Does the Mental Capacity Act create a barrier to good wound care?

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The number of people in the UK aged 65 years or over maintained an upward trajectory by mid-2024 (Office for National Statistics, 2025). While a focus on 'healthy ageing' is to be welcomed, advancing age and illness are closely associated, with one condition often leading to another, e.g. a stroke leading to the development of vascular dementia (Office for Health Improvement and Disparities, 2022).

Mental capacity is a factor in several health-related conditions, e.g. dementia, Huntington's disease, multiple sclerosis and delirium. In addition, there are those with a learning disability, autism, mental illness, or alcohol or drug dependency who may need their capacity assessed before care and treatment can be given.

The paternalistic approach in healthcare has declined from being common practice as respect for patient autonomy has increased (Schramme, 2015). Yet in wound care, even where the patient has capacity, this approach is still seen. Consider how often a patient is given a choice of different antimicrobials for their infected wound, with the pros and cons of each being explained so that they can make an informed choice. Griffith (2025a) states we need to see our patients as adults, who can not only make a choice, but also understand the risk and be accountable for their own decision.

Nurses will see multiple patients with a gamut of health needs in their everyday working life. However, while they are experienced in their own area of practice, they often lack confidence in when, and how, to apply the Mental Capacity Act (2005)[MCA] (Stokes et al, 2025).

At its heart the MCA has five core principles:

1. Presumption of capacity.
2. Supporting individuals to make their own decisions.
3. Their right to make an 'unwise' decision.
4. Their best interests.
5. Taking the least restrictive option.

A meaningful capacity assessment has a clear two-step process, a functional test (can the patient make the decision?) and a diagnostic test (is the inability to make the decision due to an impairment, or disturbance in the functioning of the mind?) (MCA, 2005).

Because it is decision specific, a patient admitted with an existing pressure ulcer could potentially need multiple capacity assessments covering repositioning, equipment, wound assessment and wound dressing. In addition, lacking capacity for two of those decisions does not equal a lack of capacity for the other two, nor does the patient 'lacking insight' equate to a lack of capacity (Griffith, 2025b).

Stokes et al (2025) considered the barriers for MCA implementation in care homes, which included lack of confidence, poor contextual understanding, resource deficits and time pressures as four of the key obstacles in applying the MCA. I would suggest that these are difficulties experienced by primary and secondary care. Beale et al (2024) expanded further on this to encompass situational disparities and the impact of clinician variability from personal values and beliefs.

A review of available resources highlights several informative guides: Ethics Tool Kit (British Medical Association, 2025), MCA Code of Practice (Office of the Public Guardian, 2013) and Mental Capacity Tool Kit (Bournemouth University and Burdett Trust for Nursing, 2026).

Comprehensive and informative modules by NHS England and eLearning for Health are completed by staff for their mandatory MCA training in Leicestershire Partnership NHS Trust.

The potential difficulty with these resources and modules is linked to their very level of comprehension – while excellent, they are very detailed and generic. Therefore, individual Trusts are beholden to look at how they deliver meaningful, service specific, MCA training. This could be as an addition to mandatory eLearning for MCA, or as bitesize sessions provided by their safeguarding team, or manager with a good foundation in the application of MCA (Stokes et al, 2025).

The challenge for healthcare professionals is to recognise not only when a mental capacity assessment is required, but also that the onus is on them to prove the patient lacks capacity, as opposed to the patient proving they have it (Beale et al, 2024).

In the next issue of Wounds UK, the Leicestershire Partnership NHS Trust Tissue

Viability team new starter induction is looked at, this includes application of the MCA. This will be followed later in the year by an article looking at the MCA in more detail.

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