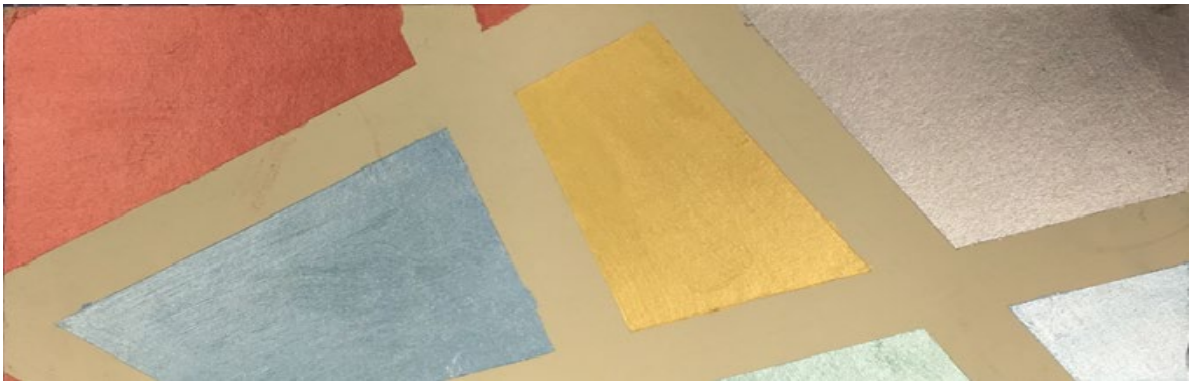

A: Introduction

1. The purpose of this document is to give guidance to provider settings such as care homes and supported living placements in England about:

   (a) when is it necessary to carry out and record a formal assessment of a person's mental capacity, and in relation to which decisions;

   (b) the difference between informally considering capacity as part of good care practice, and formally recording a capacity determination;

   (c) when a formal written record is and is not required;

   (d) how providers should approach capacity across the domains of a care plan; and

   (e) what providers should do if they receive advice from a CQC inspector or local authority quality monitoring officer that appears to go beyond what the law requires.

2. This document cannot take the place of legal advice. In any case of doubt as to what to do, it is always necessary to obtain such advice.

3. You may want also to read our guidance note on assessing and recording capacity, and to make use of the website www.capacityguide.org.uk, which draws upon research conducted by the Mental Health and Justice project to give further assistance to those thinking about capacity, especially in more difficult situations.

[1] Similar considerations will apply in Wales under the regulatory framework that applies there.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young man with autism. We are very grateful to him and his family for permission to use his artwork.

B. Why providers need to think about capacity: the legal framework

4. To understand what is and is not required of providers, it helps to start with the law. The Mental Capacity Act 2005 ('MCA 2005') is the primary legislation and its core principles are set out in s.1. They are:

    a. s.1(2): a person (P) must be assumed to have capacity unless it is established that he lacks capacity;

    b. s.1(3): P is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success;

    c. s.1(4): P is not to be treated as unable to make a decision merely because he makes an unwise decision;

    d. s.1(5): an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests; and

    e. s.1(6): before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

5. However, it is important to remember that the MCA 2005 explains how to think about capacity, not when to think about capacity. There are four key provisions of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which make thinking about capacity a regulatory requirement for care providers.

    a. Regulation 9 - Person-centred care. Delivering person-centred care requires knowing whether the person has capacity to make the relevant decisions about their care.

    b. Regulation 11 - Need for consent. Care and treatment can only be delivered lawfully on the basis of consent, or, where the person lacks capacity, in accordance with the MCA. Providers must therefore know whether a person has capacity to make decisions about the care and treatment they are receiving.

    c. Regulation 13 - Safeguarding. Where care and treatment are being delivered in circumstances which give rise to an apparent deprivation of liberty, careful consideration is required of the Supreme Court's June 2026 judgment in *Attorney General for Northern Ireland* as to whether, notwithstanding the person's lack of capacity to consent (applying the MCA 2005) to the arrangements, they are nonetheless to be seen to able to give 'valid consent' through an expression of their wishes and feelings. This is an evolving area and reference should be had to our website for guidance as it is produced.

    d. Regulation 17 - Good governance. Providers must keep proper records demonstrating the basis on which care and treatment are being delivered. This includes recording decisions made in a person's best interests where they lack capacity, and being able to evidence that those decisions were taken in accordance with the MCA 2005.

C. The difference between considering and formally assessing capacity

6. There is an important distinction between considering capacity and formally assessing and recording it. This distinction matters greatly in practice.

    a. Considering capacity is something that good care staff do informally all the time, observing and communicating with the person in a way that is sensitive to any signs they may be struggling to make a decision. This is part of good everyday care. It does not require paperwork in every case.

    It is also worth pausing on language. The phrase "completing a capacity assessment" is unhelpful, because it suggests a one-shot, tick-box exercise. Assessment is a process of thinking and evidence gathering, it takes as long as it needs to reach a conclusion.

    What gets written up is better described as a record: the documented outcome of that thinking process.

    b. Formally recording a capacity determination is what is required when:

        i. there is a specific, significant decision to be made;

        ii. there is a reasonable basis for doubting whether the person can make it;

        iii. the outcome is significant enough to warrant documentation.

    The record should set out what decision was being considered, what information was given to the person and how, what the person said or showed, and the conclusion reached.

> A key point: the assumption of capacity does not licence providers to avoid investigating where there is a genuine reason to considering it. If there is good cause for concern, the assumption cannot simply be relied upon to avoid the responsibility of assessing and determining capacity.

7. A separate but related question is what to do where a person appears unwilling or unable to engage with a capacity assessment. This should not be used as a reason to avoid assessing. A refusal to engage with, or inability to participate in, a formal assessment does not mean that no determination can be reached. Assessors can and should draw on all available evidence, including observation, care records and the views of those who know the person well.[2]

8. Note: The question of whether a person must have capacity to decide whether to undergo a capacity assessment is a live legal issue at the time of writing this guidance note (May 2026). A decision from the Court of Protection is expected in this area in due course; Alex has given some thoughts

[2] This situation is dealt with in detail at paragraphs 65 to 69 of our guidance note on assessing and recording capacity.

about it here.

D. When is a formal record of a capacity determination required?

9. Both the CQC's guidance and the MCA Code of Practice are clear that formal written records are not required for every decision:

    a. The CQC's guidance says that:

    "The code of practice does not require care services and workers to undertake formal, recorded assessments for minor day-to-day decisions about giving routine care."

    b. The MCA Code of Practice says that:

    "Assessments of capacity to take day-to-day decisions or consent to care require no formal assessment procedures or recorded documentation."

10. A formal written record is required when: (a) there is a specific matter requiring a decision to be made; (b) there is a reasonable basis for doubt about the person's decision-making ability; and (c) the significance of the decision warrants documentation.

11. The following are examples in provider settings:

    a. The care and support package. On admission, and when care arrangements change significantly, it will ordinarily be appropriate to consider and (where there is any doubt) formally to assess and record the person's capacity to make decisions about their care arrangements. This is the core decision in a provider setting and tends to cover the areas the person is assessed as needing support, the sort of support, who would provide it and what would happen without it. Where capacity is found, record that. Where it is lacking, a best interests decision must be made and recorded.

    b. A specific refusal of care. If the person refuses personal care and that refusal has or could have a significant adverse effect on their health or wellbeing, a formal determination of their capacity to make that decision is required. If they lack capacity, there should be a thorough investigation of the person's best interests, including all possible strategies for encouraging them to accept personal care, involving adult social services and any other relevant professionals.

    c. Decisions about receiving visitors. Regulation 9A of the Regulated Activities Regulations specifically requires attention to visiting arrangements. Where there is doubt about whether the person has capacity to make decisions about receiving visitors, a formal determination will be required, and any decisions made on their behalf must be in their best interests.

    d. Contact with others, both in real life and online. If there is a specific concern about the person's contact with another person, for example, distress, exploitation, or safeguarding concerns, a formal determination of capacity to decide about that contact may be appropriate. If a decision is made to prohibit contact or to require it to be supervised on a best interests basis, a decision from the Court of Protection may be required if there is a

dispute that cannot be resolved by discussion.

e. Food or clothing choices with significant consequences. If the person's choices clearly and materially affect their health or safety, or conflict sharply with their previously expressed values, a formal determination should be considered. The question is always whether the person can genuinely understand and weigh the relevant information, not simply whether the choice appears unwise. Do not be put off assessing capacity or concluding that a person lacks capacity just because of perceived difficulties in going against their expressed wishes or choices, or a desire not to be judgmental.

f. Safety when going out. If the person wishes to go out alone and there is genuine concern about their ability to keep themselves safe, a formal determination may be needed. If active steps are to be taken to prevent the person leaving, questions of deprivation of liberty may arise. See paragraph 5(c) above.

g. Self-mobilising and falls. If there is doubt about whether the person understands and can weigh the risks of mobilising independently, a formal determination of capacity and best interests may be required before a restrictive intervention is put in place. Any restriction of movement requires legal justification and may constitute a deprivation of their liberty.

h. Sharing information with family. Where there is a question about whether the person has capacity to decide whether their health and care information should be shared with family or others, a formal determination may be required.

i. Medical treatment decisions.[3] It is important to remember that responsibility for assessing capacity to decide on medical treatment (including prescribed medication and vaccinations such as the flu vaccine) rests with the prescribing clinician, not the care provider. The care provider will know the person well and should be consulted, but it is the clinician who must be satisfied as to capacity or its absence. If a person has been prescribed medication but refuses to take it, the care provider should immediately raise this with the clinician responsible. If a decision is made to provide medication covertly, in addition to following the CQC guidance available here, care providers should ensure that they participate in the best interests decision made by the prescribing doctor.

12. Where a person is found to lack capacity to make a particular decision, providers should check whether a Lasting Power of Attorney (LPA) or court-appointed deputy is already in place who has authority to make that decision. If so, the attorney or deputy may be the decision-maker, not the provider. Even if they are not the decision-maker, they must be consulted as part of the best interests process under s.4 MCA, and their views must be taken into account.[4] Remember that an LPA or deputyship for property and financial affairs does not confer authority over health and welfare decisions, and vice versa, providers should check which type is in place and what it covers.

[3] If it appears that the person may have medical needs which can only be met in hospital, but appears to be afraid of going, see the SCIE guidance document (and interactive learning) "Get me to Hospital."
[4] For more on best interests decision-making, see our guidance note.

E. When is a formal record NOT required?

13. A formal written record is not required in the following situations.

    a. **Where there is no reason to doubt capacity.** If there are no specific concerns about the person's ability to make decisions in relation to specific areas, no formal record is required. A brief note that capacity was considered and found not to be in doubt is sufficient. Providers may find it helpful to frame this positively as confirming the person's capacity, rather than as an assessment of whether they lack it. Note that if a person has been found to lack capacity in one area of decision-making, it may be harder to justify a conclusion that there is no reason to doubt their capacity in another related area.

    b. **Where no decision is currently in contemplation**. The MCA 2005 applies to matters that require a decision. Providers are not required to pre-emptively assess capacity in relation to every possible future decision.

       To take a concrete example: if a care home has a door alarm for the person's room but the alarm is not currently in use and there are no current plans to use it, there is no decision in play and no basis for a formal capacity assessment. One would only be needed if and when the question of actually using the alarm arose.

    c. **Where the decision is routine or trivial**. In principle, everyday choices, such as what to have for breakfast, what to watch on television, or whether to have a bath or a shower, do not require formal written determinations, even for people with significant cognitive impairment.[5] Good care practice supports people to express preferences and make choices at whatever level they can and records those preferences in care plans.

    d. **Where the decision is someone else's responsibility**. As above, medical treatment decisions are for the relevant clinician. Completion of the record of the outcome of the person's capacity to make the relevant treatment decision is for the clinician. The care provider should have, or have access to a copy of the record if they need to implement any treatment plan signed off by the clinician.

14. There are also situations where framing the issue as a capacity assessment is not the appropriate route, for example **where the issue is about behaviour rather than decision-making.**

15. The MCA is concerned with a person's ability to make decisions, not with whether their behaviour is acceptable or manageable. It is therefore not appropriate to frame a capacity assessment around a behaviour, even a problematic or dangerous one. For example, assessing whether a person has "capacity to assault staff"[6] or "capacity to use racist language" is not a legitimate use of the MCA. The right response to such behaviour lies in care planning and risk management, not in a capacity

[5] We say "in principle," because there may be situations in which a decision which appears 'routine' has a particular significance for the individual in question. As set out in paragraph 11 above, an example could be where a person with a significant health condition wishes to order a takeaway which contains food which is known to exacerbate that condition.

[6] For more on why this is so problematic, see the recording and slides from the webinar on "When P is an Offender."

assessment.

F. Does a provider need a formal record for every domain of a care plan?

16. No. It is not a legal requirement under the MCA 2005 or the Regulated Activities Regulations for a provider to hold a formal written capacity determination in respect of every domain within the person's care plan. Nor does the CQC's own guidance suggest that this is necessary.

17. Importantly, the courts themselves do not approach capacity in this way. They look at what might be called clusters of decisions, the key areas such as care, residence, contact, medical treatment.[7] The legislation refers to a person lacking capacity "in relation to a matter" if he is unable "to make a decision for himself in relation to the matter". They do not "salami slice" down into every individual decision a person might take. They have no interest in whether someone has capacity to decide to clean their teeth, followed by capacity for deciding what to have for dinner, followed by capacity to decide to have a dressing changed. That is not how the MCA 2005 works, and it is not what good practice requires.

18. A sensible approach is to have a core assessment covering the key matters requiring decisions (such as capacity to decide on care, capacity regarding contact etc), done by someone with a proper understanding of the law. Individual care plan domains can then refer back to that core assessment, noting whether decisions within each domain are being made on the basis of the person's own capacitous consent/refusal or on a best interests basis.

19. Providers who have been told by inspectors or quality monitoring officers that they must have a formal assessment for every care plan domain should ask for the legal basis for that requirement. Unnecessary documentation diverts staff time from people and can obscure the genuine capacity issues that do need to be properly addressed.

G. What should providers do in practice?

20. Pulling the threads together above, in practice, this means:

    a. On admission or placement: Consider the person's capacity to make decisions about their care arrangements. Record the outcome. If there is no reason to doubt capacity, record that confirmation. If there is doubt, carry out and record a formal determination. If the person lacks capacity, make and record a best interests decision.

    b. Core assessment: For people where capacity issues are known or likely (for example, those with dementia or significant learning disabilities), carry out a good quality core assessment covering the key matters requiring a decision. This should be done by someone who understands the MCA 2005 properly. Other care plan domains can cross-refer to it.

    c. Ongoing: Keep capacity under active review. When a specific concern arises, an unusual decision, a change in condition, a safeguarding issue, consider whether a formal

[7] See our guidance note on relevant information for different categories of decision.

determination is needed and make one if it is.

d. Reviews: Capacity can change. Revisit any determination if the person's condition changes significantly, if new information emerges, or if a new significant decision arises. But the mere passage of time does not automatically require a determination to be redone, only when there is a specific reason to think capacity may have changed.[8]

e. Documentation: When writing up a determination, include: a clear formulation of the specific decision being considered; the information that was identified as relevant; how that information was conveyed to the person; what the person said or demonstrated in response; and the conclusion reached. That is what the courts want to see. A record that simply asserts a conclusion without explaining the process is not adequate.

H. Summary

21. The MCA 2005 does not require care providers to hold formal written capacity determinations for every domain of every person's care plan. It requires providers to: assume capacity unless otherwise established, support decision-making; and formally assess and record capacity only where there is a specific, significant decision to be made and a reasonable basis for doubt.

22. For most people, it will be sufficient to have a confirmation that capacity to decide about their care arrangements was considered on admission, a small number of good-quality core assessments where issues have arisen, and records of best interests decisions where the person has been found to lack capacity.

23. Domain-by-domain formal records, routinely repeated at set intervals regardless of any specific concern, are not required, are likely to be counterproductive and unduly burdensome on the person being assessed.

24. Where a provider receives advice from a CQC inspector or local authority quality monitoring officer that appears to require more than the MCA demands, it is entirely appropriate to ask for the legal basis.

[8]A note on "fluctuating capacity": This term is often misused. Saying someone has "fluctuating capacity" should not be a shorthand for the fact that they have capacity to make decisions in some areas but not others. That is simply what decision-specificity means. True fluctuating capacity is a distinct and more complex situation. See our guidance note on assessing and recording capacity.

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