Please cite the Published Version

Supported decision-making and mental capacity assessment in care homes: a qualitative study

Key words: Care Homes, Decision-Making, Dementia Care, Professional/Patient

Communications, Qualitative Research, Stroke.

Authors: Mark Jayes[a]* Lynn Austin[a] and Laura Brown[b]

[a] Department of Health Professions, Manchester Metropolitan University, UK.

[b] Division of Psychology and Mental Health, University of Manchester, UK.

***Corresponding author:** Mark Jayes, Faculty of Health and Education, Manchester Metropolitan University, Brooks Building, 53 Bonsall Street, Manchester, M15 6GX, UK.
ORCID ID: 0000-0002-0371-7811
Telephone   44 (0)161 2472885
Email   m.jayes@mmu.ac.uk

Conflict of Interest statement: The authors report no conflict of interest.

Data Availability statement: The data that support the findings of this study are available from the corresponding author upon reasonable request.

Supported decision-making and mental capacity assessment in care homes: a qualitative study

Abstract

Up to 75% of UK care home residents may lack the mental capacity to make certain decisions (Wade, 2019). Care home staff need evidence-based tools to help them assess residents' mental capacity and provide decision-making support (NICE, 2018). The Mental Capacity Assessment Support Toolkit (MCAST) was designed to support multidisciplinary healthcare staff to prepare, complete and document legally-compliant mental capacity assessments. MCAST has not yet been trialled in care homes. This study used a descriptive qualitative design to: i) understand the current challenges faced by care home staff when supporting residents to make decisions and participate in mental capacity assessments; ii) explore staff members' support needs in this context; and iii) to identify if and how the toolkit could be adapted for use in care homes. A purposive sample of 29 staff working as managers (n=18), nurses (n=7) and care assistants (n=4) across five care homes in North West England participated in five semi-structured focus groups between May and July 2019. Data from the focus group transcripts were analysed thematically (Braun & Clarke, 2006). Five main themes were identified: i) involvement of residents in decision-making; ii) approaches to mental capacity assessment; iii) working with residents with communication difficulties; iv) feelings about practice; and v) responses to MCAST. Participants appeared competent and confident about supporting decision-making and assessing capacity, but recognised the complexity of this area of practice, and identified a need for further support. They reported a range of challenges, including accessing support from speech and language therapists for residents with communication needs. They responded positively to the toolkit

and were keen to use it in practice. This study suggests that care home staff would benefit from, and welcome, support to develop their practice. Furthermore, MCAST appears usable in this context and formal feasibility testing is justified.

What is known about this topic

- Many care home residents may not be able to make autonomous decisions.

- UK mental capacity legislation requires care home staff to offer decision-making support and complete mental capacity assessments when residents require them.

- Professionals need evidence-based resources to improve their practice when supporting decision-making and assessing mental capacity.

What this paper adds

- Confirmatory evidence that care home staff find this area of practice challenging and identify a need for support to improve their practice.

- Evidence that care home residents with communication disabilities may not receive the support they need to make decisions.

- Evidence that MCAST may be usable in care home settings, and its feasibility should be tested formally.

Keywords

Care Homes, Decision-Making, Dementia Care, Professional/Patient Communications, Qualitative Research, Stroke.

Introduction

It has been estimated that up to 75% of care home residents in the United Kingdom (UK) may lack the mental capacity to make certain decisions (Wade, 2019). UK mental capacity legislation requires care home staff to provide personalised, practical support to maximise residents' ability to participate in decision-making, and to complete a mental capacity assessment if they have reason to believe a resident may be unable to make a decision. In England and Wales, the legislative framework is provided by the Mental Capacity Act (MCA, OPSI, 2005). Under the MCA, mental capacity assessment establishes decision and time-specific incapacity if an individual is unable to understand, retain, use and weigh information in order to make and communicate a decision because of an impairment or disturbance in the functioning of the mind or brain. In this situation, care home staff must engage in a process of best interests decision-making with the individual and their significant others. The legislation also provides safeguards relating to deprivation of liberty and enables people to engage in advance care planning to enable surrogate decision-making at a time when capacity is lost. Similar legislation exists in other jurisdictions (Peisah, 2017).

Although health and social care professionals (HSCPs) in England and Wales have been working with the MCA since 2007, their practice may not be consistent with legal standards (House of Lords Select Committee on the Mental Capacity Act, 2014). Some HSCPs have limited understanding of their legal responsibilities, find it challenging to implement the MCA effectively, and lack confidence in their practice (Hinsliff-Smith et al., 2017; Jayes et al., 2019; Scott et al., 2020). This may be due to deficiencies in the availability and nature of training (Scott et al., 2020), and because mental capacity assessment involves complex,

subjective judgements and lacks an established gold standard method (Pennington et al., 2018).

There has been limited exploration of this area of practice in social care settings (Murrell & McCalla, 2016). Manthorpe and colleagues interviewed care home staff working with people living with dementia about their knowledge and use of the MCA in 2008 and 2016 (Manthorpe, Samsi, Heath, & Charles, 2011; Manthorpe & Samsi, 2016). These authors observed that staff knowledge increased over time, but some staff remained unaware of their responsibilities under the MCA. In general, however, most interviewees described practice that was consistent with the person-centred and emancipatory ethos of the MCA. In contrast, a recent systematic review suggested that staff working in extended care settings, including care homes, may not routinely involve people living with dementia in everyday decision-making because they lack tools and resources to help them to do this (Daly, Bunn, & Goodman, 2018).

The need to develop evidence-based tools to improve practice in this area was a key recommendation in the National Institute for Health Care and Excellence (NICE) guideline on decision-making and mental capacity (NG108) (NICE, 2018). The Mental Capacity Assessment Support Toolkit (MCAST) was developed to provide guidance and practical resources to enable HSCPs working in acute hospital and intermediate care settings to engage in supported decision-making and mental capacity assessment in line with the MCA framework (Jayes, Palmer & Enderby, 2020). This prototype toolkit of paper-based materials includes a Support Tool, a structured proforma designed to support professionals to prepare, complete and document a holistic, person-centred capacity assessment. The toolkit also contains specific resources to enable HSCPs to identify and support the decision-making

needs of individuals with communication difficulties. This is a legal requirement, but something that HSCPs without specialist knowledge and training in communication disorders find challenging (Jayes, Palmer & Enderby, 2021). MCAST includes a Communication Screening Tool, designed to enable HSCPs to identify rapidly whether to refer an individual to a speech and language therapist (SLT) for specialist assessment and support. It also contains a pack of photographic resources that HSCPs can use to support people with mild communication difficulties to engage in conversations about decisions relating to their health, care and living arrangements. Examples of these materials are shown in appendix A1.

The toolkit has been shown to have high levels of usability and acceptability to staff and patients in a range of hospital settings (Jayes, Palmer & Enderby, 2020). MCAST is yet to be used or evaluated in care home settings. The aims of this study were to understand the current challenges faced by care home staff when supporting residents to make decisions and participate in mental capacity assessments, to explore staff support needs, and to identify if and how MCAST could be adapted for use in this setting. We conceptualised this as an early intervention development study, generating data to enable us to determine whether a future feasibility study in care homes might be justified (Craig et al., 2006).

Our research questions were:

1. What are care home staff members' experiences of supported decision-making and mental capacity assessment?
2. Do care home staff need support to assess mental capacity and if so, what type of support?
3. Could MCAST provide this support?

4. What adaptations would be required for MCAST to be usable in care homes?

Methods

Study design

This study used a descriptive qualitative design (Sandelowski, 2000) informed by an interpretivist framework (Creswell, 2013). We considered this to provide a pragmatic approach to answering the research questions. Data were collected using semi-structured focus groups and a topic guide informed by the literature. We identified focus groups as an efficient means of collecting rich data relating to common and divergent views and practices (Kitzinger, 2006; Morgan, 1997). We used Braun & Clarke's (2006) thematic analysis method, which enabled us to generate themes inductively from open data coding and deductively from our research questions and knowledge of the literature and legal framework. Ethical approval was obtained from the Manchester Metropolitan University Faculty of Health, Psychology and Social Care ethics committee. The study is reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong, Sainsbury, & Craig, 2007) (appendix A2).

Participant recruitment

Participants were recruited from five care homes across North West England. We used electronic recruitment materials to advertise the study through social media, the regional National Institute for Health Research (NIHR) ENRICH network, and local gatekeepers (professional care home networks, care home managers, and healthcare professionals with links to care homes who were known to the researchers). Homes were purposively sampled

to ensure diversity, in terms of their resident and staff populations and care provision. We selected homes based on the following characteristics: care provision (nursing/residential); size (number of beds); location (urban/suburban), and Care Quality Commission (CQC) rating ("outstanding" / "good"/ "requires improvement"/ "inadequate"). Following an invitation from gatekeepers, the second author visited each home to discuss the study, distribute a participant information sheet, and recruit participants. Within each home, we aimed to include participants with a range of job roles and experience of care work and of supported decision-making and mental capacity assessment. Due to staff members' limited availability, we needed to adopt a pragmatic approach to recruitment. This meant we recruited any staff member who wished to participate and who met the broad inclusion criteria: involvement in supporting resident decision-making and mental capacity assessment and availability to take part in a focus group at the designated time.

Procedure

One focus group was conducted in each care home between May and July 2019. We considered that this setting would be more convenient and inclusive for participants, and that they might feel more at ease in a familiar environment. The number of participants in each group ranged from two to nine. All participants provided written informed consent. Focus groups took place in non-clinical areas, such as staff or training rooms. Despite this, very occasionally participants were interrupted by colleagues requesting operational support.

Focus groups were facilitated by the second author, who is a female, experienced post-doctoral qualitative researcher with no background in mental capacity research. The

facilitator established ground rules at the start of each focus group: anything discussed in the group should remain confidential; participants should not provide identifiable information about colleagues or residents; participants should provide honest responses about their practice and their perceptions of the toolkit; the researchers would treat all responses confidentially by the researchers; if any participant responses indicated unsafe practice, the researchers would encourage the participants to discuss the matter with a manager and they would discuss any concerns with the university's Research Ethics and Governance Manager (this eventuality did not arise).

The focus groups followed a semi-structured topic guide (appendix A3). Initially, participants introduced themselves (name, job role, length of time in post) and described their involvement in supported decision-making and mental capacity assessment. The facilitator asked questions using the topic guide but allowed the discussion to develop freely to enhance the breadth and depth of data. Participants were shown the prototype MCAST and invited to examine and comment on its components and respond to questions about how it might be used in a care home. Group discussions were audio recorded and the facilitator took field notes. Focus groups lasted between 55 and 105 minutes (mean = 73 minutes).

The second author transcribed audio data verbatim and completed thematic data analysis (Braun & Clarke, 2006), with support from the first author. The latter is a clinical academic SLT who developed MCAST; he had no pre-existing relationship with the care homes or participants. Analysis involved six iterative stages and was managed using NVivo 12 software. First, the second author read each transcript several times, to become familiar with the data and identify initial codes, both deductively and inductively. Second, she

developed a coding framework by re-examining the data against the initial codes and identifying new codes. Third, she organised codes into meaningful conceptual groups in order to identify initial themes and sub-themes. The fourth stage involved the first and second authors examining the coding framework together, revising and refining the themes and sub-themes, and organising them within a thematic map; they resolved any disagreements about codes or themes through discussion. During the fifth stage, both researchers reviewed the thematic map and defined, named and further refined the themes. The sixth stage involved the first author preparing a report based on the outcome of analysis.

Different techniques were used to enhance the trustworthiness of the findings (Lincoln & Guba, 1985). Respondent validation was used to increase the credibility of data interpretation (Donovan & Sanders, 2005). At the end of each focus group, the facilitator summarised her perceptions of the discussion and invited participants to comment on this. On completion of data analysis, the first author sent a summarised version of the findings to all care homes and invited comments. No revisions to the findings were suggested. The involvement of the first author in data analysis enabled a degree of peer scrutiny, to enhance the confirmability of the findings. Finally, the researchers adopted a reflexive approach, acknowledging their individual preconceptions and biases, and how these may have influenced data collection and analysis.

Findings

We recruited 29 participants from five care homes located in urban and suburban settings across North West England. The care homes varied in terms of the number of residents they

cared for (range: 17 - 180 residents), and the nature of residents' care needs; three homes

provided both residential and nursing care, whilst two provided only residential care.

Residents included young and older adults living with a range of acquired and lifelong health

conditions causing physical, learning, cognitive, and communication disabilities. Two care

homes had received "good" overall quality ratings following their previous CQC inspection,

whilst three had received "requires improvement" ratings. Participants were employed as

managers (n=18), nurses (n=17), or care assistants (n=4). Most managers were also qualified

nurses who were closely involved in frontline care delivery, implementing mental capacity

legislation, and monitoring quality of practice. Participants had been working in these roles

for between three months and 27 years (median duration: 3 years). The majority (n=25) had

direct experience of assessing mental capacity.

Five main themes were identified: i) involvement of residents in decision-making; ii)

approaches to mental capacity assessment; iii) working with residents with communication

difficulties; iv) feelings about practice; and v) responses to MCAST. Below we present each

theme and illustrate it with sections of raw data.

Involvement of residents in decision-making

Participants in all focus groups said that they thought it was important to involve residents

in decision-making and that this was promoted within the care homes as much as possible:

"day to day I think on all the units, everybody's offered as much choice as they can get"

(FG5;24). Participants appeared to involve residents in decision-making because this was a

legal requirement and also because they perceived such involvement to be a key feature of

high quality, person-centred care that values the individual and promotes their

independence: "It's about involvement…so that they feel like a person and that they're

valued" (FG1;5). All care home staff supported residents to engage in simple, everyday decision-making relating to personal care and other daily living activities, whether or not they considered residents to have mental capacity to make the decision: "all the staff get involved in that, carers, housekeepers, nurses, everybody who's working in the home" (FG1;1). In contrast, participants suggested that qualified nursing staff tended to be involved in facilitating more complex resident decisions relating to use of medication, eating or drinking orally in the presence of dysphagia, management of financial affairs, and place of residence.

Approaches to mental capacity assessment

Participants' descriptions of acts of daily care suggested that, in general, they were aware of, understood, and implemented the MCA's statutory principles, such as the presumption of capacity: "you can't just blanket it and say, she's not got capacity because she's got dementia" (FG2;10). Participants also respected residents' legal right to make capacitous decisions that they considered to be unwise:

> I think, oh, they shouldn't be doing that, but then, because they've got capacity as well, it's a case of…it's down to what they want to do. (FG4;17)

Mental capacity assessment occurred frequently in the care homes. Many residents had degenerative conditions that might affect decision-making abilities; all homes had systems for detecting when decision-specific capacity changed for residents. Qualified nursing staff took responsibility for assessing mental capacity, with the support of managers: "the nurses will do the assessment on the unit and the deputy manager will support us and the manager supports us as well" (FG1;9). Participants working as carers in a residential home reported

that they relied on professionals from external agencies to complete assessments because

they believed they were not qualified for this task: **"**they've got that nursing degree haven't

they, so they can make that decision and it will be a legal decision, whereas mine wouldn't

be" (FG3;13).

Participants used informal (e.g., observation) and formal processes (e.g., the MCA functional

capacity test, OPSI 2005, paragraphs 2-3) to assess capacity. Participants were supported in

this work by various types of internal or external (e.g., local authority) documentation.

Occasionally, participants described assessment approaches that appeared to be incomplete

or inconsistent with the MCA functional test:

> I tend to do a quick capacity assessment as well to look at time, place, person and
> see if they're orientated and ask them a few questions to see are they aware of
> where they are, and why, why they're there…it's not a full capacity assessment.
> (FG1;7)

Working with residents with communication difficulties

Participants in each group described working with residents with a range of communication

difficulties associated with conditions including dementia, acquired brain injury, Parkinson's

disease, stroke and learning disability. Participants also identified communication challenges

that arose when residents did not use English as their first or preferred language: "We've

also people where English hasn't been their first language, and they've reverted back to

their natural language as well, especially with dementias" (FG4;15).

Participants were generally aware of the nature of communication disability and appeared

to adopt an asset-based approach when working with these residents: "some people can't

verbalise, but they can communicate, but by other means, actually by facial expressions or

with their body language" (FG5;27). Most participants appeared to understand how these residents might need additional support to demonstrate their decision-making abilities. They described using various methods to support residents: using objects to help residents to make choices: "let him point to what he wants, you know, do you want to wear this shirt, or that shirt? (FG3;13); interpreting residents' non-verbal communication: "it's picking up on behaviour and body language…for those residents who can't articulate clearly what they want" (FG5;23); using communication aids, for example communication passports, pictures or photographs representing everyday objects and activities, visual food menus, or electronic aids.

Participants reported different degrees of confidence in their ability to support residents. Some found it difficult to identify new residents' communication needs and support individuals who become frustrated by their difficulties, such as a resident with the language disorder aphasia, who would "whack his wheelchair into the walls because he's getting frustrated that we can't understand him" (FG4;17). All participants expressed the view that support from SLTs would be valuable in these situations.

However, access to specialist communication assessment and practical support from SLTs, both generally and during mental capacity assessments, appeared variable. Participants might not always recognise the need to seek support, for example for residents living with dementia: "[it's] never cropped up in a capacity assessment with me" (FG2;10); or because it was not part of their normal practice: "we've never done it" (FG5;23). Participants suggested some care home staff were unaware that SLTs provide this type of support: "if you ask most people in this home, they would refer for swallowing…I don't think they're aware that you can refer for speech problems" (FG5;24). Other participants suggested

community speech and language therapy services prioritised management of dysphagia over communication difficulties, due to concerns about resident safety: "you know swallowing, they're straight in because the risks are so high…but with the communication side of things it's very limited input to be honest" (FG4;17).

Feelings about practice

Participants generally appeared confident about their ability to support residents' decision-making and assess their mental capacity. They attributed their confidence in part to the fact that they adopted a person-centred, asset-based approach to care: "[the staff are] very person-centred in treating people as individuals and valuing them" (FG1;4). This ethos, which is consistent with the MCA's focus on individual rights, helped staff to understand residents' preferences and how to support their decision-making. Participants also felt confident when they received training, and when practice was endorsed by internal and external audits, for example CQC inspections.

Despite this, many participants, including those who were very experienced, indicated that they found this area of practice complex and challenging: "Yes, it is very difficult to, to assess somebody under the mental capacity act…and to make it legal" (FG3;1). One reported challenge was the time-consuming nature of capacity assessment:

> they've got 24 people with dementia…and there's one nurse there, so doing a capacity assessment as well, they're not, if we're honest, they're not always done in a timely manner sometimes. (FG1;7)

A second challenge was perceived pressure to produce documentation that was legally compliant and satisfied the expectations of external professionals, for example CQC

inspectors. Participants viewed documentation as a form of protection, in case their practice was ever challenged: "as long as we've got the documentation to back ourselves up that they've got [mental] capacity" (FG4;17). Less experienced participants were not always able to produce clear and comprehensive documentation that demonstrated their practice was competent: "so they can do it, you'll observe them doing it, but what they've wrote down isn't what you've observed" (FG1;7). Some documentation tools used in care homes did not enable staff to demonstrate the amount of work that is involved in capacity assessments and best interests decisions: "it's all them other bits of conversations in between (meetings) that are not shown through on that document there" (FG4;1).

A third area of challenge related to participants being dissatisfied with other professionals' practice, which they thought was inconsistent with legal standards. This situation often arose when care home staff sought information during a care needs assessment for individuals transferring to the home from another setting: "when you go to do a preadmission assessment, the actual capacity assessment that's run in the hospital is either non-existent or very minimal" (FG1;8). Several participants described situations where external professionals did not involve residents directly in decision-making, but might involve a resident's family, for example in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders:

> the nurse practitioner came and actually had a meeting with the family and this
> lady's got full capacity, they discussed it with the family and not even with her.
> (FG4;15)

Participants also described situations where they disagreed with professionals from external agencies about capacity assessment or best interests decision outcomes. This often related

to decisions about implementing the Deprivation of Liberty Safeguards (DoLS). Such

disagreements were often a source of frustration and anxiety and impacted daily care:

> she's not under a DoLS, so I could open the door and let her go out. I'm not going to
> do that, because she could get run over, she clearly has not got the capacity, so that
> makes it difficult for us if she keeps saying, I want to go home. (FG3;13)

Participants suggested that external professionals may reach different conclusions about

residents' mental capacity because they do not have in-depth knowledge of residents, may

not elicit or use information about individual residents from care home staff, or may not

value their opinions:

> [Speech and language therapists] will tend to go with what their loved ones are
> saying, rather than the staff on the unit, who work with them day in day out every
> single mealtimes, may even be assisting them to eat their meals, rather than take it
> from the written documents or the staff. (FG4;16)

Participants suggested they might need to challenge some family members' views about

individual residents' involvement in decision-making, their mental capacity, and what may

be in their best interests; some relatives might not be aware of, or understand, mental

capacity legislation and its emphasis on individual autonomy. Participants felt they had a

role in educating families and in advocating for, and protecting, the rights of individual

residents:

> I don't think families realise that their loved one has got that capacity, because
> they've been so used to making those decisions for them...it's about kind of working
> with them to make them understand. (FG4;20)

Responses to MCAST

There was agreement between participants across all care homes that MCAST could improve practice. All participants were keen to use the toolkit in their workplace. Participants appreciated aspects of the toolkit's design, specifically its simplicity and clarity and the accessibility of its language, which, they suggested, increased the likelihood that they would use it. Participants' opinions about the usefulness of its individual components varied. This appeared to depend on whether they already had access to similar resources, and on the needs of the residents they worked with.

Participants responded most positively to the Support Tool, which they thought would prompt care staff to liaise with key informants and gather all necessary information to prepare a capacity assessment thoroughly:

> it breaks that down that I've covered everything and have I missed anything, have I involved everyone, have they asked all them questions beforehand, so you've got all that information ready and you're set up ready for the [assessment]. (FG4;15)

Participants felt the Support Tool could support staff to adopt a more holistic approach, because it would prompt them to consider factors that are absent from current documentation tools: "the religious factors, cultural effects, [all that] affects decision making a lot" (FG1;7). Participants suggested that use of the Support Tool could lead to improvements in documentation: "It shows that you were thorough and you tried all options, different options and different approaches" (FG2;11). Participants were able to identify a small number of ways to adapt the Support Tool to increase its usefulness and usability (e.g., the addition of more documentation prompts and space).

Participants had mixed views about the usefulness of the toolkit's communication components. They suggested the Communication Screening Tool could support staff to prepare capacity assessments more thoroughly and also screen new residents for communication needs: "we have no formal process to assess that ability" (FG4;20). Participants also indicated that they could use this tool to inform and justify their referrals to SLTs for specialist communication support and demonstrate the quality of their care to regulators.

Many participants suggested they already had access to communication resources similar to those within MCAST. Some felt the photographic resources would be useful during capacity assessments and everyday interactions with residents. Others felt these resources might not meet the needs of some residents, for example those living with dementia, who might have difficulty understanding the concepts represented in the photographs: "you might have to use a physical, like here's the chair, come and sit down, rather than show a picture of the chair" (FG1;9). Participants were able to suggest ways to improve the resources, for example by including additional items, such as an accessible visual pain scale.

Discussion

This study aimed to understand current challenges faced by care home staff when supporting residents to make decisions and participate in mental capacity assessments; to explore staff members' support needs; and to identify if and how MCAST could be adapted for use in care homes. Our findings suggest that in the homes sampled, staff generally engaged competently and confidently in supported decision-making and mental capacity

assessment. Participants appeared to understand how to address the specific needs of residents with communication difficulties, but would benefit from additional, specialist support. Challenges relating to time management, documentation standards, and partnership working with other professionals and residents' families affected participants' experience of practice. Care home staff interviewed in our study were keen to use MCAST, but suggested minor adaptations to improve its content and design.

Participants viewed resident involvement in decisions as integral to high quality, person-centred care, as well as a legal and ethical imperative. They appeared to understand the ethos of the MCA and its emphasis on the rights of people to be supported to maximise their participation in decision-making. These findings complement those of a previous UK study completed in care homes (Manthorpe & Samsi, 2016). Responsibility for supporting residents to make more complex decisions and for mental capacity assessment appeared to lie with qualified professionals based in or outside the care home. Evidence from other studies suggests that certain professionals (e.g., medical doctors, psychiatrists, social workers) and more senior team members may lead capacity assessments in some settings (Cliff & McGraw, 2016; Marshall & Sprung, 2016; Ratcliffe & Chapman, 2016).

This study provides novel findings about the verbal and non-verbal methods care home staff use to support residents with communication disabilities to make decisions and participate in mental capacity assessments. This is positive, given that Daly and colleagues (2018) found that care home staff may not routinely involve people living with dementia in everyday decision-making. Our findings complement those of an Australian study, which described the use of similar methods to involve residents living with dementia in decisions (Fetherstonhaugh et al., 2014). Challenges accessing specialist communication support

appeared to relate to misunderstandings about the SLT role and variations in local service provision. Importantly, some participants' responses suggested they did not understand that SLTs have a role in supporting residents with communication needs associated with dementia. Similar findings have been reported in healthcare settings (McCormick, Bose, & Marinis, 2017; Paul & Mehrhoff, 2015). We suggest that more needs to be done to establish and promote the SLT role in supporting care home residents with communication needs.

A key finding was that most participants involved directly in mental capacity assessment appeared confident about their practice. In contrast, studies completed in healthcare settings have reported that many staff lack confidence, and do not understand their legal responsibilities or how to exercise them (Emmett et al., 2013; Marshall & Sprung, 2016; Williams et al., 2014). These disparate findings may reflect the evolving nature of practitioner knowledge and confidence, as mental capacity legislation becomes more embedded in practice. It is notable that participants in our study appeared to attribute their feelings of confidence in part to their ability to develop in depth knowledge of residents; it is possible that healthcare professionals find it harder to develop this level of knowledge, due to the more transient nature of healthcare delivery.

Consistent with other studies involving HSCPs (Cliff & McGraw, 2016; Williams et al., 2014), participants in our study reported they find this area of practice complex and challenging, irrespective of how experienced they are or how confident they feel. Specific challenges relating to the achievement of timely assessments, legally-compliant documentation, and effective collaborations with multidisciplinary professionals appear to be common across health and social care settings (Jayes et al., 2019). MCAST was developed, in part, to address these issues. Other studies conducted in community settings have reported that family

members may not understand how mental capacity legislation affects their relatives' daily lives (Borrett & Gould, 2020; Manthorpe & Samsi, 2016; Murrell & McCalla, 2016). This suggests that more should be done to raise public awareness of the implications of the MCA.

Our findings relating to the potential use and value of MCAST in care homes are extremely positive, given that many participants felt confident about their practice and already had access to similar resources to support their practice. Participants' comments suggest that the toolkit provides additional features to increase staff members' ability to engage in holistic care and meet residents' individual decision-making needs. Although designed for use in hospitals, it appears MCAST's content and design only require slight refinements to be usable in social care settings.

Implications for practice and research

Our findings indicate a number of potential ways to facilitate and improve practice in relation to supported decision-making and mental capacity assessment in care homes. Firstly, mental capacity training for HSCPs should promote collaborative, interdisciplinary working as best practice and highlight that UK legislation does not prescribe which disciplines or levels of seniority should assess mental capacity. Improved communication between social care and healthcare staff may facilitate partnership working across professional boundaries to enable the delivery of holistic, seamless care. Secondly, public health initiatives could usefully raise public awareness of the implications of mental capacity law; supporting residents and family members to understand their rights, roles and responsibilities, and those of care home staff, could lead to improved working relationships.

Thirdly, we suggest that care home staff need increased support to work with residents with communication disabilities, for example through targeted training in communication disabilities and the SLT role. SLT services should consider, in consultation with care home staff and commissioners, how to provide more inclusive services for residents with communication disabilities. Finally, our findings indicate that use of MCAST in these settings may facilitate and improve practice. Future research should include formal feasibility testing in care homes, involving a larger participant sample and the collection of different types of data, including observational data.

Limitations

We acknowledge limitations to our participant sample. Most participants occupied management roles. Although involved in frontline care delivery and implementation of mental capacity legislation, managers may have different experiences to other staff working in care homes. Their presence may have inhibited other participants during group discussions; however, our impression is that participants who were not managers did not appear inhibited or reticent. Furthermore, we were only able to recruit small numbers of participants to two of the focus groups (FG2 and FG3). This potentially limits the credibility of our findings and their transferability to other settings (Lincoln & Guba, 1985).

Social desirability bias also may have affected the credibility of the findings (King & Bruner, 2000). Participants may have felt a need to appear confident and to describe practice that is consistent with legal standards, in order to satisfy their managers and protect their employers' reputations. In fact, we observed that some participants reported practice that was not entirely consistent with legal standards and others indicated that use of the toolkit

could improve their practice. It is possible that participants responded positively to MCAST in order to satisfy the researchers. However, some participants expressed less positive views about the toolkit, which suggests they felt able to respond honestly. We would address these potential methodological limitations when designing a future feasibility study. We would recruit a larger sample and use methodological, investigator and data triangulation, to enhance the trustworthiness of our findings.

Conclusion

This study has increased understanding of how care home staff support residents to be involved in decision-making and assess mental capacity. Until now, there has been limited published evidence about this area of practice in social care. Our findings suggest that care home staff face similar challenges to professionals working in healthcare settings and need support to document their capacity assessments and to meet the specific decision-making needs of residents with communication disabilities. This population may not access specialist support currently. MCAST should be evaluated in care homes, in order to establish its feasibility formally and to collect evidence of any associated effects on practice in this setting.

References

Borrett, S., & Gould, L. J. (2020). Mental capacity assessment with people with aphasia: understanding the role of the speech and language therapist. Aphasiology. https://doi.org/10.1080/02687038.2020.1819954

Braun V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, **3**(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Cliff, C., & McGraw, C. (2016). The conduct and process of mental capacity assessments in home health care settings. *British Journal of Community Nursing*, **21**(11), 570-577. https://doi.org/10.12968/bjcn.2016.21.11.570

Craig, P., Dieppe, P., Macintyre, S., Michie, S., Nazareth, I., & Petticrew, M. (2006). *Developing and evaluating complex interventions: new guidance.* Retrieved from https://www.mrc.ac.uk/documents/pdf/complex-interventions-guidance/

Creswell, J. (2013). *Qualitative inquiry and research design. Choosing among five approaches* (3rd edn). Thousand Oaks, CA: SAGE.

Daly, R. L., Bunn, F., & Goodman, C. (2018). Shared decision-making for people living with dementia in extended care settings: a systematic review. *BMJ Open*, **8**(6), e018977. https://doi.org/10.1136/bmjopen-2017-018977

Donovan, J., & Sanders, C. (2005). Key issues in the analysis of qualitative data in health services research. In A. Bowling & S. Ebrahim (Eds.), *Handbook of Health Research Methods* (pp. 515-32). Maidenhead: Open University Press.

Emmett, C., Poole, M., Bond, J., & Hughes, J.C. (2013). Homeward bound or bound for a home? Assessing the capacity of dementia patients to make decisions about hospital discharge: Comparing practice with legal standards. *International Journal of Law and Psychiatry*, **36,** 73-82. https://doi.org/10.1016/j.ijlp.2012.11.009

Fetherstonhaugh, D., Tarzia, L., Bauer, M., Nay, R., & Beattie, E. (2014). The Red Dress or the Blue? *Journal of applied gerontology*, **35**(2), 209-226. https://doi.org/10.1177/0733464814531089

Hinsliff-Smith, K., Feakes, R., Whitworth, G., Seymour, J., Moghaddam, N., Dening, T., & Cox, K. (2017). What do we know about the application of the Mental Capacity Act (2005) in healthcare practice regarding decision-making for frail and older people? A systematic literature review. *Health and Social Care in the Community*, **25**, 295-308. https://doi.org/10.1111/hsc.13030

House of Lords Select Committee on the Mental Capacity Act (2014). *House of Lords. Mental Capacity Act Post-Legislative scrutiny*. *HL 139*. London: HMSO.

Jayes, M., Palmer, R. & Enderby, P. (2020). Evaluation of the MCAST, a multidisciplinary toolkit to improve mental capacity assessment. *Disability and Rehabilitation*. https://doi.org/10.1080/09638288.2020.1765030

Jayes, M., Palmer, R. & Enderby, P. (2021). Giving voice to people with communication disabilities during mental capacity assessments. *International Journal of Language & Communication Disorders*, **56**(1): 90-101. https://doi.org/10.1111/1460-6984.12585

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

King, M. F., & Bruner, G. C. (2000). Social desirability bias: A neglected aspect of validity testing. *Psychology & Marketing*, **17**(2), 79-103. https://doi.org/10.1002/(SICI)1520-6793(200002)17:2

Kitzinger, J. (2006). Focus Groups. In: C. Pope & N. Mays (Eds.), *Qualitative Research in Health Care* (3rd edn) (pp. 21-31). Oxford: Blackwell.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Manthorpe, J., & Samsi, K. (2016). Care homes and the Mental Capacity Act 2005: Changes in understanding and practice over time. *Dementia*, **15**(4), 858-871. https://doi.org/10.1177/1471301214542623

Manthorpe, J., Samsi, K., Heath, H., & Charles, N. (2011). 'Early days': Knowledge and use of the Mental Capacity Act 2005 by care home managers and staff. *Dementia*, **10**(3), 283-298. https://doi.org/10.1177/1471301211403970

Marshall, H., & Sprung, S. (2016). The Mental Capacity Act: a review of the literature. *British Journal of Community Nursing*, **21**(8), 406-410. https://doi.org/10.12968/bjcn.2017.22.8.384

McCormick, M., Bose, A., & Marinis, T. (2017). Decision-making capacity in aphasia: SLT's contribution in England. *Aphasiology*, **31**(11), 1344-1358. https://doi.org/10.1080/02687038.2017.1355441

Morgan, D. (1997). *Focus Groups As Qualitative Research* (2nd edn). Newbury Park, CA: Sage

Publications Ltd.

Murrell, A., & McCalla, L. (2016). Assessing Decision-making Capacity: The Interpretation

and Implementation of the Mental Capacity Act 2005 Amongst Social Care Professionals.

Practice: Social Work in Action, **28**(1), 21-26.

https://doi.org/10.1080/09503153.2015.1074667

National Institute for Health and Care Excellence (NICE) (2018, October 20). *Decision-making*

and mental capacity NICE guideline NG108. Retrieved from

http://www.nice.org.uk/guidance/ng108

Office of Public Sector Information (OPSI) (2005). *Mental Capacity Act 2005*. London: OPSI.

Paul, N., & Mehrhoff, J. (2015). Descriptive Analysis: Survey of Direct and Indirect

Interventions for Persons With Dementia-Based Communication Disorders. *Perspectives on*

Neurophysiology and Neurogenic Speech and Language Disorders, **25**(4), 125-141.

https://doi.org/10.1044/nnsld25.4.125

Peisah, C. (2017). Capacity assessment. In H. Chiu & K. Shulman (Eds.), *Mental Health and*

Illness Worldwide: Mental Health and Illness of the Elderly (pp. 369-398). New York (NY):

Springer.

Pennington, C., Davey, K., Ter Meulen, R., Coulthard, E., & Kehoe, P.G. (2018). Tools for

testing decision-making capacity in dementia. *Age and Ageing*, **47**(6), 778-784.

https://doi.org/10.1093/ageing/afy096

Ratcliffe, D., & Chapman, M. (2016). Health and social care practitioners' experiences of

assessing mental capacity in a community learning disability team. *British Journal of*

Learning Disabilities, **44**, 329-336. https://doi.org/10.1111/bld.12172

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing*

and Health, **23**, 334-340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-

NUR9>3.0.CO;2-G

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

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative

research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal*

for Quality in Health Care, **19**(6), 349-357. https://doi.org/10.1093/intqhc/mzm042

Wade, D.T. (2019). Determining whether someone has mental capacity to make a decision:

clinical guidance based on a review of the evidence. *Clinical Rehabilitation*, **33**(10), 1561–

1570. https://doi.org/10.1177%2F0269215519853013

Williams, V., Boyle, G., Jepson, M., Swift, P., Williamson, T., & Heslop, P. (2014). Best

interests decisions: professional practices in health and social care. *Health and Social Care in*

the Community, **22,** 78-86. https://onlinelibrary.wiley.com/doi/pdf/10.1111/hsc.12066