

Care England Mental Capacity Act Implementation Survey: Report

Care England collected a total of 84 responses from care home managers to look into how successfully the Mental Capacity Act (MCA) was being implemented on the front line of residential care.

Respondents answered questions on the five principles of the MCA, and the questions asked how well they lead and supported their staff teams to understand and enact these principles.

It is necessary to say that the respondents to this survey could be, to some extent, a self-selecting group. By this, Care England acknowledges that these findings may not represent the full range of experiences of MCA implementation in social care settings.

The largely positive response to this survey is encouraging, but suggests that mainly those who are already confident in MCA implementation have come forward to respond to this survey. The survey asked tough questions about leadership, understanding and the respect of service users' rights under the act: it is probable that those care home managers who were not confident in their responsibilities under the act would have avoided such a challenging survey.

However, this is not to denigrate the survey's purpose or scope: managers showed varying approaches and practice around the MCA, and this survey's results give a strong indication of the problems faced when trying to give and manage care-giving in accordance with the MCA.

The following report explores the responses to the 12 questions we asked care home managers.

Question 1: Local Authority area

We surveyed managers of care homes across at least 50 local authorities (not including those that worked across multiple local authorities).

Question 2: Service user group

Respondents' main service user group was divided as follows:

- Care for older people with dementia = 51.19% = 43 respondents
- Care for adults with learning disabilities = 35.71% = 30 respondents
- Care for adults with acquired brain injury = 3.57% = 3 respondents
- Care for adults with a mental health problem = 15.48% = 13 respondents
- Care for adults with neurological conditions = 5.95% = 5 respondents
- Other = 22.62% = 19 (nursing, residential, combinations of the above) respondents

Question 3: How do you support your staff to understand that a resident or service user must be assumed to have capacity, unless it is proved otherwise?

Responses to this question listed a number of ways that managers supported staff to understand the first principle of the act. This list shows the methods managers used, and the number of managers who used this method:

- MCA Training = 78/84
- 1-2-1 discussion/ supervisions = 21/84
- Team meetings = 14/84
- Group discussion = 12/84
- Literature/ resources available = 12/84 [In-house library of information; MCA toolkits; MCA leaflets; Easy-format MCA forms; sharing emails and articles; guidance documentation; staff updates; care plan documentation]
- Leading by example/ mentoring/ coaching = 10/84
- Through processes [i.e. care planning/ Best Interest meetings/ capacity assessments]: 10/84
- Verbal instruction/ information giving = 8/84
- ELearning = 7/84
- Displaying information [posters] = 6/84
- Induction = 6/84
- Handovers = 6/84
- Workshops = 2/84
- Through overseeing the Care Certificate: 1/84
- By using case studies = 1/84

Care England is surprised at the relatively low numbers of managers using really good methods for implementation [i.e. everything except “training”]. These other methods [discussion 1:1 and in groups, good processes, posters, workshops, making sure staff give people time to understand and make decisions] are valuable and other care home managers should consider adopting them in their daily workings where they can.

There were some answers to this question that exhibited what might be considered ‘good practice’:

The most exciting responses to this question included a range of approaches to implementing the MCA, which complimented each other and took into account staff members’ differences in communication styles and strengths.

- Some managers used coaching to help staff understand the MCA:

“All staff undertake a four day initial training, followed up with care coaching and this training is repeated annually. We also have dementia champions and a high volume of dementia friends within the team.”

This manager linked the MCA to general good practice and dementia-awareness, and evidently sees proper MCA implementation as part of having a good culture as a care home.

- Some of the best responses to this question acknowledged that MCA training was not enough in itself, and that the MCA principles must be embedded in the core of their work:

“MCA training provided to all staff, always part of everyday decision making and conversations, discussed regularly and BI process implemented where necessary...”

- *“I always say to the staff team that everyone has capacity unless it is proven otherwise no one has the right to say that you don’t have capacity until all avenues have been explored.”*

This manager shows good, thorough understanding of what capacity means.

- *“MCA training. Discussions at team meetings. Going over the 5 principles. MCA documentation. Company Policies and Procedures. Posters around the home.”*

This manager, among other things, displays posters for staff to remind them about the MCA.

- *“Staff training through assessments. Observation one to one discussions. Through capacity assessments ensuring they involve service user. Allow service user time.”*

This manager emphasised the importance to allow service users time. This is relevant in both assessing capacity, and making day to day decisions about their lives.

- *“All staff to attend MCA/DOLS training 2. Mental capacity assessment by qualified staff, and outcome discussed with resident, family and relevant staff 3. regular review of mental capacity as the health condition of resident deteriorates”*

This manager emphasised the importance of involvement of family and friends and an awareness that capacity status can change as their health and mental health status changes.

- *“MCA training provided to all staff, always part of everyday decision making and conversations, discussed regularly and BI process implemented where necessary”*

This manager emphasised the importance of building the MCA into everyday conversations and decision-making processes, which is likely to help turn law into practice.

- *“I am a Best Interest Assessor and discuss capacity regularly at staff meetings”*

This manager also found it useful to discuss issues of capacity regularly, using staff meetings to raise this important issue. This shows that some care providers are trying to integrate the MCA into the daily working lives of staff.

- Several responses to this question said that the MCA and/or considerations of capacity were part of “care planning.”

It is really great to see answers that recognise MCA awareness belongs at every stage, and should be built into all aspects of care planning.

Some answers didn't demonstrate 'good practice' or full understanding of the MCA:

- "... Support people to make informed choices. Support people who have made poor decisions to learn from that and change direction or to live well with the consequences (e.g. of smoking, etc.) Real discussions about capacity vs making an unwise decision."

This manager, while having potentially useful conversations with service users about their decisions and what might be considered a wise decision (which would be appropriate, perhaps, if working with adults with a learning disability) demonstrates perhaps too heavy a judgement, where the principle of "unwise decisions" states that a care worker's judgement of "unwise" should be divorced from the services user's capacity to make a decision.

- This answer demonstrates that even those managers with the most training (this Manager was a Best Interests Assessor) and with the most confidence in their understanding of the MCA (this manager answered 'confident' in identifying and minimising restraint) can misunderstand fundamental principles of the MCA and misinterpret their duties as regards the act (the duty in this case being to support people to make decisions, even if you consider them unwise, not to judge 'poor' decisions and then encourage the service user "to learn from that and change direction or to live well with the consequences").

Many answers to this question said simply "MCA training".

While training is an important starting point for creating a care team who understand and use the MCA on a daily basis, MCA awareness should not just be confined to training days, but must be embedded in every day practice. For example, this answer captures a range of techniques that are designed to embed a theoretical understanding of the MCA, and a daily, practical understanding:

"Formal training, supervision and day to day support"

- The following answer is an example of a home with a thorough training schedule, but no reflection on how the manager supports staff to embed the MCA into their practice:

"Staff attend in-house training, namely; Mental Capacity Act - In Practice which looks at how said Act affects day to day practice and the Mental Capacity Act five principles. However in answer to your question principles 1 - 3 focus on assuming capacity and decision making e.g. Principle 1: A presumption of capacity 2: Individuals being supported to make their own decisions 3: Unwise decisions."

Question 4: How do you ensure that your staff support a person to make their own decisions as much and as far as is possible?

Responses to this question listed a number of ways that managers supported staff to support service users to make their own decisions where possible. This list shows the methods managers used, and the amount of managers who used this method:

- MCA Training = 26/84
- Care Planning = 20/84

- Including residents in decisions/choice/ethos of the home = 20/84 [1 respondent had service user 'involve me' forms]
- Supervisions = 19/84
- Observation = 16/84
- Team meetings = 13/84 ['regular team meetings with MCA on the agenda' 'discussed with regard to approach and consistency']
- Communication focus and communication aids use = 8/84
- Documentation = 7/84
- 1-2-1 discussion = 7/84
- Handover = 6/84
- Mentoring = 4/84
- Residents/relatives meetings = 3/84
- Role models/leading by example = 3/84
- On-the-job training = 3/84
- Information sharing = 2/84
- Group discussion = 2/84
- Promoting this among staff and home culture = 2/84
- Dignity training = 1/84
- Ensuring training is 'utilised properly' = 1/84
- By following MCA = 1/84
- Key Worker system = 1/84
- Dignity audits = 1/84
- Advocacy = 1/84
- Staff updates = 1/84

There were some answers to this question that exhibited what might be considered 'good practice':

Many care home managers had very good strategies to support a person to make their own decisions as much and as far as is possible, including:

- *"By including the resident in all the decision making processes in all areas of the daily living, including planning their care."*
- *"Person centred care planning. Empowerment and staff to understand about risk assessment and the right to make unwise decisions."*
- *"(service users are) Encouraged to participate in all decisions by staff & ethos of home"*
- *"Training and ensuring that they give choice to our residents in their day to day life and by promoting independence in the way our care plans are designed."*
- *"We encourage our staff to give the service user as much independence as possible and to offer support when it is needed."*
- *"Working alongside, checking on staff's implementation and understanding." - This example shows good, engaged and hands-on management, leading by example.*
- *"Handover, Staff meetings, Supervision, In-house training, Annual Appraisal, and Care Planning e.g. the completion of MCA 1 forms."*
- *"To promote independence allow residents/ service users to do as much for themselves as they can. Staff to encourage them to make simple decisions i.e. what to wear, what to eat, where*

would they like to sit etc. (ensuring that staff) speak to the service user (and) Use the person centred approach.”

- “...Encourage and enhance experiences so that they are making real choices. Work on ways of communicating with people so that they can maximise their decision making capacity”
- “Each resident has a keyworker for one to one support.”
- “Mentorship by senior staff.”
- “Living the life goals...”

There are many mechanisms and ideas here to inspire other managers of care homes and care providers. For example, a home could start a mentoring scheme, write goals for each service user, assign keyworkers to each service user, involve services users in the running and life of a service, maximise opportunities to allow appropriate decision-making and lead by example in embedding the MCA into all aspects of daily care.

Some answers didn't demonstrate 'good practice' in support for staff or full understanding of the MCA:

Some answers said simply “MCA training”; as before, an over-reliance on initial or classroom training should be only one part of embedding the MCA into daily care.

Some respondents said that “making sure that they have a procedure to follow” would ensure this principle was observed and carried out. As some managers' responses demonstrate, and as current 'good practice' would suggest, good MCA implementation relies on more than having a procedure in place: staff should feel confident in supporting decision making in compliance with the MCA in everyday or lone-working scenarios.

Some answers listed one approach to this principle, such as “Observations” (of staff). The most exciting examples of good practice in MCA implementation, and the most promising approaches, took multiple approaches to communication of the act, from the classroom to caring, and via a range of communication methods.

Question 5: If a person in your care who has capacity makes a decision that others consider unwise, how do you support your staff to recognise the person's right to act as they choose?

There were some really excellent answers to this question, showing awareness of all the factors that must be taken into consideration in supported decision-making, such as:

- “By ensuring that the staff member understands that the person has been given all information in a format that they can clearly understand and are aware of the consequences of making that choice. As individuals we are all entitled to take risks and to experience new things.”
- “Re-visit the mental capacity act. Reflection. Scenarios shared.”
- “Discuss the individual situation with staff at the home, promote the principles of the MCA, build the decision into the care plan with detailed actions on how to minimise any risk to the customer whilst they are undertaking their chosen activity.”
- “As above we look at positive risk management and look at their abilities and then draw up a risk assessment or care plan to support this.”

Managers responded about their efforts to engage staff in thinking about their own lives and decisions to create empathy and understanding. Sharing scenarios and experiences seems a very promising way to engage staff in the MCA and its meaning. This approach promotes empathy and enables flexibility:

“I would encourage team members to think about their own lives and the decisions they make, may not always be a wise one, residents able to choose themselves if they have capacity.”

Where some were more fixed approaches, perhaps not protecting people’s rights in a change of circumstance

However, some answers to this question promoted concern:

- *“All of my staff promote people’s rights and understand the importance of this”*

It is great to see such confidence in staff, but this response does not necessarily suggest a learning culture in the home, where staff are constantly aiming for better practice.

- *“Our staff understand that a person who has capacity can make decisions and take chances”*

This comment suggests a misunderstanding of the principle of an ‘unwise decision’: taking a chance is about positive risk-taking, which is not always or necessarily the same thing as supporting someone to make an unwise decision.

- *“Staff seek advice from deputy manager who is a mental health nurse, or from home manager who is a gerontological nurse specialist.”*

While senior staff specialisms are very important, and good leadership is linked to quality in care homes, some respondents didn’t reflect in their answers that they knew that all staff, particularly those working closest and unsupervised with clients, should understand and enact this principle of the MCA.

- *“Yes we do, this can be very difficult at times”*

It would have been nice to know why this manager and service found this difficult, but it is very good to see that this respondent was not afraid to admit challenges, and great to encounter this level of honesty about MCA implementation: it suggests an open, learning culture.

- Again in answers to this question, there was some over-reliance on the remedy of classroom training, and indications that training was not as embedded into practice as it could be:

“Staff are trained to understand that we all make unwise decisions and are given the right to do so, staff are trained to support the SU to understand the risks regarding the their decision and where possible support the SU to minimise the risks.”

Some respondents said things like: “By reading the new Care act policy”. While familiarity with legislation is a good thing, this will not ensure that staff understand the difference between making an unwise decision and having a lack of capacity to make a decision, and a person’s rights to the former. This, and other answers, suggested confusion between existing pieces of legislation.

- There was a stark contrast between those respondents that understood the principle of 'unwise decisions', and those that did not:

"By Assisting, promoting independence, Explain other choices and why it may be unwise to do certain things at certain times and in certain places."

This manager has possibly not understood the principle of unwise decisions as per the MCA.

"Staff understand that everyone has different perspectives of wise and unless the person is causing himself or others danger or harm an unwise decision is respected."

This manager has clearly understood the principle of unwise decisions as per the MCA.

Question 6: How do you support your staff in understanding and making best interests decisions?

There were some examples of good strategies and practice as regards making best interest decisions (BIDs):

- *"Again this is down to training and in particular the care coaching element of this training, where we work alongside the carer worker in the care environment."*
- *"By training our staff and reviewing each case individually, carrying out Best Interests Decision Making meetings and following up with risk assessments."*
- *"...have to work with families also who may disagree..." [This is very important, and it is good to see awareness of the needs and responses of a family.]*
- *"Support staff contact regularly to discuss ideas and solutions, best interest decisions are not made in isolation and led by the appropriate decision maker for the particular decision."*

This response has a good balance between procedure and leadership:

"This is included in the e-learning. Senior staff within the homes will support other staff with Capacity Assessments and making decisions in customers' best interest. The organisation has policies, procedures, guidelines and flow charts and paperwork to enable staff to understand the processes and be able to record Capacity Assessments and Best Interest Decisions effectively. Homes are supported by District Managers and Care and Dementia Advisors who visit Homes regularly and can be contacted for advice in this area. The organisation has a nominated lead person to go to for advice on MCA and Deprivation of Liberty."

The below response, however, prompts questions about leadership within the home, and suggests the importance of leadership through all levels of the staff team. This answer did not take the most person-centred approach:

"We have a fully inclusive meeting with reps from all sides of making a best interest decision, not just from people working directly with the person needing support. We also encourage others outside the service including advocacy and IMCAS."

Question 7: How do you ensure that your staff understand the principle of the 'less restrictive option', and always pursue the least restrictive option for a person who lacks capacity?

Respondents shared lots of ideas and techniques in answer to this question:

- *“Training and discussions. Hand-overs, observations and supervisions, led by example from experienced staff who deliver high standards of care that is least restrictive.”*
- *“This is fundamental to respect and dignity guidance which people follow. MCA is on the agenda for each staff meeting”*
- *“We would ensure this by training one to one discussions we would ensure that the service user care plan is updated regularly, the least restrictive option is highlighted in their daily care plan, we can also put more staff on duty to assist if needed.”*
- *“We would use divert techniques where appropriate. We would encourage a full activity programme.”*

Some respondents mentioned using scenario-based methods, which appeared creative and relatable for staff:

- *“By role playing, scenarios, training. Explaining the reasons why.”*
- *“Role play and using scenarios to place staff in the position of the service user. Work culture of enablement and quality of life, management of risk alongside aspirations and dreams.”*
- *“By discussing the proposed decision as a team and looking for other options, referring staff to such assistive technology, what’s been used for someone else, what enables the person rather than deprives them.”*

Some responses put a strong emphasis on ensuring staff understanding:

- *“Ensure team members understand what this principle means, using the least restrictive method possible to maintain residents safety”*
- *“All staff within our company has recently attended a 3 hour workshop on MCA which discusses 'least restrictive options.’”*
- *“One to one coaching from a competent individual is vital and reviews (of) any decisions that are made.”*

Nonetheless, there were still answers to this question that showed misunderstanding or over-simplification of the key principles of the MCA.

Question 8: Do you feel confident about recognising, recording and minimising restraint, in accordance with the MCA?

86.25% or 69 respondents said they felt confident in recognising, recording and minimising restraint in accordance with the MCA:

“We understand what the MCA means by restraint, we accurately record it and seek to minimise it”

13.75% or 11 respondents said they did not feel confident:

"I would like to improve my home/service's knowledge of what the MCA means by restraint, and understand better how to accurately record it and minimise it".

While this response is positive, there is reason to reflect that self-assessment of MCA knowledge and implementation is not the surest indicator, especially considering that some who felt confident in this aspect of MCA implementation had needs they had not identified, or perhaps were confused in answering questions about the 5 principles of the MCA.

It is possible also that homes did not want to admit to being unconfident about the MCA, and/or that, as have been previously mentioned, the respondents to this survey are a self-selecting group, who are already confident in MCA implementation and therefore will come forward to respond to such a survey.

While it is possible that many care home managers feel confident on MCA implementation, we acknowledge that this data is not consistent with experiences across the sector, which were gathered in feedback to the research at the National Mental Capacity Action Day, in March 2016. MCA and DOLS leads from local authorities, Best Interest Assessors and other MCA expert practitioners reflected that they did not feel that MCA implementation was very good in care homes.

This suggests the need for further research into care home managers' confidence in this, and all aspects of the MCA. Qualitative research, to assess managers' confidence face-to-face, might be beneficial in assessing MCA implementation in care homes more widely.

Question 9: How have you managed any additional pressures of implementing DoLS since the Supreme Court clarification that highlighted how many people in residential care might be deprived of their liberty?

Respondents to this question had had variable experiences: from finding the increase in DOLS applications no problem at all, to finding them an enormous burden.

The majority of respondents seemed to have got on top of the demands, and were now confident about their compliance. A few responses exhibited some awareness of, and made some reference to, the acid test.

Positive ways additional pressures had been managed:

- *"By not panicking and assessing each case in detail"*
- *"Struggling because of additional paper work, but it has been a good learning experience and realisation that residents whatever condition they may have still should be cared for as a unique individual with human rights within the boundaries of their health & safety." – learning process = very good*
- *"There is still a perceived misconception that we have to do DOLs on every resident. We have excellent individual plans of care that show how residents are actively involved in their choice." – recognition of common misconceptions*
- *"By prioritising the more important cases first."*
- *"Training of Assistant Managers to help to complete referrals, refer in order of priority"*
- *"By completing all paperwork fully and just getting on with it."*

Difficulties faced in managing additional pressures:

- *“It has been a very difficult task as each resident who doesn't have capacity requires a DOLS as the main doors are kept locked (with keypad), which mean each individual requires DOLS” [This comment show a lack of understanding of DOLS and the MCA: a locked door in itself is not a deprivation of liberty. The manager does not show awareness of the ‘acid test’ which relates to the entirety of the person’s experience within the service.]*
- *“This has meant extra time spent and manipulating timetables”*
- *“This has been a grey area. We take individual advice from the local Safe Guarding and DOLS team in Lincolnshire.”*

Several respondents said that delays were due to the local authority:

It is recognised that local authorities are facing great difficulties in processing the huge numbers of DOLS applications they face, particularly in the current financial climate. There was a clear and observable link between how well a home was coping with DOLS pressures, and how well the local authority were coping with processing applications.

- *“We have made applications where necessary, however the DOLS team seem unable to cope with the workload and therefore for most people applications are pending.”*
- *“This has been very difficult as and has increased pressure we have been waiting for some assessments for a year”*
- *“There are still seemingly inconsistencies in how different councils view service user's abilities within restrictions”*
- *“There has been a lot of extra paperwork and lots of delays in assessments from local authorities”*
- *“It has not caused the home any issues other than waiting for assessments to take place. Shortfalls in having paperwork returned and in one case the authority failed to send the paperwork to the home all together.”*

Responses showed that how well a care home or service manager is coping is very linked to the effectiveness of the local authority’s system for processing and prioritising DOLS applications:

- *“We did not feel any additional pressure. All applications were done in timely manner.”*

Question 10: Have you been involved in any good practice schemes or support to improve implementation of the DoLS locally?

Most respondents to this question had not been involved in any local best practice schemes.

Yes = 21.95% = 18 respondents

No = 78.05% = 64 respondents

There is definitely scope for more of this kind of work, and good reason to encourage and fund it, as the answers to the next question show.

Question 11: What would help your home/service to better implement the MCA?

Care England found responses to this question really interesting, as they speak to the heart of the issue. The below should be considered as a usable list to help those organisations seeking to improve MCA implementation to establish what could help them do it better and more responsively.

Respondents to this question generally wanted a bit more of everything: training, guidance documents, better support from their local authority and more local 'good practice' schemes. These were a particularly popular answer: it seems that there is appetite among managers to focus on MCA implementation with other local agencies or groups.

More staff training = 35.37% = 29 respondents

More guidance (for example, about MCA compliant policies and procedures) = 36.59% = 30 respondents

Better support from the local authority = 47.56% = 39 respondents

Local good practice schemes or support = 48.78% = 40 respondents

In the 'other' category, there were some interesting responses, which shine a light on what managers need to better improve their implementation of the MCA in the work of their homes:

- *"A guidance (booklet/leaflet) that could be given to both families and staff"*
- *"Families still unsure about MCA's - would benefit from training"*
- *"involving of local Dols/ MCA lead in a relatives meeting"*
- *"Someone to be responsible for this role."*
- *"At times, staff feel unconfident if health practitioners do not follow the MCA and more support around making challenges in these scenarios would be excellent."*
- *"Clear cut proposals for residents living in residential care (sometimes for many years)"*
- *"A consistent national view in what constitutes a DoL"*
- *"Once back log is addressed this would enable the monitoring of applications and requests happen more smoothly (contingent on LA processes and control)."*
- *"You cannot have enough training."*
- *"Accessible training often it is pitched and is either insulting or overly complicated."*

This last point is particularly interesting, and might well be heeded by training providers, and organisations that provide easy-read or accessible materials explaining the MCA.

Question 12: can you give any examples of best practice in using the MCA? (For example, where preparing for a DoLS application resulted in someone being cared for in a less restrictive manner, or using the MCA led to more personalised care planning?)

While a minority of managers offered examples of best practice in using the MCA, some believed that using the MCA had led to more personalised care. They reported that using the MCA had led to:

- More personalised care planning and care giving = 10
- Less restrictive care= 5 [for example using crash pads, not having to use a lap belt or harness; using key cards and not lock and key]
- More time allowed unsupervised = 2 [a resident is newly allowed to access garden alone]

- Good ideas shared between professionals involved in DoLS process leading to innovative solution = 2
- Staff are more knowledgeable = 2
- Service user is given more responsibility = 1 [cooking and preparing own food]
- Prevented movement to a secure unit or more secure setting = 3 [prevented move to a secure unit; allowed a service user to return home etc.]
- Service user has more freedom to make choices = 3
- Smaller decisions made possible = 1 [what to wear, what to eat, where to go]
- Service user has more access to the community = 1 [allowed to go into town more often]
- Service user health outcome improved = 1 [Better management of diabetes]

As demonstrated above, several managers thought that implementing the MCA had resulted in better care planning:

“Using MCA does result in more deeper care planning and risk assessing to support individuals and encourages the team to think deeper and explore every situation more thoroughly before making decisions that influences outcomes for people's lives.”

A few managers reported understanding capacity and types of decisions better:

“The outcome of a Mental Capacity Assessment was that the relevant person (resident) lacked capacity viz. making significant decisions e.g. where they wanted to live. However had capacity to make decision viz. what they wanted to wear, what they wanted to eat and how they spent their time e.g. activities in or outside of the home.”

A manager felt that the MCA was helping them protect their residents' best interests:

“When a relative felt the resident should go on holiday but it was deemed it was not in her best interest.”

Several managers felt that the MCA gave clients given more independence:

- *“By looking at least restrictive options we clarified that someone could be left at home on her own for an agreed amount of time. Use of technology such as Careline and use of falls belt means this woman does not have to go out when she does not want to and does not have to have someone with her all the time.”*
- *“In more personalised care planning; we support a gentleman who is supported to use a Houdini Harness in his vehicle. MCA and BI was followed and is reviewed 6 monthly. However, there was no clear evidence afterwards of its benefits to evidence reason for DOL. We worked with the Care Manager to develop and implement an 8 stage plan to remove the harness, through good evidencing and recording we were able to show that they plan was not safe to move past stage 2. This shows how the professionals around this gentleman are discussing and attempting where possible to support him in the least restrictive way possible.”*
- *“Resident needed to be taken on visits outside of the home more frequently to ensure mental well-being, decided by the DoLS team and at a best interest meeting by Hampshire council.”*

- *“We purchase a bed and chair alarm for a lady that kept letting herself out of the fire escape and walking along the busy road outside. This alerted staff when this lady got up so that they could monitor her whereabouts. This saved the lady being transferred to a Secure Unit.”*
- *“Customer at risk of falls supported with a pressure mat and crash mat in communal area rather than in a wheelchair with lap belt and constant staff supervision when not in bed.”*
- *“We have encouraged SU to be more independent with use of the kitchen, reducing restrictions and increasing training and support to enable the SU to complete tasks”*

A manager told us they felt better equipped to support clients to make “unwise” decisions:

“Resident wishing to eat food that did not comply to SLT recommendations; through the use of MCA two stage test and best interest with the input from a multi-disciplinary team we were able to support the resident in a less restrictive way to eat some of the foods he craved”

Some managers reported improvements in staff culture, understanding or attitudes as a result of implementing the MCA:

- *“Generally improved the staff’s thinking in a more Person Centred way.”*
- *“Staff (now) following guidelines on how to deal with residents on a safe and less restrictive manner; no critical incident noted so far on current cases.”*

One manager reported better cross-agency working for the benefit of a service user in completing a DOLS application:

- *“Telephone discussion with DoLS lead where ideas were shared to good outcome.”*

One respondent still felt like DOLS were unnecessary, and did not see that the process yielded positives:

“I feel that many applications are submitted which would not necessarily be required. However due to instructions following the Supreme Court ruling to submit an application for everyone who lacks capacity to make the decision in question has contributed to the back log. Care Homes and care providers are no longer confident to follow a checklist and make a decision not to apply for fear of criticism. In addition I believe there is an expectation to submit DoLS under the question 'what would you do if this person tried to leave'? Surely then a DoLS application should be considered when that time comes and not in advance. I do believe this would assist what appears to have become a bureaucratic approach to supporting people who lack capacity.

Key Findings

Finding 1

Managers who take a range of approaches to MCA implementation, across formal classroom learning and day-to-day methods, were implementing the MCA in 'good practice' terms, and seemingly increasing their chances of successful MCA implementation.

Finding 2

It is possible and productive to build the MCA into everyday processes and exchanges, like team meetings, supervisions, observations and daily decision-making with service users.

Finding 3

This research suggests that at present, care home managers can risk being too reliant on one-off, classroom training to support their staff to understand and implement the MCA. This requires an attitudinal change: legislation should reflect current best practice, not abstracted concepts to be absorbed only by formal learning.

Finding 4

Care home managers can be hesitant to admit where they can improve on MCA implementation, and the sector must support its care homes to work towards having a 'learning culture' when it comes to something as complex as the MCA.

Finding 5

There is 'best practice' to be found in MCA implementation in care homes, but managers and care teams must be encouraged to see MCA implementation as presenting an opportunity for better care, not a burden. This is an attitudinal change, but also relies on offering more support.

Finding 6

There is a lack of, and an appetite for, more local MCA implementation schemes and good practice programmes. There is a role here for CQC, the National Mental Capacity Forum, SCIE and Skills for Care in promoting, suggesting and potentially funding these to meet demand and improve MCA implementation in local health and care systems.

Conclusions

This research shows how some managers take a range of approaches to MCA implementation. The managers that responded most confidently to Care England's questions tended to be those using a range of approaches. Mentorship, coaching and active, floor-based management seemed to recur in the answers from managers who really wrote confidently about their staff team's understanding of the MCA.

However, as mentioned continually in this report, there was a clear theme of over-reliance on "training". While training is an important starting point for creating a care team who understand and use the MCA on a daily basis, MCA awareness should not be confined to training days, but embedded in every day workings. Some answers described a range of techniques and levels of communication, designed to embed a theoretical understanding of the MCA, and a daily, working understanding of the act.

One of the greatest apparent barriers to MCA implementation was information and knowledge not filtering down in homes where managers considered that the MCA, capacity assessments, Best Interests Decisions and DoLS were the concern of managers only, when this should not be the case and all staff should be engaged with, and inform these processes.

Nonetheless, these findings do not suggest the care sector need fall short on MCA implementation. There is desire and scope for more work to improve MCA implementation in care homes, but good reason to commend care home managers who have taken a range of creative approaches with their staff team already. Indeed, this research speaks volumes about the creativity and innovation that exists in the sector, and the importance of good management and leadership in caring for adults who lack capacity.

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