Browne Jacobson

Shared Insights: Safeguarding Forum - Safe discharge and conveyance of patients

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Safe discharge and conveyance of patients – the legal perspective

Clare Shepherd, Senior Associate, Browne Jacobson

Introduction

- It is important to bear in mind the legal framework when planning discharge and conveyance plans but practicalities are also key.
- The safety of the person is obviously the most important aspect but is balanced alongside what is practically possible and mitigation of risks as needed.
- The ideal discharge situation is when P retains capacity, there's a placement identified and there's no dispute.
- It's normal for people to want to leave hospital as soon as possible but even for straightforward discharges, there are lots of details to collate and communicate with all involved including public bodies, family and the person themselves.
- Would recommend having a discharge plan document which covers all of the relevant points and that can be shared with all parties.
- Obviously it becomes more complicated when P lacks capacity or if there is a dispute or if there is nowhere for P to move to.
- Each case will be very fact specific so if you're not sure seek advice from managers and refer to internal policies etc. for further guidance.

Those who have capacity

- If they are objecting to discharge, possibly because of a dispute over where they are going, make sure you make your position clear and set out why discharge is needed e.g. risks of staying in hospital.
- It can be helpful to arrange a meeting with the person and family to go through their concerns, make sure this is well minuted and consider confirming it in a letter afterwards.
- If someone really doesn't want to leave, the Trust can seek a court order to evict them from hospital. It's rare but in 2016 a Trust did get an order to get possession of a hospital bed from someone who had been ready for discharge for 11 months.
- Someone can make a capacitous, albeit unwise decision, to go home without a care package if they want to but make sure it's all carefully documented that they were aware of the risks and definitely had capacity – have evidence to support that.

The legal perspective

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Those who lack capacity

- Obviously capacity is decision specific so is there an up to date assessment about the relevant decision - care and residence?
- Remember the 5 principles of the Mental Capacity Act (MCA), is there an IMCA or similar for P so their wishes are being factored in?
- If you can't act in line with the person's or their family's wishes then explain why not e.g. due to their care needs and the risks to the person. If it is not possible to resolve dispute then you will need an application to the Court of Protection
- Consider the specific risks of the conveyance to the placement and how you would mitigate these, in the least restrictive way possible:
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- Practicalities of transport – does P need support for the journey?
- Would restraint or sedation be needed?
- Can familiar staff go with them to minimise distress?
- Does the new placement know enough about P's risks? Have they met them? How will they be greeted to minimise distress?
- Helpful checklist provided by DJ Avis in March 2018 – if you would like to see a copy please contact Clare Shepherd or Victoria Colclough – their contact details are at the end of this note.

What if restraint is needed?

- S.4A MCA - You cannot authorise restraint by way of a best interest decision – you need a court order
- S.4B- MCA – unless it's a vital act or done to sustain life (e.g. someone walking out in front of a bus you can absolutely restrain them). If you are making a treatment plan it is worth considering if restraint will be needed and whether a Court application needed.
- S.4B is more about an emergency situation so if you think there's a chance that restraint will be needed in the transition you will need the Court to authorise the appropriate care plan with details of MAPPA techniques etc.

Deprivation of Liberty

With restraint you need to consider whether it constitutes a DoL.

ACCG v MN [2017] UKSC 22 at paragraph 38 'an application to court may also be required where the proposed procedure or treatment is to be carried out using a degree of force to restrain the person concerned and the restraint may go beyond the parameters set out in sections 5 and 6 Mental Capacity Act 2005. In such a case, the restraint will amount to a deprivation of the person's liberty and thus constitute a deprivation of liberty. The authority of the court will be required to make this deprivation of liberty lawful.'

As a firm we deal with cases of both transfer to and from hospital – need to consider what is necessary e.g. an ambulance or police involvement and the steps to take on arrival.

Transition plans can be done in a rush but try to take a step back and consider what the person wants, what the family wants and consider what you will need. Think about whether this will need an application to Court – better to think of this at the beginning of the process rather than later down the line.

Always consider:

1. Recognise where a deprivation of liberty may be
2. Be honest about what the steps will be
3. Pause – are the steps proportionate or can the outcome be achieved in another way?
4. If necessary seek authority

Case Study

We sought an order in the High Court for authority to bring a patient who lacked capacity to make decisions about care and treatment into hospital for investigations and treatment, which were believed necessary to save his life. Appended to the draft Court Order was a very detailed care plan taking the Court through the day of the procedure in great detail, including the full conveyance. This is useful for all types of cases considering details such as:

- Engagement with P – so continuing MCA
- Transfer from Place A – If refused, restraint would be minimal possible to achieve the aim. Asked first, if says no then Lorazepam, if refused IM sedation.

- Transport? Who would go with him? How long is the journey? Is sedation needed – if so what and what dosage? On the morning P would not be given breakfast so not to affect GA
- Arrival at the hospital – Who will meet P? Taken to anaesthetic by the shortest route – minimise distress
- Procedure
- When he wakes up – who will be with him? Team on hand if case restraint needed when wakes up
- In the plan set out all contacts – names, emails and numbers

Key takeaways

- Communication
- Planning and documentation
- Involving the patient and family where appropriate
- Consider capacity – if lacking capacity consider the prompts DJ Avis provided
- Always seek support and ask questions in your organisation
- Each patient has to be considered on case by case basis

The Trust perspective – practical tips

Lisa Newboult, Named Professional in Safeguarding Adults and Mental Capacity Act, United Lincolnshire Hospitals NHS Trust

Lisa is the Named Professional in Safeguarding Adults and Mental Capacity Act at United Lincolnshire Hospitals NHS Trust. She set out some examples of how she and her colleagues have managed different situations and her practical tips

- Get appropriate people around the table early, those that know family the best, commissioners and a representative from the place they are going to. If the point of needing to go to court is reached, they will require information from all of them – the court can see appropriate people are on board.
- Provide the Court with a minute by minute care plan and set out at each stage what the back up plan is if this goes wrong.
- Start with the least restrictive measures.
- Demonstrate to the Court what the impact will be to the patient and make sure your clinicians are clear on the benefit to the patient of the proposed treatment and their quality of life.
- Identify a named individual who is available to co-ordinate if you receive a Court order out of hours. The police and ambulance service will act on the order but you will need someone to take responsibility for facilitating.
- In urgent situations - if the time it would take to make an application to court would likely result in the patient's death/serious harm, with clear evidence, detailed minuting and everyone in agreement you can bring a patient in without making an application.
- For patients who don't want to leave hospital, particularly when moving to residential care try 3 or 4 times with the least restrictive plan prior to escalating to Court – you can show you have tried this and it is clearly not working.
- Consider what level of restraint can be used before applying to Court. Low level dose of Lorazepam can be given under MCA and Best Interests.
- If you need physical restraint or medication that will effect them by making them compliant rather than just taking off the edge you would need to make an application to the COP as would be beyond the permission of the MCA section 5.
- Sometime the GP can prescribe the medication but where this is not possible it is important to liaise with the anaesthetic team.
- Planning is crucial. Often the amount of planning results in the patient becoming compliant on the day. Having a back up plan gives people confidence without that things can go wrong.

Lisa has written some guidance on conveyance and disputes for staff at her Trust. For professionals who would like more information about this guidance please contact Lisa – contact details at the end of this note.

The private ambulance provider's perspective

Marlon Fullick, CEO, LSA Secure Limited

Marlon is CEO of LSA Secure Limited, a private ambulance service which transports patients detained under MHA. Marlon is also the PMVA Lead.

When transporting patients there is a need to work out how best to do that with the least restrictive practices. There are a number of issues providers need to consider

- Individual needs
- Is the patient a morning/afternoon person
- Tailoring the care around physical or verbal aggression
- Physical needs - do they require a stretcher or wheelchair or such things as sedation or intubation.

Case study

A patient with a diagnosis of cancer who did not want to attend hospital so the Trust had been to the CoP. Marlon and his team:

- Liaised with anaesthetics and the medical team.
- Brought two ambulances, one was secure and one was A&E capable with a doctor who could manage sedation on route.
- Also had ambulance crew who were PMPA trained to deal with physical aggression.
- It was straightforward in the end and the patient agreed to get on the ambulance, but have to look at worst case scenario.

Marlon explained he tries to work with the Trust and the lawyers as early as possible to find out what is best for the patient. If you have the luxury of time and know you are going to be making an application to Court, many things can be put in place.

Tips

Make sure that when you select an ambulance provider they are able to offer you the full practice. Some are more PMPA led – you need an ambulance service with medical/clinical ability.

Your ambulance provider should be asking you a lot of questions and working collaboratively with you.

If sedation is likely, you will need a doctor, a paramedic for IV drugs, ambulance crew for physical restraint. First aiders who are PMPA trained are fine for a restraint led transfer – but if you are going to need medication before reaching your destination you will need to have additional clinical grade staff.

Discussion

During the call, a number of issues were discussed and addressed by the speakers, including

Who is the responsible body for the conveyance – the starting point or the destination?

It tends to be whoever is best placed, and has the information. If someone has made the care arrangements at the placement it is likely to be someone at the Local Authority or CCG. Have someone responsible for co-ordinating it but you still need support of all the teams involved. Good working relationships are important.

Is there particular advice surrounding end of life patients who lack capacity being transferred when they are close to death and transfer is challenged by the family?

Where possible (and clearly timescales can be limited), if you have something in writing e.g. care plan or letter for the family explaining, it can help later e.g. at inquest. Families are getting information at a time when they are under great emotional stress and may not take it on board. Having something written down including reasoning for decision making (even if they challenge it later) can show you have behaved reasonably and rationally and tried to accommodate their wishes as much as possible.

Sometimes there is a “main” family member involved and they have agreed but not communicated that to the rest of the family. Anticipatory care plans can help.

Is Advanced care planning completed as part of the care plan?

The more advanced care planning we have the easier the job becomes as it tells you what the patient wanted.

We heard about an example of shared information on individuals so everyone involved in their care is aware what the advanced care plan is with the information available to the ambulance service, GP, District Nurses and out of hours service, co-ordinated by the acute Trust.

A consideration for any transfer/intervention that requires a clinical holding/restraint is the competency of the staff undertaking those physical

interventions, CQC would not expect that those trained meet the new RRN training standards.

CQC guidance on restraint reduction is that it doesn't recommend which provider is appropriate although you do need to make sure the crew are properly trained and do due diligence on your ambulance provider and work out what sort of intervention may be required en-route. If you are going to need to administer medication or medical treatment before reaching your destination you will need to have clinical grade staff.

Thank you to everyone who has contributed to the Safeguarding Forum in 2021. Shared Insights will be back in January 2022 with the quarterly Safeguarding Forum returning in March.

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