenon in response to demographic trends of population ageing. Family caregivers are an important resource in providing home-based, long-term care and facilitating discharge planning (WHO, 2000), and have been described as the 'hidden healthcare team member' (Mogimi, 2007, p.272). Therefore, it is not surprising that many occupational therapists reported a high level of family caregiver involvement in DMC assessment processes, especially for clients with dementia and cognitive dysfunction. Family member involvement can make it difficult for the occupational therapist to establish the older person's will and preference. Furthermore, occupational therapists in this study highlighted how IL decisions were complicated by the need for family caregiver's buy-in to the IL decision-making outcome. Therefore, occupational therapists recommended the inclusion of family as stakeholders from early in the assessment process as they can assist or obstruct any plan to facilitate the older person's IL preferences. Occupational therapists acknowledged that family members involvement is often vital to facilitate the older person's will and preferences, particularly if the older person wishes to remain at home. Because the IL preferences and needs of the older person may be inextricably intertwined with those of other stakeholders, they reported that the views of relevant others, such as family members, cannot be ignored when exploring DMC and IL preferences.

Adopting a relational approach to DMC assessment and support requires that HSCPs consider the older person within the context of their social networks, such as their family. Involving family members in the overall decision-making process allows all stakeholders learn more about the older person's needs, values, preferences and the various options available to them, thus allowing a collaborative decision to be reached, that is closer to the person's wishes (Durocher et al., 2017; Hunt et al., 2021; Sherwin and Winsby, 2011). The inclusion of caregivers/family who know the person is especially important in supporting decision-making for those with cognitive disabilities (Douglas and Bigby, 2020). Occupational therapists in this study recognised that involving family members in decision-making has potential benefits, such as providing additional insights to the person's strengths, needs and values as well as providing additional information regarding the older person's living arrangements, potential risks and recent changes to the older person's circumstances.

However, occupational therapists in this study also reported it can be challenging to integrate divergent views of the older person and their family members about the older person's abilities for both decision-making and for IL. Family caregivers may dispute the outcomes of DMC assessment process, as they may not recognise the older person as having DMC for the specific decision in question and consequently, they have difficulty accepting the subsequent IL decisions. Participants in

this study also reported that if the older person is found to have DMC, but their preferred IL option is not supported by family, this can lead to many tensions in supporting their preference, similar to the literature (Murrell and McCalla, 2016; Sexton, 2012).

Sinclair et al. (2021) recommend knowing the person's support networks and key relationships in order to accurately interpret the person's wishes, yet also recognising that the family's agenda can be quite different. As highlighted in this study, while occupational therapy assessment may aim to prioritise the needs of the older adult, achieving the older person's goals may be significantly and sometimes negatively influenced by the perspectives and motivations of family members. This becomes problematic in agreeing IL plans when the family have differing perspectives about the needs, priorities and strengths of the older person. Participants in this study reported that well-intentioned family members often held dominant voices over that of the older person in IL decisions, particularly in relation to admission to nursing homes, whereby family's request for nursing home care superseded the older person's preference regarding this option, similar to other research findings (Rhynas et al., 2018). Additionally, participants reported that incidents of undue influence or suspected manipulation of the older person can arise in negotiating IL decisions, leading to the older person being coerced into accepting an option that was not their preferred choice, such as entering a nursing home.

Some participants reported that when family members disagree with DMC assessment outcome and the subsequent IL decision, they have threatened litigation against the HSCP, for example if the older person is to return home and sustain an injury from a fall. Furthermore, participants raised concerns that consequently HSCPs' practices were often focused on protecting themselves from litigation and their primary concerns in DMC assessment relate to fear of liability or public condemnation, rather than supporting the older person's choices or needs as laid out in the legislation. This may be why HSCPs privilege their own or family members opinions regarding IL options for the older person and encourage the older person to accept admission to a nursing home on the basis of them being safe there.

Recent DMC legislation advocates for the full participation of the person in decision-making process. Although occupational therapists in the NGT achieved strong consensus on the need to involve the older person throughout the DMC assessment process, during focus group discussion they described incidents where older people were alienated from decision-making processes or fully excluded from care-planning meetings. This supports the view of Sherwin and Winsby (2011) that in healthcare settings where older adults are perceived as being vulnerable or dependent, their autonomy is often undermined or limited. This aspect of practice requires attention as it is in direct conflict with the DMC approaches set out in legislation and policy which enshrine the rights of the older person to be involved in decision-making about issues relation to their own lives, regardless of their DMC. Whilst

participants recognised that family cannot be unwittingly enlisted to support discharge plans, they were also frustrated by incidents where the family attempted to negotiate IL decisions to suit the family's needs, without consideration for the older person's will and preference. Occupational therapists indicated that effective care planning for IL decisions often involves reconciliation of the older person and family member's needs and preferences. Therefore, they recommended early involvement of all relevant stakeholders to fully explore all parties' preferences and concerns. However, the dominant focus on risk reduction and safety in healthcare, as previously discussed, may explain occupational therapist's accounts of how HSCPs sometimes privileged their own expertise and family members concerns over the perspectives of the older adults in decision-making about IL.

While occupational therapists in this study expressed frustration at the dominance of family members voices over older person's expressed preferences and their potential influence on the outcome DMC assessment, especially when they threatened litigation, however they also recognised caregiving burdens borne by family members. In Ireland, current healthcare service provision has been criticised for over-relying on informal family caregivers (Hanly and Sheerin, 2017). Participants were sympathetic to situations where family members have difficulty supporting an older person's will and preference to return home, in the absence of community support services. Participants recognised that due to inadequate public services, family members often provide care themselves or privately fund services to facilitate the IL preferences of the older person. Findings from this study highlight the complex balancing act occupational therapists and other HSCPs face in eliciting family caregiver views but not letting their voice dominate discussions about the older adults' IL options and preferences. This requires clear communication with family members to ensure the person's will and preference is heard and the supported (Sinclair et al., 2021). Some participants reported using the DMC legislation with family members to help the family members recognise the older person's rights in decision-making. They reported drawing on the legislation to advocate for the older person's will and preference and to highlight the occupational therapists' professional responsibilities in supporting them.

8.5 Future developments for occupational therapy in DMC assessment for IL

Findings from this study illuminate the challenging realities of DMC assessment for IL as experienced by occupational therapists practicing in Ireland. Occupational therapists in this study described how DMC assessment for IL raises many dilemmas and issues as they attempt to align the professional philosophies of their practice with DMC legislative requirements and reconcile potentially conflicting organisational priorities. These findings regarding contextual issues affecting implementation of DMC legislation substantiate other research which demonstrates the challenges HSCPs face in

simultaneously promoting service-user autonomy, acting therapeutically towards service-users and protecting them from harm (Jayes et al., 2019; Murrell and McCalla, 2016; Ratcliff and Chapman, 2016). Furthermore, within the context of occupational therapists' professional registration status, the wording used by CORU in the Code of Professional Conduct and Ethics (OTRB, 2019) may also raise issues for clinicians. The Code sets out a requirement for occupational therapists to 'act in the best interests of service users' (p.6) which may be seen to contradict or conflate the Act's requirement to uphold 'will and preference'. This issue requires further attention from the registration board, CORU, in its guidance for all registered health and social care professionals to ensure professional practice is aligned with the DMC legislation. In facilitating and improving practices in relation to supported decision-making and DMC assessment of older adults and in developing and defining the role of occupational therapy, findings from this study suggest there are a number of potential initiatives and strategies for the profession to consider, which include the training, education and resource needs of occupational therapists and the need for occupational therapists to expand their role to include advocacy and leadership.

8.5.1 DMC education and training

Findings from this study indicates that DMC and related approaches to assess and support it are not fully understood by many HSCPs in Ireland, or at least there appears to be different levels of understanding among the different HSCPs involved in DMC assessment of older people. Thus, in addition to the need for formal education and training for occupational therapists about assessing and supporting older people's decision-making, the occupational therapists in this study identified the need for broader interprofessional education and training for all HSCPs working with older adults, to promote a thorough and shared understanding of DMC concepts, principles and legislative requirements. These findings concur with other recent Irish research (Donnelly et al., 2021) and research from other jurisdictions (Aldhous et al., 2014; Emmett et al., 2013; Hinsliff et al., 2017; Seyfried et al., 2013; Sinclair et al., 2021), that recommends HSCP training opportunities and awareness campaigns are initiated when DMC legislation is introduced. Charles et al. (2017; 2021) found that when HSCPs had access to appropriate education and tools, the DMC assessment process was demystified, and inappropriate DMC assessments were conducted less frequently.

As findings from the current study highlighted, because assessment of older people's DMC for IL is complex and has far reaching consequences for older people, it generally requires a multidisciplinary approach with input from a number of stakeholders. However, occupational therapists in this study highlighted that different HSCPs seem to hold differing levels of awareness or understanding of DMC legislation and related practice implications. Therefore, they stressed the importance of interprofessional education and training to ensure all HSCPs involved having an accurate knowledge of DMC legislation and policy and a shared understanding of how to assess and support the older

person's DMC for IL decisions. Participants suggested localised training within organisations would allow shared understanding of DMC concepts and legislative implications among MDT members and promote collaborative, interdisciplinary working. As legislation indicates the HSCP with the most relevant or appropriate knowledge or skills should undertake the DMC assessment, interprofessional DMC education and training should address current practices which are based on professional hierarchies and emphasise that Irish legislation does not prescribe which HSCPs should assess DMC. Interprofessional training may allow the roles and obligations of HSCPs be explored and developed among the MDT, which would lead to more consistent and collaborative practice between MDT members and also lend itself to development of best practices that reflect the realities, pressures and needs of the particular service or organisation.

However, Ratcliff and Chapman (2016) caution that DMC training itself may not lead to high-quality application of the statutory requirements of DMC assessment. Similarly, a generic one-size-fits-all approach to DMC assessment was not recommended by the therapists in this study. In addition to interprofessional training, they also emphasised the need for future development of tools, resources and practice guidelines specific to occupational therapy, and to particular client groups, to facilitate the implementation of DMC assessment into routine practice. Throughout each phase of data collection, occupational therapists in this study articulated a need for more continuing professional development, education and training opportunities for practicing therapists on the specific role of occupational therapy in DMC assessment. Participants in this study also recommended embedding DMC education into undergraduate and postgraduate programmes, similar to recommendations from Davies et al. (2019), who also highlighted the potential for patients and public to contribute to curriculum planning and delivery.

The findings from the current study showed that the older person was often excluded from DMC assessment and that opinions of other stakeholders often took precedence over the older person's will and preference regarding IL, which indicates that DMC education and training must specifically emphasise how to ensure involvement of older the person in the DMC assessment process and this education and training is needed by all HSCPs involved in DMC assessment. Bigby et al. (2017) observed that a lack of understanding or commitment among HSCPs to the philosophical principles of equal rights, which underpins DMC legislation and policy, inevitably undermines the process of assessing and supporting DMC. Similarly, Boyle (2011) cautions that rather than viewing compliance with DMC legislation in procedural terms, the value of the law in promoting the rights of people with diminished DMC must be recognised. This echoes recommendations from recent Irish research, that in order to bring about the required cultural shift in attitudes and practices, DMC education should not just focus on legal terminology acquisition but should encompass interdisciplinary reflection and discussion of values and principles underpinning DMC assessment, such as person-centeredness,

autonomy and a rights-based approach to health and social care (Donnelly et al., 2021; O'Donnell et al., 2018). Developing effective participation of people with disabilities in decision-making requires a cultural shift in attitudes and assumptions about disability, public awareness raising and appropriate training (HSE, 2018). Therefore, in order to develop rights-based DMC assessment practices, that will uphold the older person's perspective and that will ensure the least restrictive options as legislation requires, it is important that occupational therapists, and other HSCPs, be informed and convinced of the human rights perspective underpinning DMC assessment. This requires consideration in developing DMC assessment education and training resources for HSCPs and specific disciplines such as occupational therapy.

Previous research suggests DMC education should also include legal and ethical content, communication skills training, mentorship, and specifically address the needs of people with dementia (Davies et al., 2019; Ní Shé et al., 2020). Similar to the education format adopted by Charles et al. (2021), occupational therapists in this study expressed a preference for face-to-face workshops and use of case-studies, in order to fully engage with complexities of the topic of DMC assessment. As this current study reveals a strong tension between ethical principles of beneficence and autonomy in assessment of older adults' DMC for IL, the deliberate inclusion and articulation of ethical concepts in DMC training for occupational therapists, and other HSCPs, may allow exploration of the various tensions and issues arising in in DMC assessment for IL. Professional discussion and debate may strengthen occupational therapist's confidence in promoting older people's autonomy in IL decision-making. Addressing these tensions between autonomy and beneficence in DMC education may also help occupational therapists address both psychological and physical risk as components of beneficence and in supporting older people to make their own decisions, may help the MDT recognise risk as an integral part of IL, leading to less restrictive IL outcomes.

In addition to receiving training, participants in this study suggested occupational therapists should be involved in providing education on how to undertake DMC assessment with older adults. They recognised the need to promote the role of the profession of occupational therapy amongst their HSCP colleagues but also within wider society. Similar to findings from other international studies (Borrett & Gould, 2020; Manthorpe & Samsi, 2016; Murrell & McCalla, 2016), occupational therapists in this study suggested that family members of older people also may not understand how DMC legislation affects their relatives' lives. Therefore, occupational therapists in this study recommended initiatives such as a media campaign to raise public awareness of the implications of DMC legislation in Ireland to enable older people and their family members to understand their rights, roles and responsibilities. This is similar to the approach that was adopted to implementation of the Mental Capacity Act in the UK, in which an information campaign was undertaken to promote greater understanding of the law, particularly among people at risk of losing their DMC (Boyle, 2011). The

review by Davies et al. (2019) also found that public awareness campaigns help foster public engagement on DMC issues and they highlighted how programmes, such as ‘Think Ahead’ by Irish Hospice Foundation (n.d), empower people to consider their will and preference. Some participants reported that occupational therapists were well-placed to educate the wider public about the legislation, so as to inform older people and their family members of their rights and responsibilities and overall to empower older adults in decision-making.

8.5.2 DMC guidance and resources for occupational therapists

The need for evidence-based practice frameworks for DMC assessments and related training materials that are relevant in diverse formal and informal contexts has been identified internationally (Douglas and Bigby, 2020). As all HSCPs are required to contribute to DMC assessments, participants suggested that occupational therapists will require specific guidelines, protocol and training on how to implement legislation within the remit of their professional role, and furthermore that occupational therapists may require specific guidance relevant to the particular client groups with whom they work. As highlighted in this study, addressing the DMC of older adults for IL requires consideration of multiple stakeholders working within a context of diverse values, limited resources, and differing perspectives of preferable options. Previous occupational therapy research indicates that even within the profession, there are different perspectives on decision-making and while most occupational therapists share very general values, they frequently disagree about what to do in ethically challenging practice situations (Thomas et al., 2019). Therefore, given the particular ambiguities and complexities of DMC related to IL, findings from the current study indicate that specific guidance for occupational therapists on which issues to assess and address may be useful and ensure a structured, comprehensive and consistent approach to DMC assessment for IL.

Occupational therapists in the current study suggested that discipline-specific resources on DMC assessment would increase occupational therapists’ confidence in contributing to this area of practice and lead to more consistent practices among therapists. Participants reported that while the functional approach to capacity was conceptually straight forward, they felt a framework may offer a more structured approach to explicitly document their professional reasoning and their judgments on the older person’s DMC. The legislation sets out a functional approach to DMC assessment, in which emphasis is placed on the process of how the person reaches the decision, rather than the outcome of the decision. Therefore, the need for an occupational therapy-specific practice framework that addresses the process of DMC for IL assessment was clearly identified as a priority among occupational therapists during focus group discussions. They felt this would allow occupational therapists who engage in assessing and supporting older adult’s decision-making for IL do so in a more structured, transparent and reliable manner. This builds on research from Emmet et

al. (2013), who also argued that clearly identifying specific criteria on what constitutes relevant information may help HSCPs assess DMC for IL. As highlighted in the literature review, in other jurisdictions other professional groups, such as psychologists, have developed handbooks and guidance on DMC assessment to guide their practice (e.g., ABA-APA, 2008; BPS, 2019). It is likely that all HSCPs working in this area may need their own profession-specific guidance, which in addition to providing structure and scope to HSCPs' practice, may also enhance recognition of their role and skills among the MDT. A comprehensive guidance document may also include proforma documentation templates to document the DMC assessment process, which Emmett et al. (2013) found can lead to more comprehensive record of the assessment process which is more closely aligned to legal standards. Occupational therapists in this study who had previously worked in other jurisdictions with more established DMC legislation described how DMC assessment toolkits with such resources led to a more consistent and standardised approach to DMC assessment. This is consistent with recent findings from the UK, where a DMC assessment toolkit has been developed and trialled with MDTs in various settings with positive results (Jayes et al., 2020; 2021). This may be an important consideration for framework and resource development, as occupational therapists reported that DMC assessment practices adopted within organisations vary widely, potentially leading to subjective and inconsistent outcomes.

However, occupational therapists in this study identified the need to ensure a flexible person-centred approach that is responsive to the individual needs, expectations, values and preferences of the older person. Therefore, in developing a framework, caution must be exercised to ensure it would not become a crude and limiting assessment, which might diminish the participation of older people in decision-making. Huby et al. (2007) found that while procedurally driven care practices structure interactions about discharge planning, they can also prevent engagement and negotiation between HSCPs and older people. Similarly, Arnstein-Kerslake et al. (2017) raise concern that supported decision-making could become another bureaucratic tick-box exercise. Therefore, while establishing a practice framework may be critical in implementing the legislation, it must be suitably flexible and responsive to older person's preferences and needs.

8.5.3 Leadership

Delivery of optimal assisted decision-making practices, in an under-resourced health and social care environment, requires senior leadership (Davies et al., 2019). As this study demonstrates, in order to implement DMC legislation in healthcare practices, occupational therapists must reflect on the potential scope of their practice and review their current DMC assessment procedures and processes. As previously discussed, the introduction of DMC legislation itself may not be enough to drive widespread practice change. Education and training may help occupational therapists learn

about the legislation and underpinning concepts and any subsequent guidance frameworks or codes of practice that are developed may provide therapists with structured approaches to conducting DMC assessment for IL. However, impacting real and meaningful practice change is dependent on how occupational therapists apply this knowledge and use these resources within the environments in which they practise. Participants in this study indicated that this requires a cultural shift within the services where DMC assessments occur and therefore requires strong leadership to ensure that new legislation, policies and any subsequent framework will be used to enable practice change and development.

Many participants in the current study spoke about the potential leadership role occupational therapy could adopt in DMC assessment of older adults for IL. In positioning themselves as leaders in this area, occupational therapists in this study emphasised how the core principles of DMC assessment approaches as set out in legislation and the underlying philosophies of occupational therapy are congruent, in terms of empowering the older person to maximise their participation in decision-making and in enabling them to pursue meaningful IL choices. Due to their broad theoretical background and comprehensive understanding of the person and the environment, their holistic assessment skills and their person-centred, strengths-based value base, occupational therapists in this study asserted that they are ideally placed to embrace principles of DMC assessment and to advocate and lobby for the needs of older people.

Participants in study suggested that occupational therapists could use their foundational occupational therapy training and knowledge to frame DMC assessment and to build collective understanding of DMC assessment and support within the profession. However, findings from this study also suggest that occupational therapists must extend the parameters of their practice beyond assessment of DMC and not only develop therapeutic strategies to support DMC but furthermore, seek to address the social and economic barriers to older people's opportunities for IL. In addition to utilising components of occupational therapy practice which align with DMC assessment and support, such as the cognitive functional evaluation process, risk guidance and occupational profile as already discussed, other theoretical approaches which guide occupational therapy practice, such as occupational justice, offer much potential to occupational therapists in further developing their role in DMC assessment. Occupational justice scholars have already highlighted how social inequalities and injustices constrain occupational choice (Galvaan, 2015; Townsend and Wilcock, 2004) and justice-orientated occupational therapy practice requires occupational therapists identify and address structural, system-led and power-relation barriers to their client's participation (Baillard et al., 2020). Therefore, existing occupational therapy related theory has already drawn occupational therapists' attention to human and occupational rights and can be further used to enhance ethical

reasoning and generate relevant actions to enable older adults to participate in decision-making and pursue IL options according to their will and preference.

Findings from this study suggest the need for all occupational therapists working with older adults to engage in discipline-specific discussion and debate about current DMC assessment practice issues within the profession, as well as with wider group of stakeholders, in order to reflect on how they would like to see legislation and policies enacted within local practice. In determining their potential ability to act as leaders in this practice area, occupational therapists in this study have demonstrated commitment to building awareness of DMC legislation, developing their own knowledge and skills. Furthermore, many participants described collaborating with others on local quality improvement initiatives to enhance their DMC assessment practices, such as developing DMC care pathways. Others described efforts to innovate and create subtle changes that empower older people in decision-making processes, by engaging families in initial goal-setting, so IL options and preferences from all stakeholders are established early in the occupational therapy process leading to improved DMC assessment outcomes. While the commitment and motivation of occupational therapists to improve practice is encouraging, recent Irish research has also noted that engagement in education on DMC and initiation of changes to improve DMC practice was more personally driven by individual HSCPs rather than an explicit organisational-led change (Donnelly et al., 2021; O'Brien and Clyne, 2021).

Davidson et al. (2016) compared international legal frameworks for supported decision-making and suggested that for successful and ethical implementation of any legislation, adequate services and supports must be available and the necessary training and monitoring processes established. This study makes explicit the complexities of DMC assessment for IL and highlights the ethical tensions associated with the DMC assessment process due to the many contextual factors influencing practice. That some practices may be inconsistent with legislation raises the urgent need for professional debate, education and reform. However, efforts to resolve these tensions extend beyond individual therapists and require organisational approaches to enhance institutional and professional policies and culture. This identification and exploration of the challenges experienced by participants may be an important provisional step in allowing occupational therapists prepare to negotiate such practice tensions in their work and in clarifying their role in contributing to DMC assessment for IL. In order to make practice change more sustainable and impactful, occupational therapists who seek to lead in this practice area will need to develop clear policies and garner support from all stakeholders, at all levels, to drive the all-encompassing cultural shift required to ensure the provisions and the spirit of the DMC legislation are realised.

Despite many participants reporting that the occupational therapy profession is well-positioned to assert leadership in this emerging practice area, findings from the survey and focus group phases of

this study suggested that other disciplines may lack awareness of the role occupational therapists can play in assessing and supporting older peoples' DMC for IL. If occupational therapists in Ireland are to establish themselves as potential leaders in DMC assessment or IL, they need to firstly address their poor professional status within some MDTs and raise awareness of their role and the contribution they can make to this area of practice. Furthermore, many of the obstacles to implementing the DMC assessment approaches required by legislation that were highlighted by participants in this study are structural and systemic in nature, thus requiring a multi-disciplinary response to address these issues. By presenting the various professional and contextual factors impacting on their DMC assessment processes in this study, occupational therapists can potentially initiate and engage in debate and seek to improve practice within the profession and the wider MDT. They must question the conflicting values currently dominating service provision, such as restrictive risk averse practices prevailing over rights-based approaches. In order to promote client-centred and occupation-based practice that is in line with Irish legislation and policy, occupational therapists must reflect on their own professional beliefs and values and also challenge current DMC assessment practices within their profession and within the MDT context in which they work. Therefore, occupational therapists may need to draw on notions of social leadership, whereby people who are not necessarily in established leadership positions within the traditional hierarchy are given authority to lead by the community, based on their reputation and network of relationships (Tempest and Dancza, 2019). Although few occupational therapists hold senior leadership roles within governments or health and social care services, occupational therapists can still act as authentic and collaborative leaders to facilitate meaningful change in DMC practices by drawing on their foundational knowledge, skills and training. Adopting a broader socio-political approach to occupational therapy involves engaging in advocacy as a key strategy and professional imperative (Kirsch, 2015). While occupational therapists in this study recognised their role as advocates for older people to participate in the IL decision-making process, they mostly related this to their work with older people on an individual basis and even within that, not all participants appeared to be confident in advocating for older people's decision-making rights and/or preferences. Therefore, as a profession, occupational therapists need to address this reluctance as it is not in keeping with professional practice or DMC legislation and policy. Furthermore, as recognised by some participants in the study, occupational therapists must expand this advocacy role further to highlight systemic issues which impact on the options and choices available to older people regarding IL, and to advocate for approaches to assessing and supporting DMC that offer broader IL possibilities for a diversity of ageing individuals.

Many scholars have called for occupational therapists to become critically aware of their role within systems and structures in which they work, highlighting the political nature of their practice, which can perpetuate or transform aspects of systems in which they and their clients are situated (Aldrich

and Rudman, 2020; Gerlach et al., 2018; Pollard et al., 2008). In relation to DMC assessment, Sinclair et al. (2021) found HSCPs experience a range of expectations and obligations from their employers, regulatory bodies and their profession which can make it challenging to support the older person's DMC. Occupational therapists in this study spoke of the tension between meeting the expectations of organisations where MDT priorities and risk management policies go against occupation-based, client-centred practice. Participants highlighted the limitations of current systems and approaches which marginalise older people in DMC assessment, particularly those with disabilities and impairments. Richards and Vallee (2020) argue that to meet the needs of all people, occupational therapists must go beyond functioning and rehabilitation to advocate for contextual changes that eliminate barriers to occupational participation and engagement. Findings from this study indicate that occupational therapists are aware of contextual factors, such as a limited availability of services, high caseload demands, time shortages, concerns of being alienated from the MDT and fear of liability or public condemnation, which bring pressures for occupational therapists to practice in ways that enact system restrictions rather than enable the older person. Furthermore, they recognised occupational therapy has potential to take on a leadership position to address contextual factors that are impeding their DMC practices. The human rights perspective implicit in recent Irish DMC legislation and policy requires that attention is given to the way occupational therapists approach the assessment process, shifting from a singular focus on the older person's impairments, inabilities and deficits to the older person's abilities, resources and opportunities for IL, according to their will and preference, that are afforded or denied by structural factors such as the environment, social attitudes and policies.

8.6 Strengths and Limitations of the Study

This study was conducted to explore the role of occupational therapy in decision-making capacity assessment, an area of practice that has received little attention in the international research to date. It is the first of its kind to be conducted in Ireland, and a mixed methods approach was deemed appropriate to explore and describe the realities of this area of clinical practice. This study contributes to the growing DMC-related research field by exploring occupational therapists' perspectives on this area of practice and adding new information regarding DMC assessment approaches. These findings are important as they provide novel evidence of the Irish occupational therapy experience regarding how DMC assessment for IL is currently addressed for older adults in Ireland, and the findings provide insight into the clinical practice barriers which hamper implementation of recent developments in Irish DMC legislation.

As with any research study, there were a number of limitations in conducting the current study and so findings must be interpreted with some caution. One limitation of this study is that it relates only

to the Irish occupational therapy context. Findings may be relevant to many occupational therapists in Ireland, as participants represented a wide range of practice settings across a wide geographical area. The research could potentially be of interest to occupational therapists internationally, however as DMC legislation and policy differs in other jurisdictions, the applicability of the research findings should be carefully considered. Additionally, findings from this study demonstrated that the process of DMC assessment is greatly influenced by the availability of healthcare funding and resources, therefore the funding environment should be considered in observations drawn from the research findings.

Additionally, as this study has confirmed, DMC assessment for IL involves many HSCPs and stakeholders, yet this study only explores the role of one discipline, occupational therapy. Therefore, other HSCPs who contribute to DMC assessment may offer different multidisciplinary experiences. Furthermore, the inclusion of older people and their family member's perspectives may provide additional insights to this practice area. Nonetheless, as there was need for clarity on the role of occupational therapy in order to establish how they would engage in DMC assessments within a multidisciplinary context, this focus on occupational therapy is justified, and other disciplines may need to engage in similar research to determine their role and contribution to this practice area.

Lastly, the methodology adopted within the overall study could be viewed as a limitation because all three phases of empirical data collection involved self-report methods and the study design does not include a quantitative component or objective measure of occupational therapy's role in DMC assessment. Owing to the purposive sampling methods involved, the risk of positive selection bias should be acknowledged when considering the findings, as occupational therapists who volunteered for each of the phases may have been more knowledgeable or more interested in DMC assessment of older adults than those who did not respond, raising the issue of representativeness of participants. Additionally, self-reporting methods entail the risk of bias as participant's accounts of practice may have reflected social desirability. There are no specialised DMC postgraduate training courses or qualifications for occupational therapists in Ireland. Occupational therapists contributing to the NGT consensus meeting self-identified as having the relevant experience and knowledge of DMC assessment for IL, though there is no way to judge this expert status. Despite these possible shortcomings in the current study, the findings emerging are unique and add to the international research in the area of assessing older adults DMC for IL.

8.7 Implications for practice

This study has provided detailed insights to the role of occupational therapy in DMC assessment for IL decision among older adults. The findings from this study firstly establish a baseline of how

occupational therapists currently contribute to DMC assessments, specifically in the domain of IL. The study findings also highlight how occupational therapists view the profession as having a strong remit and a potentially important role to play in assessing older adults' DMC for IL. The study highlighted factors that impact on DMC assessment practice, which includes both barriers and facilitators.

Occupational therapists identified that occupational therapy philosophy and overall approach aligns well with the spirit and provisions of the new DMC legislation. They recognised their professional background provides a good foundation for occupational therapists to address DMC assessment in a manner that respects the older person's will and preference. The findings highlight the importance of a structured and comprehensive multi-pronged approach to the DMC assessment process. However, assessing and supporting DMC for IL is not limited to formal structured assessment, rather it is important for occupational therapists to recognise DMC assessment as an integral part of their occupational therapy assessment and interventions. Findings from this study indicate that occupational therapists have the skills to engage in this process of client-centered, occupation-based assessment and must be able to articulate and communicate their input in relation to DMC assessment and support. The need to increase occupational therapists' confidence in their contribution to DMC assessment was highlighted, as was the need to increase other disciplines' awareness and recognition of the role occupational therapists can play in assessing and supporting older peoples' DMC for IL. Following a comprehensive and multipronged approach may increase occupational therapists' confidence in their contribution to this area and may assist therapists articulate their clinical reasoning and subsequent judgments, thus helping establish and consolidate their role in this area of practice.

Additionally, the findings highlight systematic issues in the current provision of care options for older people in Ireland, which have ramifications for the implementation of the DMC legislation. A shifting recognition of the need to adopt a rights-based approach in healthcare will likely see more challenges to the current fragmented approach to DMC assessment and support. While the study focus was on the experiences of occupational therapists working with older people, it is likely that similar issues are faced by other HSCPs working in the same system, so the findings may also apply to those HSCPs.

Recommended practice in assessing and supporting DMC for IL emerging from the current study suggests that opportunity for prolonged contact with the older person to ascertain their values and preferences is the preferred approach. Findings also recommend utilising functional-based assessments in relevant environments, alongside standardised cognitive assessment. Findings suggest occupational therapists should use existing models of functional-cognitive evaluation to ensure a comprehensive, client-centred and occupation-based approach. The need for a shared

understanding of DMC among HSCPs and the need to adopt a multidisciplinary approach is also highlighted. In order to enable further development and implementation of the DMC legislation in practice, the need for further discipline-specific training for occupational therapists and interprofessional training with other HSCPs in the area of DMC assessment is implied. The findings from all phases of the current study provide a starting point for the development of education and training programmes for occupational therapists and provide a baseline from which to begin the development of practice guidelines for occupational therapists engaging in DMC assessment for IL, specific to the context of practice in Ireland.

8.8 Implications for future research

The findings provide a baseline for further research in this area of practice in the Irish context. The study has shown that occupational therapists consider themselves to have a significant role to play in DMC assessment for IL and thus a distinct need for future research regarding the role of occupational therapy in DMC assessment of older adults for IL is highlighted in order to explore and develop this remit.

As this study focussed on occupational therapists working with older adults, the findings are specific to that group, thus further exploratory research may be needed to establish if occupational therapists working with other client groups or in other areas of practice would also highlight DMC for IL as a principal area of concern within their practice or if other domains of DMC assessment are more pertinent within occupational therapy practice with other client groups. Further study could explore if the issues identified in this study are specific to the Irish occupational therapy practice context, or if similar issues are identified among occupational therapists internationally in jurisdictions with similar DMC legislation to that of Ireland. This wider exploration of these practice issues would strengthen the basis for the development of practice guidelines and training to enable occupational therapists to develop and consolidate their role and contribution to DMC assessment. Furthermore, as DMC assessment for IL is a complex area that requires input from multiple stakeholders, perspectives from other HSCPs working with older people may provide valuable insights that would enhance interprofessional collaboration in this area of practice. Lastly, research from the perspectives of older people, and other relevant stakeholders such as family members and supporters, focusing on acceptable and effective approaches to addressing the will and preference of the older person may also be useful to further elaborate on the findings from this study. Hicks et al. (2012) recommend participatory action research with older adults when developing policy on how to provide for an ageing population. Recent research describes innovative methods to ensure the priorities of people with dementia are identified, expressed and communicated effectively in

developing policy (Keogh et al., 2021). Co-production research methods with older people and their families/caregivers may be useful to ensure their voices are heard.

Lastly, the findings from this exploratory study provide baseline information and knowledge that can be used to inform the initial development of a framework to guide occupational therapists' practice in DMC assessment for IL in Ireland. Any such preliminary framework emerging from the findings of this study would require ongoing research on its implementation and applicability to practice. Using approaches such as implementation science could be useful in cyclical development, trialling, refinement and evaluation of preliminary guidelines in practice. Future research regarding development and evaluation of a guiding framework would require careful study design because of the wide-ranging issues impacting on DMC assessment.

8.9 Conclusion

Assessment of older adults DMC for IL will become increasingly common in the coming years and a prominent public concern, owing to the increased numbers of adults in Ireland reaching old age, the increasing prevalence of chronic conditions associated with ageing, along with changes in our social structures influencing where older people live. This study contributes an understanding of the assessment and support of older people's DMC in the area of independent living from the perspective of occupational therapists' practice experiences in Ireland. The study offers insights into the array of complexities experienced by occupational therapists in contributing to this challenging area of practice.

This current study is the first study to examine the occupational therapy contribution in the assessment of older adults DMC in an Irish practice context, or indeed international context. This multiphase study has contributed to the occupational therapy knowledge base by providing important description and consensus on the role of occupational therapy in DMC assessment for IL. The findings of this study, highlight the legislation-practice mismatch and challenges faced in implementing DMC assessment practices for older people as stipulated in both national and international policy and legislation. Findings illustrate many tensions and complexities within existing DMC assessment practices in relation to IL for older adults and how the absence of agreed guidelines that align with current legislation may potentially lead to practice that is variable and inconsistent. Practice constraints and resource issues are highlighted, along with issues relating to risk-adversity and restrictive practices which contribute to professional conflicts among occupational therapists regarding realisation of their professional philosophy and potential remit under new DMC legislation, given the constraints of current service provision. However, the study has provided valuable insights into current occupational therapy assessment procedures and protocols that provide a baseline from

which occupational therapists and other HSCPs can develop and enhance assessment of older adults' DMC for IL. The findings from the current study provide a reference from which future research into this area of practice can be undertaken to develop an evidence-based framework and training programmes specific to the context of practice in Ireland.

The study highlights that there is a clear interest and willingness within the occupational therapy profession for greater involvement in DMC assessment and support in relation to IL and it is a critical time for occupational therapists to articulate their distinct value and deepen their contribution to this area of practice. The recent legislative changes and current emphasis on improving DMC assessment process for people with disabilities provides an opportunity for the occupational therapy profession to consolidate their role as vital members of multidisciplinary DMC assessment teams, by articulating how DMC concepts and models relate to the central tenants of occupational therapy, and by demonstrating the ability to enhance DMC assessment processes, particularly in the area of IL.

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Appendices

Appendix A:
Published article in Health and Social Care in the Community (Usher and Stapleton,
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Assessment of older adults' decision-making capacity in relation to independent living: A scoping review

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Abstract

With a growing global ageing population, approaches to assess and support decision-making are becoming more pertinent. This scoping review aimed to identify and map current knowledge on assessment of older adults' decision-making capacity in relation to independent living. A five-stage scoping review framework was followed. Inclusion criteria were papers on assessment approaches used to evaluate decision-making capacity of older adults, aged 60 years and over for independent living, including studies involving people with cognitive impairment and dementia. Five databases were searched for publications with eligibility criteria from January 2000 to December 2020; 4,118 results were retrieved from sources, resulting in 29 publications being analysed, eight of which were research reports. Publication characteristics and methodologies varied; however, many common components of decision-making capacity assessment for independent living were identified including cognitive, functional, environmental and risk assessment. Overall, a multidisciplinary approach was recommended, and consideration of the person's values and preferences is noted in many publications. Decision-making capacity assessment for independent living of older adults requires multicomponent, multidisciplinary assessment. Future work is needed to examine this from the perspective of older adults and their caregivers.

KEYWORDS

decision-making capacity, independent living, older adults, scoping review

1 | INTRODUCTION

Assessment of decision-making capacity (DMC) of older adults is an important issue for society and within healthcare systems. Due to increasing life expectancy, associated prevalence of chronic health conditions, changing family structures and support systems, approaches to assess DMC are increasingly critical (Charles et al., 2017). Internationally, legislation guiding DMC assessment in

many western societies has undergone reform to support individuals to make their own decisions wherever possible and to protect those who lack DMC (such as the Mental Capacity Act 2005 in England and Wales, the Adults with Incapacity [Scotland] Act 2000, the Mental Capacity Act [Northern Ireland] 2016, the Health Care Consent Act [1996] in Ontario, Canada, and Powers of Attorney Act 2014 in Victoria, Australia). Although legislation varies across jurisdictions, most developed countries assume adults are competent in

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decision-making, and this right is underpinned by the Convention of the Rights of Persons with Disabilities (United Nations, 2006). In Ireland, the Assisted Decision Making (Capacity) Act 2015 provides a statutory framework for adults who are experiencing difficulties with decision-making. Legislation sets out a functional approach to DMC assessment, whereby the focus is on the person's *process* of decision-making rather than the outcome of the decision itself, that is, their ability to understand the nature and consequence of the decision at the time of decision-making and ability to express their choice. Figure 1 outlines the functional approach to DMC assessment as outlined in Irish legislation.

Although DMC assessment is a pertinent practice issue, poor understanding of DMC, lack of training, limited resources and time pressures pose many challenges for health and social care professionals (HSCPs) when conducting DMC assessment (Donnelly et al., 2018; Jayes et al., 2017; Lamont et al., 2017; Usher & Stapleton, 2020a). Bremault-Phillips et al. (2018) recommended DMC assessment processes be standardised and integrated into routine care to enable HSCPs optimise person-centred outcomes that are least restrictive for those whose DMC is in question. In Ireland, professional concerns exist regarding the implementation of legislation, which, due to its broad application, requires development of decision-making support services, codes of practice, training and advance care planning frameworks (Kelly, 2017; Ní Shé et al., 2020; Usher & Stapleton, 2020a).

Independent living (IL) is one of eight DMC domains identified by Moye and Marson (2007) as requiring assessment among older adults. IL encompasses a range of skills including, but not limited to, managing the home, money, meals, hygiene and emergencies. The majority of older adults live in their own homes, with many preferring to continue living in their homes as long as possible (Donnelly et al., 2016). Internationally, public policy on 'ageing in place' generally supports the perception that it is preferable to age in one's own home (Forsyth & Molinsky, 2020). However, formal and informal supports necessary to support IL are often not available, making IL contentious (Donnelly et al., 2016). IL DMC requires a person to have knowledge and understanding of what is required to live independently and the ability to apply this knowledge, to problem solve and have an appreciation of the consequences of potential choices (ABA-APA, 2008). Research on DMC assessment practices of occupational therapists in Ireland found that IL was the domain of DMC most frequently assessed among older adults (Usher & Stapleton, 2020a). However, there is no guidance for HSCPs on how best to assess a person's DMC for IL.

Several reviews have looked at assessment of DMC across different populations. Wilson (2017) completed a systematic review of the experiences of adults lacking DMC and their carers of mental capacity legislation in the United Kingdom. This review found that although legislation provided useful mechanisms for substitute decision-making, awareness of legislation was limited; thus, decision-making was not always compliant with the legislative principles, and benefits of advanced planning were not always realised. Most research in this review was drawn from carers' experiences,

What is known about this topic

- Due to increasing ageing populations, assessment of older adults' decision-making capacity is an important societal and healthcare issue.
- Decision-making capacity assessment is challenging, and issues with implementation of legislation have been identified internationally.
- Most older people wish to remain living in the community for as long as possible, making decision-making capacity for independent living an important domain to assess.

What this paper adds

- Assessment of older adults' decision-making capacity in relation to independent living requires multicomponent, multidisciplinary assessment.
- Awareness of multiple assessment dimensions relevant to independent living will enhance healthcare professionals' assessment approaches.
- Further research from the perspectives of older people and their caregivers is required.

rather than the person whose DMC was being questioned. Though there was reference to guardianship, this was specifically in relation to financial and welfare powers.

Further DMC-related reviews focused on HSCPs in England and Wales, namely, their knowledge and experience of capacity legislation (Scott et al., 2020) and how they assess capacity (Jayes et al., 2020). Similar to carers' experiences described by Wilson (2017), HSCPs experienced positive aspects of DMC-related legislation, whereby the underlying principles of legislation enabled the upholding of human rights in HSCP's practice (Scott et al., 2020). Efforts to support DMC and measures to enhance the assessment process were also identified, such as assessment timing, context and communication. In relation to IL, conducting assessments in a home environment was described as a measure to support people with dementia in decision-making (Jayes et al., 2020). However, many studies reported that practice was not compliant with legislation (Jayes et al., 2020), and gaps in knowledge and variable levels of confidence were reported (Scott et al., 2020). Jayes et al. (2020) cited a study whereby DMC for IL was based on functional performance of a task rather than the person's ability to make an informed decision about where to live. These reviews recommended a collaborative assessment approach as DMC assessors should have specialist knowledge and skills relevant to the nature of the decision being made. Although specific domains of DMC were not addressed, both reviews suggested that occupational therapists led assessments related to discharge destination decisions.

A systematic literature review by Hinsliff-Smith et al. (2017) reported on the application of UK legislation on DMC assessment of

FIGURE 1 Functional approach to decision-making capacity (DMC) assessment

A functional approach to the assessment of DMC as set out in Assisted Decision Making (Capacity) Act 2015

A person is considered to lack capacity to make a specific decision if they are unable:

- to understand the information relevant to the decision;
- to retain that information for long enough to make a voluntary choice;
- to use and weigh up that information as part of the process of making the decision; or
- to communicate their decision by any means (whether by talking, writing, using sign language, assistive technology, or any other means).

older adults in healthcare. It concluded that staff need more opportunities to engage with and learn about the legislation before they can implement it into their practice. A scoping review examining physician education regarding DMC assessment reported increased saliency of DMC assessment due to the ageing population, gaps in physicians' training and education, inconsistent approaches and ethical tensions (Charles et al., 2017). Donnelly et al. (2019) identified barriers influencing the promotion of assisted decision-making among older adults in acute settings in Ireland, which included the physical environment, communication, time and timing and the need for education and training. Mechanisms required to enhance HSCP's implementation of assisted decision-making in Irish healthcare highlighted the need for formal assisted decision-making services, strategies for leadership, environmental and social restructuring and training (Davies et al., 2019).

A systematic literature review of assessment tools used to evaluate DMC among people with dementia reported that structured assessment tools improve consistency between clinicians when assessing DMC (Pennington et al., 2018). However, no assessment tool was sufficiently comprehensive or flexible to capture the complexities of DMC, highlighting the need to incorporate HSCP opinion with structured assessment tools to optimise the assessment process.

Although there is a growing body of research on older adults' DMC, to date, the literature has focused on DMC for medical treatment, research participation and financial decision-making. Despite its ubiquity in clinical practice, specific discussion of DMC for IL is less frequently addressed in the literature. Poole et al. (2014) observe that IL capacity is discussed theoretically in relation to ethical tension between the principles of beneficence and autonomy. DMC assessment for IL is likely to become more pertinent as the number of people experiencing decision-making challenges increases. Older adults often face difficult decision-making situations regarding their ability to live independently, and it has been suggested that DMC assessment regarding IL requires a different approach to other DMC domains (Bourgeois et al., 2017; Schreiber et al., 2018) and can be more difficult to assess than the capacity to make medical decisions (Cooney et al., 2004). DMC for IL is multifactorial and requires addressing the overlap between family, clinical and judicial roles in responding to adults' changing capacities (Moye & Marson, 2007). A preliminary search of JBI Database of Systematic Reviews and Implementation Reports, Cochrane

Database of Systematic Reviews and PROSPERO was completed in July and December 2018 and found no relevant completed or ongoing systematic or scoping reviews on this issue. To the authors' knowledge, studies evaluating approaches to assessment of older adults' DMC for IL have not been systematically scoped. Therefore, this review aimed to identify and map existing evidence to provide an overview of current approaches of assessing DMC for IL of older adults and details of who conducts assessments, what is measured and how, and in what settings. The outcome of the review includes a summary of available evidence and an identification of gaps in research.

2 | MATERIALS AND METHODS

A scoping review design provides a systematic framework for searching, examining and summarising the literature and identifying gaps in the existing knowledge. This approach was deemed appropriate as it allows refinement of the search strategy and a deeper knowledge of the literature and the key concepts (Arksey & O'Malley, 2005; Levac et al., 2010; Peters et al., 2017). The initial inclusion criteria, search strategy, approaches to study screening and data extraction were stipulated a priori in a published protocol (Usher & Stapleton, 2020b). However, due to the iterative nature of the research and findings from an earlier study (Usher & Stapleton, 2020a), the focus of this review was refined to focus on the DMC domain of IL; therefore, the revised methods are described below.

The conduct of this scoping review was based on the framework and principles reported by Arksey and O'Malley (2005) and further recommendations provided by Levac et al. (2010) and Peters et al. (2017). Additional guidance on reporting in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews checklist (Tricco et al., 2018) was also used.

This framework recommends the following five key phases:

- Stage 1: Identifying the research question;
- Stage 2: Identifying relevant studies;
- Stage 3: Study selection;
- Stage 4: Charting the data; and
- Stage 5: Collating, summarising and reporting the results.

2.1 | Stage 1: Identifying the research question

This review aimed at answering the following overall research question: 'What approaches to assessment of older adults' DMC in relation to IL have been reported?'. This review also aimed to explore 'Which HSCPs are involved in assessment of older adult's DMC in relation to IL?', as typically this is a multidisciplinary issue.

2.2 | Stage 2: Identifying relevant studies

The search strategy and keywords were developed and refined in consultation with a university health sciences librarian. A preliminary search was conducted in Embase database to gain familiarity and an overview and to aid with the identification of key terms. The initial search terms for the scoping search reflected the key concept areas addressed by the research question: 'decision-making capacity assessment' and 'older adults' and associated Medical Subject Headings terms. The final search strategy included 'independent living' and 'discharge destination' and was also applied to the remaining databases: CINAHL, PsycINFO, Web of Science and Scopus. The search strategy was tailored to the specific requirements of each database. See Appendix S1 for sample search strategy from the Embase database. These databases were searched for relevant literature from January 2000 to December 2020 until the date that the search was conducted. Hand-searching of the reference lists of the publications identified was also conducted, and authors were contacted to find additional papers. Electronic search results were exported into EndNote™ and then to Covidence™, and duplicates were deleted. Studies were selected as per eligibility criteria (Table 1) based on the population, concept and context framework (Peters et al., 2017).

Publications regarding older people were of interest. Because there are various definitions of the age range of 'older' populations, a lower age limit was not specified as an inclusion criterion. Rather, publications were included, which identified older people as their focus. Healthy older adults and those with age-related cognitive impairment, mild cognitive impairment, dementia and neurodegenerative conditions were included. Publications that provided information on approaches and procedures used in assessment of older adults' DMC for IL were considered in this review, including related cognitive, functional and proxy assessment. Publications relating to any

clinical setting (acute hospital, community and long-term care) were included as DMC assessment is relevant in a variety of settings.

All types of qualitative and quantitative designs that verified or described current practices were considered eligible, and expert opinions that provided enough detail were included. Studies were excluded if they did not describe the assessment process in sufficient detail or focused predominantly on other DMC domains (e.g., only on consent to research and medical treatment). The search was limited to reports published in English and published from January 2000 to December 2020 to ensure that findings reflect current clinical practice and recent changes in legislation.

2.3 | Stage 3: Selecting the studies

This stage involved selecting the articles in two steps: (a) title screening and abstract screening and (b) full-article screening, as reported in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram (Figure 2). Duplicate records were removed, and remaining records were screened by title, abstract and full text. Title and abstract screening was conducted by the first reviewer (R. U.) having refined inclusion and exclusion criteria with the second reviewer (T. S.). The first reviewer read the full texts of publications corresponding with inclusion criteria. An opinion from the second reviewer was sought in case of uncertainty, and consensus was reached through discussion.

2.4 | Stage 4: Charting the data

Data from articles judged to have met all inclusion criteria were categorised, extracted and organised using Microsoft Excel. A data extraction form was developed by the primary author (R. U.) to capture information relevant to the research question and was piloted using five articles. The final charting form included the following information: author(s), year of publication, study aim(s), study location, study design, population of interest/sample, assessment approaches, HSCPs involved, main findings and recommendations regarding the DMC assessment for IL among older adults (see Appendix S2). The authors met frequently to discuss the data extraction process and to review the data extraction form to ensure that all relevant data to answer the research question were extracted from the publications.

2.5 | Stage 5: Collating, summarising and reporting results

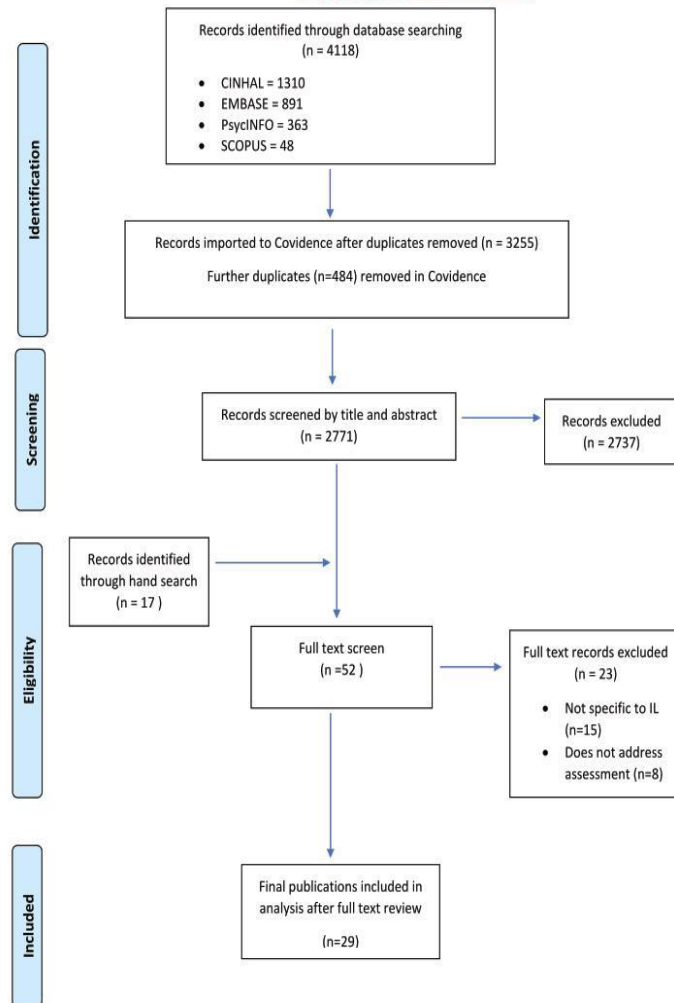
Using the data extraction chart, data were collated and summarised. Numerical summaries described the data quantitatively, and thematic analysis was conducted on all extracted data using Braun and Clarke's (2006) approach to provide a qualitative description of the findings. The first author examined the data to identify codes

TABLE 1 Eligibility criteria

Publication selection criteria	
Population	Older adults
Concept	Described approaches and procedures used in assessment of DMC for IL
Context	Included published data from any jurisdiction where DMC legislation requires functional assessment approaches

Abbreviations: DMC, decision-making capacity; IL, independent living.

FIGURE 2 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart: Extension for scoping reviews (Tricco et al., 2018). Abbreviation: IL, independent living



representing sections of data with similar meaning. These were examined in relation to each other and sorted into preliminary groupings, which were developed into sub-themes and themes. This iterative process required ongoing review and discussion among the two authors about the development of themes. Information from the data extraction was summarised in table form (Table 2).

3 | RESULTS

3.1 | Summary of the literature search/study selection

The electronic searches of databases resulted in 4,118 records. After removing duplicates, 2,771 titles were screened for eligibility. The screening of titles and abstracts resulted in identification of 35 publications relating to DMC assessment of older people for IL for full-text review. Additionally, 17 texts were identified from other sources. Following the exclusion of studies that did not meet the

inclusion criteria, a total of 52 studies were included in the full-text screen from which 29 publications were included in the final qualitative analysis.

3.2 | Characteristics of publications

As the body of research regarding other DMC domains grows, there is increasing interest and research in DMC for IL among older adults. Subsequently, there were more frequent publications of literature on DMC for IL from 2004 onwards, with most publications since 2010 (see Figure 3 displaying the number of publications over the years for the review period).

Most publications are commentary and discussion pieces rather than original research or review, reflecting how research in DMC of older adults relating to IL represents a new and emerging field. Most publications offer commentary on legal reform, discussing implications for clinical practice with suggestions for assessment approaches, and are based on expert opinion rather than empirical

TABLE 2 Description of publication characteristics (n = 29)

Publication characteristics	No. of records
Publication type	
• Original research	8
• Commentary/case discussion	13
• Book chapter	3
• Review article	2
• Letter	1
• Validation of instrument	2
Country of origin	
• United States	17
• United Kingdom	7
• Canada	1
• Australia	3
• Ireland	1
Population of interest	
• Older adults	20
• People with dementia	6
• People with stroke ^a	2
• Non-specified age group (adults lifestyle choices)	2
Healthcare professionals who may contribute	
• Physician	12
• Psychiatrist	6
• Psychologist	9
• Social worker	10
• Nurse	9
• Occupational therapist	14
• Not specified/MDT approach	15
• Physiotherapist	7
• Case manager	3
• Speech and language therapist	2
Other—family (2); healthcare admin (1); adult protective services (1); independent advocacy services (1); pharmacy (1); dietician (1); discharge planner (1)	
Context of assessment	
• Hospital	19
• Community ^b	6
• Not specified	5

Abbreviations: MDT, multidisciplinary team.

^aOne study included people with dementia and people with stroke and so was included in both categories.

^bOne study reported that assessments took place in both hospital and community settings and so was included in both categories.

findings. A summary of the characteristics of the publications from the 29 records can be found in Table 2.

The purpose of the publication and a summary of assessment approaches and recommendations are presented in Table 3. Although many authors noted that there is no gold standard for assessing

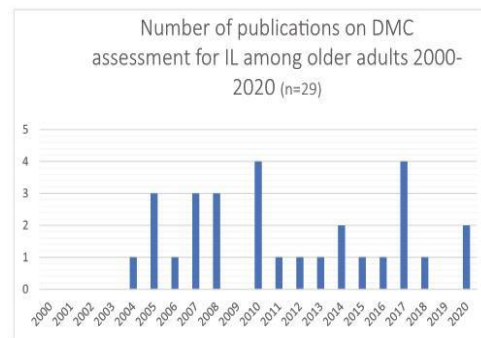


FIGURE 3 Number of publications on decision-making capacity (DMC) assessment for independent living (IL) among older adults 2000–2020

DMC, the publications reviewed often recommended similar approaches and components to include in assessment (see later theme on 'components of DMC assessment for IL').

3.2.1 | Population

Publications included in this review focused on older people, though very few defined this. Some publications specifically referred to people with dementia (Brindle & Holmes, 2005; Emmett et al. 2013; Hughes et al. 2015; Jayes et al., 2017; Poole et al., 2014; Stewart et al. 2005), and two specifically referred to people with stroke (Jayes et al., 2017; Mackenzie et al. 2008). Two papers did not specify an age group but referred to adults making lifestyle choices and so were included (Bastian et al. 2011; Darzins, 2010).

3.2.2 | Context

Publications emerged from several countries—United States, United Kingdom, Australia, Canada and Ireland—reflecting jurisdictions that have undergone legal reform regarding DMC assessment approaches. Most publications originated in the United States. Publications referred to assessing DMC in a variety of contexts, with the majority referring to hospital and rehabilitation settings; however, two publications advocated the benefits of assessment in the home environment where possible (John et al., 2020; Lai & Karlawish, 2007).

3.2.3 | Concept

As the literature relating to DMC for IL is emerging, the terminology of this DMC domain varied across publications. Although IL was frequently referred to as a DMC domain, other terminologies included residence capacity (Emmett et al., 2013; Hughes

TABLE 3 Purpose and main findings or recommendations of publications (n = 29)

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
1. Bourgeois et al. (2017)	Review clinical literature on assessment to determine the patient's 'dispositional capacity'	<p>Dispositional capacity is proposed as a new term with a separate meaning, which includes routine use of occupational therapy (OT) and social work. No definition or guidelines for determination of dispositional capacity was found.</p> <p>Complex and multidimensional process—requires a different approach. Supplement DMC assessment with assessment of functional abilities in necessary self-management activities</p> <p>Consider:</p> <ul style="list-style-type: none"> • Demographic, medical and functional factors: age and stage of illness, understanding of illness, sensory capacities, mobility and ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs; e.g., Kohlman Evaluation of Living Skills [KELS] and Assessment of Capacity for Everyday Decision-Making [ACED] and Texas Functional Living Scale). • Psychological factors: cognitive capacity (formal cognitive assessment) and other psychiatric disorders, including addictive disorders. • Social factors: housing status and status of the network of social support. <p>Modify environment and assessment approaches to maximise performance</p> <p>Standardised guidelines for capacity determinations (both for informed consent and for disposition) would be helpful to clinicians, patients and their caregivers.</p>
2. Brindle and Holmes (2005)	Present issues in discharge planning of older people with dementia; outline DMC assessment to preserve personal choice and support people in their own homes.	<p>Address:</p> <ul style="list-style-type: none"> • Cognitive status • Physical status • Functional abilities • Community resources available • Legal standards <p>Functional approach to DMC</p> <p>Consider person's social situation and cultural values along with their insight and awareness of their care needs and willingness to accept support.</p> <p>Recommends holistic and ongoing MDT approach and consultation with carers. Liaise with community support services, producing a flexible care package that mitigates risks, reduces readmission, preserves individual's autonomy and independence.</p> <p>Advocate for participation of the older person and their families in assessment, care planning and evaluation and seek regular feedback on appropriateness of care after discharge.</p>
3. Carrese (2006)	Discuss ethical dilemmas, approaches to assessing DMC, influence of physician values and how to respond to patients' refusal of care.	<ul style="list-style-type: none"> • Communicate risks, concerns and options to individual • Consider their values, consistently stated preferences (e.g., religious beliefs, cultural background, psychosocial factors, previous healthcare and personal experiences and preferences of family members/friends)• Assess cognition and insight • Functional approach to assess decision-making—four criteria—abilities to make and communicate a choice; understand relevant information about the situation; appreciate how relevant information applies to oneself in the situation at hand; and engage in rational deliberation about treatment options
4. Clionsky et al. (2016)	Discuss ethical challenges for determining capacity regarding ability for self-care and independence in discharge planning	<ul style="list-style-type: none"> • Functional approach to DMC assessment and consideration and assessment of executive autonomy to implement plans • Consider affect and medical status • Assess cognitive function, specifically executive functioning abilities • Assess functional abilities, beyond the basic self-care needs • OT assessment of IADLs, for example, paying bills, taking medications and writing checks. • Reassess capacity and preferences over time and address reversible barriers to capacity

(Continues)

TABLE 3 (Continued)

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
5. Cooney et al. (2004)	Discuss issues related to assessment of independent living capacity of older adults	<p>Assess individual's ability to provide for his or her own care, nutrition, shelter and safety needs or direct others to meet those needs.</p> <p>Need to consider</p> <ul style="list-style-type: none"> • risk • environment • individual's mental and physical capabilities, actions and behaviours in addition to condition/diagnosis <p>Incidental qualitative observations are important in addition to formal assessment of executive function</p> <p>Assess</p> <ol style="list-style-type: none"> 1. the person's ability to make a decision about where to live and understand the consequences of that decision; (functional approach—four criteria) 2. the person's actions that may put that individual or others in danger; and 3. the person's specific needs
6. Darzins (2010)	Discuss DMC assessment process; assess and document personal-care participation restrictions as part of assessment	<ul style="list-style-type: none"> • Unsafe occupational performance/personal care restrictions causing risk to self or others is a valid trigger for DMC assessment • Occupational therapists contribute by suggesting physical environmental modifications or the provision of support from families, friends or community services to accommodate activity limitations <p>Refers to six-step capacity assessment process (Darzins et al., 2000)</p> <ul style="list-style-type: none"> • Explain assessment process to person • Information gathering using assessments, for example, Personal Care Participation Restriction and Resource Tool (Vertesi et al., 2000; Turner et al., 2009) to structure assessment, document observations, gather information about the relevant choices and available supports • Inform person of relevant information • DMC assessment—functional approach • Act on findings—engage substitute decision makers
7. Bastian et al. (2011)	Response to paper by Darzins (2010)	<ul style="list-style-type: none"> • Presumption of capacity is problematic because it is often used to avoid making an assessment • Use valid instruments to obtain a profile of the situation—include neuropsychological assessment • Adopt a systematic approach, elements of assessments should be known by all members of the team • MDT approach
8. Feng et al. (2017)	Discuss conducting independent living capacity assessments within the home.	<p>In-home capacity evaluations are complex and challenging, yet results help family and HSCPs to support patients' preferences for staying in their own home as long as possible.</p> <p>Typical independent living capacity evaluation includes</p> <ul style="list-style-type: none"> • Assessment of the individual's cognition (e.g., neuropsychological testing) • Assessment of psychiatric symptoms • A functional measure, for example, Independent Living Scales (ILS) • Observations of functioning in the home • Clinical interview with the patient that includes an assessment of their values and preferences for where and how they live <p>Collaborate with other providers and family</p> <p>Benefits of assessing in home:</p> <ul style="list-style-type: none"> • Directly assess the functional elements of independent living rather than relying solely on a report from the patient or other reporters • Risks and benefits of the home situation to the patient are often evident by being in the patient's own space with them <p>Takes into account the patient's cultural background, preferences and values</p>

(Continues)

TABLE 3 (Continued)

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
9. Hicks et al. (2012)	Examine autonomy, choice, options and power in healthcare decision-making for older people	<ul style="list-style-type: none"> • Assessment of risk and availability of resources often take precedence over person's choice in determining discharge destination • Inform person of options on available discharge destinations to allow the person to make a choice • Listen to preferences and experiences of older person • Available options may not meet the needs of older adults who have diminished independence
10. Jayes et al. (2017)	Explore approaches to assessment of capacity within acute hospital and intermediate care settings	<p>Need to assess</p> <ul style="list-style-type: none"> • Functional abilities • Communication • Cognitive skills <p>Assessment process includes potentially overlapping phases of information gathering and both formal and informal assessments of patients' decision-making abilities.</p> <p>HSCPs use informal approaches to collect information to help them plan more formalised assessments</p> <p>1. Gathering information before the assessment</p> <p>Obtain information about patients' pre-admission functional abilities from their families, carers and community health and social care staff</p> <p>Use both formal and informal assessments to gain information about patients' current abilities, including their communication and cognitive skills (e.g., cognitive screening assessments).</p> <p>2. Informal and formal assessments of decision-making ability</p> <p>Conversations with patients about their home lives and hospital admissions to establish rapport with patients and to gain information about their cognitive function (e.g., their orientation and insight) and provide an informal assessment of capacity.</p> <ul style="list-style-type: none"> • Use of locally developed proforma to structure assessments and prompt staff to follow legal requirements of functional approach and can be used to document assessment. • Support patients with cognitive difficulties to learn information relevant to decision-making prior to the capacity assessment in order to enhance patients' capacity • Focus on information about risk and the long-term consequences of decisions when assessing patients' ability to make decisions about where to live on discharge • Assess patients' decision-making at different points in time • MDT approach recommended, though not widespread due to availability of staffing resources • Assessment practice is variable, and some staff would benefit from additional support in order to improve the quality of their capacity assessments. • DMC assessment of people with communication difficulties requires specialist support.
11. John et al. (2020)	Determine how clinicians in the hospital setting assess DMC in relation to consent to treatment, independent living and finances	<p>Collect detailed information concerning the person's cognitive status, functional abilities, mood, medical, social and environmental limitations</p> <p>Five domains of safe and independent living should be evaluated (Skelton et al.): ADLs; the home environment; IADLs; medical self-care (including medication management); and basic financial affairs.</p> <p>A deficit in any one of these indicates safe independence is questionable.</p> <p>Incorporate both subjective (i.e., patient self-report) and objective (i.e., performance based or direct observation) assessments of functional abilities</p> <p>Multidisciplinary approach to decision-making capacity assessment and ongoing training in DMC assessment recommended</p>

(Continues)

TABLE 3 (Continued)

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
12. Lai and Karlawish (2007)	Examine the current approaches to assessment of DMC regarding decisions about functional problems	<p>Current approaches to assessing decisional capacity for everyday activities in older people are incomplete; discussion of existing everyday decision-making tools</p> <p>Provides a template for a semi-structured interview to evaluate a person's ability to make an everyday decision, to supplement functional, cognitive and medical assessments</p> <p>This assessment is one component, integrated into a multistep assessment that incorporates knowledge of the patient's functional, psychological, socio-economic and medical state.</p> <p>Model for assessing the capacity to make decisions about how to solve functional problems</p> <ul style="list-style-type: none"> • Function—Functional testing by an occupational therapist plus history from family members on prior level of functioning • Cognition—Mini-Mental State Examination (MMSE) plus brief evaluation of executive function using an instrument such as the EXIT and delirium assessment • Psychological state—Screen for depression • Use proposed template to characterise ability to make decisions about how to solve functional problems and then document decisional skills within the context of the common language of the decisional abilities (understanding, appreciation, reasoning and choice) <ul style="list-style-type: none"> ○ Understanding the problem ○ Appreciating the problem ○ Understanding the solutions ○ Understanding the benefits and harms ○ Appreciating the benefits and harms ○ Initial choice ○ Comparative reasoning ○ Consequential reasoning ○ Expressing a choice
13. Lai et al. (2008)	Demonstrate the reliability and validity of ACED, an instrument to evaluate everyday decision-making	<p>ACED instrument measures the capacity to make decisions about solving functional problems.</p> <p>ACED uses a semi-structured interview format to assess four decision-making abilities: understanding, appreciation, reasoning and expressing a choice.</p> <p>ACED is a reliable and valid measure to assess decision-making capacity. It may serve as an important addition to current methods used to assess everyday decision-making.</p> <p>On the basis of its reliability, scoring pattern and associations with measures of cognition and the MacCAT-T, the ACED is a valid measure of EDM ability.</p> <p>The unique content focus of the instrument allows it to be useful for assessing the capacity of older persons with very mild to moderate cognitive impairment to make decisions about how to manage their IADL disabilities.</p>
14. Mackenzie et al. (2008)	Investigate the effect of cognitive problems and other factors on the DMC about discharge destination and to compare the impressions of multidisciplinary team	<ul style="list-style-type: none"> • Semi-structured interview to determine DMC regarding discharge destination, incorporates functional approach • Assesses insight to functional, cognitive, affective changes, risks in home environment, problem-solving and preferences • Also utilise standardised assessments such as MMSE, Barthel, MEAMS, BADS • Cognitive test scores, age and dysphasia are not good predictors of capacity to decide about discharge destination • MDT approach preferred (if trained in DMC) • MDT members' impressions of DMC should not be the only determinant of the need for formal assessment, as they are not closely related to the results of formal assessment.

(Continues)

TABLE 3 (Continued)

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
15. Moye et al. (2005)	Five-step clinical framework presented for assessment of DMC	<p>DMC for independent living can be the most challenging domain to assess because the range of skills necessary for independent living is so broad.</p> <p>Tasks important to demonstrate the capacity for independent living have been described as IADLs, such as management of home, health, money, transportation, meals and communication. However, assessment of these skills is not enough. Need to consider judgment in applying these skills in an organised and consistent manner.</p> <p>Judgment involves insight, planning and reasoning essential to independent living, for example, handle emergencies, compensate for areas of incapacitation, exhibit motivation for daily life and minimise risk to self and others.</p> <p>Process of assessment involves</p> <p>Referral clarification, assessment planning, assessment, synthesis of data and communication of findings and follow-up</p> <p>Assessment includes a targeted clinical interview and mental health evaluation, cognitive testing and specific capacity tests.</p> <p>Clinician must consider the diagnosis, cognitive abilities, functional abilities and skills and context.</p> <p>Utilise interviews; scales for depression, anxiety and other psychiatric symptoms; standardised cognitive tests; IADL instruments, for example, ILS (Loeb, 1996); and DMC assessments such as MacCAT-T (Grisso & Appelbaum, 1998), the Hopemont Capacity Assessment Instrument (Edelstein, 1999) and the Capacity to Consent to Treatment Instrument (Marson et al., 1995).</p> <p>DMC assessment is clinical judgment that integrates the individual's diagnosis and functional abilities and skills with sensitivity to the person's circumstances and past experiences, which may impact decision-making.</p>
16. Moye et al. (2007)	Develop a conceptual model and associated assessment template for conducting and documenting a capacity evaluation of older adults in guardianship proceedings.	<p>The model and template provide a structure for conducting and documenting a capacity evaluation in guardianship by using six assessment domains of interest to the courts.</p> <p>Six assessment domains:</p> <ol style="list-style-type: none"> 1. Medical condition that produces functional disability 2. Cognitive functioning 3. Emotional and psychiatric functioning important to assess in a capacity evaluation 4. Components of everyday functioning relevant for adult guardianship 5. Values relevant for adult guardianship 6. Risk of harm and level of supervision needed 7. Means to enhance capacity—practical accommodations (such as vision aids and medication reminders), as well as medical, psychosocial or educational interventions (such as physical therapy or OT, counselling, medications or training)
17. Moye and Braun (2007)	Discuss functional assessment of DMC within domain of independent living—specifically re guardianship	<p>Consider the relevant legal standards</p> <p>Focus on the specific functional issues and related values</p> <p>Everyday functioning can be divided into two categories: ADLs (e.g., dressing, eating, toileting and bathing) and IADLs (e.g., healthcare management, financial management and functioning in the home and community).</p> <p>Everyday functioning can be assessed through formal means, informal means or a combination of both.</p> <p>Informal methods include observing the individual or gathering information from the individual, family and staff.</p> <p>Formal assessments include ADL/IADL rating scales and OT instruments.</p>

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TABLE 3 (Continued)

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
18. Moye and Braun (2010)	Provide an overview of the theory and practice of assessing civil capacities (e.g., healthcare, finances and independent living) in older adults	<p>Summarises the framework and process from the ABA-APA Handbook for Psychologists (American Bar Association & American Psychological Association, 2008).</p> <p>Outlines components necessary for clinical capacity assessment:</p> <ol style="list-style-type: none"> 1. Understanding of the legal standard; 2. Discern the functional elements; which tasks appear to be most challenging for the individual (managing medications, keeping the home clean, maintaining adequate hygiene and exercising judgment in staying safe in the community)? How have functional concerns caused problems? Are these problems new or long-standing? Have these problems happened, or are others afraid they may happen? ADLs (e.g., grooming, toileting, eating, transferring and dressing) and IADLs (e.g., abilities to manage finances, health and functioning in the home and community) may be areas to evaluate. 3. Determine the diagnosis 4. Assess underpinning cognitive processes 5. Identify psychiatric or emotional factors which may influence function 6. Consider person's values and preferences for care, where or how they live; evaluate the decision-making process 7. Risk in the context of the supports available 8. Maximising capacity both during the evaluation and in the future—compensate for sensory, cognitive and physical deficits <p>Provide a clear, concise, clinical judgment; integrate historical information, interview data and test data in the context of a diagnosis and functional considerations to reach conclusion.</p> <p>Includes comprehensive clinical interview, standardised assessments of cognition and standardised assessments of function.</p> <p>Tests may include</p> <ul style="list-style-type: none"> • ILS • MMSE • Repeatable Battery for the Assessment of Neuropsychological Status • Trail Making Tests A and B • Clock Drawing
19. Naik, Lai, et al. (2008), Naik, Teal, et al. (2008)	Discuss assessment of capacity to make and execute decisions regarding safe and independent living	<p>Conceptualising and assessing autonomy solely in terms of DMC is inadequate and must be expanded to include decisional and executive dimensions.</p> <ul style="list-style-type: none"> • Assess cognition using standardised screens • Assess DMC using functional approach and using standardised case scenarios • Assess executive capacity using self-report and observation of performance of activities associated with independent living <p>Five domains of functioning related to self-care and placement:</p> <ol style="list-style-type: none"> 1. activities for personal care, 2. activities for independent living, 3. maintenance of the living environment, 4. basic medical self-management and 5. activities related to daily financial affairs. <p>Consider insight to limitations and awareness of supports</p>

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TABLE 3 (Continued)

et al., 2015; Poole et al., 2014; Schreiber et al., 2018), dispositional

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
20. Naik et al. (2010)	Describe HSCP's perceptions of and screening of vulnerability among older adults living in community settings	<p>Evaluate</p> <ul style="list-style-type: none"> • Cognitive abilities such as memory, attention and orientation • Decision-making processes (including reasoning or judgment) • Ability to plan and safely perform everyday tasks (Functional Independence Measure and KELS) <p>Consider physical environment and social supports, safety, personal appearance and grooming</p> <p>Interdisciplinary team approach in the home setting</p> <p>Vulnerability to risks associated with independent living is characterised by</p> <ol style="list-style-type: none"> 1. Inability to routinely perform ADLs across five domains: maintenance of personal finances, medical self-management, mobility, personal care and hygiene and maintenance of a safe living environment 2. Inadequate social support 3. Social and demographic factors 4. Neuropsychiatric conditions such as depression and dementia
21. Naik (2017a, 2017b)	Discuss assessment of capacity to make and execute decisions for safe and independent living. Present clinical model	<p>Decision-making capacity is 'the process of making decisions for oneself or extending that power to another individual when it is impaired', and executive capacity is the 'process of carrying one's decision into effect either alone or by delegating those responsibilities to another individual'.</p> <p>Decision-making and executive capacity should be evaluated independent of one another across five broad functional domains for independent living:</p> <ul style="list-style-type: none"> • maintaining personal needs and hygiene; • condition of the home environment; • maintaining activities for independent living; • healthcare self-management; and • managing financial affairs. <p>DMC assessed using functional approach</p> <p>Executorial capacity assessment—does person have a plan to person implement decision, they can adapt, plan and delegate as required</p> <p>Recommend use of MED-SAIL</p> <p>Comprehensive and standardised approaches to assess cognition, mood, ADL abilities, mobility and nutrition</p>
22. Mills et al. (2014)	Describe the development and validation of MED-SAIL, a brief screening tool for capacity to live safely and independently in the community	<ul style="list-style-type: none"> • Commonly used tools do not address the overlap of function, cognition and judgment required to assess DMC for independent living. • Use of MED-SAIL to differentiate between no capacity and partial/full capacity for independent living in community-dwelling older adults and identify older adults who may be at risk for losing their independence • Functional approach to DMC assessment applied to case scenarios related to independent living • Cognition assessed using St. Louis University Mental Status Examination. • Functioning and judgment assessed through ILS to determine the respondent's knowledge of information, ability to perform self-care tasks and care for property. • MED-SAIL was significantly correlated with the ILS. • MED-SAIL is an effective screening tool to differentiate between no capacity and partial/full capacity in community-dwelling older adults for the purposes of referral for comprehensive further evaluation and service planning. • MED-SAIL allows HSCPs in the community to identify older adults at risk for losing their independence, potentially requiring transitions into long-term care settings. <p>Responses to the MED-SAIL scenarios can be shared with family members or caregivers to contextualise capacity impairments in a manner that is meaningful to everyday living.</p>

(Continues)

TABLE 3 (Continued)

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
23. Skelton et al. (2010)	Describe interdisciplinary capacity assessment and intervention (CAI) model for home-based independent living capacity assessments with older adults.	<p>Cognitive function, affect and judgment are important for safe and independent living, and deficits in these domains are linked to impaired executive control function.</p> <p>Developed CAI model as comprehensive approach to assessment of DMC for independent living at a community outpatient geriatrics clinic to address gaps in training and consistency.</p> <p>Includes an in-home geriatrics assessment followed by an interdisciplinary team meeting to develop a plan of care to support the individual in their homes whenever possible</p> <p>Consider executive capacity as well as decisional capacity</p> <p>Ideally, assessments are performed in the patient's home but may also occur in the clinic or skilled nursing facility.</p> <p>Five domains of safe and independent living (Naik, Lai, et al. (2008), Naik, Teal, et al. (2008)) should be evaluated:</p> <ol style="list-style-type: none"> 1. personal needs, for example, bathing, toileting, dressing and feeding; 2. condition of home environment; 3. activities for independent living, for example, shopping, cooking, laundry, using telephone and transportation; 4. medical self-care, for example, medication management and wound care; and 5. financial affairs, for example, daily transactions and paying bills <p>Assessment process</p> <ol style="list-style-type: none"> 1. History, social and physical exam 2. Battery of standardised screening tools to assess cognition, affect and functional abilities (e.g., MMSE, GDS and KELS) 3. MDT meeting to examine all aspects of case history, assessments and recommend appropriate interventions 4. Meeting with the older adult and family members and social services professionals to discuss assessments and recommendations 5. Follow-up assessment to ensure that intervention recommendations have been implemented and are effective
24. Poole et al. (2014)	Explore how judgments about capacity regarding going home are made for people with dementia on medical wards and how they might be improved	<p>Assessments of residence capacity, judgments about 'best interests' and subsequent discharge decisions are complex from every perspective: HSCPs, people with dementia and for their families.</p> <p>Multiple formal and informal assessments often entail second opinions, for example, from old age psychiatry.</p> <p>Complex decisions require planning meetings and case conferences to seek the views of relatives.</p> <p>Clarity about the information to be imparted to the person concerned is required.</p> <p>Allow sufficient time and consider timing of assessment</p> <p>Need more support and training for practitioners, as well as support and advocacy for patients and families</p> <p>Need properly resourced step-down or rehabilitation units to facilitate timely and good decision-making</p>

(Continues)

TABLE 3 (Continued)

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
25. Emmett et al. (2013)	Discuss how assessments of residence capacity are performed on general hospital wards, compared with legal standards	<ul style="list-style-type: none"> • Functional approach to capacity assessment • Informal assessments of capacity occur over time—involve gleaning information from various sources, which then feeds into the overall capacity assessment, for example, OT home visit—could inform judgments about the patient's functional ability to weigh things up • Formal assessment—gather information on person's past and current living arrangements, current and future care needs and supports available to meet these needs • Present relevant information regarding various options, alternatives and risks associated with a particular choice of residence to a patient • Assess if they can understand and weigh those factors in order to demonstrate decisional capacity and make an informed choice—functional approach • Use of a pilot proforma led to lengthy, well-documented formal assessments, which closely followed the statutory requirements • Legal standards governing DMC assessment are not routinely applied in practice in general hospital settings; wide inconsistency of approach among professionals and between cases • More specific legal standards are required when assessing capacity to decide place of residence on discharge from hospital
26. Hughes et al. (2015)	Discuss the importance of residence capacity and how it should be assessed	<p>Functional assessment approach</p> <p>Assessment takes time and effort; physical environment should be quiet and private.</p> <p>Focus on information required by person with dementia to make such decision:</p> <ul style="list-style-type: none"> • Why a change of residence is being proposed: problems, concerns and reason for admission • What is being proposed (e.g., move into a care home) • Available options (e.g., if they go home, help is recommended because of the risks identified) <p>Consequences of making any decision, including a decision not to follow the advice being given, or making no decision at all</p>
27. Schreiber et al. (2018)	Discuss decisional capacity of older patients with cognitive impairment who refuse a safe discharge	<p>Residence capacity evaluations are fundamentally different from standard capacity evaluation</p> <p>MDT approach required to access the breadth of information necessary for an informed discussion of the discharge options</p> <p>Functional observation is essential in addition to self-report due to lack of insight regarding risks or capabilities, for example, hospital-based OT assessment, such as the KELS, used to characterise functional deficits (Bourgeois et al., 2017).</p> <p>Comprehensive holistic assessment—consider risks, person's values—must consider all possible risks and benefits to going home</p>
28. Stewart et al. (2005)	Discuss uncertainties and conflicts around place of discharge of older people	<ul style="list-style-type: none"> • Functional approach to DMC • Explain process, law and rights to person with dementia and family (including the right to take risks and make unwise decisions) • Use trial home discharges to assess insight, functional abilities, risks and sustainability • Liaise with multidisciplinary community mental health teams and services to assess and monitor person with dementia's ability to cope at home • Open involvement and communication with both patients and families. Need for patient advocacy for people with dementia

(Continues)

TABLE 3 (Continued)

Author, year	Aims/purpose of report	Assessment approaches and key findings/recommendations
29. Usher and Stapleton (2020a, 2020b)	Explore OT practices regarding DMC assessment	<p>Highlights role of occupational therapists within multidisciplinary assessment of DMC</p> <p>Need to assess</p> <ul style="list-style-type: none"> • functional performance abilities • cognitive skills • environment <p>OT assessment often includes gathering information about the person's past and present living arrangements, their current and future care needs and supports available to meet those needs, so the person can understand and weigh various options and risks, to demonstrate decisional capacity and make an informed choice.</p> <p>Adopt strengths-based approach—focus on what client can do</p> <p>Typical assessment approaches included</p> <ul style="list-style-type: none"> • performance-based assessments; • interview-based assessments; and • professional judgment. <p>Includes standardised assessments and structured observations of performance of daily tasks</p> <p>Structured observations of the person's ability to complete functional tasks inform assessment of DMC, for example, kitchen task assessments, home visits, washing and dressing assessments, community access and money management tasks.</p> <p>Standardised observations of function such as Assessment of Motor and Process Skills and Kettle Test.</p> <p>Cognitive screening assessments, for example, Montreal Cognitive Assessment, Addenbrooke's Cognitive Examination III, MMSE and Rivermead Behavioural Memory Test to inform DMC assessments.</p> <p>Seek collateral information from family and other HSCPs</p> <p>Assessment occurs in clinical setting, home and community</p>

Abbreviations: BADS, Behavioural Assessment of the Dysexecutive Syndrome; DMC, decision-making capacity; EDM, ethical decision-making; EXIT, Executive Interview; GDS, Geriatric Depression Scale; HSCPs, health and social care professionals; MacCAT-T, MacArthur Competence Assessment Tool-Treatment; MDT, multidisciplinary team; MEAMS, Middlesex Elderly Assessment of Mental State.

capacity (Bourgeois et al., 2017), capacity for accommodation decisions (John et al., 2020) and capacity to make everyday decisions (Lai et al., 2008; Lai & Karlawish, 2007). IL was not always reported as primary domain of interest, and approaches to its assessment were reported alongside other DMC domains such as financial capacity, medical consent and within general approaches to assessing DMC (Moye et al., 2005; Moye & Braun, 2010). Sometimes, discussion of DMC assessment for IL related to vulnerability (Naik, 2017a; Naik et al., 2010; Naik, Lai, et al., 2008) or was framed by concerns for guardianship (Moye et al., 2005; Moye & Braun, 2010).

Six themes were identified from the data extracted through thematic analysis (Figure 4). The first five themes describe the approaches to DMC assessment for IL, and the last theme outlines the multidisciplinary approach and highlights the HSCPs involved.

3.3 | Theme 1: Functional approach to DMC assessment for IL

Though legal definitions of DMC vary internationally, most legislation and literature pertaining to DMC generally define DMC for any domain in terms of four widely accepted criteria: understanding, appreciation,

reasoning and expression of choice (Grisso & Appelbaum, 1998). In relation to DMC for IL, the majority of publications in this review advocate for a functional approach to DMC assessment, incorporating these four dimensions, namely, the assessment of the person's abilities to understand relevant information about the situation, appreciate how relevant information applies to oneself in the situation, engage in rational deliberation about available options and to make and communicate a choice (Brindle & Holmes, 2005; Carrese, 2006; Clionsky et al., 2016; Cooney et al., 2004; Darzins, 2010; Emmett et al., 2013; Hughes et al., 2015; Jayes et al., 2017; Mackenzie et al., 2008; Mills et al., 2014; Naik, 2017a; Naik, Lai, et al., 2008; Stewart et al., 2005; Usher & Stapleton, 2020a).

Some authors argued that capacity assessments for IL must be expanded beyond decision-making to include executional dimensions (Clionsky et al., 2016; Naik, 2017a; Naik, Lai, et al., 2008; Skelton et al., 2010). Although DMC can be assessed using the above functional approach criteria, executional capacity assessment is concerned with the person's ability to carry out the decision and includes the additional opportunity to consider the person's ability to develop a plan, adapt the plan and delegate as required. Naik, Lai, et al. (2008) argue that disabilities or physical limitations do not affect executional capacity, as long as the older adult is aware of the limitations and cites potential supports.

Theme 1	Functional approach to DMC assessment for IL
Theme 2	Values and preferences
Theme 3	Components of DMC assessment for IL <ul style="list-style-type: none"> • Cognitive assessment • Functional performance assessment • Environmental assessment • Risk assessment
Theme 4	Maximising and supporting DMC
Theme 5	Specific assessments for IL DMC
Theme 6	HSCPs involved in assessment

FIGURE 4 Summary of themes from review. Abbreviations: DMC, decision-making capacity; HSCPs, health and social care professionals; IL, independent living

3.4 | Theme 2: Values and preferences

Many publications highlighted the need to ascertain the person's preferences and values (Brindle & Holmes, 2005; Carrese, 2006; Clionsky et al., 2016; Feng et al., 2017; Mackenzie et al., 2008; Moye & Braun, 2010; Schreiber et al., 2018), which may reflect increasing awareness of the impact of social and cultural factors, beliefs and attitudes on decision-making. A history of a consistently stated preference should be considered as this may reflect the person's values, religious beliefs, cultural background, previous healthcare and personal experiences (Carrese, 2006), as these long-held values, preferences and patterns lay the personal foundation for decisions (Naik et al., 2010). The importance of listening to the person's preferences is stressed, particularly when the options available may not suit the person's needs (Hicks et al., 2012). The need to adopt a functional approach to DMC assessment and to evaluate the process of decision-making, rather than the outcome, is important, given the individual has the right to make decisions that HSCPs may think unwise; therefore, the HSCPs' own values must be held in-check (Carrese, 2006; Hicks et al., 2012). However, although the importance of considering values and preferences is highlighted, there is little information on how to gather this information, except for Feng et al. (2017) who suggest that the clinical interview should include asking questions such as 'What makes your home a home?' in order to ensure that HSCPs' recommendations are consistent with the person's wishes.

3.5 | Theme 3: Components of DMC assessment for IL

Capacity for IL lies at the confluence of function, cognition and judgment (Mills et al., 2014). Unlike other domains of DMC, such as DMC for medical consent, which is largely a cognitive task, DMC for IL is a broad domain encompassing multiple everyday life functions and skills (Naik, Teal, et al., 2008). Thus, most publications recommended

a multicomponent approach, which includes assessment of the person's cognitive and functional abilities, their values and preferences, risks and the environment in question.

3.5.1 | Cognitive assessment

The majority of publications referred to assessment of cognition as part of a comprehensive DMC assessment for IL (Bastian et al., 2011; Bourgeois et al., 2017; Brindle & Holmes, 2005; Carrese, 2006; Cooney et al., 2004; Feng et al., 2017; Jayes et al., 2017; John et al., 2020; Mills & Naik, 2017; Moye & Braun, 2010; Naik, 2017a; Naik et al., 2010; Naik, Lai, et al., 2008; Skelton et al., 2010; Usher & Stapleton, 2020a). In assessing cognitive function for this particular domain, some authors specifically refer to the need to assess memory, attention and orientation (Naik et al., 2010), and others emphasise executive functioning abilities (Clionsky et al., 2016).

Specific standardised cognitive screens are referred to in many publications (Mackenzie et al., 2008; Naik, Teal, et al., 2008; Skelton et al., 2010; Usher & Stapleton, 2020a) such as Montreal Cognitive Assessment, Addenbrooke's Cognitive Examination III, Mini-Mental State Examination and Rivermead Behavioural Memory Test. In utilising cognitive screens, consideration of the individuals' educational and socio-economic background and use of assessments normed for older adults is stressed (Moye & Braun, 2010). However, although cognition was deemed a critical component of the DMC assessment process, some publications argued that reliance on cognitive screening is not sufficient to predict capacity to make decisions regarding IL (Mackenzie et al., 2008; Usher & Stapleton, 2020a).

3.5.2 | Functional performance assessment

Given the skills required for IL, the majority of publications refer to the need for assessment of functional skills and abilities to perform daily living tasks. Both subjective (i.e., self-report) and objective (i.e., performance based or direct observation) assessments of functional abilities is recommended (Bourgeois et al., 2017; Cooney et al., 2004; John et al., 2020; Skelton et al., 2010; Usher & Stapleton, 2020a). Both approaches are required as there can be significant difference between self-report and performance-based observations (John et al., 2020). Older people with cognitive impairment may lack insight into their deficits and may have a tendency to over-report capabilities or downplay risks (Schreiber et al., 2018).

Many authors recommend that assessment of functional abilities goes beyond evaluation of basic activities of daily living (ADLs; e.g., grooming, toileting, eating, transferring and dressing; Clionsky et al., 2016; Moye & Braun, 2007, 2010; Naik, 2017b; Naik et al., 2010; Naik, Teal, et al., 2008). They suggest that assessment should address instrumental activities of daily living (IADLs) relevant to IL, such as maintenance of the living environment, medical self-management and management of daily financial affairs, and

recommend using self-report and observation of performance of these activities that are associated with IL.

Functional performance of everyday tasks may be assessed using observations and standardised assessments, and articles reviewed highlighted assessment tools such as Independent Living Scales, Functional Independence Measure, Kohlman Evaluation of Living Skills, Personal Care Participation Restriction and Resource Tool, Assessment of Motor and Process Skills and Kettle Test (Bourgeois et al., 2017; Darzins, 2010; Feng et al., 2017; Mills et al., 2014; Naik et al., 2010; Schreiber et al., 2018; Skelton et al., 2010; Usher & Stapleton, 2020a). Occupational therapy assessments of function and performance, including home visits, were highlighted in some publications (Darzins, 2010; Emmett et al., 2013; Moye & Braun, 2007; Usher & Stapleton, 2020a) as a component of multidisciplinary assessment.

3.5.3 | Environmental assessment

Some of the publications reviewed refer to the person's home environment, recommending consideration of both the physical and/or social environment in the IL DMC assessment process (Bourgeois et al., 2017; Cooney et al., 2004; John et al., 2020; Usher & Stapleton, 2020a). As previously stated, a home-based assessment, taking cognisance of the person's ability to maintain a safe and accessible living environment, may provide some estimation of any level of vulnerability to risk associated with IL (Naik, 2017a; Naik et al., 2010; Naik, Teal, et al., 2008; Skelton et al., 2010).

Darzins (2010) suggests that physical environmental modifications or provision of support to accommodate activity limitations contributes to decision-making for discharge planning as by minimising participation restrictions and associated risks, the older person can make informed decisions about their ability to manage at home and to accept recommended supports. Feng et al. (2017) advocate the benefits of observing the older person's functioning in the home, not only in relation to risk but also in terms of understanding the person's cultural background, preferences and values. However, Emmett et al. (2013) report that although occupational therapy home assessment may contribute to DMC assessment by informing judgments about the patient's functional ability to weigh things up, conversely, it may encourage an outcome approach to DMC assessment, whereby HSCPs attribute capacity on the basis of the consequences of the older person's decision-making choices. Therefore, evaluation of the person's environment, or their functioning within their environment, must be carefully integrated into the DMC assessment process to ensure it does not detract from the recommended functional approach to DMC assessment. Rather, environmental assessment is part of the relevant information that applies to the person's situation, which they must show ability to understand, appreciate and weigh up in making a decision.

3.5.4 | Risk assessment

Consideration of risk is referred to as part of the overall assessment process or as a trigger for assessment within numerous publications (Carrese, 2006; Cooney et al., 2004; Darzins, 2010; Hicks et al., 2012; Jayes et al., 2017; Mackenzie et al., 2008; Moye & Braun, 2010; Schreiber et al., 2018; Stewart et al., 2005), though there is no recommendation on how to undertake this. Emmett et al. (2013) and Moye and Braun (2010) report concepts of risk assessment and management play a particularly important role in DMC assessment process regarding IL. Schreiber et al. (2018) argue that assessment must consider all possible risks and benefits to going home, and Feng et al. (2017) suggest that these risks and benefits are often evident when DMC assessments are conducted within the home. Identified risks and subsequent concerns must be communicated to the person in order to evaluate if they can weigh up the risk and benefit (Cooney et al., 2004; Usher & Stapleton, 2020a). Stewart et al. (2005) recommend that the person is advised of their right to take risks and make unwise decisions.

3.6 | Theme 4: Maximising and supporting DMC

In effort to support and optimise DMC, many publications highlighted consideration of assessment timing, given that DMC may fluctuate, and emphasised the importance of modifying the assessment setting and the approach taken to compensate for any physical, sensory or cognitive deficits and maximise capacity (Bourgeois et al., 2017; Clionsky et al., 2016; Hughes et al., 2015; Moye & Braun, 2010). Clionsky et al. (2016) recommend addressing reversible barriers to DMC (such as delirium) and reassessing DMC and preferences over time. Informal assessments of DMC occur over time as HSCPs utilise formal and informal approaches to gather information (Emmett et al., 2013; Jayes et al., 2017). A strengths-based approach, emphasising the person's abilities, is recommended (Usher & Stapleton, 2020a). Many publications recommended providing the person with sufficient information relevant to the decision in an accessible format, so they can make an informed choice (Emmett et al., 2013; Jayes et al., 2017; Poole et al., 2014). Clarity about the information to be imparted to the person concerned is required (Poole et al., 2014) and only then can the person's level of insight be considered (Brindle & Holmes, 2005; Carrese, 2006; Stewart et al., 2005). Stewart et al. (2005) also recommend 'trial discharges' be instigated more routinely to determine a person's insight into their ability to manage at home and subsequently to make an informed decision regarding IL.

3.7 | Theme 5: Specific assessments for IL DMC

This review included publications describing the validation of three instruments specifically concerned with DMC assessment of IL. Mills et al. (2014) describe the development and validation of the Making and Executing Decisions for Safe and Independent Living (MED-SAIL)

screening tool for identifying community-dwelling older adults at risk for losing their independence. Naik (2017a, 2017b) recommends its use in assessment of capacity to make and execute decisions for safe and IL. Naik (2017b) describe its use in the context of self-neglect in older adults. Lai et al. (2008) present the reliability and validity of Assessment of Capacity for Everyday Decision-Making (ACED), which uses semi-structured interview to evaluate the person's capacity to make everyday decisions about solving functional and IADL problems. Lai and Karlawish (2007) recommend this assessment be integrated into a multistep assessment that includes the person's functional, psychological, socio-economic and medical status. The Communication Aid to Capacity Evaluation (CACE) was developed and validated as an accessible tool, providing structure through pictorial and written choices, to allow HSCPs to evaluate capacity of people with aphasia to consent to be admitted to long-term care (Carling-Rowland et al., 2014). Although these tools were developed in the United States (MED-SAIL and ACED) and Canada (CACE), the issues that arise regarding the preservation of an individual's rights to decide where and how to live have relevance in other jurisdictions.

3.8 | Theme 6: HSCPs involved in assessment

A multidisciplinary approach was recommended in many publications (Jayes et al., 2017; John et al., 2020; Usher & Stapleton, 2020a), and a range of HSCPs were mentioned as having a potential role in contribution to the assessment process. Schreiber et al. (2018) note that no one discipline could have access to the breadth of information in relation to IL. Most publications pertained to the work of physicians and psychologists, though they often referred to the involvement of nurses, social workers, occupational therapists and mental health providers or used generic terms such as a clinician or healthcare professional. As reported by Jayes et al. (2017), the involvement of HSCPs might depend on who has relevant skills and knowledge about the person's home situation or functional abilities. For example, many publications highlighted the contribution of occupational therapy in functional performance assessments and home assessments, which is often pertinent for decisions relating to IL.

4 | DISCUSSION

This scoping review aimed to synthesise knowledge about approaches to assessing DMC for IL of older adults. This review was motivated by the need to identify ways of implementing recently commenced DMC legislation in Ireland and to improve DMC assessment practice among HSCPs who work with older adults. Twenty-nine records were identified for inclusion in this review, which relate to current approaches to assessing older adults' DMC for IL, including which HSCPs contribute to assessments, what is measured and how, and in what settings.

Given IL is a broad domain, it is not surprising that many publications recommended a multipronged approach to assessment.

Although this review has identified key components of DMC assessment for IL, there is much overlap between these areas, and assessments of cognition, function, environment and risk often occur simultaneously. The lack of clear distinction between certain concepts can lead to difficulties implementing the functional approach as outlined in legislation. Emmett et al. (2013) highlighted how conflation of perceived risk with DMC can lead to adoption of an outcome approach. This review also highlights that a person's value and preferences may not be as consistently or easily assessed as more concrete components of assessment and therefore may be overlooked as HSCPs focus on objective assessment of areas such as cognition or function. This is an issue that requires further attention, given recent legislation emphasises the person's will and preference as a core principle. By considering underlying beliefs, attitudes and expectations, HSCPs may be able to support and promote DMC of older adults for IL. Reflective of legislative and policy changes, many publications emphasise the importance of supporting people in decision-making and maximising DMC as part of the assessment process.

A multidisciplinary approach is highlighted in this review. Successful collaboration among HSCPs requires a shared and consistent understanding of DMC; however, a lack of standardised approach is reported (John et al., 2020). This reinforces the need for training and education on DMC, which has been widely acknowledged (Jayes et al., 2017; Usher & Stapleton, 2020a; Young et al., 2018). Additionally, lack of inter-professional collaboration and 'perceived' professional isolation have been identified as clinical practice issues, with medical practitioners predominantly taking responsibility for assessing DMC (Davies et al., 2019). Addressing training and education gaps may also enhance confidence and address practice issues relating to professional hierarchy, reluctance to assess and deferral to others. Multidisciplinary collaboration may also allow HSCPs share the responsibility associated with assessment and consequences of assessment.

Three specific assessment tools of DMC for IL were identified in this review, which may be useful when incorporated into a comprehensive multistage approach. Given the complexity of DMC for IL, it is unlikely any one assessment tool could consider all the individual and contextual factors that contribute to decision-making. Nonetheless, there is growing awareness of variables in clinical judgment and discrepancy between structured assessment and expert opinions in underestimating and overestimating DMC (Pennington et al., 2018). Therefore, in borderline or challenging cases, using structured assessment tools may be useful, if considered as part of a comprehensive multidisciplinary approach, which includes open discussion with the older person and their relevant caregivers.

4.1 | Recommendations for future research

A broad variety of literature was examined, encompassing scientific evidence, reviews, clinical experience and judgment and expert opinion. However, no records were found on older people's views (or

their relatives) regarding what they find appropriate to assess about their IL status, which limits the interpretation of results. There is clear need for research, which captures perspectives of older people and caregivers on their preferences and concerns regarding DMC assessment for IL and to better understand their experiences and ensure adequate attention is given to their will and preference. Hicks et al. (2012) recommend participatory action research with older adults when developing policy on how to provide for an ageing population. Additionally, to create best practices in this area, more research is needed to expand understanding of barriers and facilitators to assessment and provide more detailed descriptions of outcomes.

This review highlights the emerging literature regarding approaches to DMC assessment of older adults for IL. However, the paucity of empirical research is evident, especially given the international context and the significance of assessment outcomes for older adults. Limited literature on assessment of DMC for IL may reflect conceptual confusion and variance in terminology used to describe this domain. Much literature exists on multidisciplinary practice in discharge planning, which often relates to the DMC domain of IL. Previous research identified that DMC assessments in acute hospitals mainly relate to discharge decisions, which require patients to make choices about returning to their usual residence, with or without a package of care (Jayes et al., 2017). However, although discharge planning research may overlap with DMC research, publications that did not explicitly refer to assessment of DMC were not included within the review. This may explain the lack of literature from disciplines such as occupational therapy, which despite often being involved in DMC assessment may publish research framed as discharge planning and may not specifically address DMC issues, and therefore are beyond the parameters of this review. Previous research found that people with dementia are excluded from care-planning meetings on the assumption that they lack DMC (Donnelly et al., 2018); however, the process of determining DMC was not described. Nonetheless, discharge and care planning should incorporate aspects of DMC, and therefore, knowledge on approaches to assessment is required for HSCPs involved in discharge planning such as occupational therapists, public health nurses and community services to ensure that decision-making is compliant with legislation, promotes the rights of the older person and grounded in the underpinning principles of enablement, least restriction and participation.

Furthermore, another conceptual issue in the broader DMC assessment literature is highlighted by Moye and Braun (2010), whereby the legal use of the term *functional* in discussing DMC assessment approaches refers to one of three approaches to capacity. A functional approach to DMC assessment recognises DMC as issue specific and time specific and emphasises the process of making a decision, rather than the outcome of the decision itself. In gerontology and wider healthcare practice, the term *functional assessment* or *functional capacity evaluation* is typically used in reference to a person's ability to perform ADLs and IADLs (Quinn et al., 2011). Although this conceptual discrepancy did not limit this review, the potential misinterpretation of a core concept has implications for the implementation of legal guidance in clinical practice.

Although this review was conducted systematically and rigorously, there are several acknowledged limitations. A single researcher (the first author) was primarily responsible for study selection, data extraction and data synthesis. The first author consulted the second author throughout the review process to ensure consistency in application of the search strategy and the results obtained. This review followed the framework outlined by Arksey and O'Malley (2005) and further recommendations provided by Levac et al. (2010) and Peters et al. (2017). Due to disparate study designs and the descriptive nature of the publications included in the review, systematic quality assessments of the final included results as suggested by Levac et al. (2010) were not conducted. However, our discussion includes directions for future research and the utility of the research in practice.

This review offers a systematic overview of the existing literature regarding the assessment of older adult's DMC for IL. Both quantitative and qualitative data were sought, but most publications presented were commentaries and case discussions. As the review was limited to publication in the English language, papers published in other languages may have been missed. Additionally, most publications originated in the United States, which indicates that further research from other jurisdictions is required. As the approach to DMC assessment is framed by the context, variance in legal standards between jurisdictions must be considered. For example, the legislation in Ireland does not consider a 'best interest' approach as exists in other jurisdictions such as the United Kingdom. Equally, there is no prerequisite for an impairment of the mind or brain, whether as a result of an illness or external factors, such as alcohol or drug use, as there is in United Kingdom and United States. The prevalence of psychiatry and psychology-related publications may reflect some jurisdictions legislative requirements for a diagnosis that may impair DMC in initiating assessment. As legal reform increasingly places emphasis on the person's will and preference, research will need to address how this is best assessed and addressed as part of DMC assessment. Despite these acknowledged limitations, the body of knowledge presented in this review provides a broad understanding of how DMC of older adults regarding IL is assessed.

5 | CONCLUSION

This review identifies and maps existing literature on approaches to assessing older adults' DMC in relation to IL and highlights current gaps in research. Despite increasing literature on this topic in recent years, there is need for further research to expand understanding of the complexity of assessment and the barriers and facilitators influencing the assessment process. No studies were identified on the views of older adults and their relatives or caregivers regarding assessment of DMC for IL. Overall, findings indicate a comprehensive and multidisciplinary approach, using validated screening instruments for assessing cognition and functional performance, and clear communication of outcomes is required when assessing older

peoples DMC for IL. As older people should be involved in deciding where they live, future research gaining insights into their perspectives is recommended. It is hoped that the findings from this review can be used to inform discussion and further debate about the implementation of DMC legislation.

CONFLICT OF INTEREST

The authors report no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

How to cite this article: Usher, R., & Stapleton, T. (2021). Assessment of older adults' decision-making capacity in relation to independent living: A scoping review. *Health & Social Care in the Community*, 00, 1–23. <https://doi.org/10.1111/hsc.13487>

Appendix B:
Sample search strategy for scoping review from the Embase database

Appendix B: Search Strategy Embase

1. ('decision making'/de OR 'patient decision making'/exp) AND ('competence'/exp OR 'informed consent'/exp OR 'mental capacity'/exp OR 'senescence'/exp OR 'comprehension'/exp)
2. ((capacit* OR capabilit* OR abilit* OR competenc*) NEAR/3 (decision*)):ti,ab
3. #1 OR #2
4. 'aged'/exp OR 'aging'/exp OR 'elderly care'/exp OR 'geriatrics'/exp OR 'geriatric patient'/exp
5. (aged OR elderly OR 'senior citizen*' OR geriatric* OR 'older patient*' OR 'older people' OR senescence):ti,ab
6. #4 OR #5
7. #3 AND #6
8. 'psychologic assessment'/exp OR 'clinical assessment tool'/exp OR 'neuropsychological test'/exp OR 'Mini Mental State Examination'/exp OR 'Montreal cognitive assessment'/exp OR 'clock drawing test'/exp OR 'digit symbol substitution test'/exp
9. ('MacArthur Competence Assessment Tool for Clinical Research' OR 'macarthur capacity assessment' OR MacCAT-CR OR 'Mini-Mental State Examination' OR MMSE OR 'Folstein test' OR 'Montreal cognitive assessment' OR 'Short Portable Mental Status examination' OR 'Short Portable Mental Status score' OR SPMSQ OR CLOX OR 'Executive Clock Drawing Task' OR 'clock drawing executive test' OR 'clock drawing test' OR 'digit symbol substitution test' OR 'digit symbol substitution task' OR 'Hopemont Capacity Assessment' OR 'Hopkins Competency Assessment' Test OR HCAT):ti,ab
10. (cognitive* NEAR/3 assess*):ti,ab
11. ((Evaluat* OR assess* OR capac*) NEAR/6 decision*):ti,ab
12. #8 OR #9 OR #10 OR #11
13. #7 AND #12 AND [english]/lim AND [2000-2019]

Appendix C:
Scoping Review Data Extraction Form

Appendix C: Scoping Review Data Extraction Form

Data to be extracted	Item	Reviewer notes
Publication characteristics	Title Year of publication Author Study aims/purpose Type of study (e.g. feasibility study/pilot study/RCT/opinion piece) Country of origin	
Participant characteristics	Sample size Inclusion criteria Exclusion criteria Age Sex Diagnosis (e.g. mild cognitive impairment, dementia, neurodegenerative disease) Health service attached to Reference to relevant legislation, UN CRPD Reference to clinical guidelines	
Assessment characteristics	Assessment approaches discussed (Yes/No) Domains of capacity assessed Standardized or non-standardized approach Assessment/ instruments used Patient/proxy reported Assessment time point Assessment duration Assessment location Administration Health professionals involved Reference to staff training/education	
Gaps in research	Gaps identified Recommendations or research Reference to supported decision-making	
Overall conclusion		

Appendix D:
Phase One Online Survey

Decision-making capacity assessment: The role of occupational therapy in Ireland

Introduction to Survey

The purpose of this research project is to explore practice patterns regarding decision-making capacity assessment among occupational therapists in Ireland.

You are invited to participate in this research project because you are an occupational therapist. Your participation in this research study is voluntary, so you may choose not to participate.

The procedure involves completing an online survey that will take approximately 10 to 20 minutes.

Your responses will be confidential. Neither your name, place of work, nor your IP address will be recorded during in the survey. All data is stored in a password protected electronic format. To help protect your confidentiality, the surveys will not contain any required fields that will personally identify you.

If you have any questions about the research study, please contact usherru@tcd.ie.

This research has been reviewed for Ethical Approval from the Trinity College Dublin Faculty of Health Science Ethics Committee.

ELECTRONIC CONSENT: Clicking on the "OK" button below indicates that:

- you have read the above information
- you voluntarily agree to participate

Decision-making capacity assessment: The role of occupational therapy in Ireland

Demographic Information

* 1. Please select your gender:

- Female
- Male
- Prefer not to say

* 2. How many years have you worked as an occupational therapist?

- Less than 3 years
- 4-6 years
- 7-10 years
- 11-15 years
- 16- 20 years
- More than 20 years

* 3. What is the highest level of education you have completed?

- BSc
- MSc
- PhD

* 4. Which client groups do you typically work with? (Possible to select multiple response options)

- Older adults
- Persons with stroke
- Persons with traumatic brain injury
- Persons with progressive neurological diseases (e.g. MS, Parkinson's disease, MND, Huntington's disease etc)
- Other (please specify)

- Persons with psychiatric disorders/mental health difficulties
- People with dementia
- Persons with unspecified cognitive dysfunction
- Person with developmental disabilities/intellectual disabilities

* 5. In which practice setting do you work? (Possible to select multiple response options)

- | | |
|---|---|
| <input type="checkbox"/> Hospital based | <input type="checkbox"/> Research based |
| <input type="checkbox"/> Community based | <input type="checkbox"/> Academic |
| <input type="checkbox"/> Private practice | |
| <input type="checkbox"/> Other (please specify) | |

* 6. Which community Health Care Organisation area do you work in?

- | | |
|--|--|
| <input type="checkbox"/> Area 1: Donegal, Sligo/Leitrim/West Cavan and Cavan/Monaghan | <input type="checkbox"/> Area 6: Wicklow, Dun Laoghaire and Dublin South East |
| <input type="checkbox"/> Area 2: Galway, Roscommon and Mayo | <input type="checkbox"/> Area 7: Kildare/West Wicklow, Dublin West, Dublin South City, and Dublin South West |
| <input type="checkbox"/> Area 3: Clare, Limerick, and North Tipperary/East Limerick | <input type="checkbox"/> Area 8: Laois/Offaly, Longford/Westmeath, Louth and Meath |
| <input type="checkbox"/> Area 4: Kerry, North Cork, North Lee, South Lee, and West Cork | <input type="checkbox"/> Area 9: Dublin North, Dublin North Central and Dublin North West |
| <input type="checkbox"/> Area 5: South Tipperary, Carlow/Kilkenny, Waterford and Wexford | |
| <input type="checkbox"/> Other (please specify) | |

Decision-making capacity assessment: The role of occupational therapy in Ireland

Context of Decision-Making Assessment

- * 7. Are you aware of the Decision Making Capacity Act (2015)?
- Not at all
- Some familiarity
- Very familiar

- * 8. Has the Decision Making Capacity Act (2015) had any implications on your practice?
- Yes No

Please elaborate

- * 9. Which staff play a significant role in decision-making capacity assessment in your workplace? (Please select all that apply)
- | | | |
|--------------------------|----------------------------|--------------------------|
| <input type="checkbox"/> | Medical staff | <input type="checkbox"/> |
| <input type="checkbox"/> | Nursing staff | <input type="checkbox"/> |
| <input type="checkbox"/> | Psychology staff | <input type="checkbox"/> |
| <input type="checkbox"/> | Social work staff | <input type="checkbox"/> |
| <input type="checkbox"/> | Occupational therapy staff | <input type="checkbox"/> |
| <input type="checkbox"/> | Speech therapy staff | <input type="checkbox"/> |

Physiotherapy staff

Nutrition and dietetic staff

Psychiatry staff

Radiography/medical imaging staff

Don't know

Other (please specify)

* 10. Are you involved in contributing to the assessment of decision-making capacity in your work setting?

Yes

No

* 11. Do you receive requests from other MDT members to contribute to decision making capacity of clients in your work?

Yes

No

* 12. If yes, which MDT members typically request your contribution?

Medical staff

Nursing staff

Psychology staff

Social work staff

Speech therapy staff

Other (please specify)

Physiotherapy staff

Nutrition and dietetic staff

Psychiatry staff

Radiography/medical imaging staff

Don't know

* 13. How frequently do you contribute to decision-making capacity assessments?

Weekly

Occasionally

Fortnightly

Advice sought on an ad hoc basis

Monthly

Never

Comments

* 14. Please indicate the frequency of your involvement in the assessment of decision-making capacity for each of the following areas

	Never	Rarely	Sometimes	Often	Always
Independent living (including discharge destination)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consent to treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voting consent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testimony consent/legal decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify)

Decision-making capacity assessment: The role of occupational therapy in Ireland

Assessment Process

* 15. How do you assess Decision-Making Capacity? (Please select all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Conversation | <input type="checkbox"/> Observation of daily activities |
| <input type="checkbox"/> Semi-structured interview | <input type="checkbox"/> Professional judgement |
| <input type="checkbox"/> Structured interview | <input type="checkbox"/> Not my responsibility |
| <input type="checkbox"/> Standardized assessment tools | |
| <input type="checkbox"/> Other (please specify) | |

* 16. Do you use any of the following standardised assessment tools to assess cognitive function? (Please select all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Mini Mental Status Evaluation (MMSE) | <input type="checkbox"/> Clock drawing test, trail making test |
| <input type="checkbox"/> Middlesex Elderly Assessment of Mental State (MEAMS) | <input type="checkbox"/> Assessment of Motor and Process Skills (AMPS) |
| <input type="checkbox"/> Rowland Universal Dementia Assessment Scale (RUDAS) | <input type="checkbox"/> Kettle Test |
| <input type="checkbox"/> Addenbrookes Cognitive Examination (ACE-R) | <input type="checkbox"/> Loewenstein Occupational Therapy Cognitive Assessment (LOTCA) |
| <input type="checkbox"/> Cognitive Assessment of Minnesota (CAM) | <input type="checkbox"/> Rivermead Memory Behavioral Test |
| <input type="checkbox"/> Montreal Cognitive Assessment (MoCA) | |
| <input type="checkbox"/> Other (please specify) | |

* ~~17. What is the reason you choose to use standardised assessment tools?~~
(Please

select all that apply)

- Cognitive screening tools are being used as part of typical practice and the scores can be useful in informing the assessment of decision making capacity
- A score on a standardised assessment or screening tool is likely to be considered more objective and less open to challenge than a functional observation
- Other (please specify)

* ~~18. What is the reason you choose not to use standardised assessment tools?~~ (Please select all that apply)

The tests are designed as cognitive screening tools and are not designed specifically to assess the person's decision-making capacity

There are no guidelines on interpreting the test scores with regard to determining decision-making capacity

Scores on standardised cognitive screening tools do not always reflect the person's functional ability or decision-making capacity

I'd be concerned that a 'bad' test score could be used inappropriately to determine the person did not have decision-making capacity

Other (please specify)

Other MDT members specifically request a particular standardised assessment or screening tool be carried out to inform the overall assessment of the client's decision making capacity

I do not want to expose my clients to unnecessary assessment

I do not have access to materials/assessments in my workplace

Time constraints in my workplace do not support use of standardised assessments

* 19. Do you use any of the following structured observations of the person's ability to complete functional tasks as a method to inform the assessment of decision making capacity? (Please select all that apply)

- Washing and dressing assessment
- Kitchen task assessment
- Money management assessment
- Other (please specify)
- Community access
- Home visit

* 20. How often is the client aware that you are involved in the assessment of his/her decision-making capacity?

- Never
-
-

Rarely

Often

Always

Sometimes

* 21. Do you typically obtain collateral information from the client's carer/family members/other staff ?

Yes

No

* 22. If yes, how do you obtain this information?

Conversation

Standardized assessment

Semi structured interview

Other (please specify)

* 23. Where do you typically assess clients? (Please select all that apply)

- In the client's home environment In community (Please specify)
- Clinical setting (Please specify e.g. on hospital ward, in OT department)
- Other (please specify)

Decision-making capacity assessment: The role of occupational therapy in Ireland

Beliefs/attitudes regarding decision-making capacity assessment

* 24. Have you completed further training/education in relation to decision-making capacity assessment and related interventions?

- Attended seminars, conferences (please specify) Peer education
- Read research/journal articles/books Formal post-graduate education
- Discussion with colleagues
- Other (please specify)

* 25. Please complete each of the following questions:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
Contributing to assessments of decision-making capacity is more difficult than most other aspects of occupational therapy practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Once the assessment is completed I usually feel confident about my contribution to recommendations regarding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

capacity

	Strongly disagree Agree	Disagree	Neutral	Agree	Strongly
Occupational therapy is ideally suited for contributing to assessments of decision-making capacity	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The role the occupational therapist plays in assessing decision-making capacity in my work setting is valued	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confident being involved in administering assessments of decision-making capacity	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am satisfied with the decision-making capacity assessment procedures followed in my work place	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I base my recommendations primarily on formal assessment data	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I rely on qualitative aspects of the client's test performance more than the scores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

themselves

	Strongly disagree Agree	Disagree	Neutral	Agree	Strongly
I often feel unsure as to whether or not a client has the capacity to make important decisions	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My training prepared me well for contributing to assessments of decision-making capacity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be beneficial if there were <i>general</i> guidelines available to direct occupational therapists in their involvement in assessing decision-making capacity	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It would be beneficial if there were <i>specific</i> guidelines available to occupational therapists for assessing decision-making capacity in different practice areas and for different client groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Strongly disagree Agree
Disagree Neutral Strongly

I often feel the need to discuss decision-making assessments with other occupational therapists or multidisciplinary team members

I usually find it is unhelpful to enter into discussions with other team members about decision-making assessments

Occupational therapists would benefit from additional training in the area of assessing decision-making capacity

Being involved in assessments of decision-making capacity is a stressful part of my job

It is important to focus on what the client does/can do during capacity assessments rather than what they do

not/cannot do

Strongly
disagree
Agree

Disagree

Neutral

Agree

Strongly

Contributing to
assessments of
decision-
making
capacity is very
time consuming

Please note any further comments regarding decision-making assessments

Decision-making capacity assessment: The role of occupational therapy in Ireland

Thank you for your time and contribution

If you are interested in participating in further research regarding this topic (such as individual interviews or focus groups) please contact the researcher, Ruth Usher at usherru@tcd.ie

Appendix E:
Phase One Ethics Approval (Survey)



21st of May 2018

Re: Application 20180505

Title: Decision-making capacity assessment: The role of occupational therapy in Ireland

Dear Ruth Usher,

Your revised application has been reviewed by the School of Medicine Research Ethics Committee and we are pleased to inform you that the above project has been approved.

Applicants must submit an *annual report* for ongoing projects and an *end of project report* upon completion of the study. You will find these forms on the School of Medicine Research Ethics website.

It is the responsibility of the researcher/research team to ensure all aspects of the study are executed in compliance with the General Data Protection Regulation (GDPR) and Data Protection Act 2018.

Yours sincerely,

P.P: Laure Marignol
Chair, SOM Ethics Committee

An tOllamh Michael Gill MD FTCD MRCPsych
Ceann Scoil an Leighis

Dr. Alex McKee
Riarthóir na Scoile

Scoil an Leighis
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Baile Átha Cliath,
Ollscoil Átha Cliath
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Professor Michael Gill MD FTCD MRCPsych
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Appendix F:
Phase One Participant Information Leaflet (Survey)

Participant Information Letter

Decision-making capacity assessment: the role of occupational therapy in Ireland

Dear occupational therapist,

You are invited to take part in a survey, which forms part of a research project being undertaken by Ruth Usher, under the supervision of Dr. Tadhg Stapleton in the Discipline of Occupational Therapy, Trinity College Dublin.

The purpose of this research project is to explore practice patterns regarding decision-making capacity assessment among occupational therapists in Ireland.

You are invited to participate in this research project because you are an occupational therapist. Your participation in this research study is voluntary, so you may choose not to participate.

The procedure involves filling an online survey that will take approximately 10 to 20 minutes.

Your responses will be confidential. Neither your name, place of work, nor your IP address will be recorded during the survey. All data is stored in a password protected electronic format. To help protect your confidentiality, the surveys will not contain any required fields that will personally identify you.

Ethical approval for this research has been granted from the School of Medicine Research Ethics Committee Trinity College Dublin.

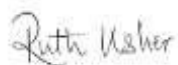
If you have any questions about the research study, please contact usherru@tcd.ie

To complete this survey please click on the following link: (insert link)

If you know other occupational therapists who meet these criteria but may not have received this email, please share this email and the attached link with them.

Your time in completing this survey is much appreciated.

Kind regards,



Ruth Usher

Appendix G:
Phase Three Ethics Approval (Focus Groups)



8th May 2019

Re: **DECISION-MAKING CAPACITY ASSESSMENT: THE ROLE OF OCCUPATIONAL THERAPY IN IRELAND**

Application no: 20190304

Dear Ms Usher,

Your application has been reviewed by the School of Medicine Research Ethics Committee and we are pleased to inform you that the above project has been approved.

Applicants must submit an *annual report* for ongoing projects and an *end of project report* upon completion of the study. You will find these forms on the School of Medicine Research Ethics website.

It is the responsibility of the researcher/research team to ensure all aspects of the study are executed in compliance with the General Data Protection Regulation (GDPR) and Data Protection Act 2018.

Yours sincerely,

Dr. Tadhg Stapleton
Chairperson, School of Medicine Research Ethics Committee
Trinity College Dublin

An tOllamh Michael Gill MD FTCD MRCPsych
Ceann Scoil an Leighis

Dr. Alex McKee
Riarthóir na Scoile

Scoil an Leighis
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Appendix H:
Phase Three Participant information email (Focus Groups)

Focus Group Participant Information Email

Study title: Decision-making capacity assessment: the role of occupational therapy in Ireland

Dear occupational therapist,

You are invited to take part in a focus group, which forms part of a research project being undertaken by Ruth Usher, under the supervision of Dr. Tadhg Stapleton in the Discipline of Occupational Therapy, Trinity College Dublin.

The purpose of this research project is to explore practice patterns regarding decision-making capacity assessment among occupational therapists in Ireland.

You are invited to participate in this research project because you are an occupational therapist. Your participation in this research study is voluntary, so you may choose not to participate.

This study involves participation in a focus group discussing your practice experience, attitudes and beliefs towards decision-making capacity assessment. This will take approximately 60 minutes.

To help protect your confidentiality, the focus group data will be transcribed and your name and place of work will not be recorded in the transcript. All data will be stored in a password protected electronic format.

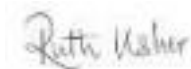
Ethical approval for this research has been granted from the School of Medicine Research Ethics Committee Trinity College Dublin.

If you have any questions about the research study, please contact usherru@tcd.ie

If you know other occupational therapists who meet these criteria but may not have received this email, please share this email with them.

Your time in participating in this research is much appreciated.

Kind regards,



Ruth Usher

Appendix I:
Phase Three Participant Information Leaflet

Focus Group Participant Information Leaflet

Study title: Decision-making capacity assessment: the role of occupational therapy in Ireland

Principal investigator's name: Ruth Usher

Principal investigator's title: Assistant Professor

Telephone number of principal investigator: 01-8963219

Supervisor: Dr. Tadhg Stapleton

Data Controller's/joint Controller's Identity: Trinity College Dublin

Data Controller's/joint Controller's Contact Details: 01-896 3216

Data Protection Officer's Identity: Data Protection Officer
Secretary's Office, Trinity College Dublin,
Dublin 2, Ireland.

Data Protection Officer's Contact Details: dataprotection@tcd.ie

Why is this study being done?

The purpose of this research project is to explore practice patterns regarding decision-making capacity assessment among occupational therapists in Ireland. We also want to explore participants' attitudes and beliefs towards decision-making capacity assessment.

Who is organising and funding this study?

This research study is being undertaken by Ruth Usher under the supervision of Dr. Tadhg Stapleton in the Discipline of Occupational Therapy, Trinity College Dublin.

Ethical approval for this research has been granted from the School of Medicine Research Ethics Committee Trinity College Dublin.

Why am I being asked to take part?

You are invited to participate in this research project because you are an occupational therapist. Your participation in this research study is voluntary, so you may choose not to participate.

How will the study be carried out?

Focus group interviews will be conducted and recorded and recorded by the researcher.

What will happen to me if I agree to take part?

This study involves participation in a focus group discussing your practice experience, attitudes and beliefs towards decision-making capacity assessment. This will take approximately 60 minutes.

Video/and or Audio recordings?

Focus group interviews will be recorded. All participants may request access to the transcript of the focus group that they attended to check the transcript for accuracy.

What are the benefits?

There is no direct benefit to the participants. The findings from the research may contribute to our understanding of how occupational therapists assess capacity and support decision-making for various client groups. It may highlight areas of challenge or different types of support which may be beneficial to their practice.

What are the risks?

No risks or potential for adverse outcomes have been identified.

Is the study confidential?

To help protect your confidentiality, the focus group interview data will be transcribed and your name will not be included in the transcript - participants will be referred to as participant 1, 2 etc, in the transcript. Your place of work will not be recorded in the transcript.

Neither your name nor place of work will be included in any publication of research findings. All data will be stored in a password protected electronic format.

Data Protection

1. Data will be stored anonymously in a database on encrypted and password protected computer accessed by the researchers only. Passwords will only be known to the researchers.
2. Only the researchers will access data. All data will be stored in a locked press accessed only by the researchers and kept for up to 5 years in line with best practice before being completely destroyed. Following this, all paper copies will be shredded and disposed of. Electronic files will be wiped and destroyed.
3. Participants have a right to lodge a complaint with the Data Protection Commissioner.

4. Participants have a right to request access to their data and a copy of it, unless their request would make it impossible or make it very difficult to conduct the research.
5. Participants have a right to restrict or object to processing of their data, unless their request would make it impossible or make it very difficult to conduct the research.
6. Participants have a right to have any inaccurate information about them corrected or deleted, unless their request would make it impossible or make it very difficult to conduct the research.
 7. Participants have a right to have their personal data deleted, unless their request would make it impossible or make it very difficult to conduct the research.
 8. Participants have a right to data portability, meaning they have a right to move their data from one controller to another in a readable format.

Where can I get further information?

If you need any further information about the study now or at any time in the future, please contact:

Name: Ruth Usher

Address: Trinity Centre for Health Science, St. James' Hospital, Dublin 8

Email: usherru@tcd.ie

Phone No: 01-896 3216

Appendix J:
Phase Three Focus Group Preparation Guide

Appendix J: Focus group preparation guide

Study title: Decision-making capacity assessment: the role of occupational therapy in Ireland
Researcher: Ruth Usher
Supervisor: Dr. Tadhg Stapleton

Thank you for considering participating in this focus group to explore issues for occupational therapists when addressing decision-making capacity assessment of older people within their clinical practice.

The aims of the study are:

- To explore how occupational therapists in Ireland are currently involved in the formal assessment of decision-making capacity
- To explore issues that impact on the current assessment practices of occupational therapists
- To explore occupational therapists' attitudes towards recent legislation regarding decision-making capacity
- To explore issues that impact on occupational therapists' readiness to engage in the assessment of decision-making capacity, such as confidence, training and education

In the focus group we will be interested to hear your views and experiences of addressing decision-making capacity with your clients.

Specifically, we would like to hear your views on the issues outlined in the topic guide below. We would ask you to consider these issues before attending the focus group. This list is not exhaustive and you may have other issues you feel are pertinent and you can of course discuss these at the focus group too.

Focus Group Topic Guide

DMC assessment process

- *What triggers DMC assessment?*
- *What is your role in the DMC assessment process?*
- *How do you assess DMC?*
- *What information needs to be considered?*
- *Who needs to be involved? (patients, families/carers, MDT professionals, advocates)*
- *Any particular assessment tools that you are aware of/ that are useful?*
- *How do you support patients during an assessment?*

DMC attitudes and beliefs

- *How do you find DMC assessment? What are the major gaps and barriers in the capacity assessment process as its being done now, and what are its effects?*
- *How confident do you feel in your level of DMCA expertise (knowledge and skills)? In what areas would you like further information and/or training?*
- *What current resources do you rely on to help support you in DMC assessment? What other resources or facilitators do you think would help in your role in DMCA?*

DMC legislation

- *Please describe your experience with DMC assessment related legislation or legal issues*
- *Has it influenced any changes in your practice (knowledge, skills and attitudes)?*
- *Have you experienced any barriers to implementing legislation in practice? If so, how have you overcome these barriers? If not, why not?*
- *Do you feel confident working with this legislation*

Appendix K:
Phase Three Consent Form

FOCUS GROUP PARTICIPANT CONSENT FORM

Study title: Decision-making capacity assessment: the role of occupational therapy in Ireland
--

I have read and understood the Information Leaflet about this research project. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	Yes	No
I am aware of the potential risks and benefits of this research study.	Yes	No
I have been given a copy of the Information Leaflet and this completed consent form for my records.	Yes	No
I consent to take part in this research study having been fully informed of the risks and benefits	Yes	No
I consent to be contacted by researchers as part of this research study.	Yes	No

Participant Name (Block Capitals) | Participant Signature | Date

To be completed by the Principal Investigator or nominee.

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have invited them to ask questions on any aspect of the study that concerned them.

Name (Block Capitals) | Qualifications | Signature | Date

Appendix L:
Phase Four Participant information email (NGT)

General introductory email for participants

Study title:

An exploration of how the components of the occupational therapy assessment process inform decision-making capacity assessment of older adults regarding independent living, using a nominal group technique.

Dear occupational therapist,

You are invited to take part in a consensus formation meeting, utilising the nominal group technique (NGT), which forms part of a research project being undertaken by Ruth Usher, under the supervision of Dr. Tadhg Stapleton in the Discipline of Occupational Therapy, Trinity College Dublin.

Occupational therapists working with older adults are often asked for their clinical opinion with regard to the person's decision-making capacity in relation to independent living. This study is being set up to try to reach some consensus on what occupational therapists think should be considered as part of a decision-making capacity assessment or how occupational therapy assessment process relates to this assessment.

It is planned to hold a one day consensus formation meeting in January 2020 to explore issues of decision-making capacity assessment of older adults regarding independent living, using a nominal group technique (NGT) approach, in order to try and reach some consensus on the issue. Occupational therapists who have experience and interest in this area of practice are sought as their opinions and experience will be essential to inform the process.

The primary focus of the study is to explore assessment of older adult's decision-making capacity for independent living from an occupational therapist's perspective:

- What areas or components are essential to assess?
- How best to assess these areas?

Emphasis will be placed on occupational therapy assessment aspects such a client's will and preference, occupational profile, functional abilities, cognitive abilities, client's environment, risk assessment, and client's decision support needs.

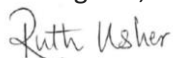
Overall, recommendations will be used to develop a practice framework to ensure assessment practices of occupational therapists are client-centred and occupation-focused and aligned with legislative and policy developments, leading to more consistent practice in this area. These will also inform future development of training and education.

Ethical approval for this research has been granted from the School of Medicine Research Ethics Committee, Trinity College Dublin. Please see the enclosed participant information letter for further detail on the study. I am happy to answer and clarify any questions you may have related to this study and can be contacted via email at ruth.usher@tcd.ie.

If you know other occupational therapists who meet these criteria but may not have received this email, please share this email with them.

Your time in participating in this research is much appreciated.

Kind regards,



Appendix M:
Phase Four Participant flyer with details of the NGT



CONSENSUSFORMATION1 DAY
WORKSHOP JANUARY 2020




Decision-making capacity assessment of older adults: Developing a framework to guide OT practice

Help us to:

- Identify key components of OT assessment to assist and support decision-making capacity
- Gather recommendations to develop a practice framework and inform training and education
- Build client-centred and occupation-focused practice aligned with legislative and policy developments

Contact Ruth.Usher@tcd.ie
for more details of this ongoing research project



**Decision-making
capacity assessment of
older adults:
Developing a
framework to guide OT
practice**

**CONSENSUS FORMATION 1 - DAY
WORKSHOP JANUARY 2020**

Help us to:

- Identify assessment protocol
and procedures
- Gather recommendations to develop
a practice
framework and inform training and
education
- Build client-centred and occupation-
focused practice aligned with
legislative and policy developments

Contact Ruth.Usher@tcd.ie for more info



Appendix N:
Phase Four Participant Information Leaflet

Participant Information Leaflet

Study title:

An exploration of how the components of the occupational therapy assessment process inform decision-making capacity assessment of older adults regarding independent living, using a nominal group technique.

Principal Investigator(s) and Co-Investigator(s) (insert names, titles and contact details)	Ruth Usher Assistant Professor 01-8963219/ usherru@tcd.ie Supervisor: Dr. Tadhg Stapleton 01-896-3214/ stapley@tcd.ie
Data Controllers	Trinity College Dublin
Data Protection Officer	Data Protection Officer Secretary's Office Trinity College Dublin Dublin 2

You are being invited to take part in a research study that is being undertaken by Ruth Usher, under the supervision of Dr. Tadhg Stapleton in the Discipline of Occupational Therapy, Trinity College Dublin.

Before you decide whether or not you wish to take part, please read this information sheet carefully. Do not hesitate to contact the principal investigator Ruth Usher should you have any questions.

This leaflet has four main parts:

Part 1 – The Study

Part 2 – Data Protection

Part 3 – Costs, Funding and Approval

Part 4 – Further Information

Part 1 – The Study

Why is this study being done?

The purpose of this research project is to

- Identify the key components to be included in assessment processes used by occupational therapists in order to support and assist the decision-making of older people, regarding independent living.
- Explore how best to assess these components to assist and support older adult's decision-making capacity, regarding independent living.
- Overall, the recommendations gathered will be used to develop a practice framework to ensure practices of occupational therapists are client-centred and occupation-focused and aligned with legislative and policy developments, leading to more consistency of practice in this area. These will also inform future development of training and education.

Why have I been invited to take part?

You are invited to participate in this research project because you are an occupational therapist with experience in working with older adults, and in contributing to assessments of their decision-making capacity for independent living. Your participation in this research study is voluntary, so you may choose not to participate.

Do I have to take part? Can I withdraw?

Participation is entirely voluntary. You can change your mind about taking part in the study and opt out at any time even if the study has started. You don't have to give a reason for not taking part or for opting out. If you wish to opt out, please contact Ruth Usher who will be able to organise this for you.

How will the study be carried out?

This study involves participation in a one-day consensus meeting on issues related to assessment and support of decision-making capacity of older adults for independent living.

What will happen to me if I decide to take part?

Participation in this study will involve participation in a consensus formation meeting.

This meeting will last one-day and will involve discussing your practice experience, attitudes and beliefs towards decision-making capacity assessment.

A nominal group technique (NGT) approach will be used in effort to reach consensus on the issues. NGT is a structured approach to brainstorming and decision-making where participants work in groups (5-9 participants) with a facilitator to explore the issue and come to agreement. The workshop will be scheduled over one full day in January/February 2020 and held at the Discipline of Occupational Therapy, Trinity College Dublin.

There will be a number of structured brainstorm (NGT) sessions over the course of the day and each session will last no more than one hour. The NGT sessions will focus on forming a consensus on *what* components should be included in an occupational therapy assessment of older adult's decision-making capacity regarding independent living and *how* these components should be assessed.

If you express interest in participating, the researcher will send you will be send an information pack and consent form, prior to the meeting. This will include information about the NGT process, a synthesis of relevant literature and some questions to consider which will be discussed at the workshop. Following the consensus meeting you will be asked to complete a brief satisfaction survey.

What will happen to my data?

- Group discussions at the consensus meeting will be audio recorded. All participants may request access to the transcript of the discussion to check the transcript for accuracy.
- To help protect your confidentiality, data will be transcribed and your name will not be included in the transcript - participants will be referred to as participant 1, 2 etc, in the transcript. Your place of work will not be recorded in the transcript. Neither your name nor place of work will be included in any publication of research findings. All data will be stored in a password protected electronic format.
- Data will be stored anonymously on an encrypted and password protected computer accessed by the researchers only. Passwords and encryption key will only be known to the researchers.
- Only the researchers will access data. All data will be stored in a locked press accessed only by the researchers and kept for up to 7 years, in line with best practice before being completely destroyed. Following this all paper copies will be shredded and disposed of. Electronic files will be wiped and destroyed.

Are there any benefits to taking part in this research?

Taking part in this study may not directly benefit you. The findings from the research will contribute to the development of a practice framework, which will ensure assessment practices of occupational therapists are client-centred and occupation-focused and aligned with legislative and policy

developments, leading to better quality and consistency of practice in this area. These will also inform future development of training and education which may be beneficial to your practice.

Are there any risks to me or others if I take part?

This study will involve an exploration of professional practice issues and will not involve gathering any personal or sensitive data.

All data gathered and used for analysis will not contain any identifiers related to your identity or place of work so therefore there is very low risk of breach of confidentiality.

Will I be told the outcome of the study?

Summary findings will be shared with participants during analysis for checking. Once analysis is completed the results of the research will be disseminated in peer-reviewed scientific journals and scientific conferences. No information which reveals your identity or place of work will be disclosed.

Part 2 – Data Protection

What information about me (personal data) will be used as part of this study?

No personal data will be collected for inclusion in the analysis.

To protect your confidentiality, data will be transcribed by a professional transcriber, your name will not be included in the transcript - participants will be referred to as participant 1, 2 etc, in the transcript. Your place of work will not be recorded in the transcript.

Neither your name nor place of work will be included in any publication of research findings. All data will be stored in a password protected electronic format.

What will happen to my personal data? How will my data be kept safe?

Data will be stored anonymously in a database on encrypted and password protected computer accessed by the researchers only. Passwords and encryption key will only be known to the researchers.

Only the researchers will access data. All data will be stored in a locked press accessed only by the researchers and kept for up to 7 years in line with best practice before being completely destroyed. Following this all paper copies will be shredded and disposed of. Electronic files will be wiped and destroyed.

Researchers are bound by a professional code of secrecy that would mean disciplinary action for disclosure or facilitation of unauthorised access to the personal data. Training in data protection law and practice has been provided to the researchers.

What is the lawful basis to use my personal data?

Prior to participating in this study you will be asked to give explicit consent that your participation and contributions can be used in the analysis as outlined in this PIL. The data gathered will not be used in any unrelated future studies.

What are my rights?

You are entitled to:

- The right to access to your data and receive a copy of it, you will be supplied with summary findings of the analysis for checking*
- The right to restrict or object to processing of your data*
- The right to object to any further processing of the information we hold about you (except where it is de-identified)*

- The right to have inaccurate information about you corrected or deleted*
- The right to receive your data in a portable format and to have it transferred to another data controller*
- The right to request deletion of your data*

By law you can exercise the following rights in relation to your personal data, unless the request would make it impossible or very difficult to conduct the research. You can exercise these rights by contacting the Trinity College Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.

Part 3 – Costs, Funding and Approval

Has this study been approved by a research ethics committee?

This study has been approved by the School of Medicine Research Ethics Committee at Trinity College Dublin. Approval was granted on 22nd November 2019.

Who is organising and funding this study? Will the results be used for commercial purposes?

This research study is being undertaken by Ruth Usher under the supervision of Dr. Tadhg Stapleton in the Discipline of Occupational Therapy, Trinity College Dublin.

There is no funding for this study.

Is there any payment for taking part?

There is no payment offered to participants to take part in the study.



Who should I contact for information or complaints?

If you have any concerns or questions, you can contact:

- *Principal Investigator: Ruth Usher, Discipline of Occupational Therapy, Trinity Centre for Health Sciences, St. James Hospital, James's Street, Dublin 8 usherru@tcd.ie 01-896-3219.*

- *Data Protection Officer, Trinity College Dublin: Data Protection Officer, Secretary's Office,
Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.*

Under GDPR, if you are not satisfied with how your data is being processed, you have the right to lodge a complaint with the Office of the Data Protection Commission, 21 Fitzwilliam Square South, Dublin 2, Ireland. Website: www.dataprotection.ie.

Will I be contacted again?

If you would like to take part in this study, you will be asked to sign the Consent Form on the next page. You will be given a copy of this information leaflet and the signed Consent Form to keep.

Appendix O:
Phase Four Consensus Formation Meeting Preparation Guide

Consensus Formation Meeting Preparation Guide

Dear occupational therapist,

Thank you for agreeing to participate in the consensus formation meeting. This information guide is provided in advance of the meeting to help you prepare for the meeting. It provides a general guide of the areas that will be discussed where your opinions will be sought.

Recent legislation and policy states that the decision-making capacity assessments should be undertaken by the professional with the most knowledge of the decision at hand. Occupational therapists who work with older adults are frequently asked to give their opinion on the person's decision-making capacity regarding independent living, based on their knowledge of the person's value and interests, their clinical judgement of the person's abilities and disabilities, and their understanding of the demands and supports of the person's environment.

There are several component areas that are typically considered by occupational therapists in giving such an opinion, namely, the older person's overall function, including their cognitive and physical abilities that may influence their choice to return to/continue living independently.

While recent legislation requires that a 'functional approach' to decision-making capacity assessment is adopted, there is perhaps less understanding on the procedures and exact components of such an assessment. There is also little guidance on how to document the process to ensure accountability and consistency of practice.

The aims of this study are to explore the opinions of therapists who have clinical experience in this area regarding what they propose would constitute best practice in the assessment of older adults decision-making capacity, specifically regarding independent living.

Participation in this study will involve attending a one-day consensus formation meeting, where the 'Nominal Group Technique' (NGT) will be used to facilitate discussion with other occupational therapists to explore their opinions on the issue of decision-making capacity assessment of older adults, regarding independent living. NGT is a structured approach to group brainstorming and decision-making and a method of facilitating the formation of a consensus on the issue being explored.

There will be two structured brainstorm (NGT) sessions over the course of the day. Each session should last no more than 2 hours.

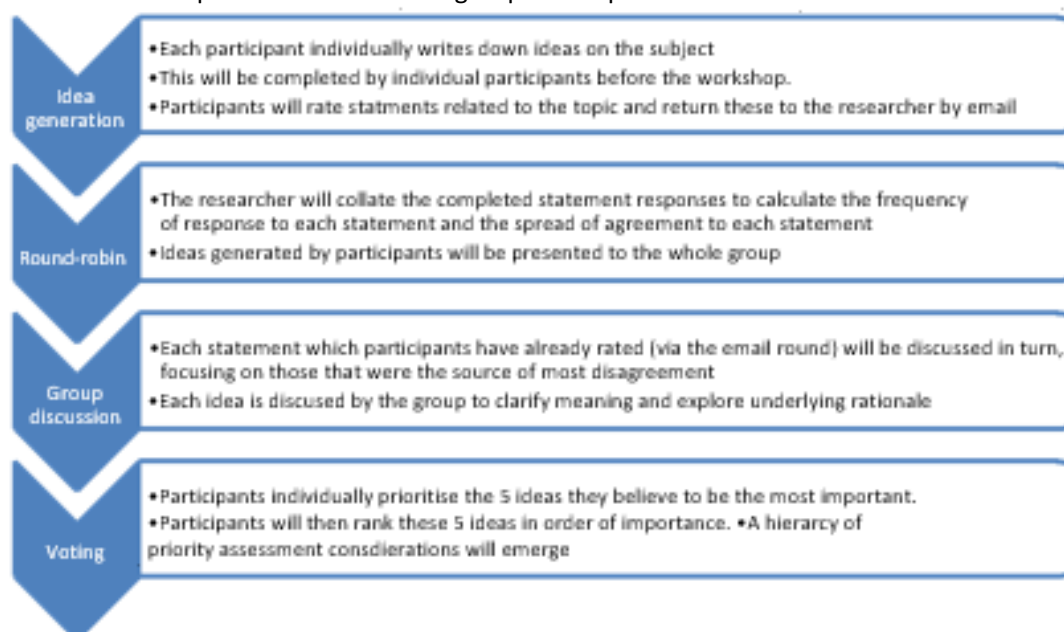
The structure of the workshop will be as follows:

1. Introduction

A short presentation will be given by the researcher on decision-making capacity assessment, based on literature, recent legislation and policy and provisional findings of research undertaken to date.

An outline of the NGT process will be presented and how the discussions will be structured. (Please see below).

2. The four phases of the nominal group technique are as follows:



3. Participants will be divided into smaller groups (up to nine people) for the NGT process where participants will try to reach consensus on the issues outlined below:

- i. The first NGT session will focus on identifying the **performance components** that should be considered by occupational therapists in their contribution to the decision-making capacity assessment of older adults, regarding independent living. Emphasis will be placed on the specific components of goal-setting to address the person's will and preference, cognitive functional assessment, environmental assessment. This will include identification of standardised assessments that are recommended to inform assessment.
- ii. The second NGT session will focus on the **assessment process** within the context of Irish occupational therapy practice. This will include issues such as identification of an appropriate trigger for the decision-making capacity assessment, gathering information relevant to the decision, how to support/enhance decision-making capacity, other views to be considered if appropriate and how to document this process.

4. Discussions will be digitally recorded and transcribed verbatim. This is to provide context to the rated statements and to draw upon when the researcher will write up the recommendations and rationale at a later date.

Please use this guide to help you prepare for the meeting. Please take some time to consider your clinical experience, your knowledge of relevant legislation, policies and literature and the realities of your context of practice. Please bring along any notes you make in preparation for the meeting.

Thank you for your time and I look forward to meeting you on the day.

Kind Regards,

Ruth Usher

Appendix P:
Phase Four Ethics Approval



22nd November 2019

Att: Ms Ruth Usher

Re: An Exploration Of The Components Of The Occupational Therapy Assessment Process And How It Informs Decision-Making Capacity Assessment Of Older Adults Regarding Independent Living, Using A Nominal Group Technique

Application No: 20191007

Dear Ms Usher,

Your revised application has been reviewed by the School of Medicine Research Ethics Committee (REC) and we are pleased to inform you that the above project has been approved.

Please note that documents submitted for GDPR purposes within your ethics application are approved by the REC from an ethical perspective only and this approval does not confirm GDPR compliance. Where a Data Protection Impact Assessment (DPIA) is required please submit the DPIA to the Data Protection Office (DPO) and seek comment from the DPO prior to commencing your study.

It is the responsibility of the researcher/research team to ensure all aspects of the study are executed in compliance with the General Data Protection Regulation (GDPR), Health Research Regulations and Data Protection Act 2018.

Yours sincerely,

Dr. Tadhg Stapleton,
Chairperson,
School of Medicine Research Ethics Committee,
Trinity College Dublin.

An tOllamh Michael Gill MD FTCD MRCPsych
Ceann Scoil an Leighis

Dr. Alex McKee
Riarthóir na Scoile

Scoil an Leighis
Institiúid Eolaíochtaí Bithleighis Choláiste na Tríonóide
152-160 Sráid an Phiarsaigh
Coláiste na Tríonóide,
Baile Átha Cliath,
Ollscoil Átha Cliath
Baile Átha Cliath 2, Éire.

Professor Michael Gill MD FTCD MRCPsych
Head of School of Medicine

Dr. Alex McKee
School Administrator

School of Medicine
Trinity Biomedical Sciences Institute
152-160 Pearse Street
Trinity College Dublin,
the University of Dublin
Dublin 2,
Ireland

T: +353 1 896 1476
medicine@tcd.ie
www.tcd.ie/medicine

Appendix Q:
Phase Four Consent Form



CONSENT FORM

Study title:

An exploration of how the components of the occupational therapy assessment process inform decision-making capacity assessment of older adults regarding independent living, using a nominal group technique.

There are two sections in this form. Each section has a statement and asks you to initial if you agree. The end of this form is for the researchers to complete.

Please ask any questions you may have when reading each of the statements.

Thank you for participating.

Please **Initial** the box if you agree with the statement. Please feel free to ask questions if there is something you do not understand.

General	Initial box
I confirm I have read and understood the Information Leaflet for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	
I understand that this study is entirely voluntary , and if I decide that I do not want to take part, I can stop taking part in this study at any time without giving a reason.	
I understand that all information will be kept private and confidential and that my name will not be disclosed.	
I understand that I will not be paid for taking part in this study	
I know how to contact the research team if I need to.	
I agree to take part in this research study having been fully informed of the risks, benefits and alternatives which are set out in full in the information leaflet which I have been provided with.	
I agree to being contacted by researchers by email as part of this research study.	

Data processing	Initial box
I understand that personal information about me, including the transfer of this personal information about me outside of the EU, will be protected in accordance with the General Data Protection Regulation.	
I understand that there are no direct benefits to me from participating in this study.	
I understand that I can stop taking part in this study at any time without giving a reason.	

Participant Name (Block Capitals)

Participant Signature

Date

Witness Name (Block Capitals)

Witness Signature

Date

To be completed by the Principal Investigator or nominee.

I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand. I have explained the risks and possible benefits involved. I have invited them to ask questions on any aspect of the study that concerned them.

I have given a copy of the information leaflet and consent form to the participant with contacts of the study team

Ruth Usher

Date

2 copies to be made: 1 for participant, 1 for PI

Appendix R:
Phase Four Feedback on the NGT process

NGT PARTICIPANT SATISFACTION QUESTIONNAIRE

Study title:

An exploration of the components of the occupational therapy assessment process and how it informs decision-making capacity assessment of older adults regarding independent living, using a nominal group technique.

Thank you for participating in the workshop.

Please rate your satisfaction with the **nominal group technique (NGT) process as a framework development tool** by rating your agreement with the below statements on a scale of 1 (1 = strongly disagree) to 5 (5= strongly agree).

	1 <i>Strongly disagree</i>	2 <i>Somewhat disagree</i>	3 <i>Neutral</i>	4 <i>Somewhat agree</i>	5 <i>Strongly agree</i>
NGT was a useful stage of framework development					
My opinions were represented					
I am satisfied with the items chosen in the area of _____					
I am satisfied with the items chosen in the area of _____					
I am satisfied with the items chosen in the area of _____					

Appendix S:
Published article in the Australian Occupational Therapy Journal (Usher and Stapleton,
2020b)

Occupational therapy and decision-making capacity assessment: A survey of practice in Ireland

Ruth Usher  | Tadhg Stapleton 

Discipline of Occupational Therapy, School of Medicine, Trinity College Dublin, Dublin, Ireland

Correspondence

Ruth Usher, Discipline of Occupational Therapy, School of Medicine, Trinity College Dublin, Ireland.
Email: usherru@tcd.ie

Abstract

Introduction: The aim of the study was to explore occupational therapy practices regarding decision-making capacity assessment and to examine factors that impact on engagement in this area.

Methods: Occupational therapists in Ireland were invited to participate in a cross-sectional online questionnaire.

Results: One hundred and seventy-two occupational therapists responded. 65.77% ($n = 98$) reported that occupational therapy plays an important role in capacity assessment in their workplace. Occupational therapists most frequently contributed to decision-making capacity assessment for independent living (79.19%, $n = 118$), driving (45.89%, $n = 67$) and financial management (44.44%, $n = 64$). Many participants reported that this is more difficult than other aspects of practice and that they are not satisfied with decision-making capacity assessment procedures in their workplace. A large majority (91.86%, $n = 113$) reported occupational therapists would benefit from additional training and practice guidelines in the area of decision-making capacity assessment.

Conclusion: The study confirms that occupational therapists have a role to play in the multi-disciplinary assessment of decision-making capacity. The results of the survey suggest that decision-making capacity assessment is complex and challenging. Factors such as confidence, education and training impact on engagement with this area of practice. There is a need to develop education resources and guidelines for occupational therapists.

KEYWORDS

assessment, capacity, cognitive disabilities, decision-making, independent living, occupational therapy

1 | INTRODUCTION

Decision-making capacity (DMC) is the extent to which an individual is capable of understanding and remembering information and using this to make and communicate their choice (Barry & Docherty, 2018). In most developed societies, adults are presumed to be competent in decision-making regarding their personal, financial and health-care affairs

(Usher & Stapleton, 2018). However, when DMC is doubted, often due to cognitive disability, a comprehensive and fair assessment is required, to maximise autonomy and safeguard from harm. Internationally it has been suggested that due to ageing population trends, associated dementia prevalence and increasing incidence of chronic conditions, the number of persons requiring DMC assessments is likely to increase (Brémault-Phillips et al., 2018).

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (United Nations, 2006) states that all people with disabilities have the right to participate in decision-making, and holds nations who have ratified the UNCRPD responsible for developing appropriate supports for person with disabilities to exercise their legal capacity and participate in decision-making. In Ireland, the Assisted Decision-Making (Capacity) Act 2015 sets out an understanding of capacity which is functional and time-bound. The Act also describes mechanisms for supporting people with cognitive disabilities in decision-making about their lives. It applies to everyone and therefore has relevance for all health-care professionals (HCPs), particularly those working with clients with cognitive disabilities.

Due to its complexity and potential ramifications for those who it affects, the commencement and implementation of the Act poses many challenges for HCPs, including occupational therapists. Codes of practice to guide health and social care staff in adopting the Act within practice are yet to be implemented. Internationally, barriers to DMC assessment have been identified including lack of education and training, differing understandings of DMC, limited resources and time pressures (Charles et al., 2017; Jayes, Palmer, & Enderby, 2017; Lamont, Stewart, & Chiarella, 2017). A range of models for DMC assessment have been developed in other jurisdictions (Bigby & Douglas, 2016; Brémault-Phillips et al., 2016; Parmar, Brémault-Phillips, & Charles, 2015) which may enhance HCP's ability to assess DMC. DMC assessment processes and best-practices need to be standardised and integrated into routine care to ensure that health-care professionals can determine person-centred outcomes that are least restrictive and intrusive (Brémault-Phillips et al., 2018). In order to develop such best-practices, it is necessary first to explore current practices, beliefs and challenges.

1.1 | Role of occupational therapy

Assessment of capacity and decision-making should be core skill of all clinicians (Barry & Docherty, 2018). While occupational therapists have been included in research examining DMC assessments in the UK (Jayes et al., 2017; Lamont et al., 2017), limited research exploring the role of occupational therapy has been conducted to date.

Moye and Marson (2007) summarised the scope and practice of judicial review of various civil capacities relevant to older adults. They identified at least eight domains of DMC requiring assessment among older adults: independent living, financial management, driving, consent to treatment, sexual consent, research consent, voting and testamentary consent. These categories are not necessarily exhaustive and additional domains may need to be considered in other jurisdictions. Occupational therapists may have involvement in DMC

assessment across these domains, according to their practice areas, yet the scope of occupational therapists practice is currently unclear in relation to their contribution to DMC assessment or how best to approach such an assessment.

UNCRPD recognises that persons with cognitive disabilities may be able to exercise legal agency if given adequate support. This requires DMC assessments go beyond identifying a person's decision-making impairments and should also include the identification of the necessary supports (Usher & Stapleton, 2018). Therefore, occupational therapists must explore the potential of their roles to ensure that individuals are given the support and accommodations that they require in order to maximise their participation in decision-making about their lives.

Given the multifaceted, and widespread consequences of DMC assessment, it is important to examine occupational therapists knowledge, practice and attitudes to DMC.

Therefore, the current study aims to:

- Explore the current practices of occupational therapists in assessment of decision-making capacity.
- Examine the factors that impact on occupational therapists engagement in the assessment of decision-making capacity.

2 | METHODS

2.1 | Study design

A cross-sectional questionnaire design using a purposively designed online questionnaire was used to explore the current practices of occupational therapists in Ireland in the area of DMC assessment. Recruitment was conducted via the Association of Occupational Therapists of Ireland (AOTI) in effort to engage a cross-section of practicing therapists across a wide variety of public and private settings, reflecting current occupational therapy practice in Ireland. The STROBE reporting guidelines for observational studies were used to guide the reporting of this study (von Elm et al., 2007). Ethical approval was granted by the university's School of Medicine Research Ethics Committee (reference number: 20180505) prior to commencement of data collection.

2.2 | Questionnaire

Following a review of literature examining health and social care professionals practice in the area of decision-making capacity, a questionnaire was developed. The survey questions were informed by surveys used in previous studies that had investigated the assessment of decision-making capacity by lawyers (Helmes, Lewis, & Allan, 2004), neuropsychologists

(Mullaly et al., 2007), speech-language pathologists (Aldous, Tolmie, Worrall, & Ferguson, 2014; Jayes et al., 2017; McCormick, Bose, & Marinis, 2017) and non-specified health-care practitioners (Lamont et al., 2017). These items were contextualised to fit within occupational therapy practice and addressed the domains of DMC assessment defined by Moye and Marson (2007).

The questionnaire consisted of 25 questions, divided into four sections:

1. Demographic information (six questions)
2. Context of decision-making assessment (eight questions)
3. Assessment process (nine questions)
4. Beliefs and attitudes regarding decision-making assessment (two questions).

Most questions allowed for multiple choice answers, many with open-ended options. The final question had 19 statements that required rating on a five-point Likert scale to indicate participants' level of agreement or disagreement with statements in relation to their confidence, attitudes and beliefs in relation to DMC assessment. Prior to recruitment, the questionnaire was piloted on six occupational therapists from a range of practice settings to ensure clarity, comprehensibility and ensure some element of face validity. Feedback from the pilot informed the final survey design.

2.3 | Participants

Occupational therapists working in Ireland were invited to participate in this research. The only other inclusion criteria was that they were proficient in English.

2.4 | Recruitment process

AOTI distributed the questionnaire via email to members who agreed to be contacted for research studies. This email included information regarding the survey, a participant information leaflet and a hyperlink to the SurveyMonkey® website, allowing members to access the questionnaire online. The survey was completed anonymously, with no identifying information sought. Informed consent was implied if the participant continued with the questionnaire, having initially read the information sheet.

To obtain the highest possible response rate, a reminder email to participate in the study was sent on two occasions. Additionally, snowball sampling techniques were used whereby special interest groups were contacted and asked to distribute the invitation through email and recipients were asked to share the email with other occupational therapists who met the inclusion criteria but may not be members of AOTI.

TABLE 1 Demographic profile

Demographic profile	%	<i>n</i>
Total number of respondents		172
Female	96.5	166
Years of work experience		
Less than 3 years	17.44	30
4–6 years	15.12	26
7–10 years	25	43
11–15 years	18.6	32
16–20 years	9.3	16
More than 20 years	14.53	25
Highest level of education completed		
BSc	55.81	96
MSc	41.86	72
PhD	2.33	4
Typical client group		
Older adults	66.28	114
Persons with stroke	31.98	55
Persons with traumatic brain injury	20.93	36
Persons with progressive neurological conditions (e.g. MS, MND etc)	36.05	62
Persons with psychiatric disorders/mental health difficulties	29.07	50
Persons with dementia	54.65	94
Persons with unspecified cognitive dysfunction	30.81	53
Persons with developmental/intellectual disabilities	15.12	26
Other (including palliative care <i>n</i> = 6 and/or oncology <i>n</i> = 2)	13.95	24
Practice setting		
Hospital-based	53.49	92
Community-based	44.77	77
Private practice	5.81	10
Research-based	1.16	2
Academic	2.91	5
Other	7.56	13

2.5 | Data collection

The survey was live over a 3-month period, from July to September 2018 and was administered through SurveyMonkey®. Online survey platforms are cost-effective and convenient for participants to access, enhance survey distribution and confidentiality, and facilitate data collection and analysis (Fox, Murray, & Warm, 2003; Fricker & Schonlau, 2002) and hence was the most efficient method to gather responses from occupational

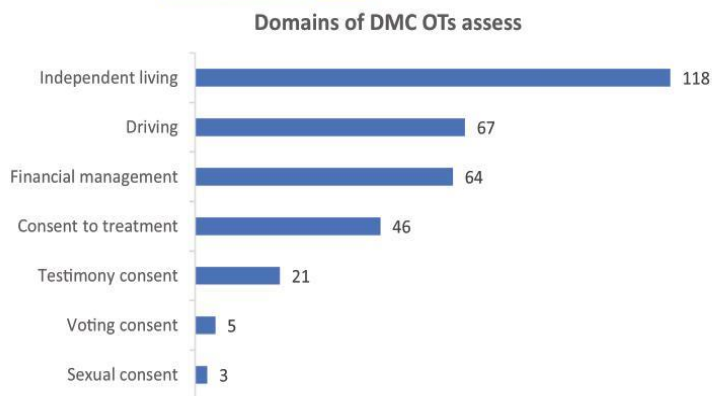


FIGURE 1 Domains of DMC assessed

therapists across a wide geographical spread and variety of practice settings.

2.6 | Data analysis

Given the design of the survey and the aims of the study, completed questionnaires were analysed descriptively. SurveyMonkey® and Microsoft Excel were used to complete the descriptive analysis and generate graphical outputs.

3 | RESULTS

In total, one hundred and seventy-two questionnaires were returned. As snowball recruitment was encouraged by third parties, the researchers were unable to obtain the exact number of clinicians who were invited to participate and therefore cannot calculate a response rate. All submitted questionnaires were included in the analysis; 121 (70.35%) were completed in their entirety. The demographic section of the questionnaire was completed by all participants ($n = 172$). The majority of respondents (86.63%, $n = 149$) completed the assessment context section and most respondents (73.26%, $n = 126$) completed the attitudes and beliefs section. The lowest response (51.74%, $n = 89$) was to the assessment process section. As a result, the sample was varied between 89 and 172 participants for each survey section. The survey took an average time of 10 min to complete.

3.1 | Participant profile

A nationwide geographical spread was noted in the responses. The majority of therapists responding to the survey had more than seven years of practice experience (67.44%, $n = 116$). Many respondents indicated that they worked with multiple

client groups and the largest subgroup of respondents worked with older adults (66.28%, $n = 114$). Socio-demographic and professional profiles are provided in Table 1.

3.2 | Context of decision-making assessment

Most respondents were aware of the Assisted Decision Making (Capacity) Act 2015:22.15% ($n = 33$) regarded themselves as “very familiar” and 68.46% ($n = 102$) reported “some familiarity” with the legislation. The majority of respondents, 63.09% ($n = 94$) reported that the Act has implications for their practice.

Most respondents (86.51%, $n = 109$) reported that occupational therapy is ideally suited to contribute to DMC assessments within a multidisciplinary context. Most respondents reported discussing assessment with other multi-disciplinary team (MDT) colleagues (78.86%, $n = 97$). The majority of respondents (69.80%, $n = 104$) reported receiving MDT requests to contribute to DMC assessment. These requests typically came from medical staff (60.40%), nursing (35.57%), social work (30.20%) and psychology staff (12.08%).

While most respondents (65.77%, $n = 98$) reported occupational therapy plays a significant role in DMC assessment in their workplace, the frequency of engagement in DMC assessment tended to be low, with 77.85% ($n = 96$) contributing to DMC assessments less frequently than monthly. Respondents working with older adults ($n = 114$) were the most likely subgroup of occupational therapists to be involved in DMC assessments (65.8%, $n = 75$), however, most reported involvement on an occasional or ad-hoc basis (51.7%, $n = 59$).

Of the categories of DMC outlined by Moye and Marson (2007), occupational therapists were more likely to be involved in DMC assessment of independent living (79.19%, $n = 118$), driving (45.89%, $n = 67$), financial management (44.44%, $n = 64$) and consent to treatment (31.94%, $n = 46$).

Occupational therapists were rarely involved in assessment of DMC for testimony (14.58%, $n = 21$), voting (3.50%, $n = 5$) or sexual consent (2.11%, $n = 3$) (Figure 1).

Occupational therapists working with older adults, persons with dementia and cognitive dysfunction, persons with stroke, neurological conditions and traumatic brain injury (TBI), and in psychiatry, were regularly involved in independent living DMC assessments (Table 2). By contrast, only 27% ($n = 7$) of occupational therapists working with intellectual disabilities (ID) client groups reported frequent involvement in independent living DMC.

3.3 | Assessment process

The assessment process section was answered by 89 therapists, with therapists typically using multiple approaches to assess DMC. Typical assessment approaches included: performance-based assessments, including standardised assessments and structured observations of daily tasks ($n = 149$), interview-based assessments ($n = 130$) and professional judgment ($n = 57$) (see Figure 2).

Performance-based assessment included both standardised assessments and structured observations of performance of daily tasks to gain information about patients' current abilities, including their functional performance and underlying cognitive skills. Many occupational therapists reported using a range of structured observations of the person's ability to complete functional tasks as a method to inform the assessment of DMC, such as kitchen task assessments (80.39%; $n = 72$), home visits (70.79%, $n = 63$); washing and dressing assessments (64.04%, $n = 57$); community access (43.82%, $n = 39$) and money management tasks (41.57%, $n = 37$). Some respondents also reported using standardised observations of function such as Assessment of Motor and Process Skills (AMPS) (19.10%, $n = 17$) and the Kettle Test (16.85%, $n = 15$).

Participants also reported using information from cognitive screening assessments such as the Montreal Cognitive assessment (MoCA) (83.15%, $n = 74$); Addenbrooke's Cognitive Examination (ACE-III) (70.79%, $n = 63$); Mini Mental State Examination (MMSE) (47.19%, $n = 42$) and Rivermead Behavioural Memory Test (RMBT) (42.70%, $n = 38$) to inform DMC assessments. Respondents reported that cognitive screening tools are used as part of typical practice and the scores can be useful in informing the assessment of decision-making capacity (66.29%, $n = 59$). Additionally, respondents reported MDT members specifically request a particular standardised assessment or screening tool be carried out to inform the overall assessment of the client's DMC (50.56%; $n = 45$). However, many respondents (76.40%; $n = 68$) reported that scores on standardised cognitive screening tools do not always reflect the person's functional ability or DMC.

Only 18.55% ($n = 23$) reported basing their recommendations primarily on formal assessment data. Over half of the respondents (54.84%, $n = 68$) reported that they rely on qualitative aspects of the client's performance more than test scores themselves. Additionally, 64.04% ($n = 57$) reported using conversation and 60.67% ($n = 54$) reported using semi-structured interviews to assess DMC. Assessments typically take place in the clinical setting (82.02%, $n = 73$), in the client's home (48.31%, $n = 43$) and in the community (20.22%, $n = 26$). An overwhelming majority (98.88%, $n = 88$) also reported that they typically obtain collateral information from the client's carer/family or other staff, through conversation, semi-structured interviews and standardised assessments. The majority of respondents (73.98%, $n = 91$) favour a strengths-based approach and reported that it is important to focus on what clients can do rather than what they cannot do in assessments of DMC.

3.4 | Beliefs and attitudes regarding decision-making assessment

Many respondents (54.76%, $n = 69$) reported that contributing to DMC assessment is more difficult than other aspects of occupational therapy practice and many respondents (52.07%, $n = 63$) did not agree that their training prepared them well for this area of practice. Respondents reported engaging in various modes of further education in relation to DMC assessment. Self-directed methods to learn more about DMC assessment were reported by many respondents: 64.29% ($n = 81$) reported engaging in discussions with colleagues, 30.16% ($n = 38$) reported engaging in peer education and 38.89% ($n = 49$) reported reading research, journal articles and books related to the topic. Formal education such as attending seminars and conferences was reported by 42.86% ($n = 54$) of respondents. The majority of respondents 91.86% ($n = 113$) reported that occupational therapists would benefit from additional training in the area of assessment of DMC. Additionally, 88.71% ($n = 110$) report that it would be beneficial if there were general guidelines available to direct occupational therapists in their involvement in DMC assessment and 81.45% ($n = 101$) would like guidelines specific to different client groups and practice areas.

Only 13.71% ($n = 17$) report that they are satisfied with DMC assessment procedures in their workplace, and 50.80% ($n = 63$) describe it as time-consuming. Nonetheless, most respondents (65.32%, $n = 81$) are confident in their contribution to DMC assessment and 53.23% ($n = 66$) reported that the role of occupational therapy is valued in their workplace.

4 | DISCUSSION

Although occupational therapists work with many clients who may require DMC assessment, limited research has been

	Never		Sometimes		Frequently	
	%	n	%	n	%	n
Older adults	8.8	10	28.9	33	52.6	60
Stroke	5.5	3	25.5	14	58.12	32
TBI	8.3	3	33.3	12	55.6	20
Neurological	6.5	4	32.3	20	54.8	34
Psychiatric	12.0	6	38.0	19	34.0	17
Dementia	8.5	8	24.5	23	56.4	53
Cognitive dysfunction	7.5	4	34.0	18	49.1	26
ID	34.6	9	30.8	8	11.5	3

TABLE 2 Frequency of DMC assessment for Independent Living

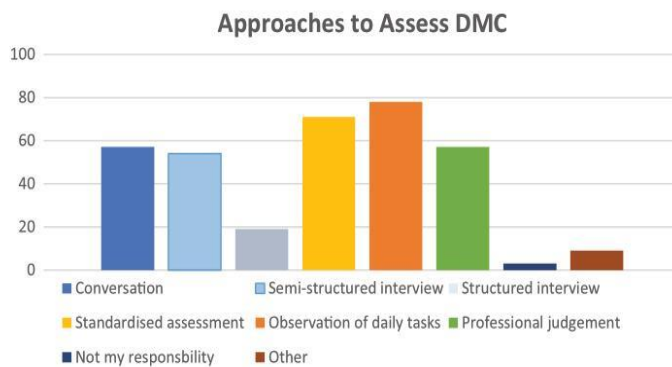


FIGURE 2 Approaches to assess DMC

conducted to explore the current practices of occupational therapists when assessing DMC. This exploratory descriptive study reports findings from a cross-section of occupational therapists in Ireland on how this complex area of occupational therapy practice is currently addressed.

4.1 | Occupational therapy input within multidisciplinary assessment of DMC

This study findings confirmed that occupational therapists were aware of DMC legislation and regarded themselves as having a role to play in the assessment of DMC. However, the findings highlighted a collaborative approach involving occupational therapists working alongside other MDT members in the assessment of DMC. Our survey found that occupational therapists primarily engaged with physicians, nurses and social workers when assessing DMC. These findings support the discourse that DMC is a complex area and should not be viewed as the sole remit of any one health-care profession. Rather it requires varied input from different HCPs who bring different competencies and knowledge-bases to comprehensively address the issue

of ascertaining the individual's DMC (Zuscak, Peisah, & Ferguson, 2016).

Our study did not seek data on which HCP were best suited to lead DMC assessment for the different areas of capacity. While Jayes et al. (2017) reported that the choice of which MDT members assess capacity may often be decided on perceptions of professional hierarchy and responsibility, it should be guided on the basis of which HCP has more knowledge, skill or information about the decision and the patient. For example, speech and language pathologists have emphasised their specialist skills and their role for people with communication difficulties like aphasia (Aldhous et al., 2014; McCormick et al., 2017; Suleman & Kim, 2015). Therefore, it is not surprising in this study that occupational therapists reported significant involvement in DMC assessment regarding independent living, and less so in other areas, such as sexual consent.

Rather than one HCP assuming principle responsibility for determining DMC, each discipline needs to be aware of their professional expertise and limitations before engaging in DMC assessment (Zuscak et al., 2016). HCPs must also consider the potential bias that their own values and beliefs may pose to the assessment process (Pachet, Allan, &

Erskine, 2012). Different HCPs bring complementary knowledge and skill to ensure a more holistic and comprehensive approach and also disperses the burden of responsibility that DMC assessment involves (Murrell & McCalla, 2016).

Wider involvement of stakeholders beyond HCPs was highlighted in our study, with a large majority of the therapists reporting involvement of caregivers/family in DMC assessment, using conversations and interviews. The inclusion of caregivers/family who know the person and their strengths, needs and values, is especially important in supporting decision-making for those with cognitive disabilities (Douglas & Bigby, 2018). This may explain the high level of informant involvement reported in our study, given that many therapists worked with clients with dementia and cognitive dysfunction. While this approach has potential benefits, it can also lead to tension when caregivers/family have difficulty accepting the outcomes of DMC assessment process (Murrell & McCalla, 2016; Sexton, 2012).

4.2 | Approaches to the assessment of DMC

Respondents in our study reported high usage of cognitive screening assessments that are typically used in older adult rehabilitation. This is not surprising given that a high proportion of respondents worked with older adults. DMC difficulties are likely to increase with the presence of cognitive impairment, therefore given the prevalence of dementia and other diseases associated with advancing age, DMC assessment may be pertinent for older adults. Seyfried, Ryan, and Kim (2013) also reported DMC assessment was more likely to occur in the setting of dementia and/or delirium.

Decision-making is underpinned by a range of cognitive skills required to consider options, consequences and plan action (Ganzini, Volicer, Nelson, Fox, & Derse, 2004; Suleman & Kim, 2015), and therefore respondents in our study reported frequent use of standardised cognitive screening tools in DMC assessment. Although cognition is an important underlying component that may potentially impact on the person's DMC, it is important to emphasise that cognition and capacity are distinct, though related, concepts. While cognitive screening tools are used to monitor changes in cognitive status and identify cognitive strengths and weaknesses affecting occupational performance (Radomski & Morrison, 2014), they are not necessarily designed to assess DMC. Capacity cannot be determined solely on the basis of cognitive assessments which do not capture whether the patient can understand, reason, appreciate and make and communicate a particular decision in a given situation (Moynihan, O'Reilly, O'Connor, & Kennedy, 2018).

Concern has been raised about occupational therapists' tendency to use impairment-focused standardised assessments rather than consider occupational performance when

assessing DMC (Usher & Stapleton, 2018). While therapists in our study reported the inclusion of standardised cognitive screening tools as part of their DMC assessment, only a small proportion (18.55%) reported basing their DMC recommendations primarily on standardised cognitive screening tools. Rather, a more holistic approach to DMC assessment was highlighted in our study, including use of standardised cognitive screening tools alongside functional observation, interviews with the patient and relevant informants, and discussion among relevant members of the MDT. Employing a variety of formal and informal methods for DMC assessment has been advocated in the literature (Aldhous et al., 2014; Jayes et al., 2017). Seyfried et al. (2013) called for capacity assessments to move beyond measurement of impaired abilities which is echoed by the therapists in our study who advocated for a strengths-based approach to DMC assessment, and focussing on what the person *can* do rather than what the person cannot do when assessing DMC. This is also aligned with the approach to DMC assessment and support advocated in the literature which emphasises focusing on the supports needed to enhance individual's strengths rather than deficits (Flynn & Arstein-Kerslake, 2014). Engaging in this broader assessment of DMC requires a clearly outlined process and structured approach to documentation particularly when less 'formal' approaches are taken (Jayes et al., 2017), as the reliability and validity of such approaches cannot always be measured and can potentially lead to inconsistent and subjective practice (Moynihan et al., 2018; Pachet et al., 2012).

4.3 | Assessment of DMC for independent living

Occupational therapists have a key role to play in the assessment of, and treatment interventions to facilitate, increased activity of daily living (ADL) performance (AOTA, 2014; Darzins, 2010). Independent living is associated with the ability to manage ADLs such as personal care, dressing, eating (with or without support) and also more complex Instrumental Activities of Daily Living (IADL) such as shopping, medication management, transportation, phone use and attending appointments. The need for assessment of capacity to live independently is frequently reported among the older adult population (Moye, Marson, & Edelstein, 2013; Skelton, Kunik, Regev, & Naik, 2010). Given that our study targeted occupational therapists and a large proportion of the respondents worked with clients in the older age categories, it is not surprising that independent living was reported as the most frequently assessed domain of DMC in our study.

Previous research identified that DMC assessments in acute hospitals mainly relate to discharge decisions, which require patients to make choices about returning to their usual residence, with or without a package of care (Jayes et

al., 2017). Information gathered by occupational therapists in their assessment of and intervention with clients often includes information about the person's past and present living arrangements, their current and future care needs, and supports available to meet those needs, all of which have been identified as underlying requirements in a DMC assessment (Emmett, Poole, Bond, & Hughes, 2013). Therapists in our study reported using a combination of approaches including interviews, standardised cognitive assessment and observation of functional performance to gather this information that would form the basis for DMC assessment. Murrell and McCalla (2016) suggested that care needs assessments should precede capacity assessments, as the outcome will determine the support options required and available. This information is required so the person can understand and weigh various options and risks, to demonstrate decisional capacity and make an informed choice with regard to their discharge destination and living environment (Emmett et al., 2013).

DMC assessments regarding independent living must address function, cognition and judgment as overlapping domains (Mills et al., 2014). Therefore, determining if an older adult can make and execute decisions to live safely at home presents a complicated challenge to health-care professionals (Skelton et al., 2010) and the concept of DMC for independent living is frequently misunderstood. While a person may not have the *functional capacity* to live independently, this is not the same as not having the *decision-making capacity* to decide on where and how they want to live. Equally those who make seemingly risky, unwise or eccentric decisions, or those who refuse to conform to social norms should not be regarded as lacking capacity (Cooney, Kennedy, Hawkins, & Hurme, 2004). However, given how closely related the issues are, it is not clear if all occupational therapists who participated in this study were reporting on assessment of ADLs and function as a determinant of capacity for independent living, or, if they were assessing the person's DMC for independent living, that is, the person's capacity and ability to self-determine their preferred living arrangements.

4.4 | Factors affecting engagement with DMC assessment

Given the complexity of DMC assessment, and the significant consequences of such assessments, the ambiguities in guidance of how to implement it in practice are critical (Murrell & McCalla, 2016) and may affect how occupational therapists engage in this area of practice. Research across a range of disciplines have reported that HCPs find DMC assessment complex and challenging (Aldhous et al., 2014; Jayes et al., 2017; Ratcliff & Chapman, 2016), with gaps in knowledge and skills, time pressures and conflicting practices being cited as issues. Similarly, many respondents in

our study reported that they find this aspect of practice more difficult than other areas of occupational therapy practice. Another interesting finding to emerge within our study was that almost half the respondents did not answer the section in the questionnaire on their DMC assessment process, but did continue to answer the other sections of the questionnaire. As the data were collected using an anonymous survey design, it was not possible to follow-up and explore the reasons for avoiding answering this section of the questionnaire. However, it may point to low confidence in current DMC assessment processes, knowledge gaps, or lack of consistent approaches to DMC assessment, as has been reported among other HCPs (Seyfried et al., 2013).

Despite a large proportion of respondents in our study reportedly being familiar and knowledgeable of the legislation regarding DMC, there was less certainty in the application of principles of DMC assessment in everyday practice. Similar findings were reported in other studies where DMC assessment was reported to be inconsistent despite familiarity with the legal standards (Emmett et al., 2013). Over half of the respondents in our study reported dissatisfaction with current DMC assessment practices in their workplace, a similar finding to that reported among speech and language pathologists in a UK survey (Aldhous et al., 2014).

The need for evidence-based practice frameworks and related training materials that are relevant in diverse formal and informal contexts has been identified internationally (Douglas & Bigby, 2018). Respondents in our study highlighted the need for further training in DMC assessment, and the need for practice guidelines to provide a framework for occupational therapists and other HCPs to guide practice in this area, which is consistent with research findings from other jurisdictions and other HCPs (Aldhous et al., 2014; Seyfried et al., 2013). However, Ratcliff and Chapman (2016) caution that training may not lead to high-quality application of the statutory requirements of DMC assessment. A generic one-size-fits-all approach to DMC assessment was not recommended by the therapists in our study, instead the future development of tools, resources and practice guidelines specific to occupational therapy or to particular client groups, may better facilitate the implementation of DMC assessment into routine practice. Bigby, Whiteside, and Douglas (2015) observe that a lack of understanding or commitment to the philosophical principles of equal rights, which underpins DMC support, inevitably undermines the process. They described tensions and dilemmas associated with supporting people with cognitive disabilities to make decisions due to power differentials, undue influence and concerns for managing risk. Therefore, it is important that all HCPs working with people with cognitive disabilities, including occupational therapists, be informed and convinced of the human rights perspective underpinning DMC assessment and support. This requires consideration in developing education and training resources for DMC assessment.

4.5 | Limitations

Our study was successful in gaining preliminary information regarding the current practices of Irish occupational therapists involved in the assessment of decision-making capacity. While the study was limited to Irish occupational therapists and may not generalise beyond this group, the issues raised are similar to those found in the international research and among other professional groups. This demonstrates commonalities in addressing this practice area.

A cross-sectional anonymous survey was the chosen methodology in an attempt to access a wider group of respondents. While there is the possibility that only therapists who were more knowledgeable in the area of DMC might be inclined to participate in the study, it is interesting that not all sections of the questionnaire were completed by all respondents thereby indicating that this response bias may not apply to our study. The use of an anonymous questionnaire may have reduced the possibility of respondents providing the more socially desirable answers and may have offered a safer means for respondents to provide honest answers with regard to gaps in current practice in the area of DMC assessments. The limitation in the chosen methodology is that the use of an anonymous questionnaire did not allow for deeper probing of the issues nor for follow-up clarifications or explanations.

4.6 | Recommendations for future research

The findings from our study and the limitations highlighted with the chosen methodology indicate a need for future research into the topic of assessment of DMC among occupational therapists and other HCPs. The findings of the current study set the context for current ongoing research in Ireland, examining this issue in depth through use of qualitative methodologies. This ongoing research aims to clarify issues and procedures impacting on the assessment of DMC, with the overall aim of developing a practice framework to guide the implementation of DMC assessment within the Irish context of occupational therapy practice. The findings from our study indicate that while there are commonalities across the challenges in assessing DMC, the need for an approach to DMC assessment that is specific to individual client groups was highlighted. The findings from the ongoing Irish research may also be of international relevance.

4.7 | Conclusion

This is the first study to examine the current practice of Irish occupational therapists in the assessment of DMC. Based on the results, most occupational therapists are aware of legislation and regard occupational therapy as having a role in DMC

assessment. Our findings highlight the gap that exists between awareness of DMC legislation and its subsequent application into everyday practice. Most respondents reported adopting varied assessment approaches, addressing multiple DMC domains, particularly regarding independent living. An overwhelming majority reported interest in further education and training. There is a need to develop education and training for occupational therapists and to promote the unique contribution that occupational therapy can make within the assessment of DMC.

KEY POINTS FOR OCCUPATIONAL THERAPY

- Occupational therapists frequently contribute to decision-making capacity assessment, within a multidisciplinary context, particularly regarding independent living.
- Decision-making capacity assessment is complex and many occupational therapists find it challenging.
- Education and training resources for occupational therapists to guide decision-making capacity assessment are required.

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AUTHOR CONTRIBUTIONS

Both authors contributed to the design of the study, data analysis, preparation of the manuscript and checked and approved the final version.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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