Fall 2023

Improving Mental Health Psychiatric Nurse Practitioners' Knowledge and Confidence to Assess Decision-Making Capacity in Geriatric Psychiatric Patients in Acute Settings

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Assess Decision-Making Capacity in Geriatric Psychiatric Patients in Acute Settings

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Date of submission: December 1, 2023

To my dearest Samantha, Andrew, and Laquann: As I reflect on my graduate school years, I am overwhelmed with gratitude for the support and encouragement each of you has provided. Samantha, my eldest, you have been my rock and confidante throughout this journey. Your wisdom and empathy have been a constant source of motivation. Andrew, my dear son, you have been a source of inspiration for me. Your unwavering support has been a true blessing. Laquann, my precious grandson, you have brought boundless joy and innocence into our lives during these challenging years. Your presence made the burdens of graduate school seem lighter, and your love and understanding made it possible for me to pursue my dreams.

I extend my heartfelt gratitude to several individuals whose unwavering support and encouragement were instrumental in my successfully completing this quality improvement (QI) project. Your dedication to learning, testing, and reflecting upon small changes that enhance patient care has been truly inspiring.

First and foremost, I want to express my deepest appreciation to Dr. Angela Braswell. Your words of encouragement, especially when I am faced with challenges, were a constant source of motivation. Your belief in the project and determination to see it through, even when the road was tough, played a pivotal role in its success. Your support and guidance were invaluable. I do remember your words: "I will fight you on this. I want to reinforce that you have an important and meaningful project; trust yourself and do not give up." The universe aligned me with the best person to help me in this endeavor.

I would also like to acknowledge Dr. Royster's tremendous support. Despite your busy schedule, you consistently provided guidance, feedback, and assistance whenever needed. Your unflagging support proved your commitment to the project's goals, and I am grateful for your mentorship.

Dr. Bassey, Dr. Doris, and Dr. Wright, I thank you for your unwavering support throughout this QI project. Your expertise and willingness to collaborate were essential in shaping the project's direction and ensuring its successful implementation. Your dedication to improving patient care was evident in your contributions, and I am thankful for the opportunity to work alongside such dedicated professionals.

In conclusion, this QI project would not have been possible without these people's collective efforts, guidance, and encouragement. Their commitment to excellence and willingness to support my goals have left an indelible mark on this project and, ultimately, on patient care. Thank you all for your invaluable contributions.

Abstract

In this quality improvement project, I aim to enhance the knowledge and confidence of psychiatric mental health nurse practitioners (PMHNPs) in completing Decisional Capacity Mental Assessments (DMCAs). I use qualitative and quantitative methods to measure the intervention's success, emphasizing PMHNPs' role in ensuring ethical DMCAs while maintaining patient autonomy. The education-based intervention significantly improves PMHNPs' knowledge and confidence levels following the pre-education survey. These findings highlight the significance of DMCA training for health-care professionals, underscoring the necessity of standardized assessments alongside improved dialogue during capacity evaluations. Limitations include limited sample sizes and dependence on self-reported measures, which may introduce bias. Using the MacArthur competence assessment tool exclusively may limit the applicability of outcomes to broader contexts. The program shows the PMHNPs at Veterans Affairs medical centers, but contextual factors decide their effectiveness. Examining broader gains beyond knowledge and confidence, such as alterations to clinical protocols or cross-functional collaboration, is critical. To ensure program longevity, the VAMC must cultivate an environment conducive to learning and integrate policies; collaboration among medical experts is crucial. PMHNPs will be able to perform accurate DMCAs while adhering to patient rights and ethical decision-making practices. In future explorations, researchers must delve into persisting impacts on patient satisfaction rates and legal consequences, thus ensuring continued training, particularly employing the MacArthur Competence Assessment Tool-Treatment.

Keywords: Decision-making capacity, assessment, autonomy competence.

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Improving Mental Health Psychiatric Nurse Practitioners' Knowledge and Confidence to

Assess Decision-Making Capacity in Geriatric Psychiatric Patients in Acute Settings

A demographic transformation has occurred around the world wherein the number of elderly people has been steadily increasing due to increase in life expectancy (Vajawat et al., 2021). According to Vrs and Pbha (2023), there are 771 million people aged 65 years and older worldwide, a threefold increase on 1980. This population is projected to increase to 994 million and 1.6 billion by 2030 and 2050, respectively. Increased longevity has resulted in an accompanying increase in the prevalence of mental health disorders in the elderly.

An example of these mental health disorders is dementia (Amaral et al., 2022). Such mental health issues compromise an elderly person in different ways, including their decision-making capacity (DMC; Amaral et al., 2022; Poppe et al., 2020; Usher & Stapleton, 2022). DMC refers to the ability of an individual to comprehend and remember vital information relevant to their health, particular decisions, and the use of such information to make and express a choice (Barry & Docherty, 2018). DMC influences virtually every aspect of an elderly person's life, including decisions with significant consequences for health, well-being, career, finances, and living situation.

A compromised DMC undermines an individual's ability to appropriately make health-related decisions, including giving informed consent for treatment and other clinical interventions (Amaral et al., 2022; Wood et al., 2020), as well as decisions pertinent to independent living (Usher & Stapleton, 2022). Compromised DMC can undermine care outcomes and patient experiences among this demographic (Usher & Stapleton, 2022). With the current aging population trends and the intrinsic incidence of chronic comorbidities that may influence decision-making (Damluji et al., 2023), practical approaches and interventions to

assess DMC among geriatric patients are increasingly necessary for health professionals. This is particularly true for psychiatric-mental health nurse practitioners (PMHNPs), who deliver care to geriatric psychiatric patients.

Problem Description

Assessing elderly patients' DMC is critical to providing the necessary level of care (Usher & Stapleton, 2022). DMC is a central concept in health-care laws and ethics and is defined as an individual's ability to make appropriate health-care decisions (Charles et al., 2021). DMC is underpinned by the doctrine of informed consent, which seeks to promote and protect patients' autonomy in making such personal decisions. In turn, DMC assessment (DMCA) evaluates an individual's ability to make decisions related to their health care, based on available information while appreciating the foreseeable consequences of the decision (Charles et al., 2021). Although DMCA is customary practice in health care, poor understanding of DMC, lack of training, limited resources, and time constraints can pose challenges for health and social care professionals (Usher & Stapleton, 2022). Misconceptions among many health professionals concerning DMC can potentially undermine clinical efficiency and patient outcomes (Ganzini et al., 2004).

As seen in the Augusta Veteran Affairs (VA) Healthcare System, previously known as Charlie Norwood Veterans Affairs Medical Center (VAMC) in Augusta, GA, a lack of training and confidence in DMCA may lead health professionals to inadvertently conduct such assessments unnecessarily, utilizing nonstandardized approaches that can harm an elderly patient (Charles et al., 2021). In particular, the VAMC mandates that all PMHNPs follow a standardized process to perform a DMCA on geriatric psychiatric patients who are thought to have questionable DMC. This stems from the assumption of VAMC leaders that all PMHNPs can

conduct such assessments. However, a significant challenge facing the psychiatric unit at the VAMC is the clinicians' need for increased confidence in performing DMCAs. The provider's confidence is pivotal for maintaining clinical excellence and fostering positive patient outcomes.

Within the Consultative Liaison Team (CL), only one PMHNP addresses the consults. The consultants must be responded to within 24 hours of each referral, and in their absence, a substitute PMHNP from the outpatient department handles the consultations. This arrangement has led to dissatisfaction among alternative providers, who often need help conducting these assessments and frequently require corrections. Several PMHNPs who were required to complete DMCAs have expressed a distinct need for specific training in this area because they were not taught this assessment in their academic institutions and, consequently, need more confidence in evaluating a patient's DMC. The PMHNPs attending to elderly patients at VAMC exhibit noticeable gaps in knowledge and confidence regarding DMCA. The urgent need for DMCA training is apparent to ensure clinicians adopt a standardized approach to care.

Available Knowledge

Aging is associated with complex interactions among functional, psychological, and social problems, and increased use of health-care services, and frequently these inevitably require patients to make many health-related decisions, including choosing among therapeutic strategies to address medical–social issues. Aging is also associated with increased illnesses, frailty, and mental health disorders such as dementia (Amaral et al., 2022; Charles et al., 2021; Santos et al., 2022). These realities affect an aging individual's DMC (Amaral et al., 2022; Poppe et al., 2020; Usher & Stapleton, 2022), Because all health-related decisions are based on free and informed consent, which requires an individual to possess cognitive autonomy and decision-making abilities (Tannou et al., 2019, assessment of these abilities is a necessity.

Competency and capacity are distinct concepts often used in legal and health care contexts. Although they may seem similar, they have different meanings and implications. Competency refers to a person's ability to understand and participate in legal proceedings or make informed decisions. The legal system typically assesses and determines if an individual has the mental capacity and comprehension necessary to make choices or understand the consequences of their actions in a specific legal context. Competency assessments are often relevant in criminal proceedings or civil cases in which decision-making abilities are questioned (Hein, 2019).

Capacity refers to an individual's ability to make decisions or engage in specific activities based on their mental and cognitive skills. It is a broader term and can encompass various types of decision-making, such as medical decision-making, financial decision-making, or the decision to consent to treatment. Capacity assessments are often conducted in health-care settings to determine if an individual can understand the information, evaluate the risks and benefits, and make informed decisions about their medical care or treatment options (Hein, 2019).

Geriatric patients, whose decision-making processes have been altered by aging, may make uninformed choices. These patients contend with various physical, cognitive, and mental health challenges that can undermine their care outcomes and experiences with the care process (Amaral et al., 2023). Challenges in decision-making raise clinical and ethical concerns and complicate daily life situations and economic activities related to aging (Tannou et al., 2020). Understanding DMC domains, such as independent living, is relevant to health-care providers working with geriatric patients who may require DMCA for cognitive processes such as integrating actions, forming strategies, making decisions, and coping with unexpected incidents. For health-care providers, the assessment of these domains influences outcomes regarding

independent living, patient support, and discharge destination (Scott et al., 2020). These implications of DMC on clinical outcomes make DMCA imperative for clinical decision-making, policy, and research.

In the United States, policy and legislative developments have increasingly emphasized how DMC is supported and assessed among geriatric patients (Usher & Stapleton, 2022). Current DMC-related legislation in the United States has been developed according to the United Nations Convention on the Rights of Persons with Disabilities (Usher & Stapleton, 2022) and the underlying assumption that adult persons can make decisions competently. However, it must be emphasized that average age-related declines experienced in various cognitive abilities do not necessarily impair the ability to make decisions crucial to daily living, functioning, and independence (Boron, 2020). Recent literature and legislation have emphasized the importance of DMCA and the role of all health-care providers, such as nurses, psychiatrists, social workers, therapists, psychotherapists, and psychologists, in determining the DMC of patients (Jayes et al., 2019). Even though there are changes in abilities, some are retained or even improved, such as abilities related to language, comprehension, and experiences that serve compensatory functions. The typical age-related decline associated with decision-making includes memory, concentration, and calculation, as seen in patients with dementia (Boron, 2020). Aging affects individuals in different ways and at different paces, so DMC must be assessed regularly, especially among geriatric patients in psychiatric care within acute settings.

The ability of psychiatric health-care professionals dealing with geriatric patients to deliver the best care is compromised by misconceptions that only mental health professionals can undertake DMCA. DMCA is a clinical determination that all health-care providers can make. Ganzini et al. (2004) presented 10 myths and misconceptions about DMC in their fundamental

study. One common misunderstanding is that people who disagree with medical advice do not have DMC. Other misconceptions are that DMCA is only required when a patient goes against medical advice or that DMC is all or nothing. Additional misconceptions are that cognitive decline indicates a deficiency in DMC, and that patients involuntarily admitted with psychiatric problems and those without consistent information all have lasting DMC deficiencies.

These myths and misconceptions about DMC can hinder the delivery of personalized care and may not align with the ethical principles of respect for autonomy and patient-centeredness. Therefore, mainstream literature emphasizes the need for health-care providers to recognize the possibility of impaired DMC among patients, how to perform DMCA, and how to promote decision-making in patients through support and acting as surrogate decision-makers (Amaral et al., 2023; Marron et al., 2020).

DMC is a complex mental process that involves four abilities. These are (a) understanding, or the ability to receive, store, and recall the meaning of information; (b) appreciation, or the ability to apply relevant information to the situation or condition; (c) reasoning, or the ability to use logical processes to compare alternatives; and (d) expression of choice, or the ability to communicate a choice and consistently maintain it until implementation (Luiza Santos et al., 2022). Interference in any of these four abilities impairs DMC. These challenges are exacerbated by progressive cognitive impairment, such as dementia.

Capacity assessment is needed in circumstances in which incapacity in the geriatric population is suspected (Vajawat et al., 2021). DMCA is always undertaken for a specific task, and a lack of capacity in one task cannot be generalized to other tasks. For example, an elderly patient may have the DMC to make treatment-related decisions but may not be able to consent to participate in research. DMCA must encompass medical history, interviews, neuropsychological

assessments, and capacity assessments using established tools to provide rigor and objectivity to collected data that are pertinent to determining capacity (Amaral et al., 2022). Various tools have been developed and tested for use in DMCA, including for elderly patients with psychiatric conditions such as dementia; the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) (Appendix A) is one such tool frequently used for DMCA, and the tool used in this quality improvement (QI) project. Many clinicians, including PMHNPs, lack knowledge, skill, and confidence in DMCA (Charles et al., 2021). The PMHNPs in the Augusta VA health-care system have expressed concerns about the lack of educational training and the reluctance to complete DMCA. As a result, these clinicians may undertake DMCAs unnecessarily, use nonstandardized approaches, or misuse standardized approaches, which can lead to inaccurate declarations of DMC. Evidence shows that health-care professionals caring for elderly patients should adhere to an established base protocol for DMCA that includes education and training (Charles et al., 2021). Appropriate DMCA education and protocol (Appendix B) can help psychiatric nurse practitioners harness standardized approaches to DMCA and avoid different types of pitfalls that can occur in administering DMCAs (Amaral et al., 2022).

In countries such as Canada, DMCA training has been provided for health-care professionals such as physicians, psychologists, nurses, occupational therapists, and social workers since 2006 (Charles et al., 2017). An established DMCA protocol helps mental health care professionals because evaluating an individual's capacity to make health-related decisions is necessary for each patient encounter. Establishing a DMCA protocol and incorporating educational sessions increases the knowledge and confidence of the health-care professionals expected to undertake such evaluations (Amaral et al., 2022).

Rationale

Although DMCA has a significant impact on patient outcomes, VAMC does not follow a standard protocol for DMCAs. A chart review of several DMCA documentations completed by the covering PMHNP and a comparison of evidence-based tools recommended for DMCAs showed that no standardized tools were used and that there is a need for a clear protocol to evaluate DMC in the VAMC. In the proposed evidence-based practice (EBP) QI project, we utilize the ADDIE model (Appendix C), a widely used instructional design framework comprising five phases: analysis, design, development, implementation, and evaluation (Shakeel et al., 2022. In the analysis phase, we identify the specific needs and goals of the project. The design phase involves creating an intervention plan and determining the appropriate assessment tools (Latif & Nor, 2020). The development phase is focused on developing educational materials and training modules. The implementation phase involves executing the intervention in a real-world setting. Finally, in the evaluation phase, the effectiveness of the intervention is assessed to determine its impact and identify areas for improvement.

The ADDIE model is supported by learning theories, the learning environment, the learner's needs, and popular approaches to practitioner training and education in EBP interventions (Chandrashekar et al., 2020). The ADDIE model is well-suited to facilitate the proposed QI project, in which we seek to improve the knowledge and confidence of PMHNPs in DMCA of geriatric psychiatric patients in acute settings. This model is increasingly used in QI projects aimed at improving patient safety and procedural competency. Its structured approach is appropriate for developing programs geared toward participant behavior and performance improvement (Patel et al., 2018).

This structured approach addresses the gaps in DMCA practice by allowing systematic analysis of the needs and opportunities for improvement, design of an intervention plan tailored to PMHNPs' requirements, development of educational materials and training modules specific to DMCA of geriatric patients, implementation of the intervention, and evaluation of its effectiveness. Following this systematic process, the ADDIE model ensures that the proposed QI project is comprehensive and evidence-based, which allows for continuous improvement in the knowledge and confidence of PMHNPs in assessing DMC in older adults in acute care settings.

In *Patricia Benner's* Novice to Expert Theory *(1982),* she described how individuals acquire knowledge and skills as they progress from novice to expert in a particular field or domain. According to the theory, individuals progress through five stages: novice, advanced beginner, competent, proficient, and expert. In the novice stage, individuals have limited knowledge and rely on rules or guidelines to perform tasks. As they gain experience and engage in deliberate practice, they progress through the stages, developing a more intuitive and holistic understanding of the domain and becoming experts who can make complex decisions based on a deeper understanding of the situation (Ozdemir, 2019). This theory has been used to understand the development of expertise, inform curriculum design and teaching strategies, and guide professional development programs across various fields including nursing, medicine, education, and other professional domains (Ozdemir, 2019).

In nursing, the novice to expert theory (NTE) has been used to effectively study and improve competency among nurse practitioners (Miller & Hill, 2018; Simpson et al., 2022). The NTE theory provides a comprehensive framework for developing and implementing an intervention to improve the knowledge and confidence of PMHNPs regarding DMCAs for patients in acute care settings. In this QI project we acknowledge that PMHNPs may be at

various stages of expertise in DMCA and highlight the inherent need to advance their proficiency in the same. By understanding the stages of the NTE theory, the intervention can be tailored to meet the specific needs of PMHNPs at various levels of expertise in the acute care setting (Ozdemir, 2019). Based on Benner's NTE nursing theory, evidence-based interventions are required to improve DMCA processes at the VAMC to provide patients with optimal care and experiences.

For instance, novices may require foundational knowledge and guidelines, whereas more advanced practitioners may benefit from case-based scenarios or opportunities for deliberate practice. This adaptation allows for the intervention to provide foundational knowledge for novices, case-based scenarios for advanced beginners, opportunities for deliberate practice for competent practitioners, and reflective training and mentorship for those striving to become proficient or expert (Benner, 1982). The NTE theory guides the design and implementation of the intervention that supports PMHNPs' professional growth, ultimately fostering the development of expertise in assessing DMC in geriatric patients in acute settings.

Specific Aims

In this QI project, we aimed to increase the knowledge and confidence of PMHNPs working in the acute care setting at VAMC to perform DMCA. The specific goals of this project were:

- Implementing an evidence-based tool to standardize the DMC documentation.

- Providing comprehensive educational training that offers PMHNPs a thorough understanding of using the MacCAT-T to complete DMCA.

- Increasing the number of completed DMCAs among PMHNPs.

Methods

Context

The Veterans Health Administration (VHA) system oversees the most extensive integrated health care system in the United States, serving over nine million veterans (Ward et al., 2021). It includes Veterans Health Administration (VHA) hospitals, clinics, nursing homes, and other medical facilities throughout the country. The VHA also provides benefits and services such as disability compensation, education and training assistance, home loans, life insurance, and burial benefits. The VA primarily serves the veteran population of the United States, including individuals who have served in the U.S. Armed Forces. In addition to helping veterans, the VA provides services to eligible veterans, including certain health care benefits, educational assistance, and survivor benefits.

The VA's mission is to fulfill the nation's commitment to its veterans by ensuring they receive comprehensive health care and support services in recognition of their sacrifices and contributions to the country. Many veterans have been diagnosed with depression, anxiety, post-traumatic stress disorder (PTSD), distressing memories, trauma related to military service, or stress related to health concerns. These health concerns include pain, difficulty sleeping, memory problems, and impaired mobility. Most of these issues have been associated with the misuse of alcohol and drugs (Miranda Jr. et al., 2020). Moreover, nearly half of the patient population at the VAMC are 65 years and older and present with different mental health conditions that may undermine their DMC, emphasizing the need to conduct DMCAs at the point of care.

Therefore, as health-care professionals, PMHNPs have the ethical duty to respect patients as autonomous agents with the right to decide what happens and does not happen to their bodies (Amaral et al., 2022; Poppe et al., 2020). At the same time, PMHNPs must also protect

vulnerable patients, such as elderly patients with psychiatric diagnoses who have diminished capacity for autonomous decision-making. If PMHNPs fail to assess their DMC properly, there is a risk of infringement on patients' rights.

As the population ages and cognitive impairment becomes increasingly prevalent among aging individuals, requests for DMCA are increasing in frequency and complexity (Amaral et al., 2022; Tannou et al., 2020). An elderly person may have the capacity to make some decisions but not others. Though necessary, DMCA can be confrontational and intrusive; therefore, it is necessary to work to protect the patient's interest and autonomy.

Current legislation—the Patient Self-Determination Act (PSDA)—is committed to preserving patient autonomy through informed consent. An individual is presumed to have capacity until proven otherwise. The PSDA is federal legislation enacted in 1990 to promote and protect patients' right to make decisions about their health care, particularly regarding advanced directives and DMC. Although the PSDA does not explicitly address DMCA, it establishes essential provisions that impact the assessment and recognition of patient autonomy. The legislation indirectly supports the DMCA process by recognizing patients' rights to make decisions and ensuring that health-care providers respect and honor those decisions. It highlights the significance of informed consent and the need for health-care professionals to engage in meaningful conversations with patients, considering their wishes, values, and preferences. Given this legislation, DMCA is the most effective way to establish DMC. Treatment can only be provided with a patient's valid, informed consent; therefore, PMHNPs, as mental health care professionals, need the knowledge and confidence to assess an individual's capacity to consent to treatment at every patient encounter. Current data on common practices are not readily available, but requests for formal assessments of health-care DMC usually happen when patients refuse

recommended treatment (Tannou et al., 2020). Another instance when DMCA is urgently needed is when an elderly patient develops declining cognitive ability due to a psychiatric condition such as dementia, alcohol abuse, or substance abuse (Amaral et al., 2022; Poppe et al., 2020; Poulton & Hester, 2019; Usher & Stapleton, 2022).

Setting

The Augusta VA health care system, formerly Charlie Norwood VAMC, provides health-care services at five locations in northeast Georgia and western South Carolina. The facilities are the Charlie Norwood VAMC in downtown Augusta and the Augusta VA Medical Center–Uptown Division. There are also three community-based outpatient clinics in Athens, GA; Statesboro, GA; and Aiken, SC (South Carolina). The setting for this evidenced-based QI project is the Charlie Norwood VAMC downtown division, which is authorized for 155 beds (VAMC, 2023). This highly complex hospital system provides primary care and specialty health services, including mental health services, physical therapy, rehabilitation, and spinal cord injury treatment, among many others. The VAMC's mental health care services cover conditions such as addiction, depression, anxiety, trauma, PTSD, bipolar disorder, schizophrenia, OCD spectrum disorder, family problems, geriatric mental disorders, neurobehavioral disorders, and mixed medical-psychiatric disorders. The VAMC has a diverse inpatient, partial hospital, and outpatient population, with almost half of the patient population aged 60 and older.

We limited the intervention to the acute care hospital at the VAMC, given the broad range of services provided to patients at the hospital, which relies on the collaboration and coordination of various health-care workers, including psychiatrists, psychologists, physicians, social workers, PMHNPs, registered nurses, licensed practical nurses, recreational therapists, and occupational therapists. There are currently 10 PMHNPs at the VAMC.

Cost–Benefit Analysis

In 2022, the typical daily cost for a veteran's accommodation at a VA hospital was approximately $4,782 (Kolade et al., 2023). As such, it is critical for PMHNPs to carry out DCMAs within 24 hours of receiving a consultation request from the medical team. Evaluating its execution requires an in-depth review of the advantages and costs linked with setting up a uniform procedure for DCMAs. The goal is to decrease unnecessary hospital stays and interventions while ensuring patients' best interests are prioritized when making health-related decisions. Providing PMHNP educational sessions did not entail any monetary expenditure on behalf of the organization. This training was efficiently integrated into both the routine schedule of PMHNPs and that of Microsoft Teams to conduct these sessions during their standard working hours, thus minimizing supplementary expenses. Throughout this process, buying the MacCAT-T, which cost $175.00, was identified as the sole financial expense associated with this endeavor.

Interventions

Through the intervention we aimed to enhance the knowledge and confidence of PMHNPs at the VAMC in assessing DMC in geriatric psychiatric patients in the acute care setting. The intervention consisted of three 1-hour comprehensive educational sessions, in collaboration with the leadership team, on proper use of the MacCAT-T tool. This tool offers a structured framework for an evaluator to systematically assess several facets of decision-making competence throughout the interview, such as comprehension, appreciation, reasoning, and ability to make treatment decisions voluntarily. This is especially helpful in psychiatric treatment or research situations where informed consent and patient autonomy are important ethical and legal considerations.

The second intervention included the development of a protocol for completing the decision-making assessment. The protocol was available in the consultative liaison office for easy access for all the PMHNPs. The project lead contacted potential participants with an invitation letter (see Appendix D), including the intervention, purpose, objectives, and participation expectations (Creswell & Creswell, 2018). We used a pre-and post-assessment survey to compare self-reported knowledge and confidence in the key concepts in conducting DMCA. After the DMCA education, we used a Likert-type scale survey (Appendix E), ranging from strongly disagree to agree, and a quiz to evaluate the PMHNPs' knowledge and confidence.

Based on the findings and feedback from the educational intervention, we developed a protocol for performing DMCAs on geriatric and psychiatric patients. The protocol is a valuable resource and reference tool, ensuring standardized documentation and evidence-based approaches to DMCA in acute care settings. Via these outcomes we assessed the qualitative feedback of participants to provide a holistic understanding of the impact of the intervention on participants' knowledge, confidence, and clinical practice at the VAMC. Health-care practitioners working with geriatric patients need to assess patients' DMC efficiently and effectively (Pennington et al., 2018). Accurate DMCAs promote patient-centered care outcomes and clinical interventions that are less restrictive (Brémault-Phillips et al., 2018). Understanding the critical need for standardized direction in undertaking DMCAs, it was apparent to the institution that despite the incumbent responsibility of providers to execute such evaluations, a systematic framework remained indispensable. The project lead embarked on an all-encompassing strategy to foster efficient protocol creation and refine operational procedures. Primary steps involved exhaustive exploration of protocols employed in other veteran-focused

health-care facilities to contemplate the adoption of preexisting frameworks, potentially

simplifying processes within Augusta VAMC.

The project aimed to create a protocol involving a multidisciplinary team, including

psychiatric nurse practitioners, physicians, and psychiatrists. The goal was to ensure that the

newly developed protocols were comprehensive, firmly grounded in empirical data, and

following best practices. Additionally, we diligently considered any specific requirements or

guidelines set forth by the VAMC or relevant regulatory authorities. Before implementing the

protocol into practice, they underwent rigorous scrutiny, incorporating feedback from key

stakeholders and subject matter experts. This thorough evaluation and the accumulation of

constructive input constituted a crucial phase preceding the protocol's initiation. Ultimately, this

process confirmed their effectiveness and ensured consistent alignment with established best

practices

The VA's National Ethics Committee (Ganzini et al., 2022) states that physicians

overseeing patient care are responsible for assessing DMC and that all clinicians caring for

patients have an ethical obligation to understand their DMC and how it is measured. The VAMC

leadership assumes that all PMHNPs can complete DMCAs for their patients. However, when

these patients are admitted to the acute care setting, the medical team consults the mental health

CL, which has one PMHNP responsible for completing DMCAs. PMHNPs from the outpatient

setting of the VAMC are asked to cover the acute care setting, and the leadership expects that

they function in the consultative liaison role. Speaking with several psychiatric nurse

practitioners about their academic program revealed that DMC was not a topic covered in the

psychiatric nurse practitioner program they attended, yet they are expected to complete such

assessments at the VAMC; hence, this project is specifically designed for PMHNPs providing care to geriatric psychiatric patients in acute settings.

For this QI initiative, we extended invitations to eight PMHNPs. All of them engaged in the first evaluation process; however, only seven could take part in the subsequent assessment due to one member being on vacation. The invitation outlined the potential benefits of the intervention on clinical efficiency. The educational sessions were conducted online using the Microsoft Teams platform. The Microsoft Teams platform is a comprehensive communication, collaboration, and project management platform that fosters organizational productivity and teamwork (Schweitzer et al., 2020). The VA uses this platform to ensure accessibility and convenience for the participating PMHNPs. The sessions cover various aspects of DMCA, including understanding the legal and ethical frameworks, assessing cognitive function, evaluating patient preferences and values, and applying clinical judgment to determine DMC. We tailored the content of the educational sessions to the specific needs and challenges faced by PMHNPs in the VAMC, as identified by the preintervention survey results.

Measures

In the QI project we regularly analyzed the monthly records to assess compliance with DMCA procedures and observe any growth in the count of DMCAs managed by PMHNPs. To gauge their understanding and certainty when utilizing MacCAT-T (Grisso & Appelbaum, 1998), we administered pre- and post-evaluation questionnaires to PMHNPs. The team deliberated identified issues pertaining to protocols and addressed them appropriately. The team also formulated strategies for the enhancement of DMCA methods and execution. This approach fosters uniformity and evidence- informed practices while considering ethical and legal implications. Utilizing Qualtrics software, we dispatched an electronic survey to evaluate the

efficacy of this intervention, thus pinpointing pivotal areas demanding improvement. We captured post-interventional feedback from participants through a questionnaire featuring a multiple-choice exam that served as a measure of learning assessment (Appendix F).

A preassessment survey determined the participants' understanding of DMC and DMCA. After the evidence-based educational sessions, participants completed a post-assessment survey to evaluate their enhanced knowledge and confidence in completing the DMCA for geriatric patients with psychiatric disorders. We analyzed the survey results using improved knowledge and confidence in DMC and the DMCA quality. We conducted pre- and post-assessment surveys electronically. We administered and collected the preassessment survey before the first educational session, and we administered and managed the post-assessment intervention after three educational sessions. We aggregated and analyzed results from the survey using the Qualtrics platform, then conducted a quiz to evaluate participants' knowledge of the interventions.

As a first measure, we conducted a retrospective chart review to determine to what extent DMCAs are being completed and to identify if the providers are using any other tools or resources to complete DCMAs. The Doctor of Nursing Practice (DNP) project site does not currently utilize MacCAT-T, nor do PMHNPs consistently conduct DMCAs. Following the intervention, we performed a chart review to evaluate the DMCA completed by the PMHNPs and determine if the documentation was completed using the MacCAT-T tool. We obtained data on the number of DMCAs completed by the VAMC from the administrators of the VAMC to identify opportunities for enhancing the quality and consistency of these assessments. This process promotes standardized and EBPs while upholding ethical and legal considerations surrounding DMC.

Although the CL comprises a psychiatrist, a social worker, and a PMHNP, the psychiatrist position is currently vacant, so we compared these numbers with the number of DMCAs administered by PMHNPs during the first months prior to the intervention. The learning objectives assess each DMCA educational session, which includes a written examination to evaluate PMHNP learning. We continuously considered contextual elements in addition to educational session materials. The project lead acquired a MacCAT-T competence assessment tool for $175 and conducted the training during working hours. Success for the DNP project is defined as QI participants achieving a 96% score on the written test. We collaborated with PMHNPs and continually evaluated chart reviews to ensure DMCAs were completed according to the established protocol. It is essential to provide training to sustain the quality of DMCAs, which includes regular sessions for PMHNPs involved in DMCA and onboarding for PMHNPs to enhance their knowledge, skills, and adherence to best practices. These training programs must incorporate the latest research and developments in DMCA.

The learning objectives measured each of the DMCA educational sessions. We gave a written examination to evaluate the PMHNPs' learning. Through DMCA instructional programs for PMHNPs, continual evaluations of contextual facets occur in tandem with written exams to gauge educational outcomes. These aspects cover environmental considerations like the nature of the clinical environment and available resources, individual backgrounds and experiences of the PMHNPs, diverse learning approaches, as well as delivery methods for teaching materials. The role of organizational culture within health-care institutions is also considered along with patient interaction characteristics and established feedback and assessment procedures. We conducted the training during working hours. We completed ongoing collaboration with the PMHNPs and continuous evaluation of chart reviews to ensure that DMCAs were being completed according

to the established protocol. Training is crucial to sustain the quality of DMCAs. Regular training

sessions for the PMHNPs involved in DMCA and PMHNP onboarding to enhance their

knowledge, skills, and adherence to best practices are necessary. Training programs must

incorporate PMHNP onboarding and annual education.

Analysis

To analyze the educational session pre- and post-assessment surveys completed by the

PMHNPs, we used Qualtrics analysis capabilities to analyze quantitative data. We provided the

narrative feedback via email. This allowed the team to find trends, patterns, or changes that may

further guide the development of a protocol for the proposed DNP project. As part of the DNP

project, qualitative data provided an in-depth understanding of the topic and allowed deeper

insight into PMHNPs' knowledge and confidence in completing DMCA. We shared the

collected data among the DNP project team members. The team lead developed the protocols in

collaboration with the mental health leadership team. After completing the educational training,

we made the video recordings of the educational sessions, MacCAT-T videos, and protocol

available for PMHNPs to use.

Ethical Considerations

The application for the clinical nursing initiative underwent rigorous scrutiny and

received approval from the DNP committee at Durham's Department of Nursing at New

Hampshire University, thereby guaranteeing that ethical guidelines were adhered to before

project commencement. Securing the institution's early authorization was pivotal to launching

this QI initiative. It is important to mention that the Augusta VA health care system provided the

green light for the QI without a prerequisite condition for supervision by an institutional review

board. After the acquisition of the Non-Research Activity Determination document (Appendix

G), along with two internal memos (Appendix H) from VA authorities, the team supervisor

granted clearance to commence the QI venture. We informed participants and other staff

members about their right to withdraw from participation in this DNP endeavor anytime they

wish while ensuring their anonymity throughout the involvement period. Ethical aspects of data

collection, especially within the context of chart audit, included acquiring explicit consent from

involved management entities and strict compliance with patient privacy norms under the Health

Insurance Portability and Accountability Act.
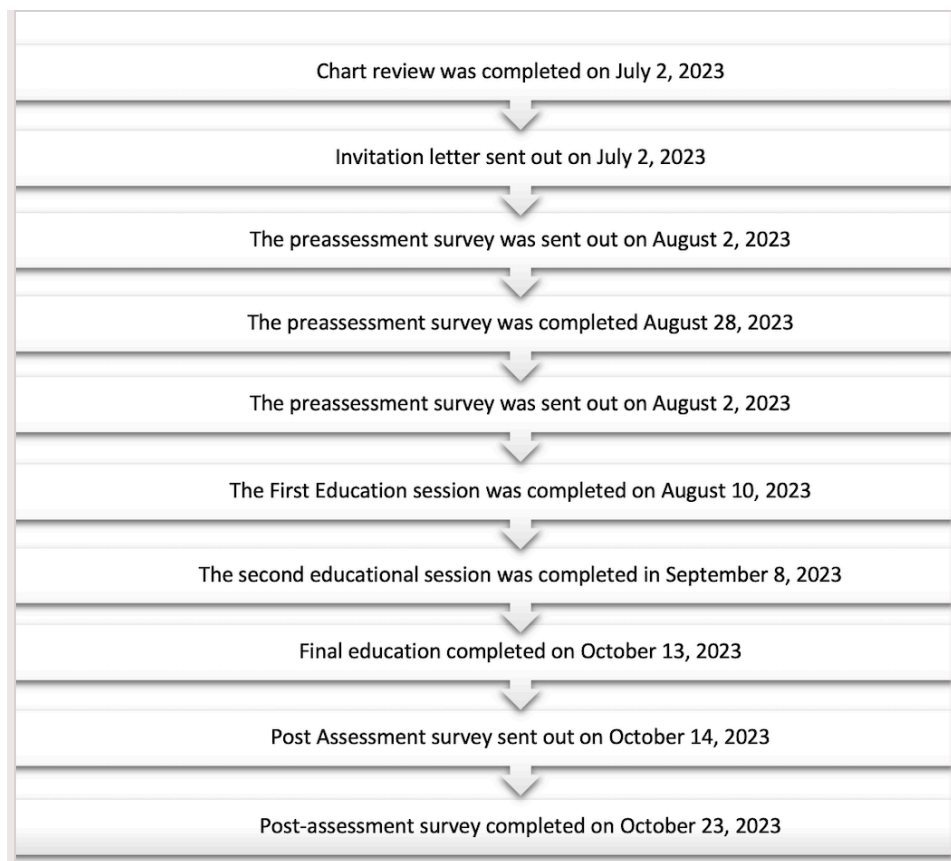
Data Collection

We gathered the project data using electronic polling via Qualtrics, allowing qualitative

and quantitative evaluation. Concurrently, we completed a retrospective review of medical

records to determine the number of DMCAs executed before and after the applied intervention.

The main objective of this analysis was to identify emerging trends, patterns, and shifts in the

comprehension and self-assurance levels among PMHNPs while also evaluating the efficacy of

an educational seminar. Eight respondents participated in the pre-intervention survey, with seven

partaking in the post-intervention assessment; each survey comprised 26 DMCA-related

questions, with two additional inquiries on PMHNP confidence included exclusively in the latter.

For the QI initiative we adopted a systematic approach initiated with an audit of medical

documentation followed by a stepwise approach (as seen in Figure 1) and the construction of a

DMCA protocol. These instructive sessions via Microsoft emphasized various dimensions,

including judicial principles, ethical norms, cognitive functioning evaluations, calculating patient

preferences and values, and wise application of clinical judgments pertaining to DMCA. We

tailored the material presented to address obstacles discerned during initial stage intervention

assessments. In these sessions, PMHNPs actively took part in surveys administered prior to and

following instructions accompanied by thorough quiz revision (Appendix I) intended to gauge their knowledge and self-confidence in completing DMCAs.

Figure 1

Initial Steps of the Intervention(s) and Their Evolution Over Time

Chart review was completed on July 2, 2023

Invitation letter sent out on July 2, 2023

The preassessment survey was sent out on August 2, 2023

The preassessment survey was completed August 28, 2023

The preassessment survey was sent out on August 2, 2023

The First Education session was completed on August 10, 2023

The second educational session was completed in September 8, 2023

Final education completed on October 13, 2023

Post Assessment survey sent out on October 14, 2023

Post-assessment survey completed on October 23, 2023

Results

We employed a survey using a 5-point Likert scale to gauge the knowledge and confidence levels of PMHNPs regarding DMC among elderly psychiatric patients at Charlie Norwood VAMC. We evaluated the participants' understanding and confidence levels through item 28 of the post-intervention survey, which aimed to assess the quantitative data gathered from question 28, revealing a significant increase in the participants' knowledge and confidence

levels. In addition to the quantitative data, respondents could provide narrative responses through email. These email responses underwent a thorough analysis, revealing consistent themes highlighting the project interventions' positive impact. These themes consistently supported the idea that the interventions substantially enhanced the participants' knowledge and confidence. Additionally, we categorized the survey statements into two groups. The first group pertained to knowledge of hospital policies and procedures. In contrast, the second group focused on familiarity with the MacCAT-T and its importance in DMC.

Knowledge of Hospital Policies and Procedures

Results demonstrated that in the pre-intervention phase (Figure 2), most respondents understood DMC, disputing the notion that it is only needed when patient decisions contradict medical recommendations. They acknowledged that DMC may fluctuate depending on the decision at stake. Views varied regarding whether cognitive deficiency invariably implies an absence of DMC, with the majority contesting that incapacity for decision-making is always enduring. Participants stressed uniformity in information as critical during a DMCA. Although many concurred that psychiatric patients have decision-making capabilities, opinions diverged regarding involuntarily admitted individuals. Generally, respondents refuted the idea of exclusive rights of mental health professionals for evaluating DMC. The QI project also revealed diverse levels of awareness concerning hospital procedures and regulations linked to evaluating DMC and variance in comprehending assessment criteria and processes, underlining the need for robust education initiatives aimed at clear conceptual understandings, facilitating optimal patient care while maintaining respect toward their autonomy.

Figure 2

Preassessment Hospital Policy Knowledge
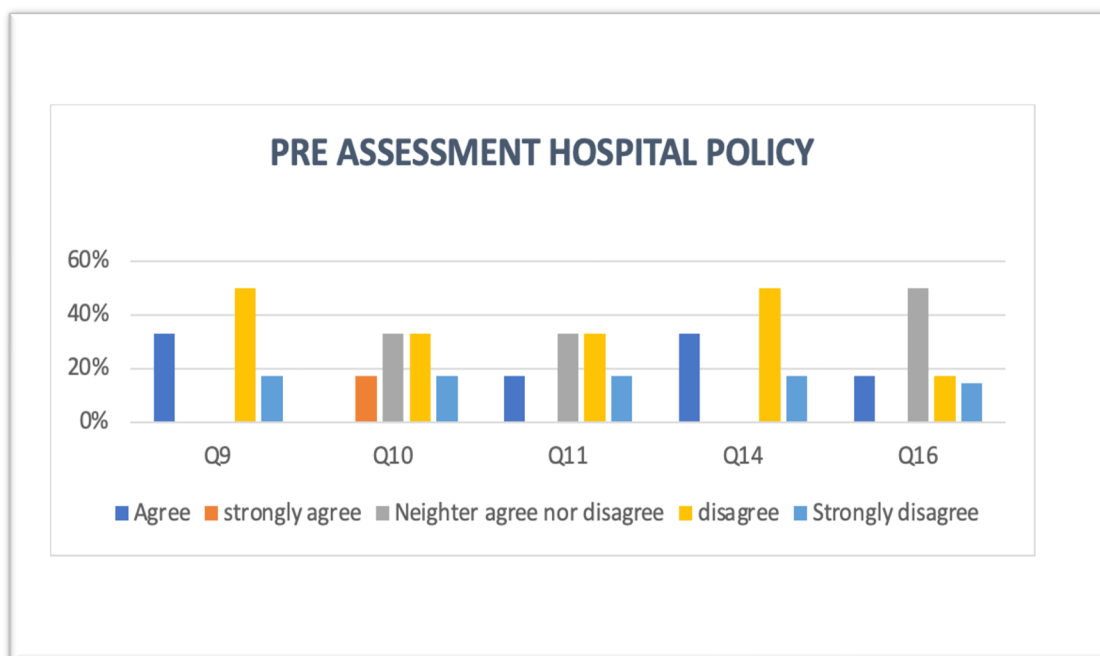
Although most understood that patients with psychiatric disorders are not necessarily incapable of decision-making, opinions differed on whether involuntarily admitted patients inherently lack DMC, recognizing the situational complexity. Overall, participants disagreed with the idea that only mental health professionals can conduct DMCAs. The survey also revealed varying levels of familiarity with hospital policies and protocols related to DMCA and differing degrees of understanding of the criteria and specific steps involved in the assessment process. The preassessment survey findings highlight the need for education and training on hospital policies and protocols to ensure a clear comprehension of DMC and the assessment

process. This knowledge is crucial for providing appropriate care and upholding patient autonomy.

      The post-assessment survey results (Figure 3) indicate varied levels of understanding and awareness regarding DMC and hospital policies among respondents. Though the majority correctly rejected the myth that DMCAs are solely triggered by decisions contradicting medical advice and acknowledged that DMC can vary based on the decision's complexity, there was less consensus on other issues. Respondents expressed uncertainty about the permanence of a lack of DMC, who can conduct DMCAs, and whether psychiatric disorders universally impair decision-making.

Figure 3

Post-Assessment Hospital Policy Knowledge
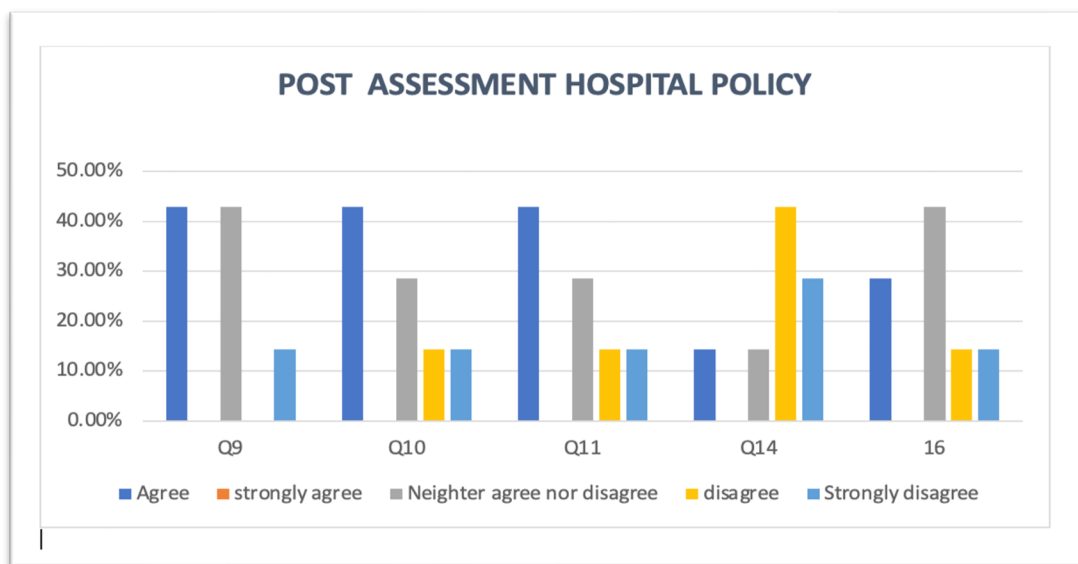
Additionally, familiarity with hospital policies and protocols on DMCAs needs to be more consistent, with a need for more comprehensive training and education on the subject. The

survey underscores the importance of clarity in DMC concepts and hospital policies to ensure that health-care professionals can effectively evaluate patients and respect their autonomy.

Knowledge About MacCAT-T

The MacCAT-T is commonly used to help with DMCA. The tool evaluates a patient's decision-making abilities across four key areas: understanding their medical condition and treatment options, weighing the pros and cons of different choices, recognizing their personal situation and the consequences of their decisions, and expressing their preferences. The MacCAT-T has shown high internal consistency (a measure of reliability) with a Cronbach's alpha value of 0.91. Additionally, it demonstrates strong agreement among different assessors (inter-rater reliability) in all its domains, with intraclass correlation coefficients ranging from 0.92–0.98 (Raffard et al., 2021).

Figure 4

Preassessment Knowledge of the MacCAT-T
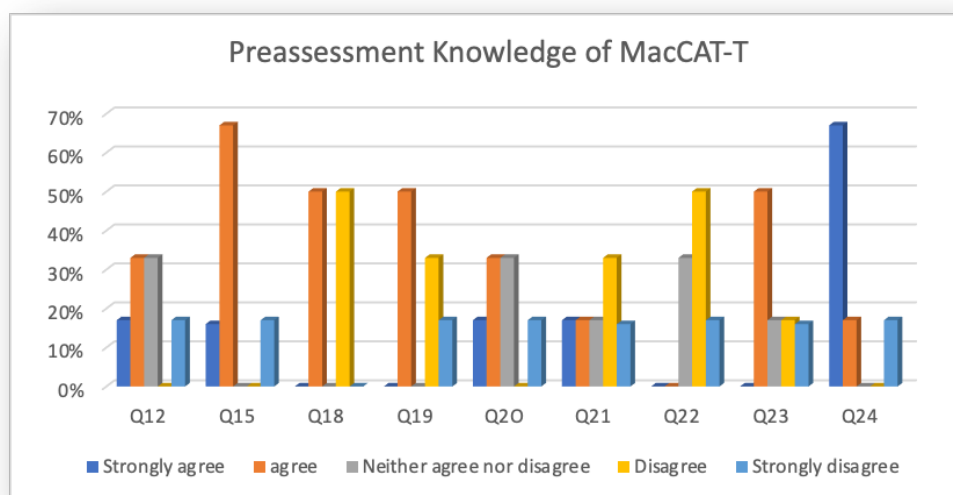
We evaluated the PMHNPs via the pre-assessment and post-intervention survey to assess their knowledge and confidence in using the MacCAT-T. In the pre-assessment survey (Figure 4), respondents established a baseline for their knowledge and confidence levels regarding the MacCAT-T and its role in assessing DMC. Subsequently, post-assessment survey (Figure 5) responses revealed that confidence in administering the MacCAT-T was evenly split, with 50% expressing confidence and 50% harboring reservations. The majority (83%) believed the MacCAT-T could enhance their competence. Familiarity with the tool and its assessed domains was divided, with half being familiar and the remainder not. A minority (34%) had prior experience using the MacCAT-T in clinical practice, and most were unaware of related guidelines or protocols.

Figure 5

Post-Assessment Knowledge of the MacCAT-T
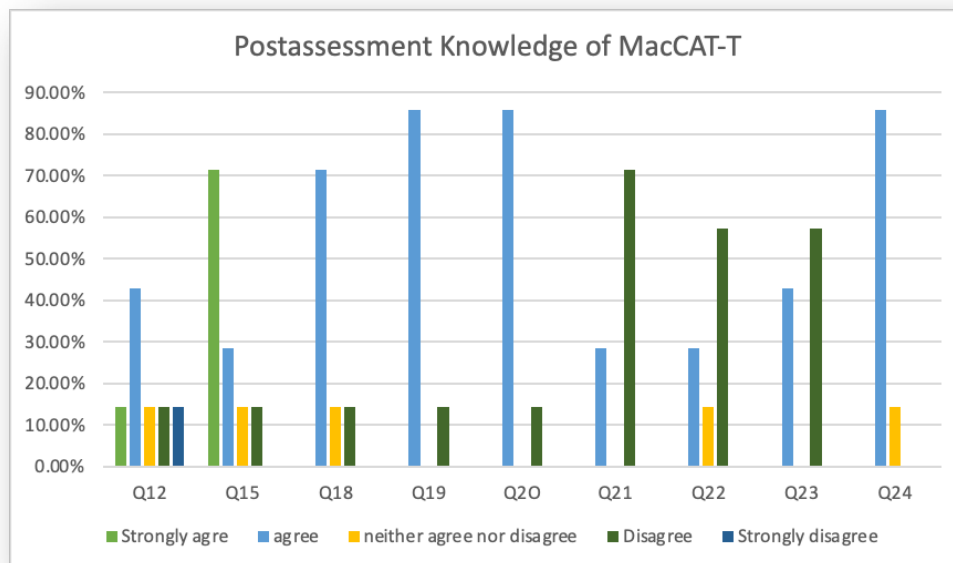
Regarding preparedness to interpret MacCAT-T results, half felt prepared, whereas a sizable portion (33%) did not. The responses conveyed a mixed picture of confidence and reservations, emphasizing the potential for competence enhancement through the MacCAT-T. They also indicated limited familiarity with the tool and associated protocols and some uncertainty regarding readiness to interpret its results.

In the post-assessment survey, respondents expressed positive attitudes toward the MacCAT-T. A majority believed it could enhance their competence in evaluating DMC (71.42%) and were familiar with the MacCAT-T itself (71.43%) and its assessed domains (85.71%). Confidence in accurately administering the tool was high (85.71%). However, respondents showed uncertainty regarding documentation requirements (42.86% neither agreed nor disagreed) and were divided on their preparedness to interpret MacCAT-T results (42.86% agreed, 57.14% disagreed). Many had not used the MacCAT-T in clinical practice (71.43%), and awareness of specific guidelines or protocols was limited (28.57% agreed). These findings suggest a need for further training and education on the MacCAT-T's practical use.

The comparison between the pre-assessment and post-assessment surveys reveals an improvement in PMHNPs' confidence in administering the MacCAT-T. In the pre-assessment survey, 50% felt confident, whereas in the post-assessment survey, 85.71% expressed confidence. However, familiarity with the MacCAT-T and its domains remained consistently high, with no substantial change observed. Practical experience using the tool in clinical practice remained limited, with the majority having yet to gain prior experience in both surveys. Awareness of specific guidelines or protocols related to the MacCAT-T remained low, and there was no meaningful change in respondents' preparedness to interpret MacCAT-T results, with a notable portion feeling unprepared. The findings suggest that although confidence in using the

MacCAT-T improved, there is still a need for additional education and training to enhance PMHNPs' overall knowledge and competence in utilizing the tool effectively.

Eight PMHNPs responded to the pre-assessment, and seven responded to the post-assessment survey. Question 28 specifically inquired about knowledge and confidence. The quantitative data showed a noticeable increase, and we provided the PMHNPs with an opportunity to respond to the question via email. We analyzed the responses for themes.

Consolidating feedback on the MacCAT-T training sessions reveals clear trends of increased competence and confidence among mental health professionals in DMCAs. These trends are marked by adopting a structured and standardized approach, courtesy of the MacCAT-T framework, which leads to more reliable and legally and ethically informed evaluations. Practitioners highlight improved expertise and confidence, with case scenarios crucial in practical learning and application. PMHNPs report that the training increases their knowledge and confidence and have pushed for the broader implementation of the DMCA training within the VA system. This emphasizes the need for ongoing education and support to keep pace with evolving best practices and ensure consistent, high-quality patient care.

The following is what participants shared:

> The MacCAT-T training sessions were transformative for my practice. They provided a structured approach to decision-making assessments. I feel more knowledgeable about legal and ethical considerations and more confident in my assessments. Before training, I always second-guessed my judgment during capacity assessments. With the MacCAT-T framework, I have a reliable tool that guides my evaluations. My confidence has increased, knowing my assessments are grounded in a validated protocol. As a result, I can make more accurate decisions about which skills the trainee needs to develop. I'm

also able to focus on the most significant skills that need to be improved. After the

training, I feel more confident about participating in decision-making consultations

downtown. (Participant 1)

The educational sessions were eye-opening. Learning to use the MacCAT-T has made

my assessments more thorough. I am now more adept at considering the nuances of a

patient's cognitive abilities and can confidently articulate my findings to the treatment

team. This has allowed me to provide better care for my patients, and I am confident that

this new knowledge will be beneficial in my future career. I am grateful for the

opportunity to attend the educational sessions and am already seeing the benefits of my

experience. (Participant 2)

As a PMHNP, I often face challenges assessing a patient's understanding, reasoning,

and choice. The training bolstered my knowledge and gave me a clear protocol to follow.

This has made a world of difference to my confidence levels. I now feel more

comfortable assessing a patient's mental status and providing effective treatment. I'm

also better able to recognize signs of cognitive decline and provide appropriate referrals.

I'm grateful for the training and for the tools it has given me. (Participant 3)

The case studies we reviewed during the training sessions were particularly helpful.

They allowed me to apply the MacCAT-T in various scenarios, enhancing my

understanding and making me feel more confident in my ability to assess decision-

making competently. I especially appreciated the feedback I received from the trainer.

This helped me refine my assessment skills and identify areas for improvement. I am now

more confident in using the MacCAT-T in real life. (Participant 4)

I appreciated the depth of the training sessions, especially the focus on differentiating

between a patient's DMC and their actual choices. It's improved my ability to evaluate

capacity without bias, increasing my confidence in my professional judgment. This has

allowed me to assess the patient's need for added support or resources. It has also enabled

me to provide more effective care for my patients. I am grateful for the information I

learned and am eager to apply for it. (Participant 5)

"Implementing the MacCAT-T protocol has standardized my capacity assessments.
The training equipped me with the knowledge to use the tool effectively and the confidence to
support my clinical decisions with solid evidence." (Participant 6)

The VA needs more training like this, all mental health professionals should receive [t]his

training to assess their patients and provide the necessary care properly. The VA should

also provide ongoing guidance and support for mental health professionals to ensure they

remain up to date with the latest protocols. The VA should emphasize the importance of

using the MacCAT-T protocol to ensure the most accurate assessments are made. The

VA should also provide ongoing training and support to ensure health-care professionals

stay current on any changes. (Participant 7)

Discussion

The QI projects highlight improvements in knowledge and confidence reported by

participants after undergoing training in using the MacCAT-T for DMCAs. It emphasizes the

importance of standardized tools and protocols in guiding DMCAs, promoting fairness, reducing

bias, and facilitating effective communication within health care teams. The QI project outlines

the need for comprehensive education and training for all health-care providers, particularly

PMHNPs, in conducting ethical DMCAs while upholding principles of patient autonomy. We

considered both qualitative and quantitative data to assess the project's effectiveness, with

narratives from PMHNPs revealing an enhancement in knowledge and confidence. Furthermore, the discussion recognizes the influence of contextual factors, such as the specific challenges faced by veterans in the VA health care system, on project outcomes, highlighting the importance of considering these unique circumstances. Overall, the project emphasizes the ongoing importance of education and training in DMCA and its potential to enhance patient care, ethical decision-making, and interdisciplinary collaboration in health care. Although there has not been a significant improvement to date in the number of DMCAs completed by the PMHNP, this QI project's primary goal was to increase knowledge and confidence in the PMHNPs completing DMCAs, and the secondary aim was to standardize documentation of all PMHNPs regarding the DMC of their patients. This change in practice and the establishment of standardized documentation among PMHNPs are essential steps toward recognizing and respecting patients' autonomy in making decisions on their behalf. This enhances the quality of care and upholds the principles of patient-centered health care. Assessing a patient's ability to provide informed consent for treatment, especially for individuals with mental health disorders who have challenges in decision-making, is a complex task that involves health-care professionals, including psychiatrists. At the end of this project, PMHNPs reported increased knowledge and confidence regarding DMC among geriatric and psychiatric patients in acute care settings. The VAMC PMHNPs should be able to successfully administer a DMCA for every patient aged 60 years and older with conditions such as dementia, PTSD, schizophrenia, mood disorders, alcoholism, substance abuse, neurobehavioral disorders, and mixed medical-psychiatric disorders. Although we completed the project 3 months before post-implementation. The monthly chart review to evaluate the tool's use of the MAcCaT-T to see if there was any

increase in the PMHNPS DMCA is ongoing. We will continue monitoring to ensure that the procedures put in place are sustainable

Interpretation

The interpretation of the information highlights the effectiveness of the educational intervention for PMHNPs in improving their knowledge and confidence in conducting DMCAs. The pre-assessment survey identified participants' deficiencies, misconceptions, and unease, providing valuable insights into areas that needed attention during the training. The post-assessment data showed a notable advancement in understanding and confidence after the training, despite the lack of statistical significance, as indicated by quantitative data. PMHNPs reported increased knowledge of legal and ethical matters, greater self-confidence, and improved DMC. Including case studies and personalized feedback in the training was highly regarded. The qualitative data supported the effectiveness of the training, even though quantitative analysis did not reveal statistical significance.

The project underscores the importance of DMCA training for health-care professionals, particularly PMHNPs, to protect patient autonomy and improve the quality of care. It emphasizes the significance of implementing ethical guidelines, standardizing assessments, and enhancing communication among clinicians during capacity evaluations. The use of standardized assessment tools helps mitigate biases, enhances efficiency, and reduces errors in DMCAs. Practical training also improves documentation practices for legal and auditing purposes while promoting a patient-centered approach to health care. The project acknowledges the influence of contextual factors on the training's outcomes, emphasizing the need to consider the distinct settings and circumstances in which the training was implemented. Overall, the educational

intervention positively impacted PMHNPs' knowledge, confidence, and proficiency in conducting DMCAs, contributing to improved patient care and ethical decision-making.

Limitations

The QI project has several limitations that should be considered when interpreting its findings: The small sample size, with only eight PMHNPs participating in the pre-assessment survey and seven in the post-assessment survey, makes it challenging to detect significant differences and attribute changes solely to the educational intervention, especially without a control group for comparison. The reliance on self-reported measures for knowledge and confidence may introduce bias and response variability due to subjectivity, and social desirability bias could lead to overestimating improvements. The QI project's focus on the MacCAT-T may limit its generalizability to other contexts, training programs, or professional groups. The absence of long-term follow-up measurements means that the QI project only measures immediate outcomes and needs more objective measures to validate self-reported improvements. The lack of control over participants' educational backgrounds, experience levels, and preexisting knowledge may have influenced their perceptions of the training. The specific nature of the training and professional group studied (PMHNPs) further limits the generalizability of the findings. It also lacks diversity in its sample, and broader participant diversity could enhance the reliability and relevance of the results.

Additionally, relying solely on pre- and post-assessment surveys to assess the educational intervention's effectiveness may only capture some shifts in attitudes, behaviors, and clinical practice. Incorporating other methods such as interviews and case studies could provide a more comprehensive understanding. Finally, using self-reported data may inflate the estimation of learning achievements and should be acknowledged. Future QI projects could employ more

extensive and diverse samples, incorporate control groups, use mixed methods, and include both short- and long-term evaluations to provide a more robust assessment of educational interventions in this context.

Conclusions

The potential of the program for PMHNPs at VAMCs is promising, although its success may hinge upon contextual variables such as participant attributes and the health-care landscape. In addition to knowledge acquisition and self-assurance, it would be prudent for this initiative to consider wider advantages such as modifications in clinical protocols and fostering interdisciplinary collaboration. Challenges pertaining to internal validity include biases and discrepancies in participant engagement levels. To ensure long-term viability, a culture that promotes continuous learning alongside policy integration is imperative. The exchange of information through collaborative communication among various health-care specialists holds paramount importance.

A comprehensive education regimen equips PMHNPs with the competencies needed for precise evaluations, respect for patient autonomy, and making ethical decisions. Future investigators could examine enduring effects on patient satisfaction and legal ramifications stemming from implementation efforts. Though initial findings have proven an average improvement rate of approximately 11.23% regarding knowledge accumulation and confidence elevation post implementation, supports sustainability needs to continue the training interventions. By employing the MacCAT-T, comprehension relating to DMCAs can notably improve—particularly amongst elderly veterans who stand to benefit significantly from this approach's application within their demographic cohort. Technology offers significant

opportunities whereby outreach capabilities are enhanced while augmenting effectiveness when delivering DMCAs.

Funding

References

Amaral, A., Simões, M., Freitas, S., & Afonso, R. (2023). Development of clinical vignettes to assess healthcare decision-making capacity in elderly with mild cognitive impairment and Alzheimer's disease. *European Review of Applied Psychology*, *73*(3), 100799. https://doi.org/10.1016/j.erap.2022.100799

Barry, C., & Docherty, M. (2018). Assessment of mental capacity and decision-making. *Medicine*, *46*(7), 405–410. https://doi.org/10.1016/j.mpmed.2018.04.003

Benner, P. (1982). From novice to expert. AJN The American Journal of Nursing, 82(3), 402-407

Boron, J. B. (2020). Cognitive competence and decision-making capacity. *Creighton Law Review*, *53*(4), 659–667.

Brémault-Phillips, S., Pike, A., Charles, L., Roduta-Roberts, M., Mitra, A., Friesen, S., Moulton, L., & Parmar, J. (2018). Facilitating implementation of the decision-making capacity assessment (DMCA) model: Senior leadership perspectives on the use of the national implementation research network (NIRN) model and frameworks. *BMC Research Notes*, *11*(1). https://doi.org/10.1186/s13104-018-3714-x

Chandrashekar, B., Chacko, T., Anand, K., Suvetha, K., Jaishankar, H., & Suma, S. (2020). Enhancing identification and counseling skills of dental undergraduate students using a customized tobacco counseling training module (TCTM) – A piloting of the process using ADDIE framework. *Indian Journal of Cancer*, *0*(0), 0. https://doi.org/10.4103/ijc.ijc_229_19

Charles, L., Brémault-Phillips, S., Pike, A., Vokey, C., Kilkenny, T., Johnson, M., Tian, P. J., Babenko, O., Dobbs, B., & Parmar, J. (2021). Decision-making capacity assessment

education. *Journal of the American Geriatrics Society*, *69*(4).

https://doi.org/10.1111/jgs.17067

Charles, L., Parmar, J., Brémault-Phillips, S., Dobbs, B., Sacrey, L., & Sluggett, B. (2017).

Physician education on decision-making capacity assessment: Current state and future

directions. *Canadian Family Physician*, *63*(1), e21–e30.

Creswell, J. W. &., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and

mixed ⌞SEP⌟ methods approaches* (Vol. 14). SAGE.

Damluji, A. A., Forman, D. E., Wang, T. Y., Chikwe, J., Kunadian, V., Rich, M. W., Young, B.

A., Page, R. L., DeVon, H. A., & Alexander, K. P. (2023). Management of acute

coronary syndrome in the older adult population: A scientific statement from the

american heart association. *Circulation*, *147*(3).

https://doi.org/10.1161/cir.0000000000001112

Derse, A. R. (2022). Decision-making capacity. In *Guidance for healthcare ethics committees*

(pp. 95–103). Cambridge University Press. https://doi.org/10.1017/9781108788250.012

De Winter, J. C. (2019). Using the Student's t-test with extremely small sample sizes. *Practical

Assessment, Research, and Evaluation*, *18*(1), 10.

Ganzini, L., Volicer, L., Nelson, W., Fox, E., & Derse, A. (2004). Ten myths about decision-

making capacity. *Journal of the American Medical Directors Association*, *5*(4), 263–267.

https://doi.org/10.1016/s1525-8610(04)70134-6

Grisso, T., & Appelbaum, P. S. (1998). *MacArthur Competence Assessment Tool for Treatment

(MacCAT-T)* (1st ed.). Professional Resource Exchange.

Hein, I. (2019). Children's competence in medical care decision-making. In *Children's rights in

health care* (pp. 150–172). Brill | Nijhoff. https://doi.org/10.1163/9789004327573_009

Jayes, M., Palmer, R., Enderby, P., & Sutton, A. (2019). How do health and social care professionals in England and Wales assess mental capacity? A literature review. *Disability and Rehabilitation*, *42*(19), 2797–2808. https://doi.org/10.1080/09638288.2019.1572793

Kolade, O., Nowell, J., Mahoney, M., Grill, L.-A., & Harper, K. D. (2023). Initiation of a comprehensive early discharge program at a Veteran's Affairs hospital. *Journal of the American Academy of Orthopaedic Surgeons*, *31*(19), 1040–1046. https://doi.org/10.5435/jaaos-d-23-00145

Latif, R. A., & Nor, M. Z. (2020). Using the ADDIE model to develop a Rusnami concept mapping guideline for nursing students. *The Malaysian Journal of Medical Sciences*, *27*(6), 115–127. https://doi.org/doi:10.21315/mjms2020.27.6.11

Marron, J. M., Kyi, K., Appelbaum, P. S., & Magnuson, A. (2020). Medical decision-making in oncology for patients lacking capacity. *American Society of Clinical Oncology Educational Book*, *40*, e186–e196. https://doi.org/10.1200/edbk_280279

Miller, E. M., & Hill, P. D. (2018). Intuition in clinical decision making: Differences among practicing nurses. *Journal of Holistic Nursing*, *36*(4), 318–329. https://doi.org/10.1177/0898010117725428

Miranda Jr, R., O'Malley, S. S., Treloar Padovano, H., Wu, R., Falk, D. E., Ryan, M. L., ... & Litten, R. Z. (2020). Effects of alcohol cue reactivity on subsequent treatment outcomes among treatment-seeking individuals with alcohol use disorder: a multisite randomized, double-blind, placebo-controlled clinical trial of varenicline. *Alcoholism: Clinical and Experimental Research*, *44*(7), 1431-1443.

Mishra, P., Singh, U., Pandey, C., Mishra, P., & Pandey, G. (2019). Application of student's T-test, analysis of variance, and covariance. *Annals of Cardiac Anaesthesia*, *22*(4), 407–411. https://doi.org/10.4103/aca.aca_94_19

Ozdemir, N. G. (2019). The development of nurses' individualized care perceptions and practices: Benner's novice to expert model perspective. *International Journal of Caring Sciences*, *12*(2), 1279–1285.

Paans, W., Robbe, P., Wijkamp, I., & Wolfensberger, M. C. (2017). What establishes an excellent nurse? A focus group and Delphi panel approach. *BMC Nursing*, *16*(1). https://doi.org/10.1186/s12912-017-0239-x

Patel, S. R., Margolies, P. J., Covell, N. H., Lipscomb, C., & Dixon, L. B. (2018). Using instructional design, analyze, design, develop, implement, and evaluate, to develop e-learning modules to disseminate supported employment for community behavioral health treatment programs in New York State. *Frontiers in Public Health*, *6*. https://doi.org/10.3389/fpubh.2018.00113

Pennington, C., Davey, K., ter Meulen, R., Coulthard, E., & Kehoe, P. (2018). Tools for testing decision-making capacity in dementia. *Age and Ageing*, *47*(6), 778–784. https://doi.org/10.1093/ageing/afy096

Poppe, C., Elger, B. S., Wangmo, T., & Trachsel, M. (2020). Evaluation of decision-making capacity in patients with dementia: Challenges and recommendations from a secondary analysis of qualitative interviews. *BMC Medical Ethics*, *21*(1). https://doi.org/10.1186/s12910-020-00498-y

Poulton, A., & Hester, R. (2019). Transition to substance use disorders: Impulsivity for reward and learning from reward. *Social Cognitive and Affective Neuroscience*, *15*(10), 1182–1191. https://doi.org/10.1093/scan/nsz077

Raffard, S., Lebrun, C., Laraki, Y., & Capdevielle, D. (2021). Validation of the French version of the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) in a French sample of individuals with schizophrenia: Validation de la version Française de l'Instrument d'Évaluation des Compétences MacArthur-Traitement (MacCAT-T) dans un échantillon Français de personnes souffrant de schizophrénie. *The Canadian Journal of Psychiatry*, *66*(4), 395–405.

Sandbrink, F., Murphy, J. L., Johansson, M., Olson, J. L., Edens, E., Clinton-Lont, J., Sall, J., Spevak, C., Sandbrink, F., Murphy, J. L., Johansson, M., Spevak, C., Clinton-Lont, J., Md, E., Olson, J. L., Brown, N., Guinta, R., Macedo, F., Nazario, M., . . . Consulting, S. (2023). The use of opioids in the management of chronic pain: Synopsis of the 2022 updated U.S. Department of Veteran's Affairs and U.S. Department of Defense clinical practice guideline. *Annals of Internal Medicine*, *176*(3), 388–397. https://doi.org/10.7326/m22-2917

Santos, R., Simões Neto, J., Belfort, T., Lacerda, I., & Dourado, M. (2022). Patterns of impairment in decision-making capacity in Alzheimer's disease and its relationship with cognitive and clinical variables. *Brazilian Journal of Psychiatry*, *44*(3), 271–278. https://doi.org/10.1590/1516-4446-2021-2180

Schweitzer, S., Gerbershagen, M., Elberzhager, F., & Braun, S. (2020). Concepts and solutions of the digital team's platform to support mobile work and virtual teams. *Procedia Computer Science*, *175*, 56–63. https://doi.org/10.1016/j.procs.2020.07.011

Scott, J., Weatherhead, S., Daker-White, G., Manthorpe, J., & Mawson, M. (2020). Practitioners' experiences of the Mental Capacity Act: A systematic review. *The Journal of Adult Protection*, *22*(4), 227–244. https://doi.org/10.1108/jap-02-2020-0005

Shakeel, S., Al Mamun, M., & Haolader, M. (2022). Instructional design with ADDIE and rapid prototyping for blended learning: Validation and its acceptance in the context of TVET Bangladesh. *Education and Information Technologies*, *28*(6), 7601–7630. https://doi.org/10.1007/s10639-022-11471-0

Simpson, M., Millerick, Y., Girdler-Heald, L., Higginbotham, K., Whittingham, K., Masters, J., & Barton, C. (2022). Developing the heart failure specialist nurse competency framework. *British Journal of Nursing*, *31*(14), 732–737. https://doi.org/10.12968/bjon.2022.31.14.732

Tannou, T., Koeberlé, S., Aubry, R., & Haffen, E. (2019). How does decisional capacity evolve with normal cognitive aging: Systematic review of the literature. *European Geriatric Medicine*, *11*(1), 117–129. https://doi.org/10.1007/s41999-019-00251-8

U.S. Department of Veterans Affairs. (n.d.). *Older veterans.* https://www.mentalhealth.va.gov/older-veterans/index.asp

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*, *30*(2). https://doi.org/10.1111/hsc.13487

Vajawat, B., Hegde, P. R., Varshney, P., Malathesh, B. C., Kumar, C., & Math, S. (2021). Civil responsibility in geriatric psychiatry. *Indian Journal of Psychological Medicine*, *43*(5_suppl), S60–S65. https://doi.org/10.1177/02537176211031062

Vrs, K., & Pbha, K. S. (2023). Grounds for post retirement jobs and elderly health. *Journal of Nursing Research, Patient Safety and Practise (JNRPSP) 2799-1210*, *3*(01), 1–10.

Ward, R., Nguyen, X.-M., Li, Y., Lord, E., Lecky, V., Song, R., Casas, J., Cho, K., Gaziano, J., Harrington, K., & Whitbourne, S. (2021). Racial and ethnic disparities in U.S. veteran health characteristics. *International Journal of Environmental Research and Public Health*, *18*(5), 2411. https://doi.org/10.3390/ijerph18052411

Wood, S., Bally, K., Cabane, C., Fassbind, P., Jox, R. J., Leyhe, T., Monsch, A., & Trachsel, M. (2020). Decision-making capacity evaluations: The role of neuropsychological assessment from a multidisciplinary perspective. *BMC Geriatrics*, *20*(1). https://doi.org/10.1186/s12877-020-01932-x

Appendix A

MacCAT-Tool

MacCAT-T RECORD FORM

Patient:_____   Clinician: _____

Date: _____   Time: _____   Unit: _____

UNDERSTANDING-DISORDER

Disclose: "Now please explain in your own words what I've said about your condition."
Probe (if necessary):   Re-Disclose and Re-Inquire (if necessary).

Disclosure	Patient Response
#1 Diagnosis	Rating ☐
#2 Feature of Disorder	Rating ☐
#3 Feature of Disorder	Rating ☐
#4 Feature of Disorder	Rating ☐
#5 Course of Disorder	Rating ☐

Understanding-Disorder (Sum) ☐

Other	

1

APPRECIATION-DISORDER

Inquire: "Now that is what we think is the problem in your case. If you have any reason to doubt that, I'd like you to tell me so. What do you think?"

☐ Agrees   ☐ Disagrees   ☐ Ambivalent

Probe: If patient disagrees or is ambivalent, description of disagreement and patient's explanation.

Explanation	
	Appreciation-Disorder

UNDERSTANDING-TREATMENT

Disclose: "Now please explain in your own words what I've said about this treatment."
Probe (if necessary): Re-Disclose and Re-Inquire (if necessary).

Disclosure	Patient Response
#1 Name of Treatment	
	Rating
#2 Feature of Treatment	
	Rating
#3 Feature of Treatment	
	Rating
#4 Feature of Treatment	
	Rating
	Understanding-Treatment (Sum)
Other	

UNDERSTANDING-BENEFITS/RISKS

Disclose:	"Now please explain in your own words what I've said about benefits and risks of this treatment."
Probe (if necessary):	Re-Disclose and Re-Inquire (if necessary).

Disclosure	Patient Response
#1 Benefit	
	Rating
#2 Benefit	
	Rating
#3 Risk	
	Rating
#4 Risk	
	Rating

Understanding-Benefits/Risks (Sum)

Disclosure	Patient Response
Other	

3

Appendix B

Title: Protocol for Assessing Decision-Making Capacity using the MacArthur Competence

Title: Protocol for Assessing Decision-Making Capacity using the MacArthur Competence

Assessment Tool for Treatment (MacCAT-T)

Objective: This protocol aims to provide a standardized framework for psychiatric nurse practitioners to assess decision-making capacity using the MacCAT-T tool. This protocol ensures consistent and reliable assessments while upholding ethical principles and legal considerations.

1. **Preparation:**
   a. Familiarize yourself with the MacCAT-T tool, its components, and scoring criteria.
   b. Obtain informed consent from the patient, explaining the purpose and process of the assessment.
   c. Ensure a comfortable and private environment for the assessment.

2. **Introduction and Rapport Building:**
   a. Establish a therapeutic rapport with the patient, fostering trust and open Communication.
   b. Explain the purpose of the assessment, emphasizing confidentiality and the voluntary nature of participation.
   c. Address any questions or concerns the patient may have before proceeding.

3. **MacCAT-T Administration:**
   a. **Begin with the Understanding section:**

4. Present relevant information about the patient's condition, treatment options, risks, and benefits.
   i. ii. Encourage the patient to ask questions and clarify any uncertainties.

5. **. Proceed to the Appreciation section:**

Title: Protocol for Assessing Decision-Making Capacity using the MacArthur Competence

       i. Assess the patient's understanding of their situation, including the consequences of treatment and the impact on their lives.

      ii. Evaluate their ability to appreciate the information presented and the potential outcomes.

b. **Move on to the Reasoning section**:

       i. Engage the patient in a discussion about the treatment options, weighing the pros and cons.

      ii. Evaluate their ability to reason logically, consider cause-and-effect relationships, and explore alternative choices.

c. **Conclude with the Voluntariness section**:

       i. Assess the patient's understanding of their right to refuse or withdraw from treatment.

      ii. Evaluate their perception of external pressures or coercion in decision-making.

d. Ensure that all sections are completed thoroughly, taking notes of the patient's responses and any relevant observations.

6. **Scoring and Interpretation:**

a. Score each section of the MacCAT-T tool based on the established criteria.

b. Evaluate the patient's decision-making capacity by considering their performance across the different sections.

c. Document the scores and interpret the findings in the context of the patient's ability to provide informed consent and make autonomous decisions.

7. **Documentation and Communication:**

Appendix C

The ADDIE
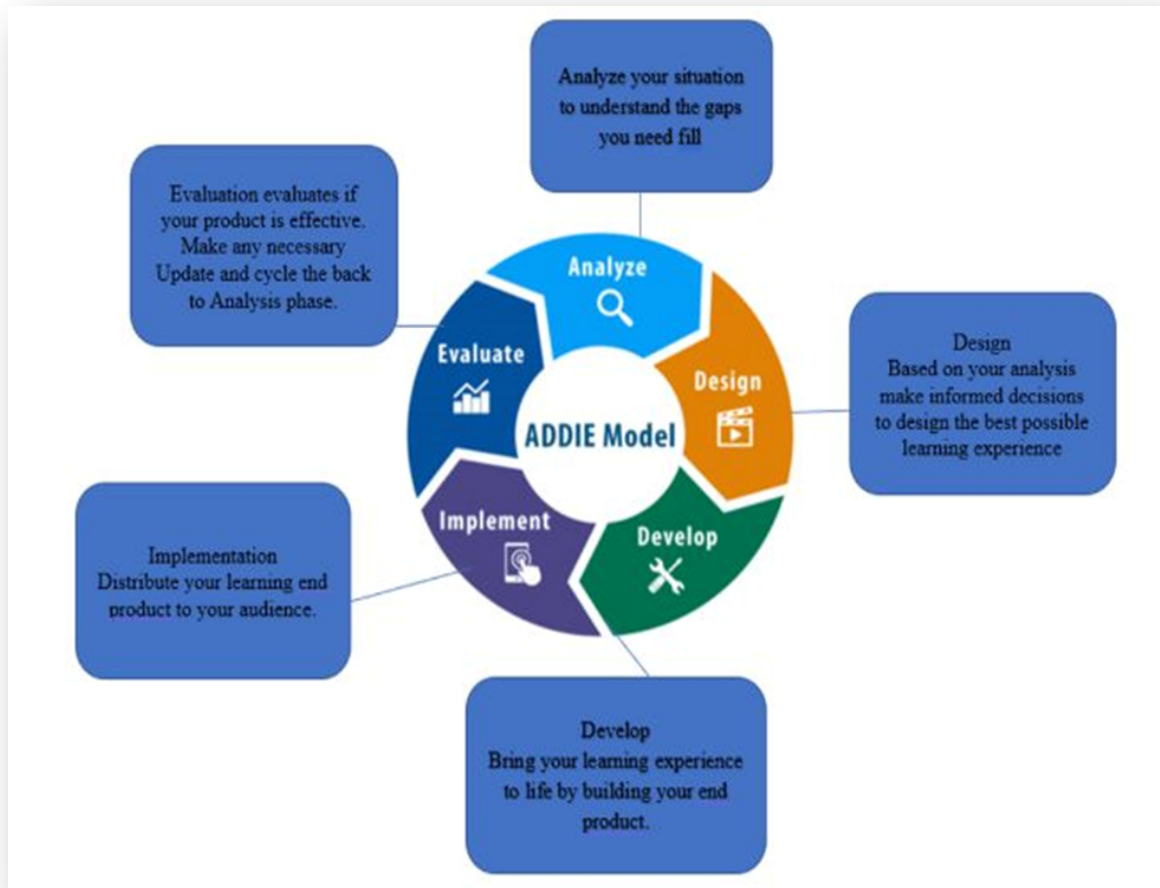
Appendix D

Lolita A Brown
Psychiatric Nurse Practitioner
Charlie Norwood Veteran Medical Center
Date

Dear Participant

Subject: Invitation to Participate in Decision-Making Capacity Education Program

I hope this letter finds you in good health and high spirits. I am writing to warmly invite you to participate in a Decision-Making Capacity Education Program organized by Lolita Brown, a DNP student. I believe your participation in this program will greatly benefit you and contribute to advancing healthcare decision-making practices.

Purpose: The Decision-Making Capacity Education Program aims to enhance knowledge and confidence related to assessing and managing the decision-making capacity of psychiatric, geriatric patients in acute settings. The aim is to provide participants with a comprehensive understanding of the principles, legal and ethical considerations, and practical approaches to decision-making capacity assessment.

Objectives: By participating in this program, you will have the opportunity to: Gain in-depth knowledge of decision-making capacity and its importance in healthcare decision-making processes. Understand the legal and ethical frameworks surrounding decision-making capacity assessment. Learn various assessment tools and techniques to evaluate decision-making capacity.
Develop strategies to effectively communicate and collaborate with patients, families, and other healthcare professionals in cases involving decision-making capacity concerns. Enhance your ability to make informed decisions and provide optimal care for patients with varying levels of decision-making capacity.

Expectations: As a participant in this program, we expect you to: Attend all scheduled sessions, which will be held on via the Team platform for about three one-hour sessions. During the sessions, actively engage in discussions, case studies, and interactive exercises. Apply the knowledge and skills from the program to your professional practice, promoting ethical decision-making.

I am confident that your participation in this program will enhance your professional development and improve patient care and outcomes. Your valuable insights and contributions during the program will enrich the learning experience for all participants. The exact date and time of the training will be emailed to each participant, also a pre-and post-intervention survey. It will be sent to you electronically using Qualtrics prior to the education session.

Thank you for considering this invitation. We look forward to your positive response and the opportunity to learn and grow together in the field of decision-making capacity assessment.
Sincerely,

Lolita Brown PMHNP Consultation Liaison.
Charlie Norwood VA Medical Center Downtown Division.
My extension is 32577.

Appendix E

Decision Making Capacity Preassessment Survey

Survey questions.   Answers: Strongly agree, Agree, Neither agree nor disagree, Strongly disagree

Q1 - DMCA is only necessary when a patient's decision contradicts medical advice.

Q2 - Decision-making capacity can vary depending on the specific decision being made.

Q3 - Cognitive impairment always indicates a lack of decision-making capacity.

Q4 - A lack of decision-making capacity is always permanent.

Q5 - Providing relevant information consistently is not necessary for a patient to have. decision-making capacity.

Q6 - Patients with psychiatric disorders are incapable of decision-making.

Q7 - Patients who are involuntarily admitted to a hospital do not have decision-making. capacity.

Q8 - Only mental health professionals can conduct decision-making capacity assessments.

Q9 - You familiar with the hospital's policies and protocols related to decision-making capacity assessment?

Q10 - You understand the criteria for determining decision-making capacity as outlined in the hospital's policies?

Q11 - You aware of the specific steps involved in the decision-making capacity assessment process as per hospital protocols

Q12 - You feel confident in your ability to administer the MacCAT-T to assess decision- making capacity accurately?

Q13 - You have received any training or education on the hospital's policies and protocols regarding decision-making capacity assessment.

Q14 - You familiar with the hospital's policies and protocols related to decision-making capacity assessment?

Q15 - You believe the MacCAT-T assessment can make you more competent in performing

Q16 - You know the appropriate documentation requirements when assessing decision- making capacity as per hospital policies

Q17 - You familiar with the procedures for involving a surrogate decision-maker in cases? where is decision-making capacity deemed lacking

Q18 - You familiar with the MacArthur Competence Assessment Tool for Treatment (MacCAT-T)?

Q19 - You familiar with the different domains assessed by the MacCAT-T, including. understanding, appreciation, reasoning, and expressing a choice?

Q20. You feel confident in your ability to administer the MacCAT-T to assess decision- making capacity accurately?

Q21 - Have you had prior experience using the MacCAT-T to assess decision-making capacity in clinical practice?

Q22 - You aware of any specific guidelines or protocols related to the use of the MacCAT- T within your healthcare facility?

Q23 - You feel adequately prepared to interpret the results of the MacCAT-T assessment?

Q24 - Do you believe the MacCAT-T assessment can make you more competent in performing

Q25 - Patients who reject medical advice automatically lack decision-making capacity.

Q26 - Decision-making capacity (DMC) and decision-making competency are the same. concepts

Appendix F

Post-Assessment Survey

Survey questions.   Answers: Strongly agree, Agree, Neither agree nor disagree, Strongly disagree

Q1 - DMCA is only necessary when a patient's decision contradicts medical advice.

Q2 - Decision-making capacity can vary depending on the specific decision being made.

Q3 - Cognitive impairment always indicates a lack of decision-making capacity.

Q4 - A lack of decision-making capacity is always permanent.

Q5 - Providing relevant information consistently is not necessary for a patient to have. decision-making capacity.

Q6 - Patients with psychiatric disorders are incapable of decision-making.

Q7 - Patients who are involuntarily admitted to a hospital do not have decision-making. capacity.

Q8 - Only mental health professionals can conduct decision-making capacity assessments.

Q9 - You familiar with the hospital's policies and protocols related to decision-making capacity assessment?

Q10 - You understand the criteria for determining decision-making capacity as outlined in the hospital's policies?

Q11 - You aware of the specific steps involved in the decision-making capacity assessment process as per hospital protocols

Q12 - You feel confident in your ability to administer the MacCAT-T to assess decision- making capacity accurately?

Q13 - You have received any training or education on the hospital's policies and protocols regarding decision-making capacity assessment.

Q14 - You familiar with the hospital's policies and protocols related to decision-making capacity assessment?

Q15 - You believe the MacCAT-T assessment can make you more competent in performing

Q16 - You know the appropriate documentation requirements when assessing decision- making capacity as per hospital policies

Q17 - You familiar with the procedures for involving a surrogate decision-maker in cases? where is decision-making capacity deemed lacking

Q18 - You familiar with the MacArthur Competence Assessment Tool for Treatment (MacCAT-T)?

Q19 - You familiar with the different domains assessed by the MacCAT-T, including. understanding, appreciation, reasoning, and expressing a choice?

Q20. You feel confident in your ability to administer the MacCAT-T to assess decision- making capacity accurately?

Q21 - Have you had prior experience using the MacCAT-T to assess decision-making capacity in clinical practice?

Q22 - You aware of any specific guidelines or protocols related to the use of the MacCAT- T within your healthcare facility?

Q23 - You feel adequately prepared to interpret the results of the MacCAT-T assessment?

Q24 - Do you believe the MacCAT-T assessment can make you more competent in performing

Q25 - Patients who reject medical advice automatically lack decision-making capacity.

Q26 - Decision-making capacity (DMC) and decision-making competency are the same. concepts

Q27 -Do you agree that the VA need to offer more training on decision making capacity

Q28 - After attending the educational sessions, do you feel that your knowledge and confidence has increased

Appendix G

Determination of Non-Research Activity Figure 1

| | | | Department of Veterans Affairs
Charlie Norwood VAMC | **Determination of Non-Research Activity** |

Instructions: This form is to be filled out when requesting a determination that an operational activity was a non-research activity for the purposes of publication or presentation.

Project Title: Improving the knowledge and confidence of psychiatric Nurse Practitioner to access the decision making capacity in geriatric population

Responsible Project Lead: Lolita A Brown	**Role Title:** PMHNP
Department: Mental Health	**Email:** lolita.brown1@va .gov

<p align="center" style="color:red">Please fill out the chart below based on the proposed project</p>

	TRUE	**FALSE**
1) The project is designed and/or implemented for internal VA purposes in support of the VA mission(s).	✔	☐
2) The findings are designed to be used by and within VA (or by entities responsible for overseeing VA).	✔	☐
3) The project is not designed for the purpose of contributing to generalizable knowledge.	✔	☐
4) The project is not designed to produce information that expands the knowledge base of a scientific discipline (or another scholarly field)	✔	☐
5) The project is not funded or otherwise supported as **research** by the Office of Research and Development (ORD) or any other entity (including the Center for Healthcare Equity Research and Promotion [CHERP] or the VISN 7 Competitive Pilot Project Funding [CPPF] program, National Institutes of Health [NIH] or Department of Defense [DoD]).	✔	☐
6) The project does not involve administration, dispensing and/or use of any drugs, devices and/or biologics.	✔	☐
7) The project does not involve design characteristics typically reflective of research: • Double-blind interventions • Use of placebo controls • Prospective patient-level randomization to clinical interventions not tailored to individual benefit.	✔	☐
8) The proposal includes provisions to ensure that the safety, rights, and welfare of patients and staff are appropriately protected as applicable. **Potential risks (including physical, psychological, social, financial, privacy, and confidentiality, and other foreseeable risks) associated with non-research operations should be evaluated and appropriate protections established to mitigate them.**	✔	☐
9) The project is **not** intended to meet the requirements set forth by an educational program that requires "research" be conducted.	✔	☐

Department of Veterans Affairs
Charlie Norwood VAMC

Determination of Non-Research Activity

10) The activity **will not be** supplemented or modified before, during, or after implementation to produce information to expand the knowledge base of a scientific discipline or scholarly field of study or otherwise contribute to generalizable knowledge.	☑	☐

Project Description

In the following fields, please provide enough information about the proposed project that a reviewer understands why and how the work will be performed. Please define all acronyms.

Reason for Project   ☑ Locally Initiated   ☐ Mandated by _____

Objectives(s): [Briefly] *What is the purpose of the project? What are the issues/questions being addressed and why?*

Within the Charlie Norwood Veterans medical center, psychiatry nurse practitioners are tasked to complete decision-making capacity for hospitalizations who are hospitalized and require evaluation of their capacity. However, some psychiatric nurse practitioners need more confidence or knowledge of the psychiatric nurse practitioner in the complete decision-making capacity of the geriatric psychiatric patient.

Methodology: *How will the work be conducted and where? Who will be involved? Please be detailed in how the work will be conducted including data collection and analyses.*

The work will not include any patient research on patients. A likert scale survey will be completed with the mental health psychiatric nurse practitioners to evaluated their knowledge and confidence in completing decision making capacity of a patient . A pretest will be conducted before the education is given and after the instruction a post test will be given to assess their knowledge and confidence improve.

Impact/Significance: *What will be done with resulting information?*

A patient's decision-making capacity can be essential in determining the length of their hospital stay. Conversely, when the patient has diminished decision-making capacity, it can result in delays and complications, ultimately prolonging their hospital stay. Overall, ensuring that the patient has the necessary decision capacity to participate in their care can help streamline their hospital stay, reduce the risk of complication and medication error, and propose and promote successful post-discharge outcomes. Overall, decision-making capacity plays a critical role in patient outcomes. Patients who can decide about their care are more likely to have better healthcare outcomes because they are more satisfied with their treatment.

Psychiatric nurse practitioners must ensure that mental health patients have the capacity and encourage inclusion in treatment choice-making ,since patients and their families are eventually subjected to the results of these choices. When patients are aware and agree with their treatment plan, it improves patient outcomes.
Psychiatric nurse practitioners will improve their knowledge and confidence and translate this into practice.

Page 2 of 3

Department of Veterans Affairs
Charlie Norwood VAMC

Determination of Non-Research Activity

If the project is deemed Quality Improvement, the Project Lead must contact the Administrative Officer of Quality Management Service for possible project tracking and further follow up.

ACOS Research & Development Determination
This study as presented to the ACOS on the date of this form has been determined to be:
☐ Research ☑ Quality Improvement

CNVAMC ACOS/R&E Signature:

Stephanie L Baer 224655
Digitally signed by Stephanie L Baer 224655
Date: 2023.05.09 08:19:05 -04'00'

Page 3 of 3

Appendix H

Department of Veterans Affairs

Memorandum

Date: 5/9/2023

From: Associate Chief of Staff, Research and Development (ACOS/R&D) (24)

Subj: Activity Review

To: Lolita A Brown
Thru:

1. Your activity entitled: "Improving the knowledge and confidence of psychiatric Nurse Practitioner to access the decision making capacity in geriatric population" has been reviewed by the Associate Chief of Staff for Research and Development, and members of the Charlie Norwood VAMC Research and Development Committee in accordance with VHA Program Guide 1200.0, VHA Operations Activities That May Constitute Research and determined to be a non-Research Activity.

   a. Members of the Charlie Norwood VAMC Research and Development Committee reviewed your project in accordance with VHA Handbook 1058.05, VHA Operations Activities That May Constitute Research, and determined that your project does not constitute research.

2. Should at any time in the future your project change, be redesigned or have its non-research data analyzed in such a way to produce information to expand the knowledge base of a scientific discipline or scholarly field of study or otherwise contribute to generalizable knowledge you must stop your activity immediately and obtain CNVAMC Research and Development Committee and/or Augusta University IRB approval of your revised project.

3. Should you intend to submit the findings from your non-research activity for peer-reviewed journal publication please complete the attached required documentation.

4. Keep a copy of this communication for your records and coordinate future activities with your immediate supervisor(s).

5. If you have any questions, please contact the Charlie Norwood VA Medical Center, Research Program Support Coordinator at (706) 733-0188, extension 32510.

X _____

Stephanie Baer

Attachment

Department of Veterans Affairs

Memorandum

Date: May 9, 2023

From: Associate Chief of Staff, Research and Development (ACOS/R&D) (24)

Subj: Publication of Non-Research findings in Peer-Reviewed Journals

To: Lolita A Brown
Thru:

Your activity entitled: "Improving the knowledge and confidence of psychiatric Nurse Practitioner to access the decision making capacity in geriatric population" has been determined to be a non-Research Activity.

1. Any publication in *peer-reviewed journals* of findings from non-research activities **REQUIRES** documentation of author attestation *prior* to publication.

2. Publication in non-peer reviewed journals and professional presentations of findings from non-research activities do not **REQUIRE** documentation prior to publication or presentation.

3. Documentation is **strongly encouraged** whenever there may be **doubt** or **misunderstanding** about the nature of the activity. The following templated attestation should be completed:

Title of Proposed Publication:

Author Attestation:
As an author of the publication referenced above (copy attached), I attest that the findings reported in the publication were not derived, in whole or part, from activities constituting research as described in VHA Handbook 1058.05.

Provide for each VA Author and Co-Author:

Author Signature: Date:

Author Name: VA Duty Station:

6. Each VA author and coauthor must retain a copy of the documentation for a minimum of 7 years after publication and in accordance with any applicable records retention schedules.

Appendix I

DMC Assessment Quiz

Question:
1. Question: Given the scenario with Mr. James, which of the following domains would be particularly important to assess using the MacCAT tool to determine his decision-making capacity?
a. Financial stability
b. Understanding of the treatment options
c. Marital status
d. Past medical history
2. Mr. James' diagnosis of schizophrenia may affect his decision-making capacity. Which domain of the MacCAT tool assesses his ability to appreciate the implications of his medical decisions?
a. Understanding
b. Appreciation
c. Reasoning
d. Choice
3. In the absence of family members for consultation, what should the healthcare provider prioritize when assessing Mr. James's decision-making capacity?
a. Completing the assessment quickly
b. Documenting the assessment thoroughly
c. Seeking a second opinion from a colleague
d. Proceeding with treatment without assessment
4. Which of the following is NOT a primary purpose of using the MacCAT tool in this scenario?
a. Assessing Mr. James' financial status
b. Evaluating his capacity to make informed medical decisions
c. Ensuring that his autonomy is respected
d. Guiding treatment decisions based on his capacity
5. What role does Mr. James' diagnosis of schizophrenia play in the decision-making capacity assessment?
a. It automatically indicates a lack of capacity.
b. It is irrelevant to the assessment.
c. It raises concerns about capacity and requires evaluation.
d. It simplifies the assessment process.
6. According to hospital policy, when a patient like Mr. James lacks family members or a designated surrogate, what is the typical process for appointing a surrogate decision-maker?
a. The healthcare provider makes the decision.
b. A close friend is automatically chosen.

c.	An ethics committee is consulted.
d.	A court-appointed guardian is required.
7.	What is the key distinction between decisional capacity and decision-making competency, as per your education with the MacCAT tool?
a)	They are identical concepts
b)	Decisional capacity includes financial decisions
c)	Decision-making competency involves legal decisions only
d)	Decisional capacity is a clinical assessment, while decision-making competency is a legal determination
8.	In using the MacCAT tool, what is the purpose of ongoing education and training for healthcare professionals?
a)	To memorize assessment questions
b)	To eliminate the need for documentation
c)	To enhance the interpretation of complex cases
d)	To speed up the assessment process
9.	What is the key distinction between decisional capacity and decision-making competency, as per your education with the MacCAT tool?
a)	They are identical concepts
b)	Decisional capacity includes financial decisions
c)	Decision-making competency involves legal decisions only
d)	Decisional capacity is a clinical assessment, while decision-making competency is a legal determination
10.	During a MacCAT assessment, a colleague needs clarification about the appropriate documentation requirements. What should be included in the assessment documentation?
a)	Personal opinions and assumptions
b)	Clinical observations, patient responses, and the capacity determination
c)	The patient's medical history
d)	The patient's family's input