**ABSTRACT**

**Aim:** To identify training strategies and determine how registered health and social care practitioners change their practice post Mental Capacity Act training.

**Design:** Narrative literature review

**Data sources:** Seventeen databases were searched up to December 2019; CINAHL, Social Care Online, PubMed, Social Policy and Practice, Discover, Medline, Science Direct, Ovid, PsycINFO, ASSIA, Social Services Abstracts, Science Direct, Academic Search Premier, Web of Science, British Nursing Index, DH-Data, King’s Fund Library Catalogue.

**Review Methods:** Empirical studies of any design investigating Mental Capacity Act training were searched and screened. Data were extracted to a bespoke spreadsheet and quality assessed. Reporting followed the Preferred Reporting Items for Systematic Reviews and Meta‐Analyses, (PRISMA).

**Results:** Of 162 papers identified, 16 were included comprising qualitative, quantitative and mixed methods studies. Trainees valued interactive training with close alignment to practice. Training did not lead to demonstrable practice change. Barriers in the context and cultures of care environments were identified.

**Conclusion:** To facilitate application of Mental Capacity Act legislation, identified barriers should be addressed.Future training should be interactive, scenario-based and relevant to trainees’ practice.

**Relevance to Clinical Practice**

The Mental Capacity Act is widely misunderstood and implementation poor. Training is proposed as a solution, but the nature of training that will positively affect practice remains unknown. This review aims to address this gap in the evidence base. Interactive training, using scenarios that reflect practice complexities, has the most positive impact. Cultural norms in care environments may impede application of this legislation.

The review has international relevance as there is a global imperative to adhere to the United Nations Convention on the Rights of Persons with Disabilities. The review will inform training design and delivery to ensure that people with impaired capacity to make decisions are given the best opportunity to act autonomously.

**Key words:** narrative literature review, nurses, health care, social care, Mental Capacity Act, training, impact

**INTRODUCTION**

Globally capacity legislation is gradually aligning with Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006), which accords equal recognition in law to people with disabilities, emphasising their rights as citizens. In line with international legislation, the intention of the Mental Capacity Act (Department of Health (DH), 2005) (MCA), which applies in England and Wales, is to promote the autonomy of people who may temporarily or permanently lack capacity to make their own decisions by providing a framework to guide decision-making (Hinsliff-Smith, Feakes, Whitworth, Seymour, Moghaddam, Dening, et al., 2015).

The act reflects a social model understanding of disability in which disability is framed as impairment in combination with societal barriers, which together impede rights to equal social inclusion (Croucher 2016). This viewpoint is increasingly influential; global capacity legislation is gradually aligning with Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which drives equal recognition in law to people with disabilities. Therefore, European capacity legislation is going through a process of reformation, away from prioritisation of safeguarding and substitute decision-making on the basis of diagnosis and towards supported decision-making (European Union Agency for Fundamental Rights 2013). This process is not universal, for example although the CRPD has been ratified by most states in the African Union, informal practices in many African countries are restrictive of people with disabilities, and current legislation reinforces discriminatory practices (Mental Disability Advocacy Center 2016). The MCA (2005) for England and Wales, the Adults with Incapacity (Scotland) Act 2000 and The Mental Capacity Act (Northern Ireland) 2016 are harmonised with the values of the CRPD in identifying capacity as ‘decision-specific’ and evaluated on the basis of cognition, rather than ‘status’ or diagnosis, while prioritising empowerment over protection.

Initially the act was well-received, it was described as ‘a sound framework for balancing autonomy and empowerment with safeguards and care’ (Ward, 2005:70). However, there are suggestions that the MCA is generally not implemented as intended (House of Lords, 2014).

Two million people in the UK are estimated to have conditions that limit their decision-making capacity (Social Care Institute for Excellence (SCIE), 2016). Consequently, the act is relevant to the practice of any registered or non-registered worker in health or social care, in addition to voluntary workers and family carers who provide informal support (Daniel & Dewing, 2012). This equates to approximately six million individuals in England and Wales (SCIE, 2016). National Institute for Health and Care Excellence (NICE) Guidance (NICE, 2018) states that training is central to effective MCA implementation. This guidance points to existing research into MCA training being of low quality and highlights the need for further research into optimum approaches to training.

Mental capacity is defined as the ability to make one’s own decisions, based on the ability to understand and reason (Daniel & Dewing, 2012). Capacity is not determined by diagnosis or individual characteristics, but is dependent on the impact of a person’s impairment and the nature of a specific decision to be made at a particular time (Taghizadeh Larsson, & Österholm, 2014). The MCA applies to all types of decisions, from the humdrum (such as what to wear) to the highly significant (which care home to choose) (Hinsliff-Smith et al., 2015). The first principle of the act requires practitioners to assume service-users’ capacity (Department of Health 2005 (s1(2)); this and subsequent provisions reflect the intent of the legislation primarily to promote autonomy, with the best-interests principle (explained below) in place should a person is not able to make a decision for themselves (Mackenzie & Rogers, 2013).

There is provision for those concerned about their future decision-making abilities to plan ahead, using advance decisions (legally binding recorded decisions to refuse treatment in specific circumstances) and statements (concerning a person’s preferences), and to clarify who they would have represent their interests should decisions need to be made on their behalf (NICE, 2018). The act provides guidance for researchers who are conducting studies involving people who may lack capacity; for example the project must have ethical approval, the focus of the research must be linked to the person’s ‘impairing condition’ and have a chance of benefitting the individual or others with the same condition (Department of Constitutional Affairs 2007). The legislation also provides a structure for professionals that clarifies and directs the process of respecting an individual’s decisions. It guides assisting with decision-making, assessing a person’s capacity to make a specific decision and, if a person is unable to make a decision, guiding the professional (or family or voluntary carer) substitute decision-makers in determining a person’s best interests so that a decision reflects their values and lifestyle, with minimal restrictions to the individual (Department of Health 2005 (s1(2-6)), Stevens, 2013). Under an amendment to the MCA, Liberty Protection Safeguards are due to replace Deprivation of Liberty Safeguards by spring 2020. These provisions authorize care in a hospital or care home for a person who does not have capacity to consent, but for whom the arrangements are necessary to avoid harm (Social Care Institute for Excellence, 2019).

Consequences of limited understanding and implementation of the MCA are significant. For example, misinterpretation of the concept of ‘capacity’ (Wilson, Seymour, & Perkins, 2010) and how it should be assessed (Marshall & Sprung, 2016a) leads staff to assume that individuals cannot make their own decisions (Care Quality Commission, 2013). People living with dementia are at particularly high risk of being systematically excluded from decision making (Taghizadeh Larsson, & Österholm, 2014) while people with intellectual disabilities still face barriers due to poor adaptation to their needs (for example provision of accessible information which would support decision-making) leading to negative experiences of services and poor outcomes (Sheehan et al., 2016).

MCA training was not and still is not always mandatory. Poor implementation of the MCA cannot continue as the outcome for service users with dementia, intellectual disabilities, mental health problems and other disorders may be to undermine their autonomy and deny their human rights (Marshall & Sprung, 2016a).

In light of the need for more effective implementation of the MCA, and allied legislation in other countries and the centrality of training in this quest, the purpose of this review is to identify, evaluate and synthesise published papers that report on health and social care practitioners’ MCA training, to explore the nature of training interventions and establish the ways and means through which practitioners change their practice post-training and make recommendations for future practice and research.

**Aims and Methods**

To identify training strategies and determine how registered health and social care practitioners change their practice post Mental Capacity Act training.

*Objectives*

In published empirical studies to identify

* types and durations of MCA training
* training evaluation methods
* participant evaluation
* impact of MCA training in practice

This review is registered with PROSPERO, the international prospective register of systematic reviews (CRD42018094478).

Design

We conducted a systematic search to identify literature. As included studies were methodologically disparate, we broadly adopted the approach of Popay, Roberts, Sowden, Petticrew, Arai, & Rodgers, et al., (2006) to guide and structure our narrative synthesis and thus ‘tell the story’ of MCA training impact. Evidence was synthesised in three main stages: developing initial synthesis of findings from identified relevant studies, exploring relationships within the findings and evaluating the strength of the synthesised outcome (Kastner, Antony, Soobiah, Straus, & Tricco, 2016). Reporting followed the Preferred Reporting Items for Systematic Reviews and Meta‐Analyses (PRISMA) format. Please see Figure 1 and Supplementary File 1.

The review team comprised three nurses, one with expertise in the Mental Capacity Act and nurse education, one with expertise in the care of older people and qualitative research methodologies and one with expertise in research into dementia care education and mixed methods research, and a research assistant.

Search methods

We searched the databases CINAHL, Social Care Online, PubMed, Social Policy and Practice, Discover, Medline, Science Direct, Ovid, Social care online, PsycINFO, ASSIA, Social Services Abstracts, Science Direct, Academic Search Premier, PubMed. Web of Science (all databases), British Nursing Index, DH-Data and King’s Fund Library Catalogue using the search terms Mental Capacity Act AND training OR education OR learning up to 6th December 2019. Limiters were articles published in English language and post 2007 as the MCA applies only to England and Wales and was enacted in this year, so training would not pre-date this. For completeness we used forward and backward citation searching and hand-searching selected journals.

*Inclusion criteria*

* Empirical studies
* Evaluating MCA training for health and social care staff

Search outcomes

The initial search yielded 162 papers; with de-duplication this was reduced to 54. One author (xx) screened title and abstract and excluded clearly irrelevant papers (n=31). The remaining full-texts (n=23) were screened by two authors (xx, xx). In the event of disagreement, we had planned to consult with other co-authors. One further paper was identified from reference checking of included papers. A total of 16 papers are included. Stages of the search are documented in a PRISMA flowchart (Moher, Liberati, Tetzlaff, Altman, & PRISMA Group, 2009) (Figure 1).

Quality appraisal

Quality of included papers was assessed using the Hawker checklist which is adaptable and designed specifically for reviewing disparate data systematically (Hawker, Payne, Kerr, Hardey, & Powell, 2002). It comprises nine questions each with a score range of 1-4 with 4 being the highest. Scores ranged from 13-36. Fourpapers (Schofield, Di Mambro & Schofield, 2012; Willner, Bridle, Dymond, & Lewis, 2011; Willner, Bridle, Price, Dymond, & Lewis, 2013; Bose & McLiggans 2019) evaluated specific training programmes and these scored most highly. However, we included lower scoring papers as these contributed to answering our review question.

Data abstraction

Data were abstracted to a bespoke spreadsheet in which we recorded standard information (author, publication date and study design / paper type). In relation to our review aim and objectives we extracted (when available) details of training intervention, trainers and trainee, evaluation approach, participant evaluation and reported impact of training (Table 1).

Synthesis

Synthesis was achieved by developing grouping tables to explore relationships within and between studies and creating brief textual descriptions of each study. From this we derived two key themes each underpinned by sub-themes. Firstly, ‘the nature of MCA training’ with sub-themes of ‘positive reactions but lingering anxieties’ and ‘misunderstandings and misapplications’. Secondly ‘problems in changing practice post-training’, with sub-themes of ‘institutionalised under-resourcing’ and ‘hierarchy confidence and responsibility’

**Results**

*Study characteristics*

Of the included studies, seven were quantitative, seven qualitative and two mixed methods. Quantitative studies (Sawhney, Mukhopadhyay, & Karki, 2009; Shah, Banner, Heginbotham, & Fulford, 2010; Willner et al., 2011; Willner et al., 2013; Schofield, di Mambro, & Schoﬁeld, 2012; Morriss, Mudigonda, Bartlett, Chopra, & Jones, , 2017; McCormick, Bose, & Marinis, 2017) investigated training experiences (Sawhney et al., 2009; and Shah et al., 2010) or post-training knowledge of psychiatrists and medical trainees (other than Willner et al., 2011 and Willner et al., 2013, who surveyed newly appointed clinical and non-clinical staff members). Response rates tended to be low (27-55%). Bias may also have been introduced due to self-selection (Morriss et al., 2017, McCormick et al., 2017).

Willner et al. (2011), Schofield et al. (2012) and Willner et al. (2013) tested knowledge post-training, which resulted in higher response rates. Using true/false statements and scored responses, all three studies found improved knowledge. However, Willner et al., (2011) noted positive bias towards ‘true’ statements, which may have skewed their results. This bias may have affected the results of Schofield et al. (2012) in a similar way, but this study did not provide a detailed breakdown of the questions and responses. The quantitative studies measured knowledge and sometimes confidence, but did not report on retention of learning, knowledge transfer or practice change. However, the quality of the quantitative studies was fair to good scoring 23-34 on the Hawker et al. (2002) scale.

Qualitative studies (Manthorpe, Rapaport, Harris, & Samsi, 2009; Samsi, Manthorpe, Nagendran, & Heath, 2011; Gough & Kerlin, 2012; Manthorpe & Samsi, 2016) were conducted using structured or semi-structured interviews, with one study (Gough & Kerlin, 2012) also using a focus group. Participants were drawn from a wide range of health and social care backgrounds. Participant numbers ranged from eight to 26. Participants expressed views which related to the nature of their own professional responsibilities, training experiences and localities, so findings may not be transferable. These studies scored between 19-36 on the Hawker et al. (2002) indicating generally good quality. We included three case studies: Phair & Manthorpe 2012; Lee-Foster 2010; Pike, Indge, Leverton, Ford, & Gilbert 2010). Case studies may be less rigorous in their methods because researchers are evaluating their own work, or because the focus of the study is necessarily local and small. The Hawker checklist scores for these studies were poor to fair (13-27). Nevertheless, the in-depth detail and reflection on outcomes can mean conclusions are valuable, bearing limitations in mind.

There were two mixed-methods studies. Marshall & Sprung (2016b) used a questionnaire (response rate 17%, despite measures to encourage participation) investigating training outcomes and confidence, followed by interviews. The evaluation of this study using the Hawker checklist was also good (31). Bose and McFiggans (2019) used a questionnaire pre and post training, measuring knowledge, confidence and awareness, followed by open-ended questions post training to gain feedback. All 39 training participants completed the evaluation questionnaires. This study scored 27 on the Hawker checklist.

*Training*

Four studies directly reported on empirical research evaluating defined training programmes (Schofield et al. 2012; Willner et al. 2011; Willner et al. 2013; Bose & McFiggans 2019). The remainder offered review of professional groups’ knowledge of the MCA and training experiences and outcomes (Manthorpe et al.2009) Sawhney et al. (2009); Shah et al. (2010), Willner et al. (2011); Samsi et al.(2011);, Gough & Kerlin (2012); , Schofield et al. (2012), Manthorpe & Samsi (2016), Marshall & Sprung (2016b), Morriss et al. (2017).

Three papers report on profession specific training (Lee-Foster 2010; Schofield et al. 2012; Bose & McFiggans 2019) and two (Willner et al., 2011; Willner et al., 2013) on mixed groups of trainees. Details of the nature of training and numbers of trainees is generally sparse. In several papers the findings reflected a range of training types, in which training might have happened recently (Lee-Foster 2010; Schofield et al., 2012; Willner et al., 2011;, Willner et al., 2013) or up to two years previously (Sawhney et al., 2009; Phair & Manthorpe, 2012; Morriss et al., 2017, McCormick et al., 2017 ), in which case participants may have attended more than one training intervention. In three cases MCA training was combined with training in related issues (communication (Lee-Foster, 2010), record-keeping (Willner et al., 2013), safeguarding and human rights (Pike et al., 2010)). Responses are varied and poorly reported.

***Theme 1: The nature of MCA training***

Early training reported on an intervention which was at least partially based on resources provided by the Department of Health. These resources included information about the act and scenarios to illustrate points. Feedback indicated that this training was perceived as helpful. For example, social workers in specialized adult protection roles (Manthorpe et al., 2009) had experienced training based on these resources, together with a range of complementary training materials (online and face to face).

Practicalities varied with training taking place in the workplace, in training centers or online (either at work or at home). Length varied from 10 minutes as part of an induction programme to one or more days (Samsi et al., 2011). Most but not all training was reported to be mandatory, often with three yearly updates. Where reported, trainees preferred face-to-face, interactive, scenario-based training (McCormick et al.,2017; Bose & McFiggans 2019).

*Positive reactions but lingering anxieties*

Safeguarding leads (adult protection co-ordinators) were positive about their training but expressed anxieties about being expected to train others based on their own limited knowledge. They reported using additional resources to bolster their understanding (Manthorpe et al., 2009). This study was conducted soon after the legislation was enacted, so the participants were pioneers and would not have been able to find support from more experienced colleagues.

Mixed-profession MCA learner participants benefitted to some extent from the MCA training they received, with improvements found in most areas of knowledge (Willner et al., 2013) while specialist nurses seemed non-committal, with the majority describing their knowledge as ‘fair’ (Marshall & Sprung, 2016b). However, it is unclear to what degree a neutral or positive response to MCA training would result in adherence to the Act in real world settings. Many participants described lack of confidence (Manthorpe et al., 2009; Samsi et al., 2011; Phair & Manthorpe 2012; Manthorpe & Samsi, 2016), while others were sensitised to capacity issues, but unsure of how to implement the legislation (Samsi et al., 2011; Willner et al., 2013). As Willner et al. (2013) noted, confidence is not a reliable proxy for measuring competence. Participants in some studies (Schofield et al., 2012; Willner et al., 2013) may have demonstrated misplaced confidence while in others knowledge appeared stronger, but confidence lower (Manthorpe et al., 2009; Manthorpe et al., 2011; Marshall & Sprung 2016b). However, Willner et al. (2013) noted that raising awareness of the legislation was a necessary first step, enabling future learning. Speech-Language Therapy (SLT) students in Bose & McFiggan’s (2019) study reported greater awareness, knowledge and confidence. These qualities were identified immediately post-training so it is unclear whether the outcomes of training would be retained and applied in clinical practice post-qualification.

Generally, the study authors conclude that participation in training improved knowledge but did not lead to corresponding improvement in application of the legislation, due to ongoing apprehension and lack of confidence. Subsequently, awareness of the limitations of training led to a reconsideration of learning approaches (Willner et al., 2013; Gough & Kerlin 2012; Schofield, di Mambro & Schofield, 2012). For example, Willner et al., (2013) suggested the role of training should only be to raise awareness, then online information should be complemented by access to an MCA expert, who would provide guidance and support.

*Misunderstandings and misapplications*

Respondents in the 2009-2010 studies accurately predicted potential barriers to correct implementation of the MCA which were confirmed by later studies. Participants noted incongruence between the MCA and professional cultures and indicated that colleagues were unfamiliar with the legislation at the time (Manthorpe et al. (2009). Medical professionals outlined concerns about the workload of psychiatrists, delays in guidance and policy, potential misunderstandings about the nature of decision-making capacity and availability of local training (Shah et al., 2010). Trainees anticipated increased workload and feared legal implications of misinterpretation or unfamiliarity (Sawhney et al., 2009). These studies reported low response rates so conclusions might be interpreted with caution, but the doctors’ fears were partially confirmed in other studies. Social care workers outlined how they would ask advice from senior members of staff, including doctors (Manthorpe et al., 2009) and multi-disciplinary staff post-training still believed capacity should be assessed by a psychiatrist (Willner et al., 2013).

Misunderstandings and misapplication of the MCA were noted in the majority of the studies. Staff lacked understanding of the definition of ‘capacity’ (Gough & Kerlin, 2012) and how to assess it (Willner et al., 2013). Study participants often failed to abide by the principles of the act; they presumed incapacity (McCormick et al., 2017), deferred decision-making to seniors or other professionals (Samsi et al., 2011; Willner et al., 2013; Manthorpe & Samsi, 2016) and had potential to over-ride ‘unwise decisions’ (Willner et al., 2013). These findings may reflect limited understanding of the importance of promoting autonomy within the act and would have a disempowering impact on patients.

Some psychiatrists were reluctant (or would refuse) to discuss Advance Decisions to Refuse Treatment (Morriss et al., 2017). Nurses mistook ‘best interests’ for a general person-centred approach (Manthorpe & Samsi, 2016) and care workers limited clients’ choices (Manthorpe & Samsi, 2016). While professionals indicated that their approaches were motivated by their perceptions of patients’ best interests, this willingness to override patients’ choices was in conflict with the principles and guidance of the legislation and seemed to be driven more by embedded cultural beliefs of ‘doctor knows best’ , despite the empowering aim of the legislation (Jackson, 2018). For example, the above findings indicated that the right of a capacitous person to make decisions, regardless of consequences, had not been absorbed in training.

Less complex elements of the legislation also appeared to have been misunderstood. Participants were unaware of the two-step (Willner et al., 2011). They struggled with best interests assessments (deciding what to do if making a decision on behalf of a person unable to do so) (Willner et al., 2013) and responding to fluctuating capacity (Marshall & Sprung, 2016b; Morriss et al., 2017). Phair & Manthorpe (2012) and Marshall & Sprung (2016b) reported poor awareness of advance decision-making processes and the designation of willful neglect and ill-treatment as criminal offences, while Willner et al. (2013) identified that staff were unsure of when to involve an Independent Mental Capacity Advocate (a professional employed to contribute to decision-making for the ‘unbefriended’) (Willner et al., 2013). These factors indicated that peoples’ rights would be undermined and that training had little impact on practice change. This theme reflects, and perhaps to some extent explains, poor implementation of the legislation as identified by the House of Lords (2014).

Studies reported on a range of training approaches. Case studies (Lee-Foster 2010; Pike et al., 2010) describe stand-alone initiatives, but make observations and share experiences that offer useful pointers for learning. Pike et al. (2010) considered the advantages and disadvantages of e-learning, concluding that it could be effective for developing basic knowledge and had benefits around flexibility and costs. They acknowledged disadvantages including lack of opportunity for discussion, poor digital literacy and inequality of access. The latter factors are supported in a recent study in which Manthorpe & Samsi (2016) identified that care home staff had not accessed available online training. Conversely Schofield et al. (2012) found e-learning was effective for doctors and medical students. These differences may reflect access to and familiarity with technology, as well as other factors including the life-stage and family responsibilities of the participant groups and the time they would therefore have free for independent learning.

Gough & Kerlin (2012) suggest that training should involve real-life scenarios to assist practitioners in linking the legislation to their practice. Many of the papers described training in which the trainers had aimed to be creative, imaginative and challenging to engage the learners in working together or individually to solve problems using case-studies or scenarios (Lee-Foster, 2010; Pike et al., 2010; Willner et al., 2013). For example, Lee-Foster (2010) developed a toolkit which participants applied to a real-life scenario drawn from their own practice and then discussed in a written assignment.

MCA training is not mandatory in all workplaces and this, together with its ‘stand-alone’ presentation may lead to an impression that the training is not important (Gough & Kerlin 2012, Phair & Manthorpe, 2012 ). However, many of the studies reported that the MCA was taught in conjunction with related topics, including communication (Lee-Foster, 2010), record-keeping and consent (Phair & Manthorpe, 2012; Marshall & Sprung, 2016b), human rights, equality, diversity and safeguarding (Pike et al., 2010). Combining topics aided participants in understanding connections between the various aspects of their practice (Gough & Kerlin, 2012), but perceptions differ and others felt that MCA training had, unhelpfully, been ‘bolted on’ to other topics (Phair & Manthorpe, 2012).

Some programmes used a ‘cascade’ model, expecting trainees to then train colleagues (or at least influence their practice) and so embed the learning among their workplace teams (Gough & Kerlin, 2012), thus minimising costs of both training and the expense associated with providing replacements to fulfill trainees’ roles in the workplace during their absence. Manthorpe & Samsi (2016) imply that a cascade model is congruent in workplaces with high staff turnover and hierarchical cultures. Gough & Kerlin (2012) concluded a top-down model is appropriate. However, the success of this approach is dependent on relevant staff feeling confident in sharing their knowledge. Senior staff were not always more knowledgeable on the topic than those they supervised (Phair & Manthorpe 2012; Marshall & Sprung, 2016b) and under-confident practitioners were concerned about taking on these responsibilities (Manthorpe et al., 2009). This may have changed over time and vary across professions; speech and language therapists, for example, were keen to share their expertise (McCormick et al., 2017) and student SLT peer trainers received positive feedback (Bose & McFiggans 2019). Therefore, it seems that knowledge transfer is dependent not only on competent, confident sharers of knowledge, but also the opportunity for those with knowledge to be heard.

***Theme 2: Problems in changing practice post-training***

Challenges in changing and sustaining change in practice were widely identified (Lee-Foster, 2010; Schofield et al., 2012; Hisliff-Smith et al., 2015) and some considered mechanisms for knowledge transfer. Two case studies demonstrated how training with follow-up activities designed to promote application in practice can be effective. Pike et al. (2010) identified difficulties with transferring safeguarding (procedures for the protection of people considered to be at risk) learning into practice pre-MCA and applied anticipatory strategies when planning MCA training. They highlighted concerns about the need for a facilitated experiential approach involving challenge of existing values and beliefs to promote reflection and enhance transfer of learning to practice. They integrated MCA training with safeguarding and human rights training to improve transferability and relevance for staff. Further steps to promote knowledge transfer included explicitly addressing the issue during training and encouraging completion of learning logs. These were designed to promote commitment to practice change and to focus conversations with supervisors. Pike et al. (2010) outlined the evidence, values and policy rationale behind a training approach yet to be evaluated. Learning transfer was successfully achieved using an assignment set post-training, together with a ‘tool-kit’ (Lee-Foster, 2010). These accounts offered detailed information on training design and suggested that training should be viewed as part of a process, embedded into organisations. While outcomes appeared positive, the information on research methods was limited and there is potential for bias in researchers evaluating the work of their own teams.

Noting the tentative and perhaps temporary nature of improvements in knowledge and confidence, many authors included recommendations for further strategies aimed towards ensuring application of learning, including clinical supervision (Schofield et al., 2012; Gough & Kerlin, 2012), supported follow-up with managers (Gough & Kerlin, 2012), in-house experts or ‘champions’ to provide MCA guidance in practice (Willner et al., 2013), team meetings (Gough & Kerlin, 2012) and more training (Phair & Manthorpe, 2012; Marshall & Sprung, 2016b). Phair & Manthorpe (2012) suggested that MCA training should be combined with training in allied subjects such as communication skills, consent and DNAR (Do not attempt resuscitation) training and be more relevant to clinicians’ specialities. Consent and DNAR training relate to MCA training in that all promote autonomy and require respect of service users’ decisions, some of which may be perceived as unwise. Phair & Manthorpe (2012) recommended promoting social media and internet resources for learning and that staff should have annual updates. Willner et al. (2013) identified that staff preferred profession specific scenarios in training, but argued that this would make release of staff more difficult. Phair & Manthorpe (2012) noted that nurses’ confidence should be improved so that they could guide colleagues and identified leadership as a factor in improving practice, but cautioned against over-loading managers by ensuring clear shared responsibility. These findings appear to indicate that a range of support strategies may be required to promote learning retention and application of the legislation.

Even confident practitioners stated they would welcome extra training (Marshall & Sprung 2016b) and Phair & Manthore (2012) reported that participants expressed preference for a range of prompts to be designed into their documentation, perhaps indicating insight into the difficulty of retaining knowledge. Manthorpe & Samsi (2016) report participants were often unable to recall what they learnt in training; an issue also noted by Marshall & Sprung (2016b). Pike et al. (2010) noted that training should not be perceived as a ‘one-off’ but be considered a process. This was confirmed by Gough & Kerlin (2012*)* and Willner et al., 2013, who found that repeated training improves outcomes to some extent. Previous practice experience also seems to aid knowledge retention and confidence post-training (Marshall & Sprung, 2016b) and the opportunity to apply learning soon and often post-training appears to embed understanding more effectively (Willner et al., 2013).

*Institutionalised under-resourcing*

Included literature points to brief training having limited impact on practice (Willner et al., 2011), but organisational factors led to difficulties in facilitating adequate training time. Gough & Kerlin (2012) identified barriers in health and social care environments that impede application of MCA training to practice, including staff turnover, costs of training and costs of replacing staff who are away on training. Gough & Kerlin (2012) noted that costs of releasing residential and nursing home staff are ‘prohibitive’, while in the National Health Service Willner et al. (2013) found managers were unable to release ward-based staff for training. Medical practitioners identified high workloads as barriers (Sawhney et al., 2009; Shah et al., 2010). Pike et al. (2010) identified organisational change and the quality of staff supervision to be additional barriers.

*Hierarchy confidence and responsibility*

Issues of power and authority could be seen to impact on application of the MCA in healthcare settings. Patterns of deference were mentioned in many of the studies. Care home staff deferred decision-making to senior carers and managers (Gough & Kerlin, 2012, Manthorpe & Samsi, 2016) and nurses and other staff deferred to doctors (Willner et al., 2013). Those with greater apparent power and responsibility found this uncomfortable or arduous (Manthorpe et al., 2009; Shah et al., 2010). Phair & Manthorpe (2012) found the knowledge-base of matrons (nurse managers) was not strong enough to support clear guidance to colleagues. Social work safeguarding leads expressed concern about their additional responsibilities and impact on time-management (Manthorpe et al., 2009). However, Speech and Language therapists wished to be consulted more often (McCormick et al., 2017) and expressed frustration at their perceived lack of power in contrast to that of a medical consultant. Marshall & Sprung (2016b) found nurses wished they had more confidence to enable them to challenge medical colleagues, who had more influence despite being less familiar with patients. In common with Marshall & Sprung 2016b), Phair & Manthorpe (2012) emphasized the personal responsibility of staff to update themselves, but dispute expectations that nurses should model good practice, acknowledging the difficulties of both finding time for learning and with challenging the practice of more powerful colleagues.

**Discussion**

This review identified 16 studies which used and evaluated a range of training interventions aimed at training health and social care professionals how to implement the Mental Capacity Act (DH, 2005). Findings indicate that training is often poorly applied to practice and confirmed existing evidence suggesting that the legislation is not followed effectively (House of Lords, 2014) and that service users’ autonomy is not respected (Taghizadeh Larsson & Österholm, 2014).

 Factors which contribute to both obstructing or facilitating learning transfer were analysed in the process of data abstraction. The majority of included studies in the review provided evidence that MCA training has limited impact in real world health and social care settings. While the studies were able to show that real world application is poor post-training, strategies to demonstrate the opposite and evaluate successful ongoing compliance with the legislation would be difficult to design, given the many confounding factors and unquantifiable nature of training outcomes. Document audits, as conducted by Dunlop & Sorinmade (2014) could address formal recorded capacity assessment processes and evaluate compliance with other documented requirements, but would not have the scope to monitor everyday ethical decision-making carried out in practice. Proxy measurements including knowledge, confidence and testing application to scenarios, were used to reflect participants’ abilities to apply the legislation in practice (Lee-Foster, 2010; Schofield et al., 2012; Phair & Manthorpe, 2012; Willner et al., 2013; Marshall & Sprung 2016b; Bose & McFiggans 2019).

Understanding how the principles of the MCA are applied in practice seems more difficult than initial feedback on the clarity of the MCA seems to warrant. Training can be limited: most common is half a day’s training every three years. Within this timeframe trainees are required to understand not only the principles and how to apply them, but also the two-step test and mechanisms for different types of advance decision-making and the nature of new criminal offences. Further complications arise when service users have complex fluctuating conditions. On detailed assessment post-training, most participants have not retained all aspects, which means they would potentially be breaking the law and failing to uphold their service users’ rights.

*Characteristics that improve training outcomes*

This review focuses directly on MCA training and training outcomes, but uses some of the same sources and confirms some of Hinsliffe-Smith et al’s. (2015) and Marshall & Sprung’s (2016a) review findings, for example that the amount, quality, application and impact of training is limited, but that scenarios, when used, make learning more relevant to trainees. Marshall & Sprung (2016a) reviewed the literature around nurses’ experiences of using the MCA. They identified 32 papers, seven of which are included in this review. Hinsliff-Smith et al. (2015) reviewed literature investigating application of the act. They identified 38 papers, six of which are included in this review. Both Hinsliffe-Smith et al. (2015) and Marshall & Sprung et al. (2016a) conclude that improved training strategies are required to embed application of the act in practice.

Hinsliffe-Smith et al. (2015) explored application of the act. In common with our review, they identified that training outcomes were not measured effectively and it appeared that knowledge was not retained so that learning could be applied. Marshall & Sprung’s (2016a) review focused more broadly around the MCA; the current review aimed specifically at exploring outcomes of training. All three reviews found barriers to knowledge transfer. Hinsliff-Smith et al. (2015) suggested the problems lay within the training itself, they considered that it was too theoretical and infrequent. Marshall & Sprung (2016a) noted barriers within the contexts of care, including paternalistic values. We suggest personal and cultural values and norms, including those related to inter-professional relationships, may impede knowledge transfer.

Training is most effective in situations when the trainee has the opportunity to apply learning soon after training. When the trainee has previous experience, training reinforces it, as does applying the act immediately after training. Within training, realistic, complex and challenging scenarios that relate to the trainees’ own practice dilemmas appear to be significant in facilitating application of learning to practice. Learning through application is central to ensuring the legislation is upheld by practitioners (Willner et al., 2013) and ongoing supervision aids this process (Gough & Kerlin, 2013).

*Resource factors*

Training is expensive (Gough & Kerlin, 2012) and with universal cuts to budgets across services (Lipley, 2018) there are scarce funds with which to pay for release of staff, cover for colleagues and the costs of a trainer and training space (Smythe et al 2017). Studies that reported on a cascade model, designed to save money, found the ‘champions’ and staff managers were not sufficiently knowledgeable or competent to take on the role of leading learning about the MCA (Gough & Kerlin 2012; Phair & Manthorpe, 2012).

Online learning is perceived as a cheaper option which is open to all (Gough & Kerlin, 2012). However, not all health and social care practitioners have internet access, they do not always find online learning effective, nor are they willing to complete online learning in their non-working time (Smythe et al., 2017; Wu, Chan, Tan, & Wang, (2018). While benefits of online learning include flexibility and convenience, together with savings related to staffing levels and funding (Wu et al., 2018) ethical issues arise as the time-related costs have often been passed on to the nurses. Managers of under-staffed organisations with high levels of staff turnover are reluctant to fund more expensive classroom-based learning for employees who may soon change workplace (Gough & Kerlin 2012). Phair & Manthorpe (2012), Marshall & Sprung (2016a) and Marshall & Sprung (2016b) reiterate registered professionals’ responsibility to keep themselves updated. However, in the context of health and social care staff who often work unpaid overtime, it has been argued that the responsibility for MCA learning should not lie with the individual (Goodman, 2016).

*Cultural factors*

A strong values-base within a professional identity may lead to ethical and practical dilemmas for professionals. Social workers share commitment to promoting social justice and challenging oppression (Chechak, 2015) but despite this may get drawn into risk-averse practice (Murrell & McCalla (2015). Health professionals are recruited partly for their caring values (Foster, 2017) which may mean they are more naturally orientated towards ‘beneficence’ rather than promoting autonomy in their relationships with service users. For example, despite increasing attention to the importance of family-based care and decision-making, practitioners continue to make paternalistic decisions on behalf of patients based on their feelings about what is best (Giles et al 2017). Aspects of the MCA require students to ‘unlearn’ outdated responses to decision-making (for example around duty of care dilemmas) while also potentially transgressing personal and professional values that prioritise taking care of others. Some nurses, even those working is specialized areas caring for people with intellectual disabilities or dementia,, struggle to limit their protectiveness towards people they perceive as vulnerable (Marshall & Sprung 2016a). Nurses and care workers retreat from confronting this conflict in values and resolve this emotional discomfort by emphasising the person-centredness of their relationships with patients. In retreating to practice based on misunderstanding of ‘best interests’ they risk the legal ramifications of failing to promote service-users’ autonomy. Short-cutting the processes of assessing capacity and following the five principles of the MCA (which promote a person’s preferences over other cultural and personal values) results in illegal practice which short-changes individuals’ rights to self-government.

Authors’ suggestion of additional strategies to embed learning may reflect implicit acknowledgement not only of the limited nature of most training interventions but also of the non-conducive nature of practice environments to accepting and promoting the spirit and directives of the MCA. The culture of the health service is described as ‘paternalistic and risk averse’ (Marshall & Sprung, 2016b:409). Review studies confirmed this statement (Morriss et al., 2017; Manthorpe & Samsi., 2016, McCormick, et al., 2017; Willner, Bridle, Dymond, & Lewis, 2013), indicating that outdated underpinning cultural values and norms may need to be challenged and addressed to facilitate correct application of the MCA.

It is apparent that a wide range of factors, in addition to the quality and frequency of training, contribute to the difficulty of applying the MCA correctly. These factors are structural (under-funded organisations, low staffing levels, high staff turnover), cultural (hierarchical professional relationships, disempowered staff) and personal (‘beneficent’ rather than autonomy orientated values). Inability to comply with legislation not only disadvantages those whom the legislation is designed to empower, it means individuals and organisations are acting unlawfully and so are open to legal consequences.

Limitations

While the authors followed guidelines on achieving a comprehensive search, it is possible that not all evaluations of MCA (DH, 2005) training have been reported or published in peer reviewed journals. Our review process aimed to minimise risk of bias, but despite this it is possible that some bias occurred. A team approach using independent perspectives was used to promote objectivity.

Although this review focuses on legislation that applies in England and Wales, it has relevance internationally because of global legislative changes following the CRPD directive. Therefore, the implications for capacity legislation training design and evaluation are transferable.

**Conclusion**

This review is the first to explore and evaluate the range of training available for health and social care professionals who need to comply with the MCA (DH, 2005) to empower service-users. The review authors discussed the contextual and cultural barriers to achieving successful implementation of the legislation, considering how under-resourcing and hierarchical professional relationships may undermine application of the legislation. Successful knowledge transfer and subsequent impact for people who may require support with decision-making will be dependent on development of professional relationships which empower practitioners with the confidence to advocate effectively for the rights of others. Further research is required, to explore the factors within the care environment that may constrain or facilitate application of learning from MCA training.

Relevance to Clinical practice

NICE (2018) suggest that further qualitative studies are required to explore the nature of effective training and the barriers to compliance with legislation following training. This review indicates that these barriers may lie partly in the culture and context of clinical practice in which the MCA is implemented. The under-resourced, hierarchical culture of health and social care environments may be impediments to correct implementation of the law. In addition, we argue that holding individuals responsible for poor practice and self-education in these circumstances is unjust. Nevertheless, the MCA is legislation and complying with it is not optional. Training recommendations should be considered in tandem with ensuring an adequately resourced, mutually supportive workplace.

As part of this culture change, identification as ‘learning organisations’ would emphasise the key importance of the nature of the workplace in knowledge transfer for effective practice. Our findings indicate that MCA training should be interdisciplinary, face to face, involve realistic, challenging scenarios, and be further embedded in practice using support from ‘champions’. Expected training content is outlined in the recent NICE (2018) guidance. While we agree with recommendations for further research to explore best practice in training for use of the MCA, we suggest that the impact of any training is also dependent on positive changes in the workplace.

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