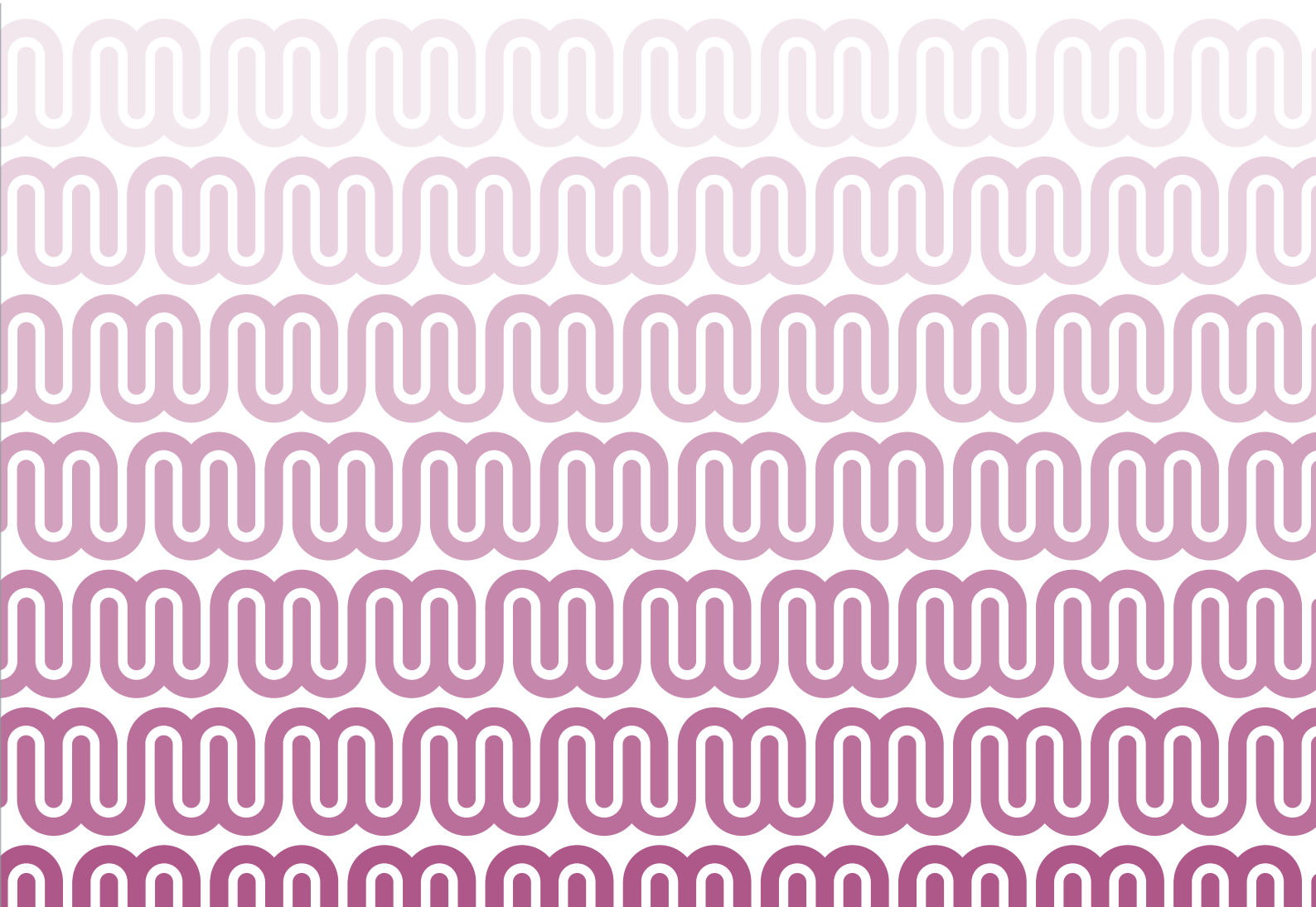
mental welfare commission for scotland

COVID-19 FAQs for practitioners (version 9, 27 May 2020)

Advice notes

27 May 2020



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Main changes in this update

The main changes are:

- Using physical restraint for patients with confirmed or suspected Covid-19 – clarification that this guidance is for staff already familiar with principles, guidelines and techniques **6.7**
- Witnessing formal named person and advance statements documents **8.2**
- Visiting and end of life care **9.8**

Contents

1. Introduction

The current pandemic is raising many questions, as practitioners face new challenges and dilemmas in a rapidly changing environment. The unprecedented circumstances and the risk to health mean that some individuals' human rights may be restricted, and it is important that any restriction is carefully considered, legal and ethical. This advice addresses a range of issues.

This advice will be updated frequently as the situation develops, and we advise that you do not print it out, but check online to ensure you have the most up-to-date advice and information.

Emergency legislation that 'relaxes' some of the current Mental Health Act (MHA) and Adults with Incapacity Act (AWI) legislation requirements has been passed by the UK and Scottish parliaments, but mush of this is not yet in operation. We will keep you updated on this over the next few weeks.

If you have any questions relating to this advice please email the Commission at enquiries@mwcscot.org.uk.

2. General principles

2.1. Human rights-based approach (updated 2 April 2020)

There will be many questions in relation to the implications of COVID-19 for individuals where there are no clear right or wrong answers. Using a human rights based approach can be helpful. In the current situation we may see a lot of "blanket policies" being introduced, particularly in residential and hospital settings.

Some human rights can be limited or restricted, as it is sometimes necessary to restrict one person's rights to ensure that the rights of another person, public safety and public health are protected. Such is the situation just now.

When considering scenarios where there are no clear right or wrong answers, you should consider if what is being proposed is:

- Reasonable
- Proportionate
- Justifiable

No human rights can be limited or restricted without good cause and certain conditions must be met if restrictions on human rights are to be justified. A restriction must not discriminate against a particular group of people and any restriction, if it is to be justified, must be necessary and proportionate. Decisions should be kept under regular review.

Proportionality means that a right can only be restricted so far as is necessary to achieve what is being sought. Consider if there is a less restrictive alternative that could have be used.

The principles of the Adults with Incapacity Act and the Mental Health Act provide a good ethical decision-making framework against which to consider any potential restriction or decision.

The Scottish Human Rights Commission has issued a briefing on the human rights implications of coronavirus emergency legislation:
http://www.scottishhumanrights.com/news/commission-flags-human-rights-implications-of-coronavirus-emergency-laws/

2.2. Human rights of care home residents (30 April 2020)

Figures published on 29 April confirmed that more than half of all deaths in Scotland due to coronavirus are happening in care homes. We have heard though calls to our Advice Line of some situations where generalised advance decisions appear to have been taken about what care and treatment individuals living in care homes would be offered should they develop symptoms of Covid-19. It is important that any such decision is taken as part of person-centred assessment that considers the risk and benefits of any particular treatment or intervention for an individual, based on, where possible, the views of the individual and their family or any proxy decision maker such as a welfare attorney or guardian.

The Commission has made it clear that people living in care settings who may be unable to state their views and wishes have the same human rights as every other person. See section 2.1, Human rights-based approach and section 9.2, Medical intervention and cardiopulmonary resuscitation (CPR) for people with dementia or learning disability and people in care homes.

The Royal College of General Practitioners has created covid-19 guidance for GP decision-making in primary care, which may be helpful to those working in care homes. The College also produced an ethical framework for covid-19 and related Q&A.

The Commission is a member of the Scottish Government's Care Home Rapid Response Team, which is working to address the specific challenges care homes face during the pandemic, and is contributing to the Chief Medical Officer's ethical framework group, seeking to ensure the human rights of all those living in care homes are respected and upheld.

2.3. International advice on maintaining human rights of people deprived of their liberty during the pandemic (2 April 2020)

The UN Subcommittee on the Prevention of Torture issued advice on 25 March 2020 in relation to the pandemic and measures taken to reduce the risk to detained people and to staff. This is broad advice relating to anyone detained, including prisoners and those detained under mental health legislation.

Some key points are:

- [People detained] should enjoy the same standards of care available in the community […] without discrimination on the grounds of their legal status
- Any restrictions on existing regimes should be minimised, proportionate to the nature of the health emergency, and in accordance with law
- Respect the minimum requirements for daily outdoor exercise, whilst also taking account of the measures necessary to tackle the current pandemic
- Where visiting regimes are restricted for health-related reasons, provide sufficient compensatory alternative methods for detainees to maintain contact with families and the outside world, for example, by telephone, internet/e mail, video communication and other appropriate electronic means. Such contacts should be both facilitated and encouraged, be frequent and free.
- Make available appropriate psychological support to all detainees and staff who are affected by these measures;

https://icva.org.uk/advice-of-the-subcommittee-on-prevention-of-torture-to-states-parties-and-national-preventive-mechanisms-relating-to-the-coronavirus-pandemic-adopted-on-25th-march-2020/

On 20 March 2020, the European Committee on the Prevention of Torture (CPT) published a "statement of principles" relating to the treatment of persons deprived of their liberty in the pandemic (also available in French and Russian). The CPT's advice includes:

- WHO and clinical guidance must be implemented in all places of detention;
- Staff availability should be reinforced;
- Persons deprived of their liberty should receive information;
- People should be tested for coronavirus;

- Any necessary restrictions on contact with the outside world, including visits, should be compensated for by increased access to alternative means of communication such as telephone or web-based communications;
- If a person is isolated, meaningful human contact should be provided every day;
- Monitoring bodies should maintain access; and monitoring bodies must promote the "do no harm" principle by taking precautions.

2.4. Scottish Government Covid-19 Ethical Advice and Support Framework (9 April 2020)

The Chief Medical Officer published an ethical advice and support framework on 3 April. The guidance will be continually reviewed and updated, and they welcome comments.

The Commission welcomes the Centre for Mental Health and Capacity Law comments on the guidance.

https://www.gov.scot/publications/coronavirus-covid-19-ethical-advice-and-support-framework/

http://blogs.napier.ac.uk/cmhcl-mhts/2020/04/06/comment-on-scottish-government-cmo-covid-19-guidance-ethical-advice-and-support-framework-version-22/

2.5. Access to advocacy (16 April 2020)

It is important that patients are helped to access advocacy by whatever means this can be provided, including by telephone or video conference. This will continue to apply in situations where they are subject to reduced safeguards under the emergency legislation.

2.6. Scottish Government Mental Health Service Principles (7 May 2020)

The Minister for Mental Health has written to NHS boards, IJBs, local authorities and local mental health services leads setting out principles for mental health service during the pandemic.

The Minister's covering letter states the purpose of the document:

> 'This guidance is designed to support active local decision making and promote consistency to provide safe, person-centred and effective service responses for people using NHS and local authority social care services during Covid-19 mobilisation. I would ask that the Principles are used to guide considerations of any changes to care and/or treatment for all patients under the care of the NHS or who may be accessing local authority directly provided, or externally commissioned mental health services. For the most part however this is operational advice which will be relevant for those managing waiting lists and referrals.'

https://www.gov.scot/publications/coronavirus-covid-19-principles-for-mental-health-services---letter-from-minister-for-mental-health/

3. Emergency legislation

3.1. Emergency powers allowing temporary changes to mental health legislation (updated 2 April 2020)

The Coronavirus Act 2020 has received royal assent. It includes emergency provisions relating to the Mental Health (Care and Treatment) Scotland Act 2003 and Criminal Procedure (Scotland) Act 1995. The Bill allows the new provisions to be put into effect by the Scottish Government, which may also suspend the provisions or put them into effect again as required. **Note that the provisions are not yet in effect at time of writing.** The Scottish Government has issued an update to clarify that at present there are no changes to the provisions of the Mental Health Act: https://www.gov.scot/publications/coronavirus-act-2020---impact-on-mental-health-legislation-update/

Schedule 9 contains temporary modifications of the Mental Health (Care and Treatment) (Scotland) Act 2003, the Criminal Procedure (Scotland) Act 1995 and related subordinate legislation, to provide measures including:

a. The modification of forms that are used in connection with the Mental Health (Care and Treatment) (Scotland) Act 2003 and Criminal Procedure (Scotland) Act 1995 or for such forms to be read as if they were so modified.

b. Extending maximum period of emergency detention to 120 hours.

c. Permitting a short term detention certificate (STDC) to be granted without the need to first consult a mental health officer in certain circumstances; and permitting a second STDC to be granted.

d. Enabling a mental health officer (MHO) to apply for a Compulsory Treatment Order (CTO) under section 63 of the 2003 Act founded on only one mental health report, provided the MHO considers that it would be impractical or involve delay to obtain two mental health reports.

e. Where a serving prisoner is found to be suffering from mental disorder and requires medical treatment, Scottish Ministers may make a transfer for treatment direction (TTD) under section 136(2) of the 2003 Act. Paragraph 6 permits that Ministers may be so satisfied on the basis of one report from an approved medical practitioner (AMP), where they consider that to obtain two reports would be impractical or involve delay.

f. Extending the limit on the length of time nurses can detain patients in hospital from 3 to 6 hours.

g. Allowing a Transfer for Treatment Direction to be made with the written report of an AMP, rather than both an AMP and another medical practitioner, where complying with two reports is impractical or would cause unnecessary delay.

h. Sections 136(3) and (6) provide that where a prisoner is to be transferred to hospital by a TTD they should be so moved within 7 days of the date the direction was made. Paragraph 8 provides that the transfer may be made as soon as practicable after that period.

i. Enabling reviews of certain orders and directions at certain specified intervals carried out by responsible medical officers (RMO) to be suspended.

j. Suspending the requirement imposed on Scottish Ministers in certain circumstances to make a reference to the Tribunal in respect of hospital directions or transfer for treatment directions.

k. Allowing that, where certain conditions are met, the RMO may administer medication to someone being treated under mental health legislation after the 2 month period laid out in the 2003 Act without the need to seek a second opinion from a designated medical practitioner (DMP) if the RMO has made a request for a DMP visit and it would cause undesirable delay to wait for the DMP's assessment.

l. Allowing a Mental Health Tribunal panel to operate with a reduced number of members where it is not practical to proceed with the required three members, as long as one of the members is a legal member or Sheriff Convener.

m. Allowing the period of extension for assessment orders to be increased at the discretion of the court, from 14 days to 12 weeks.

n. Enabling detention on the advice of just one medical practitioner (instead of the two required under the 2003 Act), if the court considers that it would be impractical in the circumstances to secure the second recommendation and the court is satisfied that the evidence of the single practitioner is sufficient.

o. Providing that the conveyance or admittance of accused or convicted persons to hospital may be achieved as soon as is practicable after the end of the prescribed time limits in the 1995 Act.

p. Allowing the Tribunal to decide a case without a hearing in the circumstance where the patient may have requested oral representations or oral evidence to be heard. In those circumstances, relevant parties could make written submissions to the Tribunal before a decision is reached.

q. Allowing medical practitioners in Scotland who are not independent (e.g. are in the same hospital, or with a supervisory relationship, or working in an independent hospital where the patient is being treated), to examine a patient for the purposes of the 2003 Act.

Act:
http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted/data.htm

Explanatory note to the Bill:
https://publications.parliament.uk/pa/bills/cbill/58-01/0122/en/20122en.pdf

3.2. Potentially infectious person (3 April 2020)

The Coronavirus Act now extends public health powers that were available for England across the UK. These powers allow for a public health officer to detain someone, and to require them to stay at a suitable place, return them to that place, and keep them in isolation or quarantine as they deem necessary. They can inform a constable as needed to enforce. The Act contains necessary powers to enter premises. These are separate powers from the Public Health (Scotland) Act 2008, which was not designed for a pandemic. The emergency legislation is designed for this purpose.

If considering how to manage someone with impaired capacity who is a 'potentially infectious person', practitioners should consider what is the primary problem that presents and whether they are detainable under mental health legislation or not. If not, then contact the public health

officer via the local health protection team. Where the individual is managed is for public health to determine, with input from mental health services. The legislation used will be the Coronavirus Act 2020 (Schedule 21).

If the individual is detainable under mental health legislation they would be admitted and care provided in the appropriate setting that meets their needs. Mental health services should lead on determining this with support if needed from public health and the acute hospital.

Contact details for Health Protection Teams in each Board are given on the last page (p10) of the guidance on management of patients with possible/confirmed COVID-19 in secondary care, at this link:

https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2936/documents/1_covid-19-guidance-for-secondary-care.pdf

3.3. New Scottish emergency legislation relating to the Adults with Incapacity Act (updated 9 April 2020)

The Coronavirus (Scotland) Act was passed by the Scottish Parliament on 1 April 2020 and most of its measures came into force on 7 April. It contains emergency measures relating to the Adults with Incapacity (Scotland) Act 2000. The Act allows the new provisions to be put into effect by the Scottish Government, which may also suspend the provisions or put them into effect again as required.

The measures that are now in force are:

- extending the period of time of guardianship orders for the duration the provisions are in force ('stopping the clock')
- guardianship orders may be continued by the Sheriff for 5 years or other such period (including an indefinite period) as the court may determine; the clock is stopped on renewals in the same way as on guardianship orders
- extending the period of time for s47 Adults with Incapacity (Scotland) Act 2000 certificates for the duration the provisions are in force ('stopping the clock')

These measures will expire after 6 months unless they are suspended by Ministers; however they may be extended if required, by regulations by the Scottish Parliament.

The following measures are not yet in force. These will only come into effect if Ministers make regulations, and the high level guidance states, "This will be strictly only when evidenced as being absolutely necessary. These provisions can come into force at different times geographically to address need."

- removing the requirement of local authorities when using s13ZA of the Social Work (Scotland) Act 1968 to take into account the views of the adult and interested parties including the nearest relative, primary carer, guardian, continuing attorney or welfare attorney with relevant powers
- allowing the local authority to use s13ZA when guardianships, intervention orders or powers of attorney with relevant powers have been granted or when applications are in process for guardianship orders or intervention orders.

The Commission has been in discussion with Scottish Government about the significant changes to how Section 13ZA would operate under the emergency measures. We were

reassured by Government that instruction was clear that this emergency provision would be used in exceptional circumstances only, and when an authority had exhausted all other measures.

During the debate, Mike Russell, Cabinet Secretary for the Constitution, Europe and External Affairs, also confirmed that whenever this provision is used, the Mental Welfare Commission will be involved in the reporting process. This is a vital additional safeguard, which we very much welcome. It means that the Commission will be able to monitor the use of this emergency provision across Scotland. Depending on the individual situation, we will consider whether we believe the case adheres to the new provision, whether we wish to call for further information, or whether we wish to go out and visit the person concerned at a future date.

Note that MWC does **not** require to be notified if local authorities are using existing S13ZA powers.

The majority of measures in the Bill will automatically expire six months after coming into force. They may be extended for two further periods of six months, giving a maximum duration of 18 months.

The Scottish Government has published high level guidance to assist public bodies to identify the provisions that are likely to be relevant and action they need to take: https://www.gov.scot/publications/coronavirus-covid-19-guidance-for-stakeholders-on-the-coronavirus-scotland-act-2020/

4. Safeguards

4.1. Extending a community compulsory treatment order (CCTO) by phone if care home is in 'lockdown' (18 March 2020)

Where a care home refuses access to an RMO to carry out a review for the extension of a CCTO, due to coronavirus, the Commission advises a pragmatic approach. The RMO should ensure that the care home manager understands the role of the RMO and that they are not a visitor but have a role within the Act; discuss any concerns with named person; and discuss with the MHO. If it remains not possible to visit, the RMO should conduct a phone conversation with the patient if possible, and ensure they understand why they are not being visited.

The RMO should make a decision about whether to extend the order on the basis of these conversations, and send the report with a cover note.

The Commission's view is that RMOs are not required to do something that would put them or others at risk, but should aim to visit as soon as is practicable.

4.2. Second report for CTO application (23 March 2020)

There may be a situation where a second report is needed for a CTO application but it is not practicable for a GP or approved medical practitioner (AMP) to visit the patient due to Covid-19 infection on the ward,

The Commission's view is that the examination by the GP or AMP should take place if possible by video or phone; or alternatively, an assessment from a colleague who is available on the ward, but declaring this conflict of interest. The patient and relevant others should be informed of the issue. It is for the Tribunal to make its decision in the light of the available evidence presented.

4.3. Moving someone without 13ZA process being completed (19 March 2020)

The Commission was consulted about a situation where assessment for 13ZA to move an individual into a care home in an urgent situation due to the carer's terminal illness was partially completed. However, the MHO was self-isolating and not able to complete the assessment. Three meetings had already taken place in relation to the situation with no objections.

We advised checking whether another social worker was available. Failing this, due to the urgency of the situation and the current lack of alternatives for care provision, and given the consultation which had already happened, they could consider the move taking place in the best interests of the individual. The decision and rationale for the move should be clearly documented along with the consideration given to the principles of AWI.

Scottish Government guidance on 13ZA
https://www.sehd.scot.nhs.uk/publications/CC2007_05.pdf

Commission note on 13ZA
https://www.mwcscot.org.uk/sites/default/files/2019-07/cheshire_west_draft_guidance.pdf

4.4. Expiry of section 47 certificates giving legal authority for medical treatment - Adults with Incapacity Act easements (updated 2 April 2020)

The Commission is receiving calls regarding the expiry of s47 certificates which give legal authority for physical healthcare treatments. When it is triggered, the new Coronavirus (Scotland) Act 2020 will provide for 'stopping the clock' so that s47 certificates do not expire.

Pending such easement, our view is that treatment should be continued where it is not possible for a s47 certificate to be renewed.

4.5. Moving an individual to a care home without family agreement (updated 2 April 2020)

Until emergency measures are in place the situation has not changed. Moving an individual without capacity to a care home under 13ZA requires the agreement of the family, that the individual is not refusing, and that there is no proxy with relevant powers.

The Commission was consulted in relation to a situation where a case conference had been held and use of 13ZA was agreed, with an application for guardianship by the family to follow. However the family were not in agreement with the proposed temporary move, and arranged for a solicitor to visit the individual, who signed a power of attorney. This is challengeable due to the individual's lack of capacity. Note that the power of attorney is not effective until registered, and if there are concerns about the capacity of the granter it is important to contact the Office of the Public Guardian so that they can examine this before it is registered (see Common Concerns with Power of Attorney).

Until emergency measures under the Coronavirus (Scotland) Act 2020 are in place there is no authority for the proposed interim placement as family agreement is required for a move under 13ZA. We suggested taking legal advice from the CLO.

They should record clearly the reasons for making the decision that they go with, which should be based on individual assessment of rights and risk, especially if a move may be needed despite dissent from the family.

4.6. MHA and AWI assessments and examinations by video technology or by telephone (3 April 2020)

Both the Mental Health Act and the Adults with Incapacity Act envisage direct, in person interviews as being the expected method for medical examination.

(In normal times, our advice would include: an interview in person must be considered to be the envisaged method of examination; an interview by remote video-link must be regarded as an exceptional situation; it would be a matter for the Tribunal or Court to decide whether evidence based on a remote interview is acceptable.)

In the current COVID pandemic situation, exceptional circumstances will clearly arise more frequently. Our advice during the pandemic is as follows:

We appreciate that professionals will need to do what they can do in the circumstances. If a face to face interview cannot happen or is impracticable, an assessment/interview using videotech or over the telephone should be conducted if possible. Where a doctor is satisfied that they have conducted a full enough assessment, and considers that the grounds are met

to complete a report or issue a Certificate, they should do so. This includes EDC and STDC. They should record on the form/certificate information about how the interview/examination was conducted and any limitations of the assessment. MHO assessments and interviews might also be undertaken this way.

Clearly, for an application to the Tribunal (e.g. for a CTO) or to Court (e.g. for a welfare guardianship), the Tribunal or Court will decide whether the evidence is acceptable.

We recommend that any such interview is followed by a face-to-face interview when that is practicable.

4.7. MHO consent to STDC where they cannot access the patient and the patient refuses to speak by telephone

The Commission was asked to advise on the position if an MHO was unable to attend a ward due to health reasons in relation to coronavirus risk, it was not possible to arrange for another MHO to attend, and the patient refused phone interview.

The Commission's view is that if no other approach were possible, the MHO should document the situation. It would be for the Tribunal to decide if this was sufficient if the STDC was appealed.

If the MHO is not able to fill in the MHO DET2 page and sign it, the notes on page 4 of the DET2 form are clear that the AMP can complete that page. It is not a requirement that MHO does so.

Section 45 of the Mental Health Act requires that if it has been impractical for the MHO to interview the patient, that they record the reasons and send this to the AMP within 7 days.

4.8. Can a hospital-based colleague complete the second medical report for a CTO application? (23 April 2020)

The question is whether it might be preferable to ask a hospital-based colleague to assess and complete the second report for a CTO application rather than the GP, during the lockdown. The Commission agrees that, given the current circumstances of social distancing, in some situations this would be a better option.

It is difficult to be exhaustive on each situation and ultimately the position may be challenged at a tribunal. However, the Commission can see scenarios where it would be preferable; for example:

- if the GP can only commit to a phone based assessment but a colleague based at the hospital and without a conflict (eg not in supervisory relationship) is able to undertake a face to face assessment
- or in the situation where the GP has little past knowledge of the patient, and given social distancing, a judgement is made that there is little longitudinal knowledge here and it would be better to seek a local second assessment.

The Act specifies that a GP may undertake a report; it's the code of practice that emphasises the GP role more clearly. A counter-situation might be if the patient is particularly keen on their GP being involved, in which case, the possibility of this ought to be considered first before going to a local colleague.

In summary, it's a judgement call in each situation with considerations of public health, patient preference, and past knowledge of the patient; and the Commission can see that seeking a local second report might be a better first option in some situations. Letting your patient know is vital for transparency.

4.9. Can RMO send T2 consent form to patient to sign? (30 April 2020)

If an RMO is interviewing patients remotely for a T2 consent to treatment form, it is acceptable in the current situation to send the patient consent form out to the patient to sign.

4.10. Authority for Covid-19 testing of individuals unable to consent (7 May 2010)

Part 5 of the Adults with Incapacity Act provides the general authority to treat an adult with incapacity provided a section 47 certificate has been completed (there are some exceptions to this). Where a resident at a care home who is lacking capacity and is unable to consent requires testing for Covid-19, the authority to provide this test to safeguard their physical health is covered by the section 47 certificate - that is: a new certificate that has testing for Covid-19 specifically authorised; or an existing certificate written to cover "fundamental healthcare procedures".

Fundamental healthcare procedures are defined in the code of practice associated with the Act, but in the current situation of a pandemic it is the Commission's view that testing for Covid-19 for care home residents (a sector in which there is known to be a higher risk) would constitute a fundamental healthcare procedure. The Commission therefore believes that such a section 47 certificate provides authority for testing for care home residents who are incapacitous.

Please note however, that where an asymptomatic, incapacitous resident objects to the test, Public Health Scotland has advised the Commission that their view is that a test should not be forced. (See section 4.11 Person without capacity resisting Covid test in a care home). Further advice on associated scenarios is contained in that section of this advice note.

Please note that following the Coronavirus Scotland Act coming into force, section 47 time periods are extended so that certificates remain valid and do not run out during the period whilst these powers are in force.

4.11. Person without capacity resisting Covid test in a care home (30 April 2020)

We had an enquiry about whether an individual in a care home lacking capacity might be tested despite resisting/objecting to the test.

We have been advised by a health protection team that hundreds of people are currently being tested in care homes but it is not the practice to test anyone who resists or does not want the test, nor to restrain anyone for COVID testing.

Their advice was that if a care home resident is symptomatic of COVID and refuses a test, staff should treat that person as if they are COVID positive, in accordance with guidelines.

A COVID test may be relevant to an individual's healthcare to rule out other causes of symptoms. When an individual refuses the COVID test, the usual other investigations for other causes of their symptoms should still be considered, e.g. a stool sample to investigate diarrhoea.

Health Protection Scotland have issued new COVID-19 information and guidance for care home settings:
https://www.careinspectorate.com/images/documents/coronavirus/1_covid-19-information-and-guidance-for-care-homes.pdf

4.12. Testing people in hospital for Covid-19 who are lacking capacity and are objecting/refusing the test (30 April 2020)

There is now a recommendation for testing anyone over 70 in a hospital setting on admission and regularly after admission, regardless of the cause of their admission:
https://www.gov.scot/publications/coronavirus-covid-19-update-first-ministers-speech-27-april-2020-1/

This has led to questions about how and whether to test a patient for Covid-19 who is lacking capacity and who is objecting to the test.

The Commission's view is that where the patient is asymptomatic, and lacks capacity but objects to the test, the test should not be forced using the authority of a section 47 certificate.

However, for a symptomatic, objecting, patient lacking capacity, our view is that it might be appropriate to test using authority under a section 47 certificate for testing. This will help to determine the optimum treatment for them, and may prevent a move to a setting that might expose them to greater risks of Covid-19 (i.e. if they were actually negative for Covid-19, but treated as if positive due to a test refusal and the need to manage them as if they were positive).

5. Designated medical practitioners (DMPs)

5.1. DMPs and self-isolating patients or patients in care homes (18 March 2020)

Where a patient has symptoms and is self-isolating in line with Government advice, or a care home has concerns about possible risk of coronavirus infection, a DMP may carry out an assessment using alternative means, where face-to-face assessment is not practicable, and issue a T3.

The Commission's view is that a telephone or video conference interview which allows the DMP to consult the patient meets the requirement under s245 of the MHA for the DMP to consult the patient unless impracticable.

At present each situation should be individually considered. The Commission will ask about any risk when a DMP visit is requested, and will also check with the DMP about any issues.

5.2. Process for DMP second opinions during COVID emergency measures (9 April 2020)

During the current Covid 19 pandemic, maintaining usual routine and standard safeguarding procedures for treatments under the Mental Health and AWI Acts may not be possible due to both the needs to respect social distancing, minimising travel, and restrictions accessing hospitals and premises and staff shortages. As a result the Mental Welfare Commission has modified advice and procedures regarding second medical opinions (DMP) work. Whilst restrictions on movement, social isolation and distancing measures are in place DMPs are requested to operate remotely using telephone assessments and electronic communication whenever possible and feasible. It is appreciated that the current situation is subject to rapid change. The advice in the following section may therefore be subject to change. Please therefore check that you are looking at the most recent advice.

KEY POINTS

1. Emergency aspects of the Mental Health and Incapacity Acts have not, as yet, been enacted.
2. Emergency legislative measures, when and if they become enacted, will relax the absolute necessity for a DMP opinion and T3 authorising continuing treatment with medication after 2 months with important caveats.
3. Standard procedures for requesting a DMP assessment and opinion will continue, with requests for a DMP opinion sent to the Mental Welfare Commission two weeks before a medication T3/T2 becomes due or as required for ECT and Nasogastric feeding.
4. Requests for a DMP opinion should be made as usual to the Mental Welfare Commission. Given that the DMP will not have ready access to patient records, the request will NOT be allocated before receipt of an Appendix E which should contain as much clinical information as consider necessary to aid the DMP in making their assessment.
5. The Mental Welfare Commission will continue to allocate requests for DMP assessments and it is currently envisaged that required authorisation eg T3s, will continue to be issued within usual timescales (2 weeks)

6. Patient assessments by the DMP may be undertaken via telephone or video facilities if these are feasible and enable the DMP greater flexibility to assess patients who may be subject to restriction of movements or isolation due to actual or possible COVID 19 infection.
7. If direct or indirect patient assessment is not possible a T3 may still be issued if the DMP considers that the treatment plan is appropriate after careful consultation and consideration of clinical information. This may well be limited to 6/12 or 1 year. RMO's are advised to note expiry dates.
8. Once, and if, emergency measures are activated, if a DMP is unable to provide a T3, ***based purely on the limitations of assessment***, then the MWC view is that treatment could continue pending future planned assessment when that becomes possible.
9. The DMP will discuss the treatment plan with the RMO if revisions are considered necessity. If there is a failure to reach agreement for reasons **other than limitation of assessment**, the authority to treat under emergency MH legislation ceases.

Enacting emergency legislation relaxes the absolute necessity for a DMP opinion and T3 authorising continuing treatment after 2 months. Standard procedures for requesting a DMP assessment and opinion should continue, with requests for a DMP opinion sent to the Mental Welfare Commission two weeks before the T3/T2 becomes due. If a request for a DMP visit isn't received by the MWC before the expiry of the 2 month treatment period, then continuing treatment is not authorised under any legislation and could be subject to legal challenge.

Procedures for requesting a DMP visit

The MWC is developing an electronic procedure for requesting a DMP opinion. This is currently being tested and will be rolled out over coming weeks.

The request for a DMP assessment will not be accepted without the provision of a completed Appendix E, containing relevant clinical information and the proposed treatment plan. Requests should be made by telephone 0131 3138777 or mwc.2ndopinionrequests@nhs.net pending the electronic referral system becoming fully operational in coming weeks.

If there is a delay in the provision of a DMP opinion, the Appendix E will be subject to review by MWC medical staff and feedback provided as appropriate.

Given the potential difficulties for the DMP accessing full and contemporary case records, the clinical summary contained within the Appendix E should be as comprehensive as possible. Additional information such as care plans, ICP documentation or admissions summaries may also be helpful. The MWC would continue to advise against the provision of treatment plans which go beyond the stated treatment needs of the patient. It is the experience of the Commission that such treatment plans are particularly subject to clarification and requests by the DMP to the RMO for change.

The DMP visit

The MWC aims to provide a continuing DMP service throughout the COVID crisis. DMP requests will be prioritised towards the more urgent and complex clinical cases. Opinions for ECT and nasogastric feeding will generally take priority. Telephone or video link assessments may be undertaken, if available and clinically appropriate. The DMP will, if necessary, require access to patient records and make prior telephone contact with the RMO to discuss the case.

The DMP will also make telephone contact with other key clinical staff (ward nursing staff / CPN) as well as the named person / welfare guardian.

DMPs should not be considered as routine 'visitors' to the ward and subject to visitor restrictions. DMP assessments remain a key component in the treatment of patients subject to measures specified within mental health and incapacity legislation. DMP's will be subject to standard PPE and other protective measures applied to clinical staff attending the patient.

DMPs have the discretion to undertake telephone assessments or, if this is not possible, provide an assessment based on available clinical information and consultation with the RMO and other key staff / named person / welfare guardian.

DMPs are advised that they may wish to issue T3s that are time limited to 6 months to 1 year, in view of the lack of a face to face patient assessment. This may be particularly relevant for initial assessments. However, DMPs retain the discretion to issue a certificate of up to 3 years' duration.

The DMP patient telephone assessment

The DMP should discuss with the patient's RMO logistics of undertaking a DMP assessment by telephone:

- Does the patient have the capacity to understand the nature and purpose of the telephone call?
    - Understand who they will be speaking to.
    - The nature of the call – 2nd independent opinion appointed by MWC as safeguard for treatment under mental health act legislation
    - Is capable of using a telephone.
    - How best to respond to patient on the outcome of the assessment. At the time of calling, in writing?
        - **If the patient does not have capacity to take part in a telephone assessment, this should not be undertaken and a T3 may be issued if the DMP is satisfied based on available clinical information and discussion with other parties (named person, RMO, other caregivers eg CPN).**
- Plan the call, schedule a time, best ward contact / phone number to call
- The patient should be offered privacy to speak without being overheard – if risk assessment does not permit this, staff supervision during the phone call is permitted provided the patient is in agreement.

The DMP should make prior contact by telephone where possible with the RMO, key clinical staff, named person/welfare guardian/POA to discuss aspects of the case and the proposed treatment plan. The DMP should check that what they have been told about whether or not there is an advance statement is correct - with RMO, nursing staff and/or patient as appropriate.

The telephone assessment process:

- The DMP should confirm details of the patient and their understanding of the purpose of the call and gains consent to continue.
- Confirm key facts as necessary, e.g. understanding of their current MHA status.

- Enquire as to named person.
- Assess patient's understanding of mental health concerns. This may include confirmation of key aspects of mental state – best discuss with RMO prior to the call.
- Assess patient understanding of treatment plan and nature of medication/treatment.
- Assess patient views about treatment and consent.
- Thank patient and provide provisional feedback if appropriate

The assessment process should be fully noted by the DMP on Appendix A.

Issuing certificates of authorisation (T3)

These will be issued by the DMP and forwarded to the RMO electronically and by post. Electronic T3's correctly completed, dated and e-signed will be acceptable authorisation for treatment pending receipt of a hard copy. DMPs are encouraged to discuss with MWC medical staff any issues or difficulties related to issuing of T3's. The fee payable for DMP assessment remains unchanged.

5.3. Clozapine monitoring when patient self-isolating (updated 25 March 2020)

We have been asked whether it could be acceptable to continue clozapine treatment but suspend routine monitoring of full blood count (usually done every 1-4 weeks), in situations where a patient is stable on clozapine, self-isolating in the community, and cannot be accessed for blood sampling. In the majority of cases this is likely to be a very short term issue – maximum 2 weeks, and any local procedures should be followed with agreement with local pharmacy services and a clinical risk assessment.

Where there are significant concerns about breaks in monitoring of under 2 weeks, or for any more extended breaks, decisions on whether or not to do this would need to be taken by the RMO on an individual basis. The RMO should consult with the relevant clozapine monitoring service. The RMO should fully take into account the patient's circumstances and health, and the risks vs benefits of continuing clozapine without full monitoring. They should provide the patient with information and discuss with them the benefits and risks as far as possible, determine their views, and take these into account.

The RMO should fully consider whether, based on the above risk assessment, it would actually be possible to undertake monitoring. This would include determining availability of Personal Protective Equipment (PPE) that would enable staff to take blood from the patient.

If clozapine is continued outwith regulatory monitoring requirements, there should be a clear documented rationale and care plan for this. We would advise the RMO to seek the opinion of a colleague such as a pharmacist, another consultant psychiatrist, or their medical manager.

For patients on a T3, the Mental Welfare Commission should be informed in writing regarding the circumstances and necessity for any break in monitoring, including mitigating arrangements. For minor breaks or extensions of under 2 weeks we would not ordinarily request a further DMP visit. If there is likelihood of more extensive breaks, a DMP opinion should be sought.

6. Restrictions

6.1. Advice on care home resident who lacks capacity and requires restrictions for self-isolation (18 March 2020)

A care home sought advice in relation to a resident with dementia who required self isolation in line with Government guidance. The resident had a welfare attorney, but family were currently not visiting. The welfare attorney and family were consulted on the measures taken. In line with guidance the resident was moved to a ground floor room, with more space and a garden view. A small stair gate was placed at the door to prevent him leaving and additional distractions placed in his room. He enjoys, folding, rummaging and going through boxes, so these have been added. Staff are interacting frequently.

The Commission's view is that in circumstances of this kind, care homes should carefully consider the benefit to the individual of any proposed restrictions and restraint measures, in line with the principles and guidance in Rights, Risks and Limits to Freedom and the new Scottish Government guidance on social care (Annex 1) Any restriction should be the minimum possible in the circumstances and should aim to minimise any distress to the individual, ensuring frequent staff interaction.

See also section 6.3 on Visitors to care homes.

6.2. Visitors to care homes (18 March 2020)

The new Scottish Government guidance on social care (Annex 1) advises reducing visitors to care homes apart from essential visits, seeking to reduce external visitors by 75%.

Where a resident has symptoms of COVID-19, Health Protection Scotland *COVID-19: Information and Guidance for Social or Community Care & Residential Settings* published 12/3/20 states that visits should be restricted to essential visitors only:

> 'Local risk assessment and practical management should be considered, ensuring a pragmatic and proportionate response, including the consideration of whether there is a requirement for visitors to wear PPE. These visitors must not visit any other care areas or facilities. A log of all visitors should be kept.'

6.3. Guidance on restricted patients (updated 25 March 2020)

The Scottish Government restricted patient team has circulated specific guidance for practitioners on restricted patients and COVID-19. Restricted patients are persons who are subject to a Compulsion Order and Restriction Order; Hospital Direction or Transfer for Treatment Direction. It is also relevant in relation to patients on remand who are subject to an assessment order, treatment order, temporary compulsion order or interim compulsion order.

The guidance sets out information in relation to restricted patients on the proposed emergency legislation. It will be updated regularly.

https://www.forensicnetwork.scot.nhs.uk/important-changes-to-procedure-for-restricted-patients/

If you have any queries about the guidance, email forensicmentalhealthpolicy@gov.scot

If you have a question about a particular restricted patient email restrictedpatient@gov.scot.

6.4. Restricting hospital visitors (25 March 2020)

The Scottish Government has asked NHS Boards to restrict hospital visiting to essential visits only. This is in light of the updated advice around reducing the risk of spreading Covid-19 and shielding vulnerable groups.

Note that the updated list of essential visits includes visits to support someone with a mental health issue such as dementia, a learning disability or autism where not being present would cause the patient to be distressed; although visitors should also consider whether a visit is essential even in these circumstances.

Anyone who is unwell and/or exhibiting symptoms of COVID-19 - a new, persistent cough and fever or high temperature - should NOT visit any patients in a hospital.

Boards must ensure that those who visit are informed of and adhere to appropriate infection prevention and control procedures as are required in this outbreak.

The Commission's view is that each situation should be individually assessed, and the need for the visit balanced against the risks. The rationale for a decision to allow or disallow a visit potentially deemed essential should be recorded and explained to the patient and the visitor.

Every effort should be made through provision of phone calls or other technology to assist patients to remain in frequent contact with family and friends.

6.5. Can guardian take adult with incapacity home temporarily from their current accommodation? (2 April 2020)

The Commission was consulted about a situation where a welfare guardian of an adult living in a supported tenancy wished to take them to the family home for a few days.

The adult receives personal care from a support provider, which was concerned about the risk this could pose in relation to coronavirus.

It is understandable that families are facing a tough time currently with self-isolating households, and lack of contact with loved ones. This will be exacerbated at occasions such as the Easter holiday weekend.

There is no concern about the quality of the care the family would provide, and their own view is that the adults are at greater risk from Covid-19 from interactions with care staff coming and going than they would be at home.

In normal circumstances guardians with relevant powers could take any action that was reasonable, proportionate, and meeting the principles of AWI. Earlier in the pandemic the Commission's view would have been that the guardians could not be prevented from bringing the adults to their own home. We would encourage the local authority guardianship supervisor to be informed and discuss with the family. However, the provider might consider that the adult could have been exposed to Covid, and pose a greater risk to staff, and ask them to self-isolate for two weeks, before resuming care provision.

However, the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020, laid before Parliament on 27 March 2020, state that no person may leave the place where they are living other than for a limited range of reasons such as to shop, for medical reasons and for daily exercise. This proposed visit does not come under any of the reasons listed and unfortunately should therefore not take place.

6.6. Use of seclusion (9 April 2020)

The Covid-19 pandemic has had a significant impact across the range of mental health, learning disability and older adult services. Services may face additional challenges in working to keep people safe from the virus. Services should consider on a case by case basis whether restrictive measures for this purpose may amount to seclusion.

The Commission has recently updated our guidance on seclusion, which is relevant across a range of settings. The basic principles set out in the guidance apply whether in a hospital, care home, other community setting or a person's own home.

Seclusion refers to a situation where an individual is kept apart from others and is prevented from leaving the area, either by a locked door or by staff. The person is not there by agreement. Seclusion is used to attempt to contain severe behavioural disturbance which is likely to cause harm to others. Essentially, it is a form of restraint and should be used in the context of an overall policy on the prevention and management of aggression and violence. It should only be used as a last resort where all other interventions have failed or where it may be safer than prolonged periods of physical restraint.

We are concerned that many instances of the use of seclusion does not respect the individuals' human rights due to being misidentified and often referred to by another name (time out, room based care etc). In these situations, however, there is usually some form of coercion involved, whether explicit or implicit.

In practice, we found that there are commonly two distinct levels of seclusion to which an individual may be subject, depending on whether the person is restricted by explicit means or by implication via instructions from staff. We have called these level 1 and level 2 respectively:

> Level 1 – usually involves a locked door or the exit blocked by a member of staff.
>
> Level 2 – may involve verbal coercion and/or restrictions on access to the physical environment.

All services which use restrictive practices of this kind should have a policy in place and a protocol to follow so that staff are clear about their role. Only by acknowledging that the restrictions placed on individuals amount to seclusion can staff ensure they can minimise the need for its use and learn from their practice. Part of the learning, moreover, is gained through regular review of individual episodes. Therefore, we expect that services will keep clear records of use of seclusion and the Commission may ask to see these, together with a copy of the local policy, when we visit or by request.

The full guidance can be found here:

https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf

6.7. Using physical restraint for patients with confirmed or suspected Covid-19 (updated 27 May 2020)

This guidance is aimed at staff who are already familiar with the underlying principles, guidelines and techniques around physical restraint and who are working with mental health and learning disability patients within inpatient mental health / learning disability settings. It should provide these staff with further guidance on using physical restraint practices for patients with confirmed or suspected Covid-19.

COVID-19 can vary in severity, generally causing more severe symptoms in people with weakened immune systems, older people and those with long term conditions such as diabetes, cancer and chronic lung disease. In what is anticipated to be exceptional circumstances, where physical restraint is deemed necessary, it should be recognised that this is intrusive in nature, reduces the ability of those involved to practise social distancing for the duration of the interaction and, increases the risk of transmission of COVID-19. It is therefore imperative that good infection prevention and control measures are implemented; in particular, appropriate personal protective equipment (PPE) is utilised. This will ensure the safe delivery of care and protection of both patients and staff whilst preventing the transmission of COVID-19.

This guidance provides advice for staff if they are required to physically restrain a patient who has or is suspected to have COVID-19 and, where physical restraint is deemed to be required after all other attempts of de-escalation have been exhausted, whilst ensuring safe practice and effective infection prevention and control management is in place.

Your service will have locally agreed protocols and guidance for the use of physical restraint and you should ensure that you are up to date with these.

Principles

Restraint should be:

- Minimised through the avoidance of triggers
- Used only as a last resort
- Used for the shortest time possible.

Clinical practice should continue to be underpinned by:

- The principles of human rights
- Respect
- Accordance with known wishes
- The use of de-escalation when possible
- The minimisation of psychological harm wherever possible
- The provision of least restrictive care
- The provision of trauma informed care.

Risk assessment & risk management

It is recognised that COVID-19 can result in severe respiratory symptomatology. Therefore, before a decision to implement physical restraint is made, a full risk assessment should have been carried out on the patient, ideally at point of admission to the service and updated as necessary. Factors such as: Covid-19 status, existing physical injuries, cardiac / respiratory problems, obesity, pregnancy, alcohol / drug use, epilepsy and psychological trauma should be considered; however this list in not exhaustive.

Certain restraint positions carry less associated risk. Seated restraint position is the recommended position to be used whenever possible, provided the patient is maintained in an upright seated position, as any compression of the patient's torso against or towards their thighs can restrict the diaphragm and ribcage, further compromising respiration. If utilising the seated or indeed the supine (face up) restraint positions, there may be a risk to staff from exposure to body fluids (spitting) from the patient so the agreed PPE should be used.

Additionally an extra member of staff will always be required to observe the patient's airway throughout these restraints.

Prone (face down) restraint should be avoided as far as possible and must only ever be used as a last resort in extremely high risk situations, for the shortest length of time possible and only when all other restraint positions are deemed unsuitable / unsafe. When utilising a prone restraint position, it is imperative that even minimal pressure is not placed on any part of the patient's torso as this could restrict diaphragmatic movement, lung function, affect the ability to breathe and further compromise the patient's airway. Staff must ensure that the patient's airway is maintained at all times. The possible risk of death due to positional asphyxia can result from any restraint position and long and protracted restraint should be avoided. This is especially pertinent if restraining a patient who has or is suspected to have Covid-19.

Regardless of what restraint position is being used, the patient should be constantly monitored for any signs of distress and these must be acted upon immediately.

Following any restraint with patients who have or are suspected to have Covid-19, local infection prevention and control procedures must be adhered to.

Restraint personal protective equipment (PPE)

The Chief Nursing Officer and Chief Medical Officer for Scotland have reviewed and continue to review guidance on PPE, in conjunction with Health Protection Scotland and the UK nations. The most recent updated guidance on the use of PPE can be accessed via the following link:

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe.

Staff should be supported by their employer to familiarise themselves with PPE equipment.

Post incident debrief

As soon as practicably possible following a physical restraint, the staff involved should meet in order to discuss, reflect and consider any issues anyone may have as well as reviewing the details of the incident itself, the infection prevention and control practices and any revised risk assessment and care planning opportunities. Any significant points raised must be documented and discussed. It is essential to identify what went well and what improvements should be made to ensure practise remains person centred, safe, effective and underpinned by the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 . All persons involved in the restraint must be offered post-incident support by the appropriate line manager and be involved in any support or feedback process. Additionally managers should ensure staff and patients are signposted to available local and national wellbeing resources.

Further information

If staff have any concerns regarding any aspect of restraining a patient with suspected or confirmed Covid-19, they should discuss these with their line manager in the first instance. Additional information can be obtained from your local Occupational Health service, Infection Prevention and Control Team, Violence Reduction Service and the Scottish Government website.

See Clinical guidance for NHS Scotland: using physical restraint for patients with confirmed or suspected COVID-19: https://www.gov.scot/publications/coronavirus-covid-19-clinical-guidance---using-physical-restraint-for-patients/

6.8. NHS Trust in England changes coronavirus visits policy following legal challenge (16 April 2020)

In an English case, the parents of a young man detained in hospital under the Mental Health Act challenged the NHS Trust over arrangements for communicating with their son. The young man has autism, learning disabilities and anxiety. His parents have visited him twice a week for two years but this was stopped due to the pandemic and replaced with telephone calls. However, this was not suitable for him and the lack of face to face contact was distressing him and affecting his behaviour.

The Trust refused to arrange other means of communication. The parents cannot afford to buy smart phones or tablets.

On behalf of the young man, his parents instructed lawyers to challenge the Trust's policy. They wrote to say they would seek judicial review unless the Trust either provided the means to have virtual contact or allowed visits with a two meter distance. This was on the basis that the Trust's policy of telephone-only communication breached human rights and indirectly discriminated against people with disabilities.

The Trust amended its policy to reflect their duty to facilitate the use of online communication between patients and their relatives, and provided the young man with an iPad.

See https://www.doughtystreet.co.uk/news/nhs-trust-changes-its-coronavirus-visits-policy-following-legal-challenge

7. Mental Health Tribunals and courts

7.1. Hearings to be held by teleconference (19 March 2020)

Mental Health Tribunals Scotland (MHTS) intends to hold all hearings by teleconference from Monday 23 March 2020 onwards. Specific instructions on taking part in a hearing by teleconference will be sent to those involved. MHTS has asked for support for patients by assisting them to participate in proceedings. Where the patient is in hospital and wishes to take part in their hearing, a member of the hospital staff would be expected to accompany the patient for the duration of the hearing. For patients based in the community, support for a patient could be provided by an MHO, an advocacy worker or a solicitor.

See https://www.mhtscotland.gov.uk/mhts/News/News for further information.

7.2. Applications by email (31 March 2020)

An MHTS update on 31 March says:

> Routine applications including requests for the appointment of a curator *ad litem* may be sent to MHTS by email, although we will still require enough information to determine that a patient lacks capacity to instruct a solicitor. The same applies to applications to withhold intimation of certain paperwork, including CTO applications, from patients where the risks to the patient or to others as a consequence of disclosure are significant. We will also accept motions made in the course of a case by email. As you may already be aware, a CTO1 form does not require to be signed by the MHO if it comes from a secure email address. We will extend this practice to allow other statutory forms to be sent from professional staff using a secure email address, without a signature.

See https://www.mhtscotland.gov.uk/mhts/News/News for further information.

7.3. Late Tribunal documents guidance (23 April 2020)

MHTS issued guidance on 16 April 2020 that any reports sent less than three days before a hearing should be copied by the sender to the patient and named person (or any other relevant person) and MHTS advised of this.

If a document must be submitted less than 24 hours before a hearing, it should be provided to the patient and named person by any appropriate means, such as personal delivery to home or ward. Copies should be emailed to any parties with secure email addresses and those with non-secure email should be notified that the document exists. If a way cannot be found to provide them with it, Tribunal members will do their best to communicate its content, but depending on its significance, there may be no option but to continue the hearing to another date.

Full guidance is here: https://www.mhtscotland.gov.uk/mhts/News/News

7.4. Patients whose court date is postponed (30 April 2020)

The Commission has been asked about situations where a patient on a treatment order (TO) on a general adult IPCU has had their court date postponed, and the treatment order is no

longer felt to be necessary. The pandemic situation may mean more court dates are postponed.

The usual practice would be to phone the procurator fiscal office for the area, explain the situation and request them to organise for the date to be brought forward.

If there is a problem, the RMO could consult the Scottish Government restricted patients team or their local forensic colleagues. The restricted patient team must also approve any suspension of detention for a patient on a TO.

7.5. Guidance on civil court cases during the pandemic (7 May 2020)

The Scottish Courts and Tribunals Service has issued updated guidance and a summary on the processing of civil cases during the pandemic. Included in the list of business considered urgent and/or necessary are urgent applications/motions:

- for interim orders under the Adults with Incapacity Scotland (Act) 2000
- under the Mental Health (Care and Treatment) (Scotland) Act 2003
- under the Adult Support and Protection (Scotland) Act 2007.

There is also a process that can be followed to restart cases which are stuck in the system having been sisted or adjourned at the start of the lockdown, where:

- the court is satisfied there is good reason for doing so;
- the action can be progressed remotely; and
- a hearing requiring the leading of evidence is not required.

8. Administrative practicalities

8.1. Can I send an unsigned form to the Commission by email? (updated 30 April 2020)

We have previously said that in situations where it is not possible for a form to be signed and scanned during the pandemic situation, the Commission would accept an emailed form without a signature, provided the email is coming from a recognised, secure email address.

We have reviewed this advice, and assessed that it is not necessary now that the situation has moved on and there has, fortunately, not been widespread workforce shortage. This arrangement is not currently being used.

We therefore now require forms to be signed as normal. We will revisit this if the circumstances change.

8.2. Witnessing formal named person and advance statements documents (27 May 2020)

The Coronavirus (Scotland) (No 2) Act came into force on 27 May 2020. Among its provisions, it temporarily removes the requirement for witnessing the signature of a person nominated to be a named person. The Act is in force initially until 30 September 2020 but could be extended to 31 March 2021 and thereafter to 30 September 2021.

The patient's signature still requires to be witnessed for both named person nominations and advance statements. This should not be a difficulty where an individual is an inpatient. However, there may be difficulties in the community in witnessing these documents in person due to Covid-19 issues. It is important that patients are not disadvantaged and are able to appoint a named person and make an advance statement.

The law is that the original document must be signed by the witness. However, section 3 of the Requirements of Writing (Scotland) Act 1995 allows that a person may witness a signature if they see the granter sign it, or if the granter acknowledges to the witness that they have signed it.

Our view is that this could be achieved by a conversation between the witness and the granter with an e-mail exchange of copies of the document, or looking at it by video. The granter could confirm that it is their signature, and the witness confirm by email that they are happy to witness it. The original document would be posted to the witness and a copy kept. The witness should speak again to the granter at the point of signing and add a signed and dated annotation to say that the granter confirmed before them that this is their signature. If this is done, the validity of the document could be considered robust, which could be more important if the patient's capacity were to change. The witness would then return the signed original.

There would necessarily be a time lag before the witnessed document was available. The Commission's view is that during this period the document should be treated as though it were operational, on the basis of the confirmatory email from the witness. This could be challengeable, but in our view is a proportionate response in the current circumstances.

8.3. Can an MHO ask a colleague to sign and submit documents to the Commission? (7 May 2020)

An MHO contacted the Commission seeking clarification about whether it is acceptable for another MHO to sign then scan documents, so that they can be submitted to the Commission within the statutory timescales.

We can confirm that in the current circumstances the Commission will accept documents pp'd by a colleague MHO.

9. Other issues

9.1. Depot for patient with COVID-19 symptoms (26 March 2020)

We are aware that some patients are concerned about what might happen if they are unwell with virus symptoms when they are due to receive their depot.

Guidance from the Royal College of Psychiatrists sets out consideration of short term alternatives such as deferring treatment for 2 weeks or switching to oral medication. However, depot should be administered if it is essential, by staff using personal protective equipment (PPE) and following Infection Protection and Control (IPC) procedures.

For detailed guidance see https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services-covid-19-guidance-for-clinicians

9.2. Medical intervention and cardiopulmonary resuscitation (CPR) for people with dementia or learning disability and people in care homes (updated 9 April 2020)

We have heard through our advice line and other contacts that many people are worried about coronavirus and whether someone having dementia, a learning disability or similar condition that may affect their capacity to make medical decisions will negatively influence medical decision making.

This is a big worry for family, friends and other carers, particularly about medical decisions to resuscitate someone in the event of a cardiac arrest (CPR) and some other health care interventions such as access to ventilators.

Clinical decisions about whether or not to attempt CPR are complex and rates of survival and recovery following CPR are much poorer for those with increased levels of frailty or other conditions.

However, dementia or a learning disability should not in themselves be a reason not to provide CPR or other medical treatments. They should be considered as part of person-centred assessment that considers the risk and benefits of any particular treatment or intervention.

The assessment should include, where possible, the views of family or any proxy decision maker such as a welfare attorney or guardian. This will help inform the doctor when making a decision. However, family and proxy decision makers cannot insist that a doctor initiates any treatment or an intervention the doctor believes will not benefit the patient.

In relation to care homes, the most recent Scottish Government guidance states:

2.5 Anticipatory Care Plans (ACP) should be in place for as many residents as possible (and ideally all residents) in these settings. Clear documentation of 'What matters to me' is helpful in the event of changing circumstances. In many cases the staff in the care home settings are able to start these conversations with involvement of families. Healthcare Improvement Scotland are adapting ACP documentation to a 1-2 page summary tailored to dealing with the current situation. Do Not Resuscitate paperwork should be in place where appropriate and discussed appropriately with residents or carers.

https://www.gov.scot/publications/coronavirus-covid-19-clinical-guidance-for-nursing-home-and-residential-care-residents/

Up to date advice in relation to CPR can be found at:

https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/

Note that the current guidance from the BMA, Resuscitation Council and RCN still stands, as supplemented by Covid-19 specific guidance; see: https://www.bma.org.uk/advice-and-support/ethics/end-of-life/decisions-relating-to-cpr-cardiopulmonary-resuscitation

To be clear, CPR is a specific medical intervention aimed at restarting the heart in the event of a cardiac arrest. A DNA CPR notice relates only to that specific intervention. It does not replace the need for wider conversations and the recording of individual wishes regarding end of life care.

9.3. Clarification on the use of Clinical Frailty Scale and DNACPR within the Scottish Clinical Advice on Covid-19 (7 May 2020)

Coronavirus (Covid 19): Clinical Advice- CMO (Approved 2 April; Published 3 April; Version 2.3): https://www.gov.scot/publications/coronavirus-covid-19-clinical-advice/

This clinical advice from the CMO's office was published on Friday 3 April and provides a protocol and templates for the approach, assessment, care and treatment of people with or suspected to have Covid-19. The Commission wrote to the CMO's office about aspects of the guidance that we suggested should be highlighted more prominently, relating to the limitation around the use of Clinical Frailty Scale for people with disabilities. We also suggested that the reference to whether a person can undertake Activities of Daily Living in the consideration of care escalation pathway is similarly accompanied with a note on the limitations of this for some groups.

The CMO issued a letter on 5th May highlighting that clinicians should have awareness of the limitations of the Clinical Frailty Scale particularly in younger patients and those with long-term conditions or disabilities. The guidance has been reviewed and a new version will be issued once approved.

The CMO's letter also clarifies that a stable long-term physical need, learning disabilities or autism should never be a reason for issuing or encouraging the use of a DNACPR order. Social care needs, health conditions or disabilities that are unrelated to a person's chance of benefiting from treatment must not be a part of clinicians' decision making regarding accessing treatment.

Decisions regarding appropriateness of admission to hospital and for assessment and treatment for people with learning disabilities and/or autism must be made on an individual basis and in consultation with their family and/or paid carers. These should take into account the person's usual physical health, the severity of any co-existing conditions and their frailty at the time of examination. Treatment decisions should not be made on the basis of the presence of learning disability and/or autism alone.

9.4. Mental health support services (updated 16 April 2020)

Information and support is available via the NHS 24 Mental Health Hub. They are expanding their service to include Psychological Wellbeing Practitioners (PWPs) - registered mental health nurses including senior charge nurses.

The current approach is largely to provide psychological support including Distress Brief Intervention model (DBI) triage and signposting to appropriate services.

Should an individual calling into the MH Hub require additional support or mental health assessment a referral can be discussed with CPN, psychiatrist, emergency department or home visit. A joint pathway has been created between Police Scotland and Scottish Ambulance Service in an effort to ensure the public can access appropriate services when needed.

Services currently providing input into the MH Hub are CAMHS, LD, Older People and Addiction services.

To access:

1. Call NHS 24 on 111, message will offer menu options e.g. press x for mental health (Mental Health Hub currently available 6pm to 2am, but this is likely to increase)
2. www.nhsinform.scot Coronavirus (Covid19) page for specific advice on mental wellbeing during the pandemic
3. www.nhsinform.scot Mental Health Self-Help Guides (under 'Symptoms and self help' menu) offer a wide range of information and guidance for conditions including managing symptoms of stress, anxiety, low mood etc.

Breathing Space and 3rd Sector partners

Breathing Space (0800 83 85 87) has expanded capacity with additional funding and staff from third sector organisations.

Times will remain the same for now: Mon – Thurs 6pm to 2am and Fri – Mon 6pm to 6am.

9.5. Detained patients receiving palliative care for Covid-19 (16 April 2020)

We have been asked for advice about revocation of detention in these circumstances. If an individual subject to a STDC or CTO has Covid-19 and is receiving end of life care, the RMO may decide that detention under the Mental Health Act is no longer appropriate. In these circumstances, a revocation form must be completed. It is important that the reason for revocation is stated eg patient is receiving palliative care for Covid-19.

This is in keeping with previous advice given for patients who are in receipt of end of life care when clinical needs have changed significantly.

9.6. Place of safety orders (section 297) (16 April 2020)

We are aware that mental health assessment centres are being set up around the country to divert unnecessary attendance at A and E departments and to limit the number of home assessment visits.

This will involve review of the local NHS mental health service current psychiatric emergency plan (PEP).

We have been made aware of concerns that this could result in the inappropriate use of police custody cells as a "place of safety".

Our view is that police stations should only be used as the Place of Safety in exceptional circumstances, where it is the best option for the individual.

Place of safety orders are not included in modifications of the Mental Health (Care and Treatment) (Scotland) Act 2003 emergency provisions.

Background

Place of safety orders can be used by the police under section 297 of the Mental Health (Care and Treatment) (Scotland) Act 2003 when they find someone in a public place who they believe may have a mental disorder and be in immediate need of care and treatment. The individual can be taken to, and detained in, a Place of Safety for up to 24 hours in order to be assessed by a medical practitioner, and for any necessary arrangements to be made for that person's care and treatment.

The police are required to notify the Commission within 14 days of any person held under this power and provide details of the date and time of the removal from a public place, the circumstances giving rise to this, the address of the Place of Safety and, if the removal was to a police station, why this was done. They also have a duty to inform the local authority and nearest relative, if possible.

Further details on section 297 can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-06/Place%20of%20safety%20report%202018_0.pdf

9.7. Person with learning disability living in shared accommodation attending a family funeral – no requirement for self isolation afterwards (7 May 2020)

The Commission was contacted by family about an individual with learning disability attending the funeral of a close family member. The funeral director had advised that this was possible: funerals can be attended by immediate family only, but a carer could attend to support the individual. This was in line with Scottish Government guidance on funerals: https://www.gov.scot/publications/coronavirus-covid-19-guidance-for-funeral-services/

However, the individual lives in shared accommodation with other residents, and the family were advised that if he did attend the funeral he would then need to self-isolate in his room for 14 days. This advice was based on Health Protection Scotland's advice on new admissions, section 2.5, which states that 'admissions to care homes regardless of origin should be tested and isolated for 14 days.'

We discussed this with Health Protection Scotland, who agreed that this was an over-interpretation of their guidance. The same guidance on Page 9 states that patients discharged from hospital should be isolated for 14 days, but that 'an attendance at A&E that didn't result in an admission would not constitute an admission'.

The attendance at a funeral (which will have stringent measures in terms of attendance to reduce risk of infection) would be commensurate with a care home resident being transferred to, and attending at, an A&E department. Isolation of an individual with learning disabilities who is likely to need more support and human contact after a family funeral would be very distressing and should only occur if a risk assessment locally identified that there was a significant unexpected COVID-19 exposure in the process of travelling to or attendance at the funeral.

Attendance at the funeral should be in line with the guidance; which sets out that attenders must observe social distancing guidance, can be supported by a carer, and should not attend if they are in a high risk group or if any member of their household has symptoms.

However, it is possible that there are particular circumstances which might require risk assessment, such as another resident being in a high risk group. For some individuals, alternatives to physical attendance, such as live-streaming, might be considered, where this would benefit the individual and be acceptable to them.

9.8. Visiting and end of life care (27 May 2020)

The Royal College of Physicians of Edinburgh, with the Academy of Medical Royal Colleges, Marie Curie and Scottish Care, have published new guiding principles on Covid-19 end of life care, designed to ensure that dying patients in Scotland are treated humanely, compassionately and with dignity. The principles say that all patients in Scotland who are judged to be dying from COVID-19 or other terminal conditions - within hours or days - must receive equal access to visits from family or friends. The document sets out an ethical framework and practical principles to minimise risk.

10. Information governance

10.1. Scottish Government guidance on data sharing (19 March 2020)

The Scottish Government has published new COVID-19 information governance advice in relation to data sharing:

https://www.informationgovernance.scot.nhs.uk/

https://www.ehealth.scot/resources/information-governance/

10.2. Information Commissioner guidance on data protection and COVID-19 (25 March 2020)

Data Protection and Coronavirus- what you need to know - for organisations.

Coronavirus and personal data 18 March 2020 – for the public.

Data Protection and Coronavirus - statement for health and care practitioners.

10.3. Changes to Freedom of Information arrangements (9 April 2020)

The Coronavirus (Scotland) Act 2020 includes measures to address the current pressures on public bodies in responding to Freedom of Information requests. The measures:

- extend the time limit for responding to requests and reviews under FOISA from 20 to 60 working days
- enable the Information Commissioner to take into account the effect of coronavirus on authorities when deciding appeals where authorities have failed to comply with timescales
- enable authorities and the Commissioner to issue formal notices by electronic means.

See the Scottish Government high level guidance for more information:

https://www.gov.scot/publications/coronavirus-covid-19-guidance-for-stakeholders-on-the-coronavirus-scotland-act-2020/

11. Other useful information (updated 7 May 2020)

11.1. Guidance for clinicians

The Royal College of Psychiatrists has produced information for clinicians in the community and in hospitals, which includes specific advice around different patient groups and information for patients: https://www.rcpsych.ac.uk/about-us/responding-to-covid-19

Guidance for clinicians on a range of topics including workforce, digital, patient engagement and ethical considerations is here: https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/guidance-for-clinicians

Their advice re care on inpatient wards and in community services is here: https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/guidance-for-clinicians/community-and-inpatient-services-covid-19-guidance-for-clinicians

NHS Education for Scotland Coronavirus (COVID-19) Learning materials for professionals: https://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/coronavirus-(covid-19)-learning-materials-for-professionals.aspx

Royal College of Psychiatrists in Scotland webinar (24 April 2020) – The impact of COVID-19 emergency measures: https://www.youtube.com/watch?v=kDLRNITEYpM&feature=youtu.be

11.2. Social work and social care

The Scottish Government has published guidance for managers and field social workers regarding home visits and other face-to-face direct contact with service users. Coronavirus (COVID-19): safe and ethical social work practice: https://www.gov.scot/publications/coronavirus-covid-19-social-worker-guidance-on-safe-contact/

Health Protection Scotland have issued new COVID-19 information and guidance for care home settings: https://www.careinspectorate.com/images/documents/coronavirus/1_covid-19-information-and-guidance-for-care-homes.pdf

Scottish Government additional national adult support and protection guidance for chief officers and adult protection committees relating to the COVID-19 pandemic: https://www.gov.scot/publications/coronavirus-covid-19-adult-support-and-protection-guidance/

11.3. Learning disability

Accessible easy-read guidance for people with learning disabilities on the Coronavirus outbreak and how people can protect themselves, from the Scottish Commission for Learning Disability: https://www.scld.org.uk/information-on-coronavirus/ This site also includes a collation of materials relevant to people with learning disability during the pandemic from a wide range of organisations.

A series of guided self-help booklets developed with four universities to support people with mild to moderate learning/intellectual disabilities during the COVID-19 outbreak: https://www.scld.org.uk/covid-19-guided-self-help-booklet-series/.

Scottish Commission for Learning Disability Statement on Human Rights and COVID-19: https://www.scld.org.uk/a-statement-on-human-rights-and-covid-19/

11.4. Dementia

Coronavirus Coming into Hospital Guide, for people living with dementia, their families and carers:
https://www.alzscot.org/sites/default/files/2020-04/Coronavirus%20-%20Coming%20Into%20Hospital.pdf

11.5. Children and young people

Advice on supporting children and young people:

https://www.cosla.gov.uk/__data/assets/pdf_file/0018/15570/covid19adviceforsupportingchildrenandyoungpeople.pdf

11.6. Sensory loss

Communication for people with sensory loss during the COVID-19 pandemic: advice for health and social care staff in Scotland – produced by a group of organisations:
https://www.pmhn.scot.nhs.uk/wp-content/uploads/2020/04/COVID-19-Communication-for-people-with-Sensory-Loss.pdf

11.7. Support for frontline staff

A group of mental health charities have launched 'Our Frontline' to support the mental health and wellbeing of key workers by offering round the clock emotional support, practical advice and resources: www.mentalhealthatwork.org.uk/ourfrontline/

12. Glossary

AWI	Adults with Incapacity (Scotland) Act 2000
MHA	Mental Health (Care and Treatment) Scotland Act 2003
STDC	Short Term Detention Certificate
MHO	Mental Health Officer
CTO	Compulsory Treatment Order
TTD	Transfer For Treatment Direction
TO	Treatment Order
AMP	Approved Medical Practitioner
RMO	Responsible Medical Officer
DMP	Designated Medical Practitioner
CCTO	Community Compulsory Treatment Order
13ZA	Section 13ZA of the Social Work (Scotland) Act 1968
Proxy powers	Powers held under the Adults with Incapacity Act on behalf of someone unable to take their own decisions – power of attorney, guardianship or intervention order
Section 47 (s47) certificate	Certificate under the Adults with Incapacity Act which gives legal authority for physical healthcare treatments
T3	certificate for medical treatment, where a patient is incapable of consenting to treatment, completed by a designated medical practitioner
T4	Notification of urgent medical treatment given

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