

JISC update February - March 2018

Place of Safety issues

Question from Barnet - 'This is a pragmatic question ...I would value some ... thoughts please. We have lots of mental health presentations to ED but we are not the designated 136 POS.

We have got to the stage where the hospital generally agrees there are cases where a patient should not be allowed to leave. However we can't get an agreement on how this should be done. My suspicion is that there is a gulf between practice and policy up and down the country. I think nurses in ED do what is necessary and stop people, but the hospital's policy is that they should not.

I would be interested to know if this is a common experience and if any institution has satisfactorily resolved it.

Response from the West Country: They share Barnet's pragmatic solution. However acknowledge that 'It would be good to get shared best practice because this seems to be becoming commoner - although I think the revision to legislation makes ED clearly a place where a section 136 could legally be applied. That wouldn't help with the supervision/management during the 24hrs waiting for the assessment though'.

Impressive response from Macclesfield: This service has put in joint training with security staff and acute hospital staff around conflict resolution and managing difficult situations where restraint might be needed. We have done this using simulation scenarios where security staff are called in to play their role and are part of the debrief. 'We are very fortunate to have well trained engaged security staff and the process has allowed discussion back and forth informed by MCA about what staff would like, how this can be best achieved. The feedback for the training has been very positive. We have also tacked on breakaway training for general hospital staff which has never been offered to them before to help them feel empowered. We have trained about 80 people.'

Advance directive question

A question from the south coast of England: What if a patient has an advanced directive saying he/she doesn't want (if required) to be ventilated and kept alive – no mention of cause of need – and trust solicitors have said the A/D is valid. And there are concerns concerning suicide attempts.

What are your thoughts on legality of trying to keep patient alive following suicide attempt?

From Cambridge – and this is largely verbatim as so well written: This clinician takes the approach that where there is ambivalence you may have reason to doubt an advance statement or ADRT; though ADRTs should be situation specific and you should be happy that they were not written under duress or when lacking capacity. MCA and MHA may both have a place at different stages of management and of course prolonging life after a suicide attempt is not a one off decision. Initial life-saving actions may be highly justifiable regardless of advance statements in any form, but prolongation of irreversible conditions needing long term invasive support measures would need careful consideration in the presence of any indication of wishes to the contrary.

Shared decision making is always the key.

Tony David wrote an editorial in the BMJ about the case which is an interesting read

<http://www.bmj.com/content/341/bmj.c4489>

From Shropshire: who thinks that in the case of a psychiatrically unwell (depression or personality disorder) patient he would consider MHA 'which potentially "trumps" AD' and as part of her psychiatric treatment she needs to be kept alive with physical treatment which I believe also is supported by case law under MHA.

From Dublin – again this is largely as per response as so eloquent: The issue is Capacity to refuse treatment. If there is no risk of harm to the patient (or others) in the advance directive, there is no need to assess capacity. If there is risk of harm, then the principle of Duty of Care applies in considering treatment or not. There is divided opinion about whether the principle of assumed capacity applies to advance directives where harm may result. Legal opinion often leans in favour of assuming capacity because British jurisprudence is historically based on the fundamental principle of Autonomy. Medical opinion on the other hand, often leans in favour of requiring capacity to be proven (if there is risk of harm), because medical ethics is historically based on the principle of Best Interest / Duty of Care.

In the case of an advance directive for treatment refusal following a suicide attempt, the case for assumed capacity is missing; and therefore it would need to be established that the person had demonstrated capacity (in relation to the specific treatment refusal) at the time the advance directive was made in order for it to be valid.

A complex case discussion...

... was had; around the management of a patient with diabetes and extremely poor control resulting in frequent and highly dangerous DKA episodes. No specific ICD diagnosis appears to be present. Psychotherapy has been offered and rejected.

Responses to this case questioned whether the patient's thinking around the diabetes and treatment may be delusional; and therefore potentially treatable under the Mental Health Act.

A useful case was cited where a person 'who has the capacity to decide may, for religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequence may be ... her own death' (Re MB (Medical Treatment) [1997] EWCA Civ 3093, [17] (Butler-Sloss LJ)).

The need to consider cultural and religious factors was thought to be vital in this case – and the need to keep trying and remain involved in the quest to improve diabetes control despite there being little change to date – and not to give up.

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