Evaluating Capacity for Safe and Independent Living Among Vulnerable Older Adults

2

Aanand D. Naik

Case Presentation

Mr. Davis is an 84-year-old widower who lives alone in an apartment having retired from a long career as a corporate accountant. He ambulates with a rolling walker but has some difficulty rising from a chair and gets short of breath when walking across his home. He needs assistance with most instrumental activities of daily living, which he receives from his daughter and son-in-law who live 20 miles away. They help with driving but he remains insistent on managing his own medications and basic finances. He is independent in most basic activities of daily living but has some difficulty with bathing due to osteoarthritis of both shoulders. His past medical history is remarkable for ischemic cardiomyopathy with an ejection fraction of 30 %, atrial fibrillation, diabetes mellitus, chronic renal insufficiency, lower urinary tract symptoms with enlarged prostate, osteoarthritis of shoulders and knees, and gastroesophageal reflux disease. He takes more than a dozen medications (aspirin, metoprolol, carvedilol, atorvastatin, dabigatran, metformin, sitagliptin, furosemide, finestride, tamsulosin, acetaminophen, vitamin B12, and esomeprazole) and has four regular physicians. Four months ago he was admitted to the hospital due to heart failure exacerbation. At hospital discharge, he transitioned to a skilled nursing facility for 3 weeks due to functional impairment and multiple changes to his medications. After returning home, Mr. Davis' daughter suggested helping him prepare his medications using a pill tray, but he got angry and insisted that his memory was "just fine" and he would "manage his own damn pills." About that time, she also noted some late utility bills and his water was turned off for several days, which Mr. Davis blamed on the mail service not delivering his payment on time.

A.D. Naik, MD
Houston Center for Innovations in Quality, Effectiveness and Safety (IQuESt), Michael E. Debakey VA Medical Center, Houston, TX, USA

Department of Internal Medicine, Baylor College of Medicine, Houston, TX, USA
e-mail: aanand.naik@va.gov; anaik@bcm.edu

A.G. Catic (ed.), *Ethical Considerations and Challenges in Geriatrics*,
DOI 10.1007/978-3-319-44084-2_2

Despite getting his water service turned back on without his family's involvement, Mr. Davis' daughter had her father see a neurologist as she was worried that he was developing Alzheimer's dementia. The neurologist conducted a series of tests and noted that Mr. Davis has minimal changes on an MRI consistent with his vascular disease and a score in the normal range on a dementia screening test. His memory was appropriate for his age and education. On examination, he was pleasant with refined social graces and was able to express clear preferences. He reports feeling fine and states that he came to the neurologist only at his daughter's insistence. His neurological examination was otherwise unremarkable. The neurologist didn't find compelling evidence for Alzheimer's and recommends increasing his blood pressure medication to reduce his cardiovascular risk factors. Mr. Davis was doing well for the next month but then became acutely short of breath requiring another hospital admission for heart failure exacerbation. The admitting physician noted that Mr. Davis had gained 10–15 pounds since he was discharged from the hospital previously and his lungs had evidence of extravascular overload. Mr. Davis was able to describe his medications but also admitted he occasionally skips his furosemide dose because he gets frustrated with having to go to the toilet too frequently, especially at night. He was discharged home with skilled nursing care to help with medications and teaching for several weeks. His shortness of breath improved, but he complains that some days he feels lightheaded and he does seem to have more difficulty with getting dressed and bathing.

Mr. Davis has always been an independent person since he was 15 years old and took pride in being the one others turned to for help. He isn't worried about death but insists that his only wish is to live in his home until he dies. He is willing to accept some help from his daughter and son-in-law but doesn't want any strangers in his home. His daughter has become frustrated and tired as she now spends many more hours each week helping Mr. Davis with his activities of daily living and, when her father allows, supervising his medications and bills. She also worries about his safety when she is not at his home. At her wit's end, she comes to a local geriatric medicine clinic asking for guidance about how to manage her father, his safety, and if there are issues related to his competence.

Capacity for Safe and Independent Living

Mr. Davis has many of the characteristics of vulnerability [1]. Vulnerable older adults often present with recurrent morbidity (frequent readmissions and emergency department visits, adverse events related to medications, accidents and falls, etc.), despite availability and access to preventive therapies. They are also at high risk for harm including physical abuse, caregiver neglect, and financial exploitation. While cognitive impairment and depression are often associated with vulnerability and self-neglecting behaviors, this vulnerability does not typically result in complete incapacity to make decisions. Mr. Davis' neurological evaluation is consistent with

this observation as his cognitive impairments were minimal and decision-making capacity remains mostly intact. However, as evidenced by the details of Mr. Davis' story, the capacity to identify, avoid, and remove oneself from harmful situations may be diminished. The clinical ethics consideration in these situations of vulnerability is determining whether or not a patient can both make and execute decisions regarding personal needs, health, and safety. In other words, *does the individual have the capacity to make and execute decisions for safe and independent living*? [2].

From a legal perspective, declarations of competence are often treated as a dichotomous phenomenon. One has capacity until a threshold is reached and then competence is lost. In situations of complete incompetence, access to treatment and legal rights can be taken away. Recent advances in the legal understanding of competence now include allowances for partial competence in which most rights and abilities are maintained except for narrow declarations of incompetence (e.g., medical decisions, voting, managing finances). However, in these declarations, the determination of competence is exclusively related to decision-making capacities [3]. In contrast, the capacity for safe and independent living is based on a two-dimension model of autonomy: decision-making and executive autonomy. These two dimensions are better characterized later in this chapter. Furthermore, the capacity for safe and independent living is best understood as a gradient rather than as a threshold phenomenon. This distinction is important to avoid unnecessary infringements of patients' rights. As a clinical phenomenon, the health-care team can identify a range of medical and psychosocial interventions to address some of the impairments contributing to declines in the capacity for safe and independent living. If the impairments are too severe, interventions fail to ameliorate them, or an older adult refuses to implement these interventions, then legal steps may be considered to more fully redress persistent deficits in capacity. With this approach, medical and social interventions are applied first and foremost before burdening the legal and governmental support systems.

Educational Pearl #1

- Vulnerability among older adults is best understood as impairments in the capacity to *make and execute decisions* regarding one's health, safety, and independence (this includes the abilities to recognize and to extricate oneself from harmful situations).
- Problems arise because, legally, capacity is often viewed as an all-or-nothing phenomenon.
  - Capacity should be viewed along a clinical gradient.
  - Treatments and interventions should focus on maintaining as much of the older adult's *autonomy* as possible without compromising health and safety.
  - Legal intervention, in the form of guardianship, is a last resort.
- When older adults lack this capacity, they are susceptible to medical morbidity and harms from self-neglect and elder mistreatment.

- In the USA, approximately 5 million older adults are exposed to these harms annually, including:
  - Physical violence
  - Emotional or psychological abuse (i.e., infantilizing the older adult)
  - Financial exploitation (includes material exploitation)
  - Neglect (intentional and unintentional)
  - Self-neglect

Two-Dimension Model of Autonomy and Capacity

Our clinical model of capacity for safe and independent living is grounded in the clinical ethics foundations of Faden and Beauchamp's Theory of Autonomous Action [4]. Their general theory of what makes action, not just decisions, autonomous was grounded on three principles: understanding, intentionality, and voluntariness. *Understanding* is defined by actions based on understanding of situation and choices. Understanding exists when an individual has the ability to (a) comprehend the circumstances and facts of a situation, (b) appreciate the personal consequences of each choice and/or action, and (c) demonstrate a rational process for choosing one versus another option. *Intentionality* is the state where actions are willed and performed according to one's plan. For intentionality to exist, individuals must have the ability to make and express preferences and choose a single option, develop strategies and tactics for executing a choice, and ensure the performance of strategies and adaptations to changing circumstances. *Voluntariness* is defined by an ability to act without controlling influences. This is manifested when actions are free of external coercion or manipulation and not compelled or inhibited by internal impairments. Adapting these three pillars of autonomous action to clinical care, it becomes clear that ethical standards based only on a capacity to make informed decisions is inadequate. Such standards do not consider most of the *intentionality* principle and part of the *voluntariness* principle. In response to this ethical gap and clinical need, we have previously proposed a two-dimension model of capacity, especially as it relates to the capacity for safe and independent living [5].

Our two-dimension model of capacity includes the dimensions of decision-making capacity and executive capacity. In this model, decision-making capacity is "the process of making decisions for oneself or extending that power to another individual when it is impaired" and executive capacity is the "process of carrying one's decision into effect either alone or by delegating those responsibilities to another individual." When applying this model to clinical care, especially the capacity for safe and independent living, both dimensions should be evaluated independent of one another.

Decision-making capacity is a well-studied area with conceptual and empirical foundations. Appelbaum and Grisso's empirically grounded model of decision-making

capacity is defined by four criteria that parallel the Faden and Beauchamp's *understanding* principle described above. Applying these criteria to vulnerable older adults, an individual must *understand* the basic facts surrounding a decision; *appreciate* the personal impact of the decision, including one's capabilities and limitations; have a *reasoning process* for comparing the options and predicting the consequences of alternative choices; and be able to *make a choice* [6]. These criteria are the basis for most informed consent documents and similar legal declarations related to the capacity to consent for treatment (medications, diagnostic tests, surgery, and other therapeutic or diagnostic procedures).

In contrast to decision-making, *executive capacity* is the ability to execute one's decisions. Executive capacity is not the same construct as executional or performance capacity. Individuals with physical disabilities may not be able to perform their activities of daily living on their own. However, nearly all have the capacity to ensure that these activities are done appropriately and on time by other caregivers. In this sense, executive capacity is the ability to ensure that one's decisions have a predetermined plan, adapt that plan in response to changing or unexpected circumstances, and delegate these responsibilities to appropriate caregivers or surrogates when necessary or appropriate.

The interaction of decision-making and executive capacity in the context of the capacity for safe and independent living can be complex. Vulnerable older adults, such as Mr. Davis, retain some or all of their ability to make decisions about being admitted to the hospital or moving into long-term care but lack the ability to safely and effectively manage their medications or pay bills on time. From a clinical perspective, it may be difficult, and often impractical, to determine whether impairments are purely executive in nature or a mix of impairments in decision-making and executive capacity. A practical approach grounded in the functional domains of the activities of daily living are needed to better clarify how impairments in the capacity for safe and independent living impact health and safety in daily life.

Educational Pearl #2

The capacity for safe and independent living is based on two distinct dimensions:

Decision-making capacity—does the vulnerable older adult have the capacity to make decisions regarding safe and independent living?

Evaluated using four criteria:

- Understanding the basic facts surrounding a decision
- Appreciating the personal impact of the decision
- Reasoning through the options by comparing them and predicting the consequences of those options
- Choosing an option

Executive capacity—does the vulnerable older adult have the capacity to implement decisions (by themselves or with the assistance of others) regarding safe and independent living?

- Having a plan
- Adapting the plan when circumstances change
- Delegating responsibilities if one cannot physically enact the plan

The Functional Domains of Safe and Independent Living

For clinicians, it is important to move from theoretical concepts of capacity to practical domains that aid clinical assessment and intervention planning. Clinicians are often asked to assess vulnerable older adults, like Mr. Davis, who demonstrate declines in self-care behavior, live in unsafe settings, or have frequent exacerbations of treatable chronic conditions. The first step of this evaluation is to identify how impairments present within the context of five broad functional domains for safe and independent living: maintaining personal needs and hygiene, condition of the home environment, maintaining activities for independent living, health-care self-management, and managing financial affairs.

Personal needs and hygiene include the basic physiological needs for personal living and safety, for example, activities of daily living (ADLs) such as bathing, dressing, sleeping, toileting, and feeding. Transferring and ambulation within the home are other aspects of personal needs and hygiene. The condition of one's home environment includes routine maintenance, appropriate repairs, and the physical structure of the living environment. Respect for differences in lifestyle choices and cultural standards must be honored and respected. However, living situations and environments that threaten one's basic health or safety are not ethical and warrant a clinical evaluation. Dangerous environments include those with excessive exposure to toxins from pet and animal waste, accidents related to fire and electrical hazards, extremes in weather, and pathogens arising from garbage and sewage. Clinicians may examine whether patients understand their personal and environmental needs and the health and safety risks arising from the gap between their needs and current status. Patients should be able to participate in making a plan to accomplish tasks that address these gaps. Patients physically unable to perform the appropriate tasks may still retain capacity by identifying appropriate social and caregiver supports to fulfill these needs.

The other three functional domains include many functions classically thought of as instrumental activities of daily living (IADLs). Instrumental activities of independent living include shopping and meal preparation, laundry and cleaning, using the telephone, and transportation. Here again, executive capacity is a key consideration. Most vulnerable adults have begun to experience physical impairments and disabilities that limit the ability to personally perform these instrumental activities. However, most still retain executive capacity to participate in planning and ensure execution of these tasks by formal and informal caregivers. Management of health

care and financial affairs is differentiated from the other activities for independent living because of their specific correlations to medical morbidity and elder mistreatment that often present to health-care and social services professionals, respectively. Health-care self-management includes all the routine activities associated with managing a medication regimen, monitoring of blood pressure or glucose, wound care, attending to medical appointments and tests, and communicating with professionals about changes in health status. For example, assessment of this domain includes evaluation of how an individual handles acute problems (e.g., infected cut on one's foot or severe chest pain) or practical obstacles (e.g., running out of medications). Managing financial affairs includes managing one's bank account or making everyday transactions, having an understanding of the importance and role of money, being aware of and paying routine bills, and a reasoning process for making financial decisions and reacting to new or unexpected circumstances (e.g., exploitation schemes). These latter two domains demonstrate the equal and robust roles that both decision-making and executive capacity have on maintaining key functional domains of safe and independent living.

Educational Pearl #3

The clinical assessment of a vulnerable adults' capacity for safe and independent living should include evaluation of *decision-making* **and** *executive* **capacity across each of five functional domains for safe and independent living**:

- Maintaining *personal needs and hygiene* (includes bathing, dressing, mobility and transferring, sleeping, and feeding)
- Condition of the *home environment* (includes maintenance and the physical structure of one's living environment)
- Performing *activities for independent living* (includes shopping, cooking, cleaning)
- *Health-care self-management* (includes medication management, wound care, self-monitoring glucose levels, attending routine medical appointment, awareness of acute symptoms)
- *Managing financial affairs* (includes managing daily transactions, awareness and payment of routine bills, and a reasoning process for making financial decisions)

Practical Approach to the Assessment of Capacity for Safe and Independent Living

Clinicians should assess capacity when a vulnerable older adult presents with signs or symptoms similar to those in Mr. Davis' presentation. These include:

- Frequent hospital or emergency department visits for treatable chronic conditions
- Frequent falls and injuries

- Change in physical appearance
- Unexplained weight loss
- Cognitive impairment or disordered thinking
- Depression or generalized anxiety
- Excessive polypharmacy, medication adverse events, and gaps in medication refills
- Missed appointments and poorly controlled blood pressure or glucose despite medications
- Limited support system and reports to social and/or adult protective services

When these warning signs present with greater frequency or number, clinicians should undertake a comprehensive assessment to identify specific impairments in the capacity for safe and independent living and identify specific interventions to address these gaps. Clinicians can target gaps in decision-making and/or executive capacity across the five functional domains of safe and independent living. Assessments should include the use of validated screening instruments and tests with population-based norms as well as more personalized clinical assessments including screening for judgment and capacity. Proxy reports and in-home assessments are also useful for gaining a clear understanding of executive capacity across the five domains. Many of these validated assessment instruments are common to the practice of geriatrics. We recommend that clinicians start with standardized assessment instruments as well as individualized clinical evaluations. Proxy reports and home evaluation should follow, especially if initial assessments fail to provide definitive understanding of executive capacity. All capacity evaluations should include individualized assessments of decision-making or judgment as well as strategies to ensure implementation of an agreed upon care plan.

We recommend beginning with *standardized assessment instruments* that have well-validated population norms and cut scores that can evaluate each of the following domains: cognitive function, mood (depression or depression and anxiety), activities of daily living (basic ADLs and instrumental IADLs or a combined tool such as Vulnerable Elders Scale-13), mobility screens (timed up and go or formal gait speed), and nutrition. The classic cognitive function screen is the mini-mental state examination (MMSE). However, other screening tests, like the St. Louis Mental State Examination (SLUMS) or Montreal Cognitive Assessment (MOCA), are now favored due to their greater ability to identify impairments in executive cognitive functions. Still other cognitive screens, such as the Executive interview (EXIT) and clock-drawing tasks, are more specific screening tools of executive cognitive functions and associated with declines in functional status and the capacity to consent to treatment. Another highly specialized screening tool is the Financial Capacity Instrument (FCI) which is used to evaluate decision-making and executive capacity for managing one's financial affairs and estate and conducting financial transactions. Additional standardized scales, often performed by occupational therapists, can evaluate a vulnerable older adult's executive and performance abilities with everyday, independent living skills. We have previously demonstrated the effectiveness of one such tool, the Kohlman Evaluation of Living Skills (KELS), in identifying adults with self-neglecting behaviors sufficient enough to be reported to Adult Protective Services [7].

Standardized assessment should always be followed with *individual assessments* of medical status (i.e., progress note with history and physical) and psychosocial status (commonly done by social work). Traditional medical examinations can identify geriatric syndromes that are common contributors to vulnerability, such as depression, delirium, and dementia, as well as diseases that impact everyday functions: memory, judgment, mobility, cardiopulmonary status, pain, etc. As part of the medical and psychosocial assessments, the clinical team should assess executive function within the context of the five domains of capacity for safe and independent living. The following are some examples of items that may be included:

- Personal needs and hygiene: physical examination of the hair, skin, and nails, gait evaluation, and screening for balance problems and recent falls.
- Condition of the home environment: proxy reports of the home environment or a home safety evaluation performed by an occupational therapist or home health service.
- Activities of daily living: ask patient to use the clinic's phone and call a friend or other service to ask for a ride (done through actual demonstration).
- Health-care self-management: ask patient to bring all medication bottles from home, even empty ones. Review medication fill and refill dates and pill counts or have a home health nurse do a home medication assessment.
- Managing financial affairs: proxy reports of bank statements, uncollected debts, or bills. Can formally assess performance with routine financial tasks, such as 1- or 3-item transactions, including making change or conducting a payment simulation using a check and register.

MED-SAIL Instrument

We have previously developed and validated a screening tool for Making and Executing Decisions for Safe and Independent Living or MED-SAIL [8]. The MED-SAIL tool was designed with the acknowledgment that remaining independent in one's own home is a primary goal for older adults, capacity for safe and independent living is threatened with vulnerability and aging, and health-care and social service providers in the community lack adequate screening tools. The tool draws from the conceptual and empirical literature in clinical ethics. Numerous focus groups enrolling community-based healthcare and social services professionals guided the design of the instrument and contents of the screening tool. Specifically, they helped identify scenarios that are intended to provide a sense of the respondent's executive capacity across each of the five domains for safe and independent living. These seven scenarios are as follows:

1. The door to your home is locked and you do not have a key.
2. You run out of a medication you take regularly.
3. You are home and suddenly there is a fire in your kitchen.

4. You notice that the cut on your foot is not healing and has become infected.
5. Someone calls saying you've won $100,000 and all they need from you is your social security number to verify your identity.
6. You are driving to the grocery store and you get a flat tire.
7. Your heating unit [air conditioner] breaks down and it is very cold [hot] outside.

The tool follows the structure of the decision-making capacity standards as developed by Appelbaum and Grisso and described in Table 2.1. These decision-making capacity standards are then applied conceptually to the specific real-world scenarios described above. When using the MED-SAIL tool, the clinician typically works through two to three of the real-world scenarios. Each scenario has prompts (see Table 2.1) that relate to the standards for decision-making capacity. Each of the standards are then scored and a total score is calculated. Population norms and precise cutoffs across a wide range of patient types have not been developed as of this writing. However, the tool is still of practical clinical use because clinicians can use MED-SAIL results in conjunction with the other parts (i.e., the standardized and individualized assessments) of their evaluation of the vulnerable older adult's capacity for safe and independent living. The clinical team may need to make additional referrals (e.g., occupational and physical therapists) when particular healthcare professionals are not part of the immediate team. Referrals for home-based assessments are particularly common and provide an important opportunity to evaluate the physical state of the older adult's home environment.

Table 2.1 Eliciting standards of decision-making capacity

Standards for decision-making capacity	Descriptions of each standard	Questions or prompts to eliciting each standard
Understanding	Repeat the simple scenario phrase in his/her own words	Please tell me in your own words what I just said
Appreciation	Assesses respondent's ability to appreciate impact of scenario on his/her own life	Would this be a problem for you? Why or why not?
Expressing a choice	Assesses respondent's ability to express choices/plans	What would you do in this scenario?
Problem-solving/ consequential reasoning	Assesses whether respondent can perform abstract problem-solving in a new hypothetical situation	What would you do if [response to previous question] didn't work?
Comparative reasoning	Assesses respondent's ability to compare two options	Explain what is good or bad about these options
Generate consequences	Assesses respondent's ability to generate ideas on how to prevent the scenario from occurring or preparing in case it does	What could you do to prevent this from happening?

Interventions to Support Capacity for Safe and Independent Living

We recommend that clinicians create a final summary of all assessments to identify precise impairments across each of the five functional domains for safe and independent living and whether these deficits are in decision-making capacity, executive capacity, or both. By identifying precise functional impairments, the clinical team can then identify specific medical, healthcare, and social services interventions that can be prescribed/recommended to address these impairments. Interventions will either support the deficits of the vulnerable adult (e.g., treating symptoms of depression, providing a transfer bench for the bathroom) or reduce the effort needed to accomplish a task (e.g., engaging a home health nurse to assist with medication management, designating a proxy for financial affairs). This method of intervention is more aligned with traditional healthcare services and targets supporting of autonomy to live independently before restraining the vulnerable older adult's autonomy in the name of safety. However, the range of interventions can be quite varied from medical to social to legal. We categorize them broadly as:

1. Medical—medication management, disease management, psychiatric treatment referral, etc.
2. Environment—alternative living arrangement, home health, home safety evaluation, mobility aids, etc.
3. Social support—adult daycare, patient and family education, caregiver support, etc.
4. Community resources—link to community services, link to health insurance benefits, etc.
5. Legal services—advance directives, APS, power of attorney, representative payee, etc.

Appointment of a guardian or other legal surrogate decision-maker is a potential option to avoid subsequent placement in long-term care. Follow-up evaluations can then be used to determine the effectiveness of the prescribed interventions and the older adult's responsiveness to those interventions. The following table provides a set of treatment suggestions that link different intervention types that might be necessary based on the level of capacity impairment present (Table 2.2).

Conclusion

The local geriatrics clinic conducted a comprehensive geriatric assessment of Mr. Davis. The clinic confirmed many of the findings of his prior medical evaluations, all pointing to a state of vulnerability. The assessment found evidence for mild cognitive impairment not outside the range of normal for his age. Mr. Davis does not have major depression but does report some apathy and occasional feelings of sadness related to his current medical conditions. He requires assistance for most activities of daily living and has increasing difficulty with personal care and hygiene. The clinic placed a referral to a physical medicine physician for evaluation and possible joint injections to reduce pain and improve shoulder

Table 2.2 Suggested intervention for impaired capacity for safe and independent living

Intervention	Full capacity	Partial capacity	No or limited capacity
Medical	Disease management	Medication management Disease management Medication therapy	Psychiatric referral Assisted medication management
Environment	Home modifications Senior apartments Independent living Mobility aids	Independent living Assisted living Home health Mobility aids	Assisted living Nursing home 24-h personal care Mobility aids
Social support	Senior center Volunteering	Adult day care Senior center Caregiver support group	Adult day care Activities for stimulation Respite
Community resources	Housekeeping	Meals on wheels Geriatric care manager	Meals on wheels Geriatric care manager
Legal services	Power of attorney Living will	Representative payee Power of attorney Legal/financial oversight	Representative payee Power of attorney Guardianship Out-of-hospital DNR

Suggestions provided by Tziona Regev, MSW for the Capacity Assessment and Intervention clinic at Quentin Meese Community Hospital, Harris Health System, Houston, Texas

functioning with the goal of improving bathing and dressing. His home environment is stable but requires his daughter and son-in-law's involvement to remain at this level. He was found to have difficulties with executive capacity, especially with managing his medications and finances. While Mr. Davis was resistant to this finding at first, his difficulties during the evaluation itself seems to have been a tipping point. He was now willing to allow his family to prepare a pill tray for his medications, and his son-in-law became his formal power of attorney for financial decisions (Mr. Davis had a soft spot for a fellow accountant). The family also determined that adult day services once or twice a week might be of interest to Mr. Davis. An occupational therapy consult was also ordered to do a home safety evaluation and determine if any assistive devices were needed in the bathroom to further improve function and safety. Mr. Davis and his daughter agreed to return in 3 months to reassess his status and the success of these interventions. This capacity assessment and intervention plan will not reverse Mr. Davis' vulnerability, but may allow him to remain at home living as independently as possible for the immediate future.

References

1. Dyer CB, Pickens S, Burnett J. Vulnerable elders: when it is no longer safe to live alone. JAMA. 2007;298(12):1448–50.
2. Skelton F, Kunik ME, Regev T, Naik AD. Determining if an older adult can make and execute decisions to live safely at home: a capacity assessment and intervention model. Arch Gerontol Geriatr. 2010;50(3):300–5.
3. Moye J, Naik AD. Preserving rights for individuals facing guardianship. JAMA. 2011;305(9):936–7.
4. Faden RR, Beauchamp TL. A history and theory of informed consent. New York: Oxford University Press; 1986.
5. Naik AD, Dyer CB, Kunik ME, McCullough LB. Patient autonomy for the management of chronic conditions: a two-component re-conceptualization. Am J Bioeth. 2009;9(2):23–30.
6. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. N Engl J Med. 1988;319(25):1635–8.
7. Pickens S, Naik AD, Burnett J, Kelly PA, Gleason M, Dyer CB. The utility of the Kohlman evaluation of living skills test is associated with substantiated cases of elder self-neglect. J Am Acad Nurse Pract. 2007;19(3):137–42.
8. Mills WL, Regev T, Kunik ME, Wilson NL, Moye J, McCullough LB, Naik AD. Making and Executing Decisions for Safe and Independent Living (MED-SAIL): development and validation of a brief screening tool. Am J Geriatr Psychiatry. 2014;22(3):285–93.