



This is a repository copy of *An exploration of mental capacity assessment within acute hospital and intermediate care settings in England: a focus group study*.

White Rose Research Online URL for this paper:

<https://eprints.whiterose.ac.uk/107299/>

Version: Accepted Version

Article:

Jayes, M.J. orcid.org/0000-0002-0371-7811, Palmer, R.L. and Enderby, P.M. (2017) An exploration of mental capacity assessment within acute hospital and intermediate care settings in England: a focus group study. *Disability and Rehabilitation*, 39 (21). pp. 2148-2157. ISSN 0963-8288

<https://doi.org/10.1080/09638288.2016.1224275>

This is an Accepted Manuscript of an article published by Taylor & Francis in *Disability and Rehabilitation* on 10/11/2016, available online:

<http://www.tandfonline.com/10.1080/09638288.2016.1224275>.

Reuse

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.



eprints@whiterose.ac.uk
<https://eprints.whiterose.ac.uk/>

Pre-publication, accepted version of

Jayes, M., Palmer, R., & Enderby, P. (2016, online) An exploration of mental capacity assessment within acute hospital and intermediate care settings in England: a focus group study. *Disability & Rehabilitation*, DOI: 10.1080/09638288.2016.1224275

Title: An exploration of mental capacity assessment within acute hospital and intermediate care settings in England: a focus group study

Mark Jayes ^{1,2} Rebecca Palmer ^{1,2} Pamela Enderby ¹

1. School of Health and Related Research, University of Sheffield, Sheffield, UK.
2. Speech and Language Therapy, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK.

Correspondence:

Mark Jayes, 1.07 The Innovation Centre, 217 Portobello, Sheffield, S1 4DP, UK.

Telephone 44 (0)114 2225427

Fax: 44 (0)114 2724095

Email mark.jayes@sheffield.ac.uk

Keywords: *decision-making, communication disorders, cognitive disorders, stroke, dementia, Framework Analysis.*

Implications for Rehabilitation

- This study contributes to our understanding of how staff assess capacity in hospital and intermediate care settings.

- Mental capacity assessment is a complex activity and many staff reported finding it challenging.
- Patients with communication difficulties need additional support during capacity assessments but may not always receive this.
- Current practice needs to be improved and staff need support and resources to achieve this.

Abstract

Purpose: To explore approaches to the assessment of mental capacity within acute hospital and intermediate care settings in England.

Methods: Two focus group interviews were conducted with multidisciplinary staff (n=13) within a large hospital trust. Data were analysed using a Framework approach.

Results: Three main themes were identified: i) the assessment process; ii) staff experience of assessment; iii) assessing capacity for patients with communication difficulties. Staff identified the main patient groups, patient decisions and professionals involved in capacity assessment. They described using both formal and informal approaches to assess capacity and specific methods to identify and support the needs of patients with communication difficulties during the assessment process. Most staff reported finding capacity assessment challenging, due to time pressures, a perceived lack of knowledge or skills and encountering practice that is not consistent with legal requirements. Staff stated a need for initiatives to facilitate and improve practice.

Conclusions: These findings provide confirmatory evidence that mental capacity assessment is complex and challenging and that staff would benefit from additional support and resources to aid their practice. It provides new evidence about the methods used by staff to assess capacity, particularly for patients with communication difficulties.

Introduction

The involvement of patients in decision-making is considered to be fundamental to the provision of high quality, patient-centred care [1]. However, patients may have difficulty making decisions due to cognitive or communication impairments associated with neurological or psychiatric disorders. A recent review of 23 studies estimated that 34% of medical patients may lack the ability or capacity to make decisions about their treatment [2]. Demographic changes indicate that this number is set to rise [3].

In the UK, different legislative frameworks require health and social care professionals to assess a patient's decision-making capacity if they have reason to believe the individual may have difficulty making decisions. In England and Wales, the legal framework is provided by the Mental Capacity Act (MCA) [4], in Scotland by the Adults with Incapacity Act (2000) [5], whilst in Northern Ireland the draft Mental Capacity Bill (MCB NI) [6] is currently under consideration by the Northern Ireland Assembly.

The Mental Capacity Act (MCA) defines a two-stage process of capacity assessment. The first stage of the assessment process states that an individual may lack capacity if it can be established that they have an impairment or disturbance of their mind or brain which may affect their ability to make decisions [7]. Conditions that might cause such impairment or disturbance include temporary disturbances due to a delirium or alcohol use, and longer term conditions including neurological change, mental illness or learning disability.

If such an impairment or disturbance is present, stage two of the assessment involves a functional assessment of decision-making ability. The MCA defines the abilities the individual needs to demonstrate in order for it to be concluded that s/he has capacity: i) the ability to understand information relevant to the decision to be made; ii) the ability to retain that information; iii) the ability to weigh the information; iv) the ability to communicate a decision

using any means [8]. A capacity assessment should only be used to determine a person's ability to make a particular decision at the specific time it needs to be made and not to make judgements about general decision-making ability [9]. Anyone "directly concerned" with the individual at the time the decision needs to be made can assess capacity [10]. If an assessor finds that a person cannot demonstrate one or more of the defined decision-making abilities, and judges that the impairment of decision-making is caused by an impairment or disturbance of the mind or brain, s/he should conclude that the individual lacks capacity to make the decision. When this is the case, the MCA outlines a process whereby the decision can be made on the person's behalf by others acting in her/his "best interests" [11].

Mental capacity assessment is challenging because the MCA and its Code of Practice do not provide detailed instructions about how capacity should be assessed in practice. In addition, there is no established gold standard mental capacity assessment tool available for staff to use. As a result, capacity assessment is "subjective and can be complex" [12 p56]. Capacity assessments become especially complex when the person being assessed has communication difficulties, for example if the person has the language disorder aphasia, which can affect the ability to understand and express spoken and written language [13]. The MCA requires assessors to make practical adjustments to the assessment process to support patients with communication needs. For example, information about decisions should be provided "in a way that is appropriate to (the patient's) circumstances" [14].

Since the implementation of the MCA, a small number of studies have been published which provide limited information about how capacity assessments are carried out. These studies suggest that many staff find mental capacity assessment difficult and their practice is not always consistent with legal requirements [15-17]. Recent case law also highlights examples of practice that falls short of legal requirements (e.g., *L v J* [2010] EWHC 2665 (Fam)). Furthermore, in 2014, the House of Lords published a Post-Legislative Scrutiny of the MCA and its implementation and concluded that health and social care staff need better training,

assessment tools and resources to support them to improve the quality of their capacity assessments [18].

This article reports a focus group study which aimed to explore how health and social care staff assess mental capacity in acute hospital and intermediate care settings. The study was designed to build on previous evidence that indicates that mental capacity assessment is challenging by generating more comprehensive data about *how* staff assess mental capacity, especially for patients with communication difficulties, and by providing a detailed exploration of how they experience this area of clinical practice. The study was designed to generate data to inform the user-centred development of a toolkit to facilitate multidisciplinary staff's mental capacity assessments.

Method

This exploratory study was designed to collect data relating to people's experiences, behaviours, understandings and opinions about mental capacity assessment. A qualitative methodology that involved the thematic analysis of data collected in focus groups was employed. This research strategy was informed by a subtle realist ontological and epistemological framework. This theoretical perspective acknowledges that an external social reality exists and can be studied but recognises that the research process provides a subjective representation of this reality from the researchers' perspective rather than a recreation of it [19, 20].

Focus groups are semi-structured interviews involving groups of participants. This method was chosen because it provides an efficient method of generating rich, complex and potentially unexpected data, as a result of interactions between focus group participants and group dynamics [21]. Focus groups composed of multidisciplinary staff can provide opportunities to explore common and divergent views and practices across different staff groups [22].

The study was designed specifically to answer the following research question:

How do health and social care staff assess mental capacity in acute hospital and intermediate care settings?

The following sub questions were identified:

- i. Which types of patient decisions form the focus of mental capacity assessments?
- ii. Which groups of patients require mental capacity assessments?
- iii. Which staff groups carry out mental capacity assessments?
- iv. How do staff currently assess mental capacity, particularly for patients with communication difficulties?
- v. What do staff perceive to be barriers and facilitators to effective mental capacity assessment?

Ethical approval

Ethical approval was obtained from the University of Sheffield School of Health and Related Research Ethics Committee.

Participant identification and eligibility

An aim of the study was to sample the experiences and views of staff working in different professional roles across a range of clinical settings. It was possible to access these settings within a single large teaching hospital trust in the north of England. The trust provides acute medical care and rehabilitation services for adult patients and has approximately 2000 beds across two hospital sites. It also provides intermediate care services in a range of community settings. The trust employs over 16000 staff. All staff involved in mental capacity assessment were eligible for inclusion in the study; there were no identified exclusion criteria. The most relevant staff groups to recruit were identified from a literature review carried out to investigate capacity assessment in England and Wales. The staff groups included doctors,

nurses, occupational therapists, physiotherapists, psychiatrists, psychologists, social workers and speech and language therapists.

Information about the study was disseminated electronically to these staff groups via their managers. A participant information sheet was emailed to interested individuals on request. Staff were contacted 48 hours later by the first author to check if they wished to participate. Those who agreed to participate were invited to attend a group.

Sampling strategy for constituting focus group membership

A purposive sampling strategy was planned, in order to ensure representation from each staff group and from a range of clinical settings. However, certain staff who expressed interest in participating were unable to attend one of the scheduled groups due to work commitments. Therefore, a convenience sampling strategy was used whereby all staff that expressed an interest in participating and were able to attend a group were recruited. Attempts were made to ensure that each group included staff from a range of professional groups and clinical settings.

Materials

A topic guide was developed in order to collect data to answer the research questions, based on themes emerging from the literature on mental capacity assessment. The guide included the following topics:

- i. the main decisions that staff need to support patients to make;
- ii. the types of patients that have particular difficulty making these decisions;
- iii. the types of staff involved in mental capacity assessment;
- iv. how professionals currently assess patients' decision-making capacity, particularly for patients with communication difficulties;
- v. perceived barriers and facilitators to effective mental capacity assessment.

A digital recording device was used to make audio recordings for each group.

Data collection

A focus group was held at each hospital site. The groups took place in rooms that were amenable to confidential group discussion and were not associated with the participants' clinical work locations. Written informed consent was taken at the beginning of each focus group.

Each focus group was facilitated by the primary author. The second author assisted and was responsible for taking field notes relating to the general nature of the discussion. At the start of each session, the facilitator provided an overview of the discussion topic and reminded participants to maintain group confidentiality. Participants were asked to introduce themselves by providing their name, job role and clinical base. Following this, the facilitator asked questions using the topic guide but also allowed discussion to develop freely in order to generate rich data [23]. At the end of each session, the assistant facilitator read back the field notes. Participants were able to comment on the field notes and correct any misunderstandings or misinterpretations.

Data analysis

The digital recording of each session was transcribed verbatim into a Microsoft Word file. Any unintelligible utterances were transcribed as "(unintelligible)". Data from the field notes were transferred to Word files, which were imported into QSR NVivo 10 software to facilitate rapid data analysis.

Data were analysed thematically, using a Framework approach [24]. Framework enables large amounts of raw data to be reduced through five iterative stages of thematic analysis involving transparent, systematic data summarisation and synthesis [25]. This analysis method was chosen because it allowed themes and subthemes to be generated deductively

from the research questions and previous literature review and also inductively, from open data coding. These themes and subthemes were organised within a Framework matrix.

Rigour

A number of techniques were employed to ensure the research process was rigorous, in order to increase the credibility, transferability, dependability and confirmability of the findings [26]. For example, respondent validation was used at the end of each focus group to establish the credibility of initial data interpretation in the field notes [27]. Second, the primary author kept a reflective journal which provided an audit trail for the analytic process. Next, an independent qualitative researcher was invited to review the thematic framework against the original data. This peer scrutiny process did not suggest any changes to the analytic framework, which provided indicative evidence of the credibility of the analysis method [28]. Finally, specific strategies were used to establish rigour when reporting the study. These included providing “thick description” [20] of the research participants, context and research methods and making comparisons between the study findings and published evidence from other sources [29].

Results

Participants

Thirteen staff were recruited to the study. The majority of participants (11) were female. Participants were from the following professional groups: doctors, nurses, occupational therapists, physiotherapists, psychiatrists, psychologists and speech and language therapists. No social workers were recruited. Staff worked in different clinical locations across the hospital trust. They had varying levels of professional experience and had received either general training on the MCA delivered as part of the hospital trust’s staff training programme or more specialist, profession-specific training (see table 1). Participants were invited to attend one of two focus groups. Two focus groups were held in order to ensure that each

group included the optimum number of participants to facilitate discussion [22]. Each group included participants working in a range of professional roles and clinical settings.

Focus group	Participant identification number*	Gender	Professional role	Clinical setting	Years working in professional role	Type of training received in MCA
1	001	Female	Occupational Therapist	Acute Care of the Elderly wards	14 years	General** and self-directed learning
	002	Female	Speech and Language Therapist	Acute medical wards	8 years	General
	003	Female	Clinical Psychologist	Acute Care of the Elderly wards / Neuropsychology outpatients clinics	7 years	General and specialist
	004	Female	Consultant Geriatrician	Colo-rectal surgical wards	3 years as Consultant, 13 as doctor	General and specialist
	005	Male	Consultant Geriatrician	Acute Care of the Elderly wards	4 years as Consultant, 14 as doctor	General and specialist
	007	Male	Consultant Psychiatrist	Acute medical wards	Data not provided	Data not provided
2	006	Female	Physiotherapist	Intermediate care service	6 years	General
	008	Female	Clinical Psychologist	Acute Infectious Diseases / Endocrinology wards	20 years	General and specialist
	009	Female	Speech and Language Therapist	Stroke services (acute wards and intermediate care)	24 years	General
	010	Female	Occupational Therapist	Stroke services (acute wards)	14 years	General
	011	Female	Speech and Language Therapist	Stroke services (acute wards)	38 years	General
	012	Female	Consultant Neurologist	Stroke services / Cognitive Neurology (acute wards and outpatients clinics)	22 years	General and specialist
	013	Female	Mental Health Nurse Assessor	Older People's Liaison Psychiatry (acute wards)	Data not provided	Data not provided

Table 1: Participant characteristics

*Participant identification numbers were allocated when participants were allocated to each group rather than in order of recruitment. This explains why they do not appear in numerical order in table 1.

** General training refers to training in the MCA provided by the hospital trust as part of its staff training programme.

The findings are presented in terms of three major themes that were developed deductively from the focus group topic guide: i) the assessment process; ii) staff experience of capacity assessment; iii) assessing capacity for patients with communication difficulties. Sub themes associated with these themes are summarised in table 2.

Themes	Sub themes
The assessment process	<ul style="list-style-type: none"> • Patients who require capacity assessment • Types of patient decision involved • Who assesses capacity • Activities involved in assessment
Staff experience of capacity assessment	<ul style="list-style-type: none"> • Time pressures • Having the right knowledge and skills • Other people's practice
Working with patients with communication difficulties	<ul style="list-style-type: none"> • Identifying communication difficulties • Supporting people's communication needs • Challenges associated with working with this group

Table 2: Themes and sub themes identified within data

These themes and sub themes are discussed below and illustrated with sections of original data.

The assessment process

Participants' responses suggest a number of variables within the mental capacity assessment process. These are described below.

Patients who require capacity assessment

Participants identified two main groups of patients who require capacity assessments: those with cognitive and communication difficulties following stroke and those with cognitive difficulties due to dementia or delirium. Other groups who they suggested require assessment include people with learning disabilities, those with mental health conditions (e.g., depression, psychosis, schizophrenia and personality disorder) and patients with acquired brain injury.

Types of patient decision involved in capacity assessments

The majority of mental capacity assessments appear to involve patients needing to make decisions about discharge arrangements or treatment options. Discharge decisions often require patients to choose between returning to their usual residence with or without a package of care or moving to a care home setting. Treatment decisions involve making choices about taking medication or undergoing therapeutic or surgical procedures. Patients with swallowing difficulties may need to make decisions about whether to eat and drink orally or receive nutrition or hydration alternatively, for example via a Percutaneous Endoscopic Gastrostomy (PEG) tube. A Consultant Geriatrician suggested that capacity to consent to surgical procedures is not routinely assessed in all clinical settings:

*...I'm often consulted about discharge destination or future care
but no one ever talks to (me) about whether or not these patients can consent
to their operations (004)*

Staff working with patients with mental health conditions described being asked to assess patients' capacity to make decisions about refusing medications or treatment or to consent to sexual relationships.

Who assesses capacity

Participants' responses indicated that a range of different professionals carry out capacity assessments within hospital and intermediate care settings, as shown in table 3. Participants reported that social workers can influence the assessment process but did not describe this group as being directly involved in assessments.

Staff who assess mental capacity
<ul style="list-style-type: none">• Clinical Psychologists• Doctors• Nurses: Transfer of Care Nurses, Mental Health Nurse Assessors• Occupational Therapists• Physiotherapists• Psychiatrists• Speech and Language Therapists

Table 3: Staff involved in assessing mental capacity

A number of factors appear to determine which staff groups assess capacity in particular settings. A consultant geriatrician commented that in her experience, the most senior members of medical teams tend to carry out capacity assessments, perhaps because they consider this area of practice to be too challenging for more junior staff:

I tend to own it I think it's a huge responsibility I wouldn't really want to give that to someone who didn't feel they wanted it (004)

Another consultant geriatrician (005) held a different view, arguing that other members of staff may be more qualified to carry out assessments, provided they have enough opportunities to gain experience and confidence.

In other settings, participants reported that the choice of assessor might depend on which staff members have access to important information that is required during the capacity assessment. This could include specific information about the patient (e.g., medical status, home situation, functional abilities) or decision options (e.g., the nature, risks and benefits of a surgical procedure). Doctors would usually be involved in assessing capacity for decisions about treatment, whilst occupational therapists would tend to be involved in assessments about discharge arrangements. An occupational therapist commented:

it makes sense for the people who are getting that information to begin with to actually then use that...rather than it being passed to somebody else (001)

Participants reported that particular staff groups might be asked to carry out or facilitate assessments, because of their specific skills and knowledge. For example, liaison psychiatrists and mental health nurses are often asked to complete capacity assessments for patients with mental health conditions on medical wards; speech and language therapists may be asked to facilitate communication between staff and patients with communication disorders during capacity assessments. In these circumstances staff may not know the patient they are asked to assess beforehand.

Several participants indicated that the involvement in the assessment process of staff outside the treating team can be challenging. Firstly, the assessor may not know the patient or understand the decision options well, which means the assessment process is more difficult. A consultant psychiatrist (007) commented that when he is asked to conduct a capacity assessment, he prefers a member of a patient's treating team to be present, because s/he is likely to have better understanding of the decision options. The involvement of a member of staff perceived to be outside the patient's team may also cause resentment amongst staff in that team. A physiotherapist commented:

I personally would feel quite insulted if somebody that didn't know that person came in and did the capacity assessment when you know we've potentially been working with that person for five to six weeks, know all the ins and outs, we've done the assessments (006)

Furthermore, staff who receive referrals for capacity assessments from ward-based teams sometimes feel the teams should complete the assessments themselves rather than create additional work for other professionals. A mental health nurse assessor (013) commented that she is often asked to complete capacity assessments on a particular unit because other staff (nurses, therapists) perceive that she is more competent than them to do this because of her background in mental health. She believed this resulted in an excessive workload for her, which caused her to be frustrated.

Participants suggested that ideally, assessments should be carried out jointly by staff with specialist knowledge and staff who are familiar with the patient and the decision. Joint assessment appeared to be standard practice in certain settings (e.g., on a stroke unit). Participants who had experience of joint assessment found this beneficial, as it afforded opportunities for joint reflective practice and learning.

Activities involved in capacity assessment

Participants described several distinct activities involved in mental capacity assessment. These are discussed below.

Gathering information before the assessment

Staff gather information from a number of sources in order to prepare for capacity assessments. For example, staff obtain information about patients' pre-admission functional abilities from their families, carers, community health and social care staff or from a local

adaptation of the Alzheimer's Society's "This is Me" booklet [30]. This booklet is designed to provide information to caregivers about a person with dementia's lifestyle and care needs. Participants also described gathering information about treatments or interventions that might need to be discussed with patients during capacity assessments.

Participants reported using both formal and informal assessments to gain information about patients' current abilities, including their communication and cognitive skills. For example, participants reported using information from cognitive screening assessments such as the Mini Mental State Examination (MMSE) [31] to gain an understanding of a patient's cognitive ability. This information might be used to help staff prepare an assessment of decision-making ability for that patient. It might also be used to provide evidence that a patient has an impairment of the mind or brain that may affect decision-making, in the absence of any formal diagnosis, in order to satisfy stage one of the two-part functional test of capacity [7].

Informal and formal assessments of decision-making ability

Participants described both informal and formal processes involved in capacity assessment. Several participants reported that they have conversations with patients about their home lives and hospital admissions before commencing an assessment of decision-making ability. These conversations were reported to serve several functions. They can enable staff to establish rapport with patients and to gain information about their cognitive function (e.g., their orientation and insight); they may also provide an informal assessment of capacity. A consultant geriatrician indicated that if a patient was unable to provide information about their home life and hospital admission, she might not proceed to a formal capacity assessment:

I certainly start those same questions you know, do you know where you are, do you know why, do you know how long you've been here erm do you (know) where you normally live tell me a bit about that...but you know

sometimes really I don't get much further than that 'cos if they really haven't got a clue about any of those things (004)

A clinical psychologist described using this type of conversation as an informal process of exploring a patient's ability to understand information relevant to a decision and communicate a decision. She might assess the patient again to explore particular aspects of decision-making more thoroughly:

are they weighing up and judging (and) you know that might take a whole sort of assessment in itself (003)

Other participants described more formalised ways of assessing decision-making. Some use a local developed proforma to structure their assessments; this proforma prompts staff to follow the requirements of the MCA functional test and can be used to document an assessment. Participants identified a need to record clear, detailed information about assessments. An occupational therapist commented that using the proforma facilitated this:

it's clear for people to see that you've followed the process and they can see what evidence has made you come to that conclusion (001)

An occupational therapist working on a stroke unit reported that her team use a standard assessment process for all patients, although assessments are still patient and decision-specific. Part of this approach involves supporting patients with cognitive difficulties to learn information relevant to decision-making prior to the capacity assessment. This practice appeared to be designed to enhance patients' mental capacity, in order to support them to be fully involved in decision-making:

we give them time to relearn that information so we actually prepare them for the assessment itself and then we come to a conclusion (010)

Participant 003 described a similar approach used to enhance patients' mental capacity in a different inpatient rehabilitation setting, for patients with executive dysfunction secondary to acquired brain injury; this approach used different methods to maximise patients' ability to weigh information about decision options and their consequences. Other participants said they were keen to adopt such approaches in their own practice.

Several participants described focusing on information about risk and the long term consequences of decisions when assessing patients' ability to make decisions about where to live on discharge:

I'll say ok then so you say you'll be fine but what would you do if there was a fire? (010)

99.9% of people might say they want to go home, but do they understand then what their life's going to be like at home that they might have to sit in a wet pad for eight hours overnight (006)

Several participants reported they sometimes assess patients' decision-making at different points in time. A consultant geriatrician (004) reported that she might repeat an assessment to reassure herself that a previous assessment was accurate or in situations when capacity might be expected to fluctuate, for example due to a temporary condition such as delirium. A clinical psychologist (008) argued that capacity assessment should always be a repeating process, especially for patients who may have fluctuating capacity due to mental health conditions. However, other participants reported that repeat assessment would not be

possible in all clinical areas (for example in medical assessment units) due to workload pressures.

Staff experience of capacity assessment

Most participants, irrespective of their professional role or level of seniority, reported finding assessment of mental capacity challenging. A consultant geriatrician stated that this clinical activity made her “quite stressed” (004). Participants described different sources of challenge, including: time pressures; having the right knowledge and skills; encountering practice that is not consistent with the MCA.

Time pressures

Participants reported finding mental capacity assessment time-consuming and some said they can feel under pressure from other staff to provide rapid judgements about capacity. A mental health nurse assessor (013) described needing to complete four or five assessments a day and only being able to spend 45 minutes on each assessment. A consultant psychiatrist reported having to be assertive with other staff about needing extra time to complete assessments:

having that confidence to say actually I don't think I can make a decision based on what I've got today...I need more time...because there is a pressure...you know you have to produce the answers today (007)

Having the right knowledge and skills

Participants identified situations where they felt they lacked the necessary knowledge or skills to carry out effective mental capacity assessments. These situations sometimes involved not having detailed knowledge about a particular treatment option or being asked to assess unfamiliar patient groups or patients with special characteristics. A consultant geriatrician commented:

I find it really hard with conditions that aren't related to dementia and delirium...so I find depression really, really hard (005)

Participants who were not speech and language therapists spoke of various challenges associated with assessing patients with communication disorders. These are discussed in a separate section below.

Colleagues' practice that is not consistent with the MCA

Participants talked frequently about aspects of other staff members' assessment practice that they find challenging. A clinical psychologist expressed concern that many staff lacked awareness about the MCA and commented that in her experience, some staff failed to recognise when patients may require an assessment:

They don't identify that there's a capacity issue...they refer their patients to me for other things and I go have you not noticed then that they haven't got the capacity to boil an egg let alone make a decision about treatment (008)

Other participants identified that even when staff do recognise that a patient needs a capacity assessment, they may not understand that this assessment should be decision and time-specific and may need to be repeated, for example for patients with fluctuating capacity. A physiotherapist (006) reported a situation where hospital staff had concluded that a patient with delirium lacked capacity to make a decision about discharge arrangements but did not reassess the patient when the delirium had resolved.

Other participants described situations where staff do not complete or document capacity assessments in ways that are consistent with the MCA. A consultant geriatrician (004) reported that she receives referrals to assess capacity for patients who do not fulfil stage one of the MCA functional test because there is no clear evidence of any impairment of the mind

or brain that may cause a problem with decision-making. Another consultant geriatrician suggested that some staff make assumptions about patients' capacity based on informal impressions and do not use the two-stage test:

...people can often make mental shortcuts about whether someone will have capacity, you know things like well I saw them today and they seemed a bit muddled so they can't have capacity (005)

Participants reported that they can find it difficult not to be influenced by other people when carrying out capacity assessments. They described how other staff members' opinions about a patient's capacity can be very influential:

it can sometimes skew your thinking...it's very hard to keep that clarity of thinking and don't go into the room with a pre-conceived idea (005)

Similarly, different people's views on what is in a patient's best interests can also impinge on the capacity assessment process. A consultant psychiatrist (007) commented that sometimes, prior to the capacity assessment, professionals and a patient's family members can hold strong opinions about what decision should be made by the patient or by others in her/his best interests. This can be challenging to the capacity assessor who needs to remain impartial when making a judgement about the patient's decision-making capacity.

Assessing capacity for patients with communication difficulties

Identifying communication difficulties

Participants reported that patients requiring capacity assessment might present with different types of communication difficulties. These include language deficits associated with post-stroke aphasia or dementia, speech and language difficulties due to autism or psychiatric

conditions, or the effects of hearing or visual impairments. Participants reported using different methods to identify communication difficulties. A speech and language therapist (002) described completing an informal language assessment prior to a capacity assessment, in order to gain baseline information about patients' abilities and how the assessment process should be adapted to meet individual communication needs. A clinical psychologist (003) said she made judgements about spoken language functioning during conversations with patients, based on techniques she had learned from speech and language therapists. A consultant neurologist (012) described observing non-verbal behaviours to gain information about patients with dementia:

I'm actually reliant quite a lot on their eye contact, their facial expressions, their gestures when I'm talking about certain things to see whether there's any distress (012)

Other participants reported that they find it useful to talk to hospital and community staff who know the patient well or to relatives and carers in order to learn about an individual's communication difficulties and support needs. This type of information might also be available in a patient's medical notes or within documents such as the adapted "This is Me" booklet [30].

Supporting people's communication needs

Participants described different methods they would use to support patients with communication needs during capacity assessments. Several participants (002, 004, 007, 013) described making adjustments to their communication in order to support people with communication difficulties to engage in decision-making more easily. This might include trying to use simplified language and gesture to facilitate a patient's comprehension:

a long sentence perhaps wouldn't be understood but you know perhaps

something as simple as can you hear or can you hear (gesture to ear) (013)

Most participants were able to describe alternative methods of communication they might use to support a patient with receptive or expressive language difficulties. These methods included writing information down or using gestures, drawing or photographs to explain information about decisions. Participants said they might use communication aids such as an alphabet chart to support a patient to express themselves during a capacity assessment.

Whilst some staff reported that they attempt to complete capacity assessments for patients with communication difficulties independently, others said they would refer to speech and language therapy for specialist support. Participants described a possible lack of awareness amongst the workforce that speech and language therapists provide this type of support, perhaps because they are perceived to be primarily involved in assessing and managing swallowing difficulties. A consultant geriatrician (004) commented:

...we as clinicians feel that referrals for language are not a priority you know because you've got to get these people who are nil by mouth they've got to be assessed (004)

Challenges associated with working with this group

Participants identified that assessments for patients with communication difficulties present a number of specific challenges. Firstly, participants reported that they had difficulty identifying communication needs or differentiating these from other impairments and would welcome support with this activity. For example, a clinical psychologist (003) described problems differentiating short term memory deficits from communication impairments in patients with dementia. Secondly, participants reported varying levels of confidence in their ability to adjust their communication style in order to meet patients' individual needs (for example by using

alternative methods such as writing or drawing to explain information). They also described difficulties knowing how to determine and provide evidence about a patient's ability to understand information for the purposes of decision-making. A consultant geriatrician described the challenges of testing understanding robustly:

trying to find exactly the right question to elicit the fact that they don't understand it so that I can show that as evidence when I write this all down later (004)

Finally, participants identified that capacity assessments for patients with communication difficulties require a significant amount of time and that additional time needs to be allocated to these assessments.

Discussion

This study was designed to explore mental capacity assessment practice within acute hospital and intermediate care settings in England. Specifically, it aimed to identify which types of patient decisions and which groups of patients and staff are involved in mental capacity assessments, how staff assess capacity, particularly for patients with impaired communication, and what they perceive to be barriers and facilitators to carrying out capacity assessments.

Participants in this study suggested the two most important groups of patients requiring capacity assessment were patients who have a diagnosis of stroke or who have cognitive impairment due to dementia or delirium. Most previous studies have focused on assessments for two different groups: people with learning disabilities and those with mental health conditions [e.g., 32, 33]. In the current study, most participants indicated that they did not carry out assessments for these groups of patients very often. This difference reflects the professional roles of the participants recruited to this study from an acute hospital setting.

Participants identified the main patient decisions implicated in capacity assessments as those relating to discharge arrangements and treatment planning. This is consistent with data reported by previous studies [e.g., 16, 17, 34]. One participant in the current study expressed concern that sometimes staff may not assess patients' capacity to consent to surgery. Other studies have identified situations in which capacity assessments are not completed but are indicated [15, 16, 34]. Failure to complete a capacity assessment in these situations means that patients may be denied the right to make important decisions about their treatment, care and living arrangements, or instead may be asked to make uninformed decisions, because they are not given support to understand different decision options and their consequences.

Participants in this study identified that different multidisciplinary staff tend to be involved in capacity assessment. They did not describe the direct involvement of social workers, which is surprising as other studies have emphasised this group's role within capacity assessment in the acute hospital setting [15]. The choice of which member of staff assesses capacity appears to depend on a number of factors. In certain settings, more senior doctors tend to carry out assessments and this appears to be related to perceptions of professional hierarchy and responsibility. This trend has been reported in earlier studies [16, 17, 35]. In other settings, professionals external to the treating team may be asked to complete assessments because of their specialist knowledge and skills. This may be challenging to the individual assessor and cause resentment amongst other staff. Participants suggested that the choice of assessor should depend on which member of staff has access to information about the decision and the patient and can best support the patient's needs. This view is consistent with guidance provided by the MCA Code of Practice [10]. Participants also identified that joint assessment by staff with complementary knowledge and skills can be beneficial; however, this practice did not appear to be widespread throughout the hospital trust, perhaps due to the variable availability of staffing resources in different settings.

Participants provided novel data about the methods staff use to assess mental capacity in acute hospital and intermediate care settings. Their responses suggest that the assessment process includes potentially overlapping phases of information gathering and both formal and informal assessments of patients' decision-making abilities. Staff appear to use informal approaches to collect information to help them plan more formalised assessments. A number of participants described using a local proforma to structure their assessments and their documentation and finding this helpful. Previous studies have described similar initiatives that have facilitated assessments [15, 32, 36, 37]. This finding suggests that staff identify a need for support with assessment of capacity and are keen to use tools and resources to facilitate specific aspects of their practice. Participants also described local initiatives to support patients with neurological diagnoses to learn information relevant to decision-making as part of their rehabilitation, in order to enhance their capacity. This approach does not appear to have been reported in previous published studies.

The majority of the participants in this study had received some level of training in the legal requirements of the MCA and some had received further specialist, profession-specific training. However, most participants reported that they find capacity assessment to be challenging. Perhaps unsurprisingly within the context of a busy acute hospital environment, staff identified pressure of time as an important source of challenge. Several participants also expressed concern that they might lack specific knowledge and skills required to carry out capacity assessments in certain situations. This often related to working with particular patient groups, for example those with mental health conditions or those with communication needs. Participants in previous studies have expressed similar concerns, and like certain participants in the present study, have reported preferring to assess capacity jointly or to refer patients to more specialist or senior colleagues for assessment, instead of attempting to assess them themselves [16].

When participants described aspects of their assessment in the focus groups, their practice appeared to be generally consistent with the requirements of the MCA. However, they spoke at length about their concerns about other staff members' practice and provided examples of practice that would not be consistent with the MCA, for example failing to initiate an assessment or to meet the requirements of the MCA two-stage test. Earlier studies have reported similar concerns expressed by staff and also evidence from case note reviews and ethnographic studies that assessments may not be compliant with the law [e.g. 34, 38].

These findings all indicate that assessment practice is variable and some staff would benefit from additional support in order to improve the quality of their mental capacity assessments.

Participants provided important data relating to how hospital staff with and without specialist training in communication disorders assess capacity for patients with these types of difficulties. Very few published studies have investigated how staff identify and support this patient group during capacity assessments. Patients with impaired communication skills are especially vulnerable during the assessment process because they are likely to require additional, individualised support to understand, use and express information about decisions [13]. This makes capacity assessment more complex. Furthermore, staff without specialist training or experience of working with this patient group may find it difficult to identify patients with communication difficulties or know how to support such difficulties [15, 37]. Participants in this study confirmed that they find it challenging to work with this patient group and require additional support. They also indicated that patients who require communication support may not always be referred to speech and language therapy, due to a misperception amongst staff that speech and language therapists may not provide this type of support or may need to prioritise patients with swallowing disorders instead. These are important findings that indicate a need to develop novel capacity assessment training or other practical resources.

This study has provided new evidence about how capacity is assessed in acute hospital and intermediate care settings and how staff experience and reflect on this activity. Most previous

studies used case study or survey methods or reviewed case notes [e.g. 33, 39]. This study reports data that complement findings from three previous studies using interview methods [15, 16, 34], but also provides new information about the methods hospital staff use to assess mental capacity, particularly for patients with communication difficulties. The findings add support to the conclusions of the House of Lords' post-legislative scrutiny [18] that capacity assessment practice needs to be improved and that staff need to have access to a range of practical resources and tools to assist them to carry out assessments more easily and rigorously.

Limitations of current study

It was not possible to employ a purposive sampling strategy due to the reduced number of participants who were available to attend a focus group. Although the sample did include participants with different professional roles, working in a range of clinical settings and with varying amounts of professional experience, the use of convenience sampling may have introduced selection bias.

The composition of the sample may have influenced the credibility of the study findings in a number of ways. Firstly, social workers were not represented as they have been in previous studies [e.g., 15]. This professional group may have provided unique insight into the process of capacity assessment and should be included in future studies related to this topic.

Furthermore, staff may have volunteered to participate in the study because they have a special interest in mental capacity assessment. Their knowledge about the MCA and their practice may be different to those of other staff working in the hospital trust. The fact that the sample included significantly more female participants than male is also noteworthy. This is likely to be because many of the professional groups represented in the sample are composed largely of women. It is possible that this gender imbalance affected social dynamics within the focus groups, which may have influenced the data collection process.

Another potential limitation is that data collection took place within a single hospital trust. This means that it is unclear how transferable the findings are to other settings in England and Wales. The fact that many of the findings are broadly consistent with evidence provided in previous studies, however, suggests commonalities between the experiences and practices described by participants in this study and those observed elsewhere.

It is possible that the primary author's professional role as a speech and language therapist working in the hospital trust may have influenced data collection and analysis. This represents a potential limitation to the confirmability of the study findings. Participants may have perceived an expectation to provide particular responses, despite reassurances that the study was not designed to test their knowledge or identify inadequate practice and that data would be used confidentially. For example, it is interesting that participants were sometimes critical of other staff members' practice but did not tend to criticise their own practice or describe aspects of their own practice that were inconsistent with the MCA.

Furthermore, the primary author may have made assumptions about the meaning of certain participant responses based on contextual knowledge gained from assessing mental capacity in the same hospital trust. However, peer scrutiny of the thematic framework by an independent researcher with no experience of mental capacity assessment provided confirmatory evidence of the credibility of the analytic process.

Conclusions

Participants reported that the main patient groups requiring mental capacity assessment in these acute hospital and intermediate care settings are patients with diagnoses of stroke and cognitive impairment secondary to dementia or delirium. Most assessments appear to relate to patient decisions about discharge arrangements or treatment options. A range of multidisciplinary staff are involved in capacity assessment but different factors can determine which staff assume the assessor role. Capacity assessment appears to be a complex activity that involves significant information gathering and formal and informal approaches to

assessing patients' decision-making abilities. Some staff members find it beneficial to use external supports to structure their assessments and documentation. The study contributes to our understanding of how both specialist and non-specialist staff assess capacity for patients with communication difficulties. The findings suggest that currently, patients with communication needs may not always receive specialist support during capacity assessments. Most staff in this study reported that they find capacity assessment challenging. They were able to identify various sources of challenge and also different types of support that may be beneficial to their practice; they described practice which was sometimes inconsistent with the MCA. These findings, together with similar data reported in previous studies, indicate that staff need additional support and resources to facilitate and improve their practice in this important area of patient care.

Acknowledgements

We would like to thank the staff who agreed to take part in this study and Dr Michelle Marshall, who kindly reviewed the data and the analytical framework.

Declaration of interest

This article presents independent research funded by the National Institute for Health Research (NIHR). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health. Mark Jayes is funded by an NIHR Clinical Doctoral Research Fellowship. Rebecca Palmer is funded by an NIHR Senior Academic Clinical Lectureship.

References

1. Stojan JN, Clay MA, Lypson ML. Assessing patient-centred care through direct observation of clinical encounters *BMJ Qual Saf* 2016;25:135-137.

2. Lepping P, Stanly T, Turner J. Systematic review on the prevalence of lack of capacity in medical and psychiatric settings. *Clinical Medicine* 2015;15(4):337-43.
3. Moye J, Marson D. Assessment of Decision-making Capacity in Older Adults: An Emerging Area of Practice and Research. *Journal of Gerontology* 2007;62B(1):3-11.
4. Office of Public Sector Information. *Mental Capacity Act 2005*. London: OPSI; 2005.
5. The Scottish Government. *Adults with Incapacity (Scotland) Act 2000*. Edinburgh, The Scottish Government; 2008.
6. Department of Health, Social Services and Public Safety [Internet]. Draft Mental Capacity Bill (NI) Consultation Document [cited 2015 July 15]; Available from: <https://www.dhsspsni.gov.uk/consultations/consultation-proposals-new-mental-capacity-legislation-northern-ireland>
7. Office of Public Sector Information. *Mental Capacity Act 2005 paragraph 2(1)*. London: OPSI; 2005.
8. Office of Public Sector Information. *Mental Capacity Act 2005 paragraph 3(1)*. London: OPSI; 2005.
9. Department of Constitutional Affairs. *Mental Capacity Act Code of Practice paragraph 4.4*. London: Department of Constitutional Affairs; 2007.
10. Department of Constitutional Affairs. *Mental Capacity Act Code of Practice paragraph 4.38*. London: Department of Constitutional Affairs; 2007.
11. Office of Public Sector Information. *Mental Capacity Act 2005 paragraph 1(5)*. London: OPSI; 2005.
12. Ripley S, Jones S, Macdonald A. et al. Capacity assessments on medical in-patients referred to social workers for care home placement. *The Psychiatrist* 2008;32:56-59.
13. Zusack SJ, Peisah C, Ferguson A. A collaborative approach to supporting communication in the assessment of decision making capacity. *Disability & Rehabilitation* 2016;38(11):1107-1114.

14. Office of Public Sector Information. Mental Capacity Act 2005 paragraph 3(2).
London: OPSI; 2005.
15. Emmett C, Poole M, Bond J, Hughes, JC. 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* 2013;36:73-82.
16. Williams V, Boyle G, Jepson M, Swift P, Williamson T, Heslop, P. Best interests
decisions: professional practices in health and social care. *Health & Social Care in
the Community* 2014;22:78-86.
17. Shah A, Banner N, Heginbotham C, Fulford B. The early experience of Old Age
Psychiatrists in the application of the Mental Capacity Act 2005: a pilot study.
International Psychogeriatrics 2010;22:147-57.
18. House of Lords. Mental Capacity Act Post-Legislative Scrutiny. HL 139, 2014.
London: HMSO; 2014.
19. Hammersley M. What's wrong with ethnography? London: Routledge; 1992.
20. Murphy E, Dingwall R, Greatbatch D, Parker S, Watson P. Qualitative research
methods in health technology assessment: a review of the literature. *Health
Technology Assessment* 1998;2(16).
21. Kitzinger J. Focus Groups. In: Pope C, Mays N, editors. *Qualitative Research in
Health Care*. 3rd ed. Oxford: Blackwell; 2006. p 21-31.
22. Morgan, D. *Focus Groups As Qualitative Research*. 2nd ed. Newbury Park, CA: Sage
Publications Ltd; 1997.
23. Mason, J. *Qualitative researching*. 2nd ed. London: Sage Publications Ltd; 2002.
24. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman
A, Burgess, A, editors. *Analysing Qualitative Data*. London: Routledge; 1994. p 173-
94.

25. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology* 2013;13:117. <http://www.biomedcentral.com/1471-2288/13/117>. Accessed 2015 Jan 06
26. Lincoln YS, Guba EG. *Naturalistic inquiry*. Newbury Park, CA: Sage, 1985.
27. Donovan J, Sanders C. Key issues in the analysis of qualitative data in health services research. In: Bowling A, Ebrahim S, editors. *Handbook of Health Research Methods*. Maidenhead: Open University Press; 2005. p 515-32.
28. Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information* 2004;22:63–75.
29. Silverman D. *Doing qualitative research: a practical handbook*. 2nd ed. London: SAGE; 2005.
30. Alzheimer's Society [Internet]. This is me [cited 2015 Jan 12]; Available from: <https://www.alzheimers.org.uk/thisisme>
31. Folstein MF, Folstein SE, McHugh PR. "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research* 1975;12(3):189–98.
32. Ramasubramanian L, Ranasinghe N, Ellison J. Evaluation of a structured assessment framework to enable adherence to the requirements of Mental Capacity Act 2005. *British Journal of Learning Disabilities* 2011;39:314-20.
33. Linn K, Sayer C, O'Connor G, Magee T. Reflections on mental capacity assessments in general hospitals. *BMJ Case Reports* 2013 [online] doi:10.1136/bcr-2012-008538 <http://casereports.bmj.com/content/2013/bcr-2012-008538.long> Accessed 2014 Mar 21
34. Scope 2009 *A Long Road to Travel: The impact of the Mental Capacity Act on Adults with Complex Needs in Residential Settings*.

<http://www.scie.org.uk/publications/mca/files/longroadtotravel.pdf> Accessed 2014

April 24

35. Shah A, Banner N, Heginbotham C, Fulford B. The application of the Mental Capacity Act 2005 among geriatric psychiatry patients: a pilot study. *International Psychogeriatrics* 2009;21:922-30.
36. Guyver P, Hindle P, Harrison J, Jain N, Brinsden M. The Mental Capacity Act 2005: Review of mental capacity assessment in people with proximal femoral fracture. *The Psychiatrist* 2010;34:284-286.
37. Oldreive W, Waight M. Assessment of capacity: reflections from practice. *Learning Disability Practice* 2011;14:31-6.
38. Sorinmade O, Strathdee G, Wilson C, Kessel B, Odesanya O. Audit of fidelity of clinicians to the Mental Capacity Act in the process of capacity assessment and arriving at best interests decisions. *Quality in Ageing & Older Adults* 2011;12:174-9.
39. Shah A, Banner N, Newbigging K, Heginbotham C, Fulford B. The early experience of consultant psychiatrists in application of the Mental Capacity Act: issues for black and minority individuals. *Ethnicity and Inequalities in Health and Social Care* 2009;2:4-10.