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Jayes, M., Palmer, R. orcid.org/0000-0002-2335-7104 and Enderby, P. orcid.org/0000-0002-4371-9053 (2022) Evaluation of the MCAST, a multidisciplinary toolkit to improve mental capacity assessment. Disability and Rehabilitation, 44 (2). pp. 323-330. ISSN 0963-8288

https://doi.org/10.1080/09638288.2020.1765030

This is an Accepted Manuscript of an article published by Taylor & Francis in Disability and Rehabilitation on 23rd May 2020, available online: http://www.tandfonline.com/10.1080/09638288.2020.1765030.

Evaluation of the MCAST, a multidisciplinary toolkit to improve mental capacity assessment

Purpose: To evaluate the usability and acceptability of the Mental Capacity Assessment Support Toolkit (MCAST) in healthcare settings and whether its use was associated with increased legal compliance and assessor confidence.

Materials and Methods: A mixed methods convergence triangulation model was used. Multidisciplinary professionals used the MCAST during mental capacity assessments for UK hospital patients with diagnoses of stroke or acute or chronic cognitive impairment. Changes in legal compliance were investigated by comparing scores on case note audits before and after implementation of the MCAST. Changes in assessor confidence and professionals' perceptions of the MCAST's usability and acceptability were explored using surveys. Patients' and family members' views on acceptability were determined using semi-structured interviews. Data were integrated using triangulation.

Results: 21 professionals, 17 patients and two family members participated. Use of the MCAST was associated with significant increases in legal compliance and assessor confidence. Most professionals found the MCAST easy to use and beneficial to their practice and patients. Patients and family members found the MCAST materials acceptable.

Conclusions: The MCAST is the first toolkit to support the needs of individuals with communication disabilities during mental capacity assessments. It enables assessors to deliver high quality, legally compliant and confident practice.

Keywords: cognition disorders, communication disorders, decision making, informed consent, mental competency, neurological rehabilitation.

Introduction

Mental capacity assessment is common in rehabilitation settings, where many patients have life-long or acquired neurological or mental health conditions. These conditions can affect patients' ability to consent to medical and care interventions and make other decisions about their health and living arrangements. Jurisdictions across the world use different legal frameworks to establish whether individuals have decision-making capacity [1]. In England and Wales, the Mental Capacity Act (MCA) [2] defines a process for assessing decision-making capacity for people over the age of 16 years and requires health and social care professionals to provide support with decision-making (e.g., communication support) if individuals require this.

Current mental capacity assessment practice needs to be improved to maximise patient autonomy, safety and well-being [3]. Professionals need evidence-based tools to improve their practice [4]. Current practice is not always time-efficient, rigorous or legally compliant [5]. Professionals find mental capacity assessment challenging because it involves complex, subjective judgements and there are no accepted, standardised assessment tools [6,7]. Poor practice risks service providers receiving legal challenges, financial penalties and inferior ratings by regulatory bodies [8].

The Mental Capacity Assessment Support Toolkit (MCAST) was developed to support multidisciplinary healthcare professionals to carry out high quality, MCA-compliant mental capacity assessments. It was designed to be used specifically with patients with a diagnosis of stroke and/or cognitive impairment in acute hospital and intermediate care settings. Uniquely, the MCAST was designed to enable professionals to identify and support the needs of individuals with communication disabilities during capacity assessments. Currently, this clinical population may not be adequately supported to make decisions during capacity assessments [9,10].

Here we report a mixed methods study that aimed to evaluate the feasibility of using the MCAST in healthcare settings. To our knowledge, the MCAST is the only resource developed to support the needs of patients with communication disabilities during capacity assessments that has been evaluated in practice. We evaluated the toolkit's feasibility by investigating: i) its impact on practice, in terms of its effect on compliance with legal standards and on how confident professionals felt about their practice; ii) its usability, the extent to which users considered it to be useful and easy to use [11]; and iii) its acceptability, the degree to which users judged it to be "agreeable, palatable, or satisfactory" [12,p.67].

The specific research questions were:

(1) Does use of the MCAST increase compliance with the Mental Capacity Act (2005)?
(2) Does use of the MCAST increase professionals' confidence levels when assessing mental capacity?
(3) Do professionals find the MCAST useable and acceptable?
(4) Do patients and family members find the MCAST acceptable?

Method and Materials

Development of the MCAST

The MCAST's development was informed methodologically by user-centred design (UCD) principles [13], co-production techniques [14] and the UK Medical Research Council (MRC) framework [15] for developing and evaluating complex interventions. A content and design specification for the MCAST was based on the findings of a review of evidence and case law [16] and a qualitative study which explored healthcare professionals' experiences of mental capacity assessment and their support needs [17]. Successive iterations of toolkit materials were designed, reviewed and tested collaboratively with healthcare professionals, service users and their family members and experts in UCD and mental capacity law and practice [18,19].

A prototype toolkit of paper-based materials was created. This comprised: i) a Support Tool, designed to support professionals to prepare, complete and record a capacity assessment in line with legal requirements; ii) a Communication Screening Tool, designed to support professionals to identify and support patients with communication difficulties during a capacity assessment; iii) a Resource Pack, comprising simple language and photographic materials that professionals could use to support patients with communication disabilities to engage in conversations about decisions relating to their health, care and living arrangements. Examples of the MCAST materials are available in Appendices A1-3, published as supplemental online material.

Evaluation study design

A mixed methods convergence triangulation design was adopted [20]. Different data collection methods were used to generate data that were analysed separately and then integrated to inform the answers to all research questions (RQs). Table 1shows these different data collection methods and how these map onto the research questions. The design was informed by a subtle realist epistemology, which means that the researchers acknowledged that the research process was subjective and data were socially constructed from the underlying reality [21]. Ethical approval was obtained from the Bradford Leeds NHS Research Ethics Committee (15/YH/0468). The study took place within two acute hospitals and four nursing homes providing intermediate care services in a large city in the north of England.

Table 1 here

Participant recruitment

Three participant groups were recruited: healthcare professionals, healthcare patients and patients' family members. We targeted the following professional disciplines: liaison psychiatrists, nurses, occupational therapists, physicians, physiotherapists, psychologists, speech and language therapists and social workers. Eligible patients were identified by professional participants. Patients with diagnoses of stroke and/or cognitive impairment were included. Patients with visual difficulties that prevented them from seeing the MCAST materials and those who required information to be provided in a language other than English were excluded. Patients were also excluded if they needed an urgent capacity assessment, because the data collection process might have prevented this. Family members were identified by patient or professional participants to participate in acceptability interviews if the patient requested this or lacked capacity to consent to participate.

All professional and family member participants provided written informed consent after reading written information about the study. We gave patients an accessible participant information sheet and used communication strategies to support them to understand what participation in the study would involve. If a patient was not able to give informed consent, but appeared willing to participate, their family member was invited to complete a consultee declaration [2] to confirm that they were satisfied that the patient wanted to participate.

Data collection

Following recruitment, professional participants attended a 45 minute training session, during which they learned about the MCAST, patient identification and data collection procedures. In order to obtain a baseline measure for legal compliance of assessments for the period prior to the introduction of the MCAST (T1) (RQ1), we asked professional participants to identify the records of up to three capacity assessments they had carried out in the twelve-month period before their recruitment to the study. We selected one of the three assessments at random for each participant. The first author audited the assessment record in the patient's clinical notes using the British Psychological Society audit tool [22] at the end of the data collection period. This tool enabled us to score aspects of the assessment process and its documentation numerically against quality standards in order to obtain a composite score for each assessment (maximum score 86).

We also asked professional participants to complete an anonymous questionnaire in order to obtain a baseline measure of their reported level of confidence in their ability to assess capacity before they used the MCAST (RQ2). The paper questionnaire instructed respondents to tick a box on a four option rating scale corresponding to a written statement that best described how confident they felt at that moment about assessing mental capacity. Each statement corresponded to a numerical score from 1 ("not confident at all") to 4 ("very confident"). The questionnaire also asked respondents to use a free text box to explain why they chose this rating.

We invited professional participants to use the MCAST materials to plan and complete mental capacity assessments for at least two different patients who required them within their clinical locality during a six month data collection period. These assessments were not observed by the researchers but we collected the completed MCAST Support Tool and Communication Screening Tool proformas to inform our assessment of their usability (RQ3). The first author completed a documentary analysis of the completed proformas and recorded observations relating to how participants had completed each section. When professional participants had used the MCAST materials to compete at least two mental capacity assessments, they were invited to continue using the toolkit for up to two months or until the end of the six-month data collection period (whichever was earlier). We did not collect proformas for these assessments.

At the end of the data collection period (T2), we asked professional participants to identify the records of up to three mental capacity assessments completed between T1 and T2. The first author audited one of the three assessments at random using the British Psychological Society audit tool [22] (RQ1). The first author audited T1 and T2 assessments at the same time and was not always blinded to the order in which the assessments had taken place. We also asked professional participants to complete a second copy of the confidence questionnaire (RQ2) and an anonymous online usability-acceptability questionnaire (RQ3). We developed the questionnaire using SurveyMonkey® software. Its content was informed by data collected in the earlier qualitative study, which explored healthcare professionals' practice support needs [17]. It included multiple-choice questions, open questions and rating scales relating to the MCAST materials' ease of use, usefulness and their perceived impact on patients and capacity assessment outcomes, including assessor confidence. The survey questions are available in Appendix A4, published as supplemental online material.

We invited patients to participate in a semi-structured interview in order to collect data relating to the acceptability of the MCAST's patient-facing materials (RQ4). We also invited family members to participate if the patient requested this or if a family member had completed a consultee declaration during the informed consent process. We conducted these interviews as soon as practicable after the patient had been assessed by a professional participant using the MCAST. Interviews were audio recorded with consent, using a digital recorder. A topic guide was developed to collect data about patients' experience of being assessed using the MCAST. A set of inclusive communication resources were created to support patients with communication difficulties to participate in the interviews; these resources included written versions of interview questions in simplified language formats and accessible rating scales designed to enable patients to indicate their responses non-verbally to questions.

Data analysis

Consistent with the mixed methods convergence triangulation design [20], we completed analyses of quantitative and qualitative data separately before integrating them to enable interpretation of the results in relation to the individual research questions.

Quantitative audit score (RQ1) and confidence rating data (RQ2) collected before and after use of the MCAST were analysed using the Wilcoxon signed-rank test for non-parametric data. Responses to multiple-choice and rating scale questions on the usability-acceptability questionnaire (RQ1-3) were analysed using frequency counts.

Qualitative data from the confidence questionnaire, usability-acceptability questionnaire and patient and family member interviews (RQ1-4) were transcribed verbatim into separate Microsoft Word files. Each Word file was imported into QSR NVivo 9 software to aid thematic analysis using a Framework approach [23]. Themes were generated deductively from the research questions and inductively from open data coding [24].

Integration of the entire dataset enabled us to increase the knowledge yield of individual data collection methods and obtain more comprehensive answers to the research questions [25]. Data were integrated using methodological and data triangulation [26]. We used a triangulation protocol [27] to facilitate integration.

Results

Participants

Twenty-one professional participants were recruited: 20 females and one male. Individual participant characteristics are shown in table S1 published as supplementary online material. Five different professional groups were represented in the sample: physicians (n=3), nurses (n=1), occupational therapists (n=10), physiotherapists (n=2) and speech and language therapists (n=5). Participants worked in a range of acute hospital contexts and or in multidisciplinary intermediate care teams providing rehabilitation. Participants had worked in their professional role for between three and twenty-four years (median 10 years). The majority of participants (n=17) had received general training in mental capacity assessment from their employer. Five participants had received additional training within their multidisciplinary team, two had observed colleagues completing capacity assessments and three had attended professional conferences or taught courses that focused on capacity assessment. One participant had received no formal training.

Seventeen patients were recruited to the study: nine males and eight females. Participant characteristics are presented in table S2 published as supplementary online material. Participants' ages ranged from 48 to 93 years. Six individuals had a diagnosis of acute stroke whilst one participant had had a stroke prior to this episode of care. The other ten participants had diagnosed cognitive difficulties, due to sub-arachnoid haemorrhage (n=3), diagnosed or suspected dementia (n=6), or a reported history of memory impairment (n=1). Participants were recruited from a range of clinical settings, including acute and intermediate care stroke services (n=6), an inpatient post-acute neuro-rehabilitation unit (n=3) and an acute hospital dementia unit (n=2). Six participants were able to provide informed consent, whilst family members provided a

Consultee Declaration for the remaining 11 participants. Four participants took part in an acceptability interview (P01, P04, P08, P17). We recruited the spouses of two other patient participants (P14, P15) to take part in interviews.

Most capacity assessments completed using the MCAST related to decisions about choice of residence or care arrangements on discharge from hospital (n=15). In the other two cases, the decisions related to consenting to inpatient rehabilitation and to a Percutaneous Endoscopic Gastrostomy (PEG). Twelve participants were found to lack mental capacity to make the specified decision, whilst three were found to have capacity. Capacity assessment outcome data were not available for two participants because the professional participant did not complete the planned assessment.

Effect on compliance with the MCA (RQ1)

Audit scores are shown in table 2. It was only possible to audit mental capacity assessments at both T1 and T2 for 10 of 21 professional participants. Three participants had not completed capacity assessments by T2 and four did not identify patient records to be included in the audit. We were unable to locate six mental capacity assessment records in patient notes (four at T1, two at T2). Assessments completed at T1 and T2 involved similar types of patient decision (e.g., relating to care and discharge arrangements).

Table 2 here

The mean audit score increased from 51/86 (range 42-68) at T1 to 68/86 (range 51-83) at T2 and this difference was significant (Z = -2.703, p=0.007). This indicated that these professional participants' documented assessments were more consistent with the requirements of the Mental Capacity Act (2005) [2] when they used the MCAST. This positive outcome was supported by themes arising in the qualitative data collected in the confidence and usability-acceptability surveys. Professional participants suggested that using the MCAST enabled them to complete higher quality assessments that were more thorough and patient-centred:

> I feel like I understand better how to prepare for an assessment to ensure the patient is fully supported. (E004)

> It provided a structured approach ensuring capacity is thoroughly assessed (anon)

Participants reported that use of the MCAST ensured that those with communication disabilities were given more support to understand information and demonstrate their mental capacity, as required by law:

> [the MCAST] prompted us to check we had covered all the vital elements of communication required to support a patient during the assessment process. (anon)

> I think it made me think about my communication and process leading up to the capacity assessment in more detail to ensure best practice. (anon)

Two respondents reported that using the MCAST enabled them to document their assessments more effectively. They commented:

> [The MCAST] would be a really reliable way of recording a capacity assessment and decision (anon)

> The forms are very useful for recording the outcome and enabling the assessor to provide clear documentation and feedback for the rest of the MDT. (anon)

Effect on professional confidence (RQ2)

Confidence survey scores are shown in table 3. We were able to compare confidence rating scores at both T1 and T2 for 17 of 21 professional participants. Four participants did not complete the questionnaire at T2.

Table 3 here

Quantitative data collected from the confidence survey indicated that professionals felt significantly more confident when they used the MCAST (Z = -2.646, p=0.008). The majority of respondents (12/18) to the usability-acceptability survey reported that using the MCAST helped them to feel more confident. Qualitative data from the confidence and usability-acceptability surveys indicated that professionals associated enhanced confidence with specific benefits provided by the MCAST: increased assessment structure, an improved ability to prepare, carry out and record assessments and a greater awareness of the needs of patients with communication difficulties:

> I think using the MCAST has helped me prepare better for capacity assessments and think about different aspects…much more than I would have done before. Therefore, I think I'm now doing better assessments and feel more confident doing them and more confident that I'm coming to the right conclusion. (E009)

> I feel that before using the MCAST I rushed into a capacity assessment without doing the necessary preparation which should really have been done. It is the extra preparation which helped with the confidence and allowed me to think about exactly what I was trying to achieve. (anon)

Usability (RQ3)

Most professionals appeared to find the toolkit useful. 17/18 respondents to the usability-acceptability survey reported that using the MCAST helped them to assess capacity. Qualitative survey data confirmed this result: respondents reported that using the toolkit helped them to prepare, structure and document assessments and to work with patients with communication difficulties. Several individuals suggested that the MCAST might be particularly beneficial to more junior members of staff with less experience of capacity assessment. This might be because respondents indicated that using the toolkit made the assessment process easier:

> Using the MCAST helped me feel much better prepared and made the assessment easier. The communication tool prompted me to use tools/resources I wouldn't have before which again made the assessment process easier. (E015)

All respondents to the usability-acceptability survey indicated they found each component of the toolkit easy to use. Professionals associated the toolkit's ease of use with the clarity of its instructions and layout. For example, respondents described the Communication Screening Tool as:

> [a] logical, step by step, clearly explained sequence of assessments. (anon)

> Clearly set out for people without a background in speech/language (anon)

Some professional participants were able to suggest minor changes to the content and design of the Support Tool to make it easier to use:

> Making the arrows/instructions clearer as to which part to look at next (anon)

> Perhaps slightly more space to write the assessment in (anon)

Our documentary analysis of completed MCAST proformas found supporting evidence that these documents might benefit from minor refinements to make them easier to use. For example, certain professionals did not complete all required sections of the Support Tool and others completed unnecessary sections of the Communication Screening Tool. It was also noticeable that some participants did not have enough space to record their responses to specific questions on the Support Tool.

Importantly, professionals appeared to want to use the MCAST. When asked in the usability-acceptability survey how often they thought they would use the MCAST in future capacity assessments (i.e., after the study had ended), 10/18 respondents chose the response "often", whilst 8/18 chose "sometimes". When asked in the same survey how helpful it would be for staff to be able to use the Support Tool to document their assessments in patient records, 16/18 respondents selected the response “very helpful” and 2/18 chose “quite helpful”.

Acceptability (RQ3, RQ4)

No professionals expressed any concerns that use of the MCAST had a negative impact on patients. Most professionals appeared to find that the time taken to use the MCAST was acceptable. 11/18 respondents to the usability-acceptability survey suggested that capacity assessments took the same or less time when they involved the MCAST, whereas 7/18 respondents reported they took more time than they would normally. Qualitative data collected in the usability-acceptability survey indicated that for 2/7 participants, unfamiliarity with the MCAST materials contributed to the additional time required to complete assessments:

> …was because I was less familiar with using the tool. With routine use would become faster. (anon)
>
> I wasn't overly familiar with the paperwork (anon)

Most professionals (5/7) who took longer felt that the additional time was justified because the quality of their assessments was superior:

> It’s probably a good thing. I think it’s taking longer because I’m doing a better and more thorough assessment (anon)
>
> The longer time was useful preparation (anon)

In contrast, one professional participant suggested that the additional time required to use the toolkit impacted negatively on efficiency:

> I'm the only OT on a busy ward, so time-management has a massive impact – the tool is good to remind ourselves of the process, but in terms of completing the assessment, it was quicker without (anon)

All patients and family members appeared to find the MCAST processes and materials acceptable. The husband of a woman with severe dementia (P14) commented that he thought it was acceptable to use the Communication Screening Tool with people like his wife but recognised that she might not be able to complete many of its tasks: "…there's no objection to me with trying but I can't see as if she'll realise what you're doing or understand." (C02). Similarly, patients and family members reported that they did not object to professionals using communication strategies suggested by the Screening Tool or items from the Resource Pack to support patients during mental capacity assessments. One patient participant (P04) indicated that he had found it helpful when a speech and language therapist (E004) had written key information down to help him understand decision options during his capacity assessment. Another patient participant (P17) commented: "…it doesn't offend me or anything", when asked what he thought about staff using the Resource Pack photograph cards to explain important information. No patients or family members interviewed reported finding any of the photographic images from the Resource Pack offensive or distressing but acknowledged that some patients might.

Discussion

Our findings suggest that professionals completed assessments that were more compliant with the MCA when they used the MCAST. This is an important result because the MCAST was developed in response to an identified need to improve the quality of capacity assessments [5,28]. It could be argued that a capacity assessment record is merely a proxy measure for the quality of the actual assessment; however, it is on the basis of documentation content that assessment quality is currently judged by healthcare regulators and legal experts. Our finding is consistent with two other UK studies that reported improvements on a capacity assessment case note audit following the introduction of assessment guidance and documentation aids [29,30]. We associate the observed improvements in documentation in our study with participants' reports that the MCAST enabled them to prepare more thorough, structured and person-centred assessments and included explicit prompts regarding what to record on the Support Tool.

The findings also indicate that professionals felt more confident about their ability to assess capacity when they used the MCAST and they associated their feelings of increased confidence with specific benefits provided by the toolkit. This is a positive outcome because professionals have reported that they lack confidence in their ability to assess capacity, particularly for certain patient groups (e.g., people with communication difficulties) [17,31]. Our finding is consistent with the results of a qualitative investigation of social care professionals' experiences of capacity assessment; these professionals also associated increased feelings of confidence with the use of capacity assessment resources such as documentation proformas [32].

The findings demonstrate that the MCAST has high levels of usability and acceptability, which should facilitate its future implementation. A small number of content and design refinements should be made to the Support Tool and Communication Screening Tool proformas to increase their ease of use. When the prototype design has been optimised, it will be important to establish that the MCAST enables professionals to make valid and reliable judgements about people's mental capacity. Inter-rater reliability could be investigated by comparing judgements obtained by two or more assessors when they have used the MCAST. Measurement of validity would be more challenging due to the absence of an accepted gold standard method to serve as a criterion variable [33]. Mental capacity assessment tools developed in other jurisdictions have used capacity judgements made by expert assessors (e.g., psychiatrists) as criterion variables [34].

The main limitation of this study was its uncontrolled design, which means that we cannot infer a causal relationship between use of the MCAST and the observed outcomes. A further limitation relates to composition of the professional sample. Despite attempts to recruit them, social workers, psychologists and psychiatrists were not represented; these disciplines were involved in the development of the MCAST and are often involved in capacity assessment [17]. It will be essential to identify effective ways to recruit these groups in a future evaluation study. We did not recruit any black and minority ethnic people as study participants or to our Public, Patient and Care Involvement group; this means that we cannot be sure that the MCAST is usable with and acceptable to this population. Furthermore, it is possible that professional participants selected mental capacity assessments to be included in the audit (RQ1) that they judged to be of superior quality. This may have introduced bias to the data collection process. However, if participants behaved in the same way at both T1 and T2, it is likely that any effects of this bias were reduced.

The MCAST is a unique resource because it supports professionals to complete high quality, legally compliant mental capacity assessments that are responsive to the needs of people with communication disabilities. This evaluation demonstrates that the MCAST is usable and acceptable and has the potential to make an important contribution to mental capacity assessment practice. In future, the MCAST could be adapted for use with different populations and in different contexts. Although the prototype was designed to be used with stroke survivors and people with acute or chronic cognitive and communication disabilities, it might also feasibly be used with people with learning disabilities or mental health conditions. Similarly, although the toolkit was developed for use in acute hospital and intermediate care settings within England and Wales, this does not preclude its adaption for use in other rehabilitation contexts and jurisdictions around the world.

Word count: 4340 words

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Data collection method / RQ	Documentary Analysis T2	Case note audit T1 & T2	Confidence Survey T1 & T2	Usability-acceptability Survey T2	Patient / family member interviews T2	Reflective journal / field notes T2
1. Does use of the MCAST increase compliance with the MCA?	Qualitative: researcher review of completed MCAST proformas.	Quantitative: numerical audit score.	Qualitative: participant responses to an open question.	Qualitative: participant responses to open questions.	------	Qualitative: researcher observations and reflections.
2. Does use of the MCAST increase professionals' confidence levels when assessing mental capacity?	------	------	Quantitative: numerically scored response to a rating scale question. Qualitative: participant responses to an open question.	Quantitative: frequency counts for participant responses to a multiple-choice question. Qualitative: participant responses to open questions.	------	Qualitative: researcher observations and reflections.
3. Do professionals find the MCAST useable and acceptable?	Qualitative: researcher review of completed MCAST proformas.	------	Qualitative: participant responses to an open question.	Quantitative: frequency counts for participant responses to multiple choice and rating scale questions. Qualitative: participant responses to open questions.	Qualitative: participant responses to open questions.	Qualitative: researcher observations and reflections.
4. Do patients and family members find the MCAST acceptable?	------	------	------	Qualitative: participant responses to open questions.	Qualitative: participant responses to open questions.	Qualitative: researcher observations and reflections.

Table 1: Mapping of data types and data collection methods to research questions (RQs)

Table 2. Case note audit data

Professional participant identifier	**Audit score T1**	**Audit score T2**
E001	46	59
E003	43	72
E004	44	67
E005	55	No data provided
E006	68	83
E007	42	Unable to locate data
E008	47	66
E009	Unable to locate data	51
E010	Unable to locate data	No assessments completed
E011	49	No assessments completed
E013	68	60
E014	55	75
E015	60	No data provided
E016	46	No data provided
E017	45	61
E018	Unable to locate data	No data provided
E020	51	71
E021	Unable to locate data	57
E022	57	Unable to locate
E023	57	No assessments completed
E024	43	70

NB Audit score min=0, max=86

Table 3. Confidence survey data

Professional participant identifier	**Confidence score T1**	**Confidence score T2**
E001	3	3
E003	3	4
E004	3	3
E005	4	4
E006	3	4
E007	3	No data provided
E008	3	No data provided
E009	3	3
E010	3	4
E011	3	3
E013	3	4
E014	3	3
E015	3	3
E016	3	No data provided
E017	2	3
E018	2	No data provided
E020	3	3
E021	3	4
E022	3	3
E023	3	3
E024	2	3

NB Correspondence of survey scores to survey written statements:

1: “not confident at all”

2: “not too confident”

3: “fairly confident”

4: “very confident”