RESTRAINTS FOR MEDICAL INTERVENTION

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CASE SCENARIO 1

- Mr E a 50yr old man on the MH unit
- Psychotic? But no verbalization and minimal collateral as he was a foreign national
- Concerns re food and fluid intake for weeks, lethargic, dehydrated, hypoglycaemic? But non adherent with observations and blood tests. GP called to assess
- Declined any examination. On balance thought to lack capacity to refuse
- WHAT WOULD YOU DO?

CASE SCENARIO 1

- No interpreter needed as had spoken good English previously
- Persuasion exhausted
- Restraint for physical observations deemed to be the least restrictive option
- Mr E did not resist, and the observations and blood tests were reassuring
- His mental and physical condition improved over the following weeks, prior to deportation

CASE SCENARIO 2

- Mr Z was a 39yr old foreign national admitted to the MH unit with a working diagnosis of schizophrenia
- Concerns re food and fluid intake for weeks, but non adherent with observations and lacked capacity. GP called to assess
- Cold cell, minimally clothed, clinically dehydrated and tachycardic at rest
- Officers advised GP to withdraw due to aggressive behaviour
- WHAT WOULD YOU DO?

CASE SCENARIO 2

- GP called an ambulance and gave advice about vulnerability during transfer
- The governor phoned the GP with concerns about safety in an ambulance
- Mr Z was transferred to hospital in a prison van with a paramedic, with the ambulance following
- Mr Z arrived at hospital, collapsed from hypothermia and renal failure admitted to ITU, where he made a full recovery

CASE SCENARIO 3

- Mr O was a 28yr old man acutely psychotic on the mental health unit
- Food and fluid refusing, non compliant with observations
- Paranoid and agitated, leading to an unprovoked assault on a staff member
- Accepted by a medium secure mental health unit, but only if cleared by ED on basis of full neuro exam, bloods and MRI head

ISSUES RAISED

- Medical uncertainty: when is a dehydrated patient at risk significant enough to intervene? What treatments are available?
- When can we restrain from restraint, and watchfully wait?
- How to assess and monitor patients who won't/can't engage?

National Early Warning Score (NEWS) 2

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Royal College of Physicians

Visual A-E Assessment

NHS Mersey Care NHS Foundation Trust
Community and Mental Health Services

Only to be used if patient refuses or it is unsafe to complete physical observations (NEWS2)

Assess patients A-E and tick the most appropriate statement
If ANY orange statements are ticked an immediate review by a registered nurse in charge must be completed and medical staff contacted
Complete NEWS2 as soon as possible

Name: _____ **DOB:** ___/___/_____ **ID No:** _____

		Date											
		Time	Prior	A	10	20	30	1 Hr	1.5 Hrs	2 Hrs	2.5 Hrs	3 Hrs		
Why are you unable to do physical observation (NEWS2)? Refused (R) Unsafe (U) **If patient is in seclusion time physical obs in line with Seclusion policy*														
A	• Talking (not just moans and groans) within patient's normal parameters • Breathing is quiet and regular													
	• Breathing is noisy – irregular, fast • Increased breathlessness or airway obstruction causing reduced ability to talk/communicate normally													
B	• Respiratory rate is between 12-20 per minute PLEASE RECORD RESPIRATORY RATE ON NEWS2 OBSERVATION CHART • It requires no extra effort and does not appear difficult													
	• Respiratory rate is below 12 per minute or above 20 per minute PLEASE RECORD RESPIRATORY RATE • Breathing appears to be difficult and/or noisy													
C	• Normal level of mobility for patient • Orientated to time, person and place • Normal skin tone for that patient													
	• Reduced level of mobility which is normal for that patient • Mottled or cyanosed skin • Blue grey tinge to lips • Appears sweaty and clammy													
D	• Alert, responsive and active • Spontaneous speech													
	• Unexpectedly sleepy/drowsy • Change in responsiveness • Unexpected or new confusion, coherence and/or disorientation													
E	• Patient's condition appears stable • No known underlying physical health conditions, interventions or substance misuse													
	• Rash, wounds, actively bleeding • Staff or patient expressing concerns • New pain/discomfort													
Observations completed by:														

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TO BE SCANNED INTO ELECTRONIC PATIENT RECORD

SCENARIO 4

- Mr J was a 42yr old man with a history or substance misuse
- Found unconscious in cell head down in vomit, respiratory arrest
- Given naloxone by the attending nurse, spontaneous respiration restored
- GP reviewed: still drowsy, borderline oxygen sats, aspiration pneumonia?
- Mr J refused to go to hospital, officers and LAS reluctant to escort
- It was 5pm
- WHAT WOULD YOU DO?

SCENARIO 4

- Mr J lacked capacity due to intoxication/hypoxia, naloxone wearing off
- Persuasion exhausted
- Officers agreed to escort with GP in attendance using least force
- Patient admitted to hospital, uneventful recovery

ISSUES RAISED

- Medical uncertainty: how long can we wait for capacity to recover?
- How urgent is the medical intervention?

SCENARIO 5

- Mr P was a 36yr old man with history of schizophrenia and violence
- Months after reception he refused antipsychotics, had capacity, on MH caseload
- Sudden deterioration in MH, agitated, precipitated by spice? Admitted to MH wing
- Sustained a hand injury from punching walls and a severe burn
- Declined examination and oral antibiotics, deemed to lack capacity to decline
- Psychiatrist concerned about excrement on open wound, bone visible
- WHAT WOULD YOU DO?

SCENARIO 5

- Clinical staff failed to persuade Mr P to engage in observations and wound care
- Clinical and prison met to discuss restraint for wound care, physical obs, and perhaps intramuscular antibiotics
- Vulnerabilites identified: avoid handling affected wrist
- Restraint challenging in small cell, tension between safety and patient dignity
- Healthcare camera unavailable
- Examination did not confirm fracture but did reveal significant cellulitis
- Intramuscular antibiotics and wound care led to rapid healing
- Several day later Mr P responded to oral antipsychotics and his mental health improved

ISSUES RAISED

- Interprofessional working: how quickly can we consult the necessary parties?
- Maintaining both staff and patient safety and dignity: guidance for discipline staff

4 Procedure for restraint for medical intervention

1 A patient refuses a medical intervention. A senior clinician must ask the question “does this refusal put the patient at risk of serious physical harm?”

Yes

2 A senior clinician must ask the question “can the patient understand the information relevant to the decision, retain that information, weigh up that information as part of the process of making the decision and communicate their decision?”

No = patient lacks capacity for this decision

3 The clinician documents their findings on S1 and alerts the Head of Healthcare (or deputy) who convenes a multidisciplinary meeting between healthcare and discipline staff. They address the key question “Is use of force deemed necessary and proportionate for medical care under best interests? If so what procedures would be least restrictive and maximise the dignity of the patient and safety of staff?”

Yes

4 The security team leads a briefing for all the staff to be involved in the restraint and medical intervention

5 The security team leads the restraint and instructs healthcare staff when and how to approach for the medical intervention. Security will film the restraint, but avoid recording any views where the patient’s dignity might be compromised

6 The security team leads a debriefing for all the staff to be involved in the restraint and medical intervention

7 Hotel 3 fills out a F312 use of force form, detailing any injuries

8 The responsible clinician and other clinicians involved document their medical intervention on S1, and makes a care plan outlining any monitoring required, further conditions for any future restraint and a handover to a named lead clinician

1. Medical risk
2. Capacity assessment
3. Interprofessional partnership
4. Restraint planning: least restrictive option?
5. Prison led restraint
6. Debrief
7. Documentation
8. Handover

PROPOSED GUIDANCE (SEE DRAFT)

- Should outline clear roles and responsibilities
- Should address medico legal frameworks re capacity, duty of care, best interest decisions, and seeking the least restrictive options
- Should be realistic about time frames for interprofessional meetings
- Should address the use of patient advocates (where time allows)
- Should offer practical advice for managing vulnerable patients including parenteral antibiotics (see pathway), monitoring patients who won't/can't engage, and maintaining staff safety and patient dignity
- Should address documentation and continuity of care

Legal issues relating to compulsory treatment

21 October 2022

Francis Lyons, **Partner**

RCGP Secure Environments Group
9th Health & Justice Summit

Mental Capacity Act
Capacity and best interests

Capacity Test Mental Capacity Act – Section 2

"…a person lacks capacity ... if at the material time he is unable to make decision for himself in relation to the matter, because of an impairment of, or disturbance in the functioning of, the mind or brain."

- **Time specific:** Loss of capacity may be temporary or permanent.
- **Decision specific:** May be capable of making some, but not all, decisions.
- Decide on balance of probabilities.

Capacity Test Mental Capacity Act – Section 3

- A person is unable to make a decision for themselves if, at the material time, they are unable to
  - **understand** the information relevant to the decision
  - **retain** that information
  - use or **weigh** that information as part of the process of making the decision; or
  - **communicate** his decision
- You can use the MCA to treat both physical and mental health if the patient does not object.

Best Interests Mental Capacity Act – Section 4

- “Must consider” all relevant circumstances and in particular:
  - whether P will regain capacity, and if so, when
  - past and present wishes and feelings of P;
  - beliefs and values likely to influence decisions;
  - consult named persons, carers, donee of lasting power of attorney (LPA);
  - Involve P wherever possible;
  - Life sustaining treatment: must not be motivated by desire to bring about death

Unwise and irrational decisions
Mental Capacity Act – Section 1(4)

- *“A person is not to be treated as unable to make a decision merely because he makes an unwise decision.”*
- There is little other guidance other than to note (2.11) that concerns can arise if somebody:
  - *repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or*
  - *makes a particular unwise decision that is obviously irrational or out of character*

Mental Capacity Act
Restraint and Deprivation of Liberty

Use of restraint Section 6 MCA

6.1 If D does an act that is intended to restrain P, it is not an act to which section 5 applies unless:

6.2 D reasonably believes that it is necessary to do the act in order to prevent harm to P;

and

6.3 The act is a proportionate response to:

(a) the likelihood of P's suffering harm, and

(b) the seriousness of that harm

Use of restraint
Section 6 MCA cont'd

6.4 Under this section D restrains P if he

(a) uses or threatens force to get P to comply, or

(b) restricts P's liberty of movement

6.5 D does more than restrain P if he deprives him of his liberty under Article 5.1 of the ECHR

Use of Restraint
MCA Code of Practice

6.43 of the MCA Code

"…staff may, under common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else…"

"…However, within this context, the common law would not provide sufficient grounds for an action that would have the effect of depriving someone of their liberty."

Mental Health Act

Admissions under parts I and II of the Mental Health Act 1983

Part I MHA

- s. 2 = Admission for assessment and treatment
- s. 3 = Assessment for treatment
- s. 4 = Urgent admissions (“emergency application”)
- s. 5 = ‘holding’ power over informal patients

Part II MHA

- s. 47 = Removal to hospital of persons serving prison sentence
- S.48 = Removal of other prisoners
- All require admission to a hospital for use of the MHA

Practical challenges of using MHA

- Timings
- Available personnel:
  - Approved psychiatrists
  - Social workers / Approved mental health professionals
- Available hospital:
  - Is there an appropriate (mental health?) hospital available?
  - Is there a bed available within it?

Issues and Risks

Legal risks of treatment
Damned if you do, damned if you don't ...?

- Criminal issues: assault and battery
- Breach of duty in negligence:
  - a failure to give sufficient information could be negligent e.g. *I would / wouldn't have had treatment if you had told me …*
  - A failure to treat can give rise to harm.
- Breaches of MCA and HRA. ECHR "operational duty" to take reasonable steps to protect patients from the real and immediate risk of suicide.
- In addition: CQC, Inquest proceedings and SI investigations

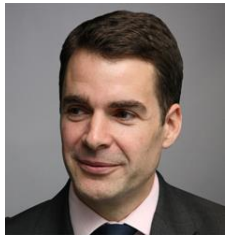
Reducing legal risks - 1

- Do you believe P has capacity?
- Have you taken account of P's wishes
- Identify the risks posed to P and / or by P
  - Clinical concerns
  - Security concerns
  - Death / serious injury
- Is the proposed plan in P's best interests if they lack capacity? Are you seeking to protect others?
- Is the plan proportionate to the likelihood of harm and the seriousness of that harm? Is the plan the least restrictive option?

Reducing legal risks - 2

- Have you consulted colleagues or independent professionals on P's capacity and the options?
- What lawful authority do you have if you are restraining or depriving P of their liberty?
  - Common law
  - Criminal Law
  - MCA
  - Court Order
  - MHA
- Have you documented your discussions?
- When are you reviewing / revisiting the decision?

Questions



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