mentalwelfare commission for scotland

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INVESTIGATION REPORT

The care and treatment of Ms AB

Contents

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and guiding and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

Individuals with mental illness, learning disability and related conditions have the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recover and lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Introduction

Introduction

This investigation was conducted under section 11 of the Mental Health (Care and Treatment) (Scotland) Act 2003. Section 11 gives the Mental Welfare Commission (the Commission) the authority to carry out investigations and make related recommendations as it considers appropriate in a number of circumstances. Among these circumstances are those set out in sections 11(2) (a) and (d).

Section 11 (2) (a) authorises the Commission to investigate if it appears that a patient may be unlawfully detained in hospital.

Section 11(2) (d) relates to circumstances where an individual with mental disorder may be, or may have been, subject, or exposed, to:

(i) Ill-treatment;

(ii) Neglect; or

(iii) Some other deficiency in care or treatment.

We knew of Ms AB because of a telephone call for advice from MHO1. This related to the operation of a welfare power of attorney. We heard that she had been admitted to Ward A, Hospital 1 in October 2011. As we were visiting the hospital, we took the opportunity to review her care and treatment.

We found that she had been admitted to Hospital 2, a community general hospital in a rural location prior to her transfer to Hospital 1. We were concerned that she had been repeatedly sedated with intravenous midazolam during her admission to Hospital 2. Over a 52 hour period from admission until transfer to Hospital 1, she was sedated on 11 occasions with intravenous midazolam. Each individual dose was low, but the total amount was in the region of 27mg.

We had concerns about the clinical appropriateness and legality of Ms AB's care and treatment over this time. Initial evidence indicated that she lacked capacity to consent to this treatment. It also appeared that she may have been prevented from leaving hospital and thereby deprived of her liberty without the use of proper legal procedures and safeguards. We decided to investigate further.

The investigation team comprised Mrs Susan Tait, Nursing Officer, and Dr Donald Lyons, Chief Executive. Dr Steven Morgan, Medical Officer, assisted with examination of medical case records. Ms Christine Pacitti, Commission Visitor and Clinical Pharmacist, provided advice. The investigation was conducted under the following terms of reference:

- To examine the care and treatment of Ms AB during and around the time of her admission to Hospital 2;
- To examine the legality and clinical appropriateness of her treatment;
- To make recommendations to the NHS Board and others in order to address any deficiency of care or unlawful treatment.

Method of investigation

We obtained case records from NHS Board A and Council A. We also contacted the Scottish Ambulance Service and received recordings of telephone conversations between medical staff at Hospital 2 and the ambulance service. Following this, we visited the hospital to meet staff, view the layout and operation of the ward and discuss the particular challenges in providing care and treatment for people with dementia.

We then met practitioners who were most involved in Ms AB's care. These were:

- Lead Rural Practitioner 1
- Staff Grade Physician 1
- Clinical Director 1
- Senior Charge Nurse 1
- MHO1

We discussed this episode of care in a group meeting in order to collectively:

- Understand the challenges in providing care for people with dementia in the hospital;
- Understand the legal and ethical framework that practitioners must observe when providing this care;
- Review Ms AB's care and treatment in order to determine how staff met the challenge of providing lawful and ethical care in this situation;
- Consider recommendations to the service and to the Scottish Government about the care and treatment of people with dementia in hospitals serving remote and rural communities.

We greatly appreciated the cooperation of all the organisations and staff in assisting us with this investigation. We also took into account the views of a relative of Ms AB who was a joint holder of continuing and welfare powers of attorney and informed this relative of our findings.

Background

Ms AB lived in a rural area of Scotland on a family croft with siblings. She granted joint continuing and welfare powers of attorney to a sibling and a friend. She worked locally and continued to live with a family member. After she retired, the other family member developed dementia and eventually had to be admitted to a care home.

Ms AB was known to have dementia. In September 2009, she was detained in Hospital 1 for a short period of time for assessment and treatment of dementia. In December 2009 Ms AB was admitted to hospital in Town 1 with a chest infection and the other family member was also in hospital at this time with a fractured hip. Sadly the other family member died and Ms AB had a severe grief reaction which seemed to lead to a further period of confusion and distress. Ms AB was supported at home with the assistance of neighbours and input from the local social work services until the events of October 2011.

Chronology

We recorded the events from Ms AB's first presentation to Hospital 2 on 7/10/11 until her transfer to Hospital 1 on 10/10/11.

7/10/11

7/10/11. Ms AB fell at home and was admitted briefly to hospital but went home again the same day. The cause of the fall was not recorded and Ms AB could not be persuaded to stay.

7/10/11. 1854. GP1 phoned the hospital to request a review the following morning by out-of-hours doctor. The following day was a Saturday. The hospital coordinates out-of-hours medical cover.

8/10/11

Early in the morning, she was found on the floor by carers. They called for an ambulance. Ms AB refused to go to hospital by ambulance. The ambulance phoned the hospital to request a visit.

0845. Lead Rural Practitioner 1 visited her at home. He recorded that she had facial lacerations and unequal pupils. She was aggressive and uncooperative. Lead Rural Practitioner 1 inserted an intravenous cannula and sedated her with midazolam 3mg. She was then admitted to hospital as an informal patient.

Note: midazolam is a benzodiazepine drug licensed for sedation for procedures (e.g. endoscopy where the individual is conscious but sedated to reduce distress and discomfort. It is also used in palliative care. In the absence of other appropriate treatments, it has been used for rapid sedation for individuals with acute psychosis. We have not seen it used by injection to treat agitation and distress in people with dementia.

She was found to have a slow pulse of 50 (after sedation). Medical staff suspected a brain injury or stroke. She was observed for the rest of the day. She was aggressive and uncooperative at times but was calmed by the presence of a friend.

2030. She was given a further 3mg midazolam IV. This was recorded in notes and the prescription record.

2240. She was given 25mg quetiapine orally. She had been on this medication for some time before admission. Reported subsequently as calm overnight.

9/10/11

0750. She was agitated and aggressive on waking. She pulled the IV cannula out. Lead Rural Practitioner 1 re-sited the cannula and administered 3mg midazolam IV. This was recorded in case notes but not the prescription sheet.

1115. She was given a further oral dose of quetiapine 25mg

1430. She was given a further dose of IV midazolam 2mg. She was restless and trying to leave the hospital. Again, this was recorded in case notes but not the prescription sheet.

1730. Further 3mg IV midazolam. She was described as aggressive and slapping staff. Yet again, this was recorded in case notes but not the prescription sheet.

2130. Further 3mg IV midazolam. She was described as wandering, agitated and aggressive. Bed cotsides were used to prevent her from leaving or falling. Medication was recorded on notes and prescription sheet. She had low body temperature and low oxygen saturation.

10/10/11

0145. Given midazolam IV. The dose was either 1 or 2mg (hard to decipher). This time, the administration was recorded in the prescription documentation but not clinical notes.

0310. "Wandering around ward, agitated and aggressive." "Wants to leave ward." Given 3mg midazolam IV, properly recorded. On oxygen, bed sides up.

0750. "Agitated and aggressive". Given 2mg IV midazolam (ninth dose, recorded in notes and prescription sheet) plus quetiapine 25mg and citalopram 10mg orally. The latter two were long-standing prescriptions.

At some point that day, time unknown, Staff Grade Physician 1 completed a section 47 certificate authorising medical treatment under the Adults with Incapacity (Scotland) Act 2000/ giving the treatment as, "acute confusion for medical treatment."

1100. Further IV midazolam administered, recorded in notes but not the prescription sheet. Following this, there was discussion with the mental health team at Hospital 1 who declined to admit her because it was not an emergency. This decision was apparently reversed following referral to, and discussion with, social work staff at the Town 1 office.

Staff Grade Physician 1 called ambulance control to ask for a transfer for Ms AB to Ward 1 at Hospital 1. Ambulance control asked what the diagnosis was and Staff Grade Physician 1 told them it was 'confusion' and that she would need a stretcher as she was sedated. Ambulance service checked and asked if she was a voluntary patient. Staff Grade Physician 1 advised "no, she's sectioned under the Incapacity Act". Ambulance control advised that if patients are travelling under section that the booking actually has to come from Hospital 1. Staff Grade Physician 1 advised that it was for medical management and was a section under 47 of the Incapacity Act. He said that the mental health officer told him that he had to book the transport. When the ambulance control queried this Staff Grade Physician 1 asked to speak to the supervisor and he advised her that he was told by the mental health officer that they had to arrange an ambulance transfer from Hospital 2 because Ms AB was "sectioned under section 47 of the Adults with Incapacity Act" and that she had been sedated and was being transferred there for medical management.

Entry in the social work notes dated 10/10/11 by mental health officer 1 (MHO1) stated, "went to Hospital 2 regarding Ms AB and concerns about her ongoing behavioural difficulties. In the circumstances there is consideration being given to a transfer to Ward 1, Hospital 1. She is currently being treated under AWI and I advised that in my opinion that remains the least restrictive option but if matters deteriorate I can be contacted to agree to an EDC". There was no other entry from MHO1 following this.

1310. Agitated and aggressive. Lead Rural Practitioner 1 gave a further dose of midazolam 3mg IV. This was prescribed on the prescription sheet. She had now received 11 administrations

of IV midazolam over a 52 hour period, the total dose being in the region of 27mg. Later that afternoon, she was transferred to Hospital 1.

Ms AB was transferred to Nursing Home 2 on 8/2/2012 following a period of inpatient care at Ward 1, Hospital 1. This placement was not successful due to behavioural difficulties that Ms AB presented and on 12/3/12 she returned to Ward 1 at Hospital 1 for a further period of assessment. During this second admission to Ward 1, Ms AB was fairly settled and she was then transferred to Nursing Home 1, Town 2 on 9/4/2012 where she remains to date. She was visited by Susan Tait, Nursing Officer, at Nursing Home 1 on 23/5/2012 and then again on 13/9/2012. At first, Ms AB was a little unsettled and distressed at times. However, staff were confident that they would be able to meet her needs, and there was a discussion with Ms AB's sister who said that she was happy with the placement at Nursing Home 1. Ms AB had an acute urine infection in July 2012 and she was admitted to Hospital 3. She returned to Nursing Home 1 for palliative care; however, she subsequently recovered well and is now very settled and content.

Description of the in-patient ward, Hospital 2

The ward has 20 beds. Usual staffing by day is three qualified nursing staff and two health care assistants. At night, it is usually two qualified and one HCA. Staff work a 12 hour shift. The ward manager is extra to this and works 9am to 5pm Monday to Friday.

Around 95% of admissions are emergencies via GPs or A&E (the hospital offers an A&E service to the community). Many of the people admitted are well known to the service.

The hospital also offers out-patient and day care, including chemotherapy and day case procedures such as colonoscopy.

The ward layout makes observation difficult due to many potential exits and corridors with exits at the end. Also, there is no physical barrier to stop a confused individual entering the theatre area. It is an entire general hospital condensed into a single ward, making managing a confused patient even more challenging than a medical admission ward in a large hospital. Doors are alarmed and there is always someone on duty at the front desk when the front door is not locked.

For mental illnesses other than dementia, there is no major problem. There is ready transfer to Hospital 1. For detained patients, a retrieval team will escort the patient between 2pm and 10pm Monday to Friday. Overnight care is sometimes needed with one-to-one nursing observation (within sight and sound at all times, appropriately sensitive for use of toilet etc). Informal patients who present a potential suicide risk are observed close to the nursing station and are checked every 15 minutes (we drew attention to advice against interval observations in the CRAG Engaging people guidance). Immediate nursing advice from Hospital 1 or the CMHT is readily available.

Alcohol problems are common. There is an alcohol service CPN who provides a liaison service, and many people receive out-patient detoxification. There is good care for people with alcohol related brain damage via family support and supported accommodation.

Management of people with dementia is a challenge. We were pleased with the many efforts that were being made, e.g. good signage on toilets (although perhaps more directions from main corridor would help). There was also a policy of lowering beds and avoiding bed rails unless the patient asked for them.

Reasons for admission of people with dementia were usually falls, infections and burns. Some people were admitted with worsening confusion. This results in investigation for remediable causes and planning for as early a discharge as possible.

Staff have not had formal training on managing people with dementia but have had many years of experience. They are confident in managing acute delirium. They use relatives where possible to help with care and reassurance. Advice is readily available from Hospital 1 and the older people's CPN who provides some training. There is no specific 'dementia champion' but there is a staff member who is interested in taking on this role.

There is OT and physiotherapy input to the ward on most days. Home assessments are provided, there is a handyman service and a joint equipment store.

There are major challenges in supervising the confused person who may walk out of the ward and come to harm, or may interfere with the care and treatment of other patients. Poor ward layout and lack of staff were identified by the ward manager as particular problems.

Analysis

When we first looked at Ms AB's care and treatment, we had concerns about the amount and frequency of medication she received. We were keen to hear about the challenges facing a general hospital in a remote community where one ward carries multiple functions. We have considerable sympathy with the difficulty in providing care and treatment for a person with dementia who becomes agitated and distressed in such an environment. As the previous section of this report shows, the challenges are greater than, for example, a care of the elderly ward in an acute general hospital because of the multiple functions of the ward and the fact that the layout and safety of the ward are even less likely to be designed for people with dementia.

Our greater concern, however, is that a person with dementia in such a situation has her needs met and her rights respected. This was the focus of our investigation. We looked at the process of care and practitioners' understanding of the law.

Process of care

We were pleased to hear that staff had made significant efforts to provide care for Ms AB without resorting to medication. We heard from nursing staff that it was possible to provide care for periods of time. They had tried various distraction techniques. They knew of Ms AB's liking for dogs and a member of staff brought a puppy into the ward in the hope that this might help to occupy her and distract her. Ultimately, this was only achieved for short periods.

Ms AB readily became agitated, distressed at not recognising her surroundings and was regarded as not being safe to leave hospital. From what we know of Ms AB, we agree that allowing her to leave hospital under those circumstances would have placed her at significant risk.

During her time in the ward, medical staff formed the view that her clinical condition had not changed to precipitate her admission, and there had been no acute event that required medical intervention. It was clear that her behaviour and safety at home were problematic and that further care and assessment were required, hence the request for admission to Hospital 1.

We remain concerned that she was sedated on so many occasions and we have considered the reasons for this. These are:

1) **Environment** – the ward does not have a layout or function that allows staff to provide appropriate care and treatment for people with dementia who are agitated and distressed.

2) **Availability of appropriate numbers of staff with sufficient expertise**. Staff have a lot of experience in managing acutely confused people but there is lack of flexibility in staff numbers. From what we were told, extra staff can be brought in when people are subject to mental health legislation. We felt that the requirement for additional staff was too focussed on the individual's legal status and less on the individual's needs. In a previous report (Starved of Care[1]), we were critical of the lack of thought given to bringing in extra staff with mental health expertise. In a remote hospital, we understand that this may be difficult, if not impossible. Better knowledge and training and the availability of a 'dementia champion' may have made a difference here.

3) **Task of prescribing and recording medication**. It is unusual to use intravenous midazolam in a situation like this. Having said that, administering the medication via an indwelling cannula would have caused much less distress than in the case of Mrs V in 'Starved of Care'. However, we have concerns that medication was prescribed and administered on 'one off' occasions. Ordinarily, we would have expected that maximum daily dosages and intervals for 'as required' medications would be considered and prescribed. This is difficult with midazolam which is not a licensed medication for this purpose but is used frequently at present because of a lack of other alternatives. The total dose of around 27mg in 52 hours is unusual in this situation but well within the maximum recommended dose for use, for example in palliative care where doses as high as 5mg hourly have been recommended[2]. Our other concern was that medical staff did not always remember to record the prescription and administration of individual 'one-off' doses in medication sheets. We found several discrepancies between the sheets and the case notes. This is something that NHS Board 1 needs to examine, audit and give further guidance on.

Because of our concerns over the use of midazolam in this way, we looked into whether or not the NHS Board had clinical guidelines on prescribing psychoactive medication for older adults. We located guidance dated February 2012. We are not sure whether or not this superseded previous guidance. However, the primary purpose of this report is to ensure that people with dementia are, in future, managed lawfully and in a clinically appropriate way.

Present guidance is as follows:

For regular medication to treat behaviour disturbance:

a) Quetiapine 25mg orally up to 100mg in 24 hours *(she was already receiving this so it would have been reasonable to increase this if there were no significant side effects)*

1 http://www.mwcscot.org.uk/media/52047/Starved%20of%20Care%20Mrs%20V.pdf

2 http://www.palliativecareguidelines.scot.nhs.uk/documents/Lastdays.pdf

b) Lorazepam orally 500mcg-1mg maximum dose in 24 hours 2mg *(this could have been used on its own or in conjunction with quetiapine)*

For challenging behaviours requiring urgent treatment in older adults with dementia the recommendations are:

a) Haloperidol orally 500micrograms to 1mg repeated after 1-2 hours if necessary; maximum dose in 24 hours is 10mg. If oral route not available by intramuscular (IM) injection 500mcgs to 1mg repeated after 1 hour if necessary; maximum dose in 24 hours is 5mg.

b) Lorazepam 500micrograms to 1mg orally or if not available by IM injection. Leave at least 1 hour between doses. Maximum dose in 24 hours is 2mg.

The maximum dose in 24 hours of lorazepam administered IM in the older adult guidance is a quarter of the maximum dosed in the general adult population. The older adult guideline also suggests avoid the IV route altogether and using the oral or, where unavailable, IM.

We consider that the NHS Board should audit compliance with this guideline, especially in Hospital 2. At the time of Ms AB's care, intramuscular lorazepam was not available. This may be a persisting or recurring problem. There are no guidelines for the use of midazolam in this situation. If medical staff in this hospital consider that they would continue to use IV midazolam in this situation, we strongly advise the NHS Board to issue guidelines for dosage and frequency of administration. We again emphasise that this was unusual practice.

Understanding of the law

This was the area where we had greatest concern about Ms AB's care. While it may have been clinically appropriate to prevent her from leaving hospital and, to some extent, to use sedation to relieve distress, it appeared to us that this was not always managed in accordance with the law. Accordingly, we think she may have been deprived of her liberty unlawfully during her period of care.

a) Emergency Situation

Lead Rural Practitioner 1 had been asked to visit Ms AB at home because she had fallen and she had been fighting with her carer. When he visited her, she was acutely agitated and distressed and may have suffered a serious physical illness such as a head injury or stroke. Lead Rural Practitioner 1's decision was that she should be sedated and transferred to hospital.

When we discussed this with Lead Rural Practitioner 1, we were satisfied that his explanation warranted action under the common law doctrine of necessity. Lead Clinician 1 had a duty of care to Ms AB and exercised this appropriately in an urgent and difficult situation. We thought that Lead Rural Practitioner 1 could have made a clearer record of his reasons for doing this, noting that the Scottish Public Services Ombudsman had upheld a complaint in a similar situation where the action may have been justified but that this justification was not properly documented[3].

3 http://www.spso.org.uk/investigation-reports/2010/september/grampian-nhs-board

b) Ongoing Care in Hospital 2

It was clear from reading the case notes and from discussion with staff that Ms AB was being prevented from leaving hospital and treated for mental disorder by means of nursing care and administration of sedative medication. The appropriate legal procedures available are:

1. Section 47 of the Adults with Incapacity (Scotland) Act 2000. At some point on the second day of her admission, a Section 47 certificate was completed. This gives the authority for medical treatment but only authorises the use of force or detention "where immediately necessary and only for as long as is necessary". Our view is that, for repeated attempts to leave as in Ms AB's situation, a Section 47 certificate did not give authority for ongoing detention. In any event, her treatment within at least the first 24 hours was not covered by the certificate.

2. The other option open was emergency detention under the Mental Health (Care and Treatment) (Scotland) Act 2003. Having read Ms AB's notes and discussed her care with staff, we consider that the grounds would have been met. It was likely that she had a mental disorder and that her ability to make decisions about provision of medical treatment was significantly impaired. We think that it was necessary as a matter of urgency to detain her, otherwise there would have been a significant risk at least to her own health, safety or welfare and that making arrangements with a view to the grant of short term detention certificate would involve undesirable delay.

We examined this case in the light of Article 5 of the European Convention on Human Rights. This requires that any person deprived of liberty because of 'unsound mind' may only be detained if this is in accordance with a procedure prescribed by law. This article also requires that the person deprived of liberty must have the right to appeal to a competent court or tribunal.

It is not unusual for people who lack capacity to be admitted to hospital and we are not arguing that all such people must be detained. The Scottish Law Commission is consulting on this matter at the time of writing. However, we do consider that continually thwarting an individual's desire to leave in the way that occurred in Ms AB's case constitutes a deprivation of liberty, and that formal powers should have been used to prevent this. We looked into why this did not happen in Ms AB's case. The reasons were:

- **Education and Knowledge**. Several of the staff, including the lead practitioner, were of the understanding that the Mental Health Act did not apply to confused elderly people and was not an appropriate mechanism to be used. They accepted that there were gaps in their understanding and were open to becoming more knowledgeable on this area of law. Also, the mental health officer had considered that it was lawful to keep her in hospital following consultation with the welfare attorney. Again, we do not consider that a welfare attorney has the authority to deprive an adult of liberty under these circumstances. Also, we found that the welfare attorney had been consulted about Ms AB's stay in hospital but there was no record of consultation over the decisions to sedate her. When we asked the attorney about this, she had no recollection of being consulted over the issue of sedation.
- **Task of Detention**. Staff were generally anxious about using mental health legislation because of the paperwork and procedures involved. There was also the challenge of arranging a review "as soon as practicable" by an approved medical practitioner. This would ordinarily have involved transfer to Hospital 1. Where a person continues to suffer from a delirium this may not be appropriate, but examination by an AMP may be difficult to achieve. We have considered the possibility of

examination by remote video link in some situations but we consider that this would require the informed consent of the patient and that Ms AB may not have been able to do this. This would have remained a significant challenge were she to remain in Hospital 2.

- **Nursing policy and accountability**. We heard from nursing staff that they were concerned that detention places an extra responsibility on them to ensure the person's safety. Also, local policy insists that any detained patient must have one-to-one nursing observation. We take the view that safety concerns and observation levels are determined primarily by clinical need, not solely legal status.

c) Transfer to Hospital 1

There was some difficulty in arranging transfer to Hospital 1. We consider that it was clinically appropriate to transfer her under some quite difficult circumstances. We were concerned that Staff Grade Physician 1 had described her, in a telephone conversation with the Scottish Ambulance Service, as having been "sectioned under the Adults with Incapacity Act". Staff Grade Physician 1 acknowledged this but pointed out that he was very keen to get her transferred as soon as practicable due to safety concerns. He was not able to remember the exact conversation but there was an agreement that ambulance staff would transfer her under the circumstances. She was sedated prior to transport with a two person ambulance crew and no nurse escort.

The legality of transfer between hospitals, especially from a general to a mental health hospital, for a reluctant patient using an Adults with Incapacity Act certificate is open to question. We have already agreed with the Scottish Government that a Section 47 certificate does not authorise transfer from home to hospital for a person who refuses. Likewise, it would be likely to be considered unlawful for such a certificate to be authorised to transport a patient from general to a psychiatric hospital. This is a case where we consider the Mental Health Act should have been used. It was not used because:

There was a lack of understanding of the relevant powers available under incapacity and mental health legislation.

Local protocols require that an outreach team from Hospital 1 collects the patient. In this situation, this would have delayed the transfer and may therefore have contributed to the decision not to use the Mental Health Act. We think this patient could have been appropriately transferred with judicious sedation and nursing staff who were familiar with her care. In any event, we would again take the view that staffing requirement for transfer between hospitals should be based more on clinical need than just on the individual's legal status.

Summary and Recommendations

In our view, Ms AB was presenting a difficult challenge to this particular hospital under these circumstances and we considered that staff, at all times, acted in good faith and did what they genuinely believed was best for Ms AB. Ultimately, she was managed safely and was treated with all the compassion and dignity that were possible under the circumstances. We have concerns about the lawfulness and clinical appropriateness of some aspects of her care. It is important that hospitals which service remote communities should have proper policies and procedures and staff with appropriate training and knowledge about legal, ethical and clinical aspects of acute mental health care and treatment.

We consider that she was unlawfully deprived of liberty during her period of time in Hospital 2 and have identified some important learning points for the staff of the hospital, NHS Board 1 and other NHS Boards where there are remote hospitals carrying out a similar function. She was sedated in a way that caused her minimal discomfort, but with a frequency that we thought excessive in this situation. Guidance on the use of medication has been updated but needs further consideration if midazolam is to be used again in this way. It also reflected the difficulty of caring for this particular individual in this ward with the resources available.

Accordingly, we make the following recommendations to NHS Board 1 and its local authority partners. The NHS Board has appointed a dementia nurse consultant. This postholder would be the ideal person to address most of these recommendations. Other NHS Boards serving remote communities should take note of our findings and recommendations.

Recommendation 1

Practitioners working in hospitals in remote communities should have updated education on the implications of mental health, incapacity and human rights legislation. We are doing all we can to assist with training in this area.

Recommendation 2

NHS Board 1 should audit compliance with its prescribing guidelines for people with dementia who present a behavioural challenge and should ensure proper documentation of all medication. If it considers midazolam to be an option for this, it must issue clinicians with guidance on dosage and frequency of administration.

Recommendation 3

We recommend a revision of local procedures and policies for the use of mental health legislation. In particular, we consider that staff should receive greater assistance and support in managing the paperwork and that arrangements are made, wherever practicable, for approved medical practitioner review.

Recommendation 4

NHS Board 1 should reconsider the arrangements for transfer from remote hospitals to Hospital 1 for people with dementia. This review should include establishing criteria for transfer and a flexible mechanism for staff escorts.

Recommendation 5

NHS Board 1 should review policies and procedures for observation and staffing levels where a person with a mental illness, learning disability or related condition requires ongoing care in a general hospital ward in a remote location. Observation should be based primarily on clinical need rather than on legal status.

Recommendation 6

NHS Board 1 should audit the environments in Hospital 2 and other remote hospitals to make them as safe and enabling as possible for people with delirium or dementia. It may need to consider re-provision for hospital environments that are not suitable for this purpose.

Recommendations to the Scottish Government

We also considered that the Scottish Government's Dementia Strategy should consider the needs of people with dementia who are admitted to remote hospitals under these circumstances.

Recommendation 7

The Scottish Government should consider the needs of people with dementia in hospitals in remote and rural communities as part of a dementia strategy. This review should address:

- Greater investment in the support of a person with dementia in this environment.
- The greater need to remove a person with dementia from an unsuitable hospital accommodation at an earlier stage.

Other learning points

This investigation again raised the issue of availability of approved medical practitioners in remote and rural locations. We have previously held discussions with the Scottish Government and others over the possibility of medical examination by remote video link for Mental Health Act purposes. We consider that this case again emphasises the need for greater clarify of the law in this area.


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