**Capacity Determination Resource**

**F600 §483.12 Freedom from Abuse, Neglect, and Exploitation**

**Effective November 28, 2017**

**Capacity and Consent – Example of Capacity Determination for Sexual Activity**

Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must ensure the resident is evaluated for capacity to consent. Residents without the capacity to consent to sexual activity may not engage in sexual activity.

**NOTE**: For information related to determining consent, refer to “Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists” - © American Bar Association Commission on Law and Aging – American Psychological Association, located at http://www.apa.org/pi/aging/programs/assessment/capacity-psychologist-handbook.pdf

This resource includes a discussion on determining issues related to determining consent including:

The legal standards and criteria for sexual consent vary across states (Lyden, 2007; Stavis et al., 1999). The most widely accepted criteria, which are consistent with those applied to consent to treatment, are: (1) knowledge of relevant information, including risks and benefits; (2) understanding or rational reasoning that reveals a decision that is consistent with the individual’s values (competence); and (3) voluntariness (a stated choice without coercion) (Grisso, 2003; Kennedy, 1999; Stavis, 1991; Stavis et al., 1999; Sundram et al., 1993).

When investigating an allegation of sexual abuse, the facility must conduct a thorough investigation to determine the facts specific to the case investigated, including whether the resident had the capacity to consent and whether the resident actually consented to the sexual activity. A resident’s voluntary engagement in sexual activity may appear to mean consent to the activity; in these instances, if the facility has reason to suspect that the resident may not have the capacity to consent, the facility must protect the resident from potential sexual abuse while the investigation is in progress.

Determinations of capacity to consent depend on the context of the issue and one determination does not necessarily apply to all decisions made by the resident. For example, the resident may not have the capacity to make decisions regarding medical treatment, but may have the capacity to make decisions on daily activities (e.g., when to wake up in the morning, what activities to engage in). Determinations of capacity in this context are complex and cannot necessarily be based on a resident’s diagnosis alone. Capacity on its most basic level means that a resident has the ability to understand potential consequences and choose a course of action for a given situation. Decisions of capacity to consent to sexual activity must balance considerations of safety and resident autonomy, and capacity determinations must be consistent with State law, if applicable. The facility’s policies, procedures and protocols, should identify when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded. See also 42 CFR 483.10(f) [F561] for concerns related to the resident’s right to self-determination through support of resident choice, and 42 CFR

483.10(b)(3)-(7) [F551] for concerns related to the exercise of the resident’s rights by the resident representative.

**NOTE**: CMS is not requiring facilities to adopt a specific approach in determining a resident’s capacity to consent. However, the facility administration, nursing and medical director may wish to consider establishing an ethics committee, that includes legal consultation, in order to assist in the development and implementation of policy related to aspects of quality of life and/or care, advance directives, intimacy and relationships.

Cognitive functioning may change due to health issues such as, but not limited to stroke, dementia, depression/psychiatric illnesses or other impacts such as medication(s), hearing/visual loss, and stress. Therefore, the facility should continue to monitor and re-evaluate a resident’s capacity to consent over time, as needed, based on the individual resident’s physical, mental and psycho-social needs. See also 42 CFR 483.10(g)(14) [F580-Notification of Changes].

**Residents with Designated or Legally Appointed Representatives**

A resident may have a representative that has been appointed legally under State law through, for example, a power of attorney, guardian, limited guardian, or conservatorship. These legal appointments vary in the degree that they empower the appointed representative to make decisions on behalf of the resident. While a legal representative may have been empowered to make some decisions for a resident, it does not necessarily mean that the representative is empowered to make **all** decisions for the resident. The individual arrangements for legal representation will have to be reviewed to determine the scope of authority of the representative on behalf of the resident.

A resident may also have designated an individual to speak on his/her behalf for decisions for care or other issues. However, it is necessary for the resident, his/her representative and the facility to have a clear understanding of the types and scope of decision- making authority the representative has been delegated.

Any decision-making power that is not legally granted to a representative under state law is retained by the resident. It is the responsibility of the facility to ascertain what decisions the representative is legally empowered to make on behalf of the resident.

More specifically, regarding consent for sexual activity, State law and the legal instruments setting up resident representation may be silent on that topic. The facility must be aware of the representative’s scope of authority regarding resident decision-making.

When a resident with capacity to consent to sexual activity and his/her representative disagree about the resident engaging in sexual activity, the facility must honor the resident’s wishes irrespective of that disagreement if the representative’s legal authority does not address that type of decision-making for sexual activity. If the resident representative’s legal authority addresses decision-making for sexual activity, then the facility must honor the resident representative’s decision consistent with 42 CFR 483.10(b).

**NOTE**: See F551 at 42 CFR 483.10(b)(6)- If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns in the manner required under State law.

**TYPES OF CAPACITY and CRITERIA**

**LEGAL DEFINITIONS**

1. **Capacity to give informed consent:**
	1. Understand nature of illness and treatment/circumstance
	2. Understand risks and benefits of treatment/interventions
	3. Understand treatment/intervention alternatives
	4. Understand risk of refusing treatment/intervention
2. **Testamentary capacity:**
	1. Understand that he/she is making a will
	2. Know the nature and extent of their property
	3. Understand the “natural objects” of their bounty and their claims upon them
3. **Contractual capacity:**
	1. Understand the transaction
	2. Act in a reasonable manner

\*\*\*

**DETERMINATION OF CAPACITY**

**Source: NYS Family Health Care Decisions Act (FHCDA)**

**SPECIFIC REGULATIONS FOR NEW YORK STATE ONLY**

1. Presumption of Capacity. Every adult shall be presumed to have decision-making capacity unless determined otherwise as set forth herein or by court order or the appointment of a guardian pursuant to Article 81 of the Mental Hygiene Law.
2. Determination by Attending Physician. An initial determination of incapacity shall be made by the attending physician to a *reasonable degree of medical certainty*. Such determination shall include an assessment of the cause and extent of the incapacity and the likelihood of regaining capacity.
3. If the attending physician determines the incapacity is due to mental illness, such determination must be made by a physician licensed to practice medicine in New York State or is board certified or eligible in Neurology or Psychiatry and recorded in the medical record. If the determination of incapacity is due to mental retardation or developmental disability, such determination shall be made by the attending physician or another qualified professional (either a physician or clinical psychologist) who is (i) employed by a school named in Mental Hygiene Law section 13.17; (ii) has been employed by a facility licensed by OMRDD for a minimum of two years, or (iii) has been approved by the Commissioner of Mental Retardation and Developmental Disabilities and recorded in the medical record.
4. Concurring determinations. In a residential health care facility, a concurring determination of incapacity shall be independently made and documented in the medical record by a Health or Social Service Practitioner employed by or formally affiliated with the facility and credentialed to make such determinations. Such determination shall include an assessment of the cause and extent of the incapacity and the likelihood of regaining capacity. In a hospital, such concurring determinations shall only be required when a surrogate has decided to withhold or withdraw life sustaining treatment. Disagreements which cannot be resolved on the determination of incapacity by the practitioner asked to render a second opinion shall be referred to the ethics review committee.
5. Notice of incapacity determinations shall be made to the resident, if there is any indication of an ability to comprehend; at least one person on the surrogate list in the highest order of priority; to the director of the mental hygiene facility and Mental Hygiene Legal Service, if the Resident is from a Mental Hygiene Facility.
6. The resident’s objection to a finding of incapacity, the choice of a surrogate and a healthcare decision shall prevail unless: (a) a court of competent jurisdiction determines that the Resident lacks decision-making capacity or is incompetent and makes any other finding required by law to authorize treatment or (b) another legal basis exists for overriding the Resident’s decision.
7. The resident’s continuing incapacity shall be confirmed before complying with any decisions made subsequent to the original determination. Additionally, a concurring determination of continuing capacity shall be made for any decisions to withhold or withdraw life sustaining treatment.

**CAPACITY CONSIDERATIONS IN DEMENTIA**

**Source**: The Last Taboo: A Guide to Dementia, Sexuality, Intimacy and Sexual Behaviour In Care Homes, Alzheimer’s Association, UK

[www.ilcuk.org.uk](http://www.ilcuk.org.uk)

