Welsh Intensive Care Society WICS

CYMDEITHAS GOFAL DWYS CYMRU

Response to the Law Commission Consultation on Deprivation of Liberty 2015

Following an internal consultation of it's professional members, I am pleased to respond to the Law Commission public consultation on the proposed new law on Deprivation of Liberty on behalf of the Welsh Intensive Care Society.

The members of the Welsh Intensive Care society are all professionals directly involved with providing Critical Care to the people of Wales. As a result our response will mainly be concerned with hospital practice and specifically the challenges faced by Intensive Care Units with regard to possible Deprivation of Liberty (DoL) legislation.

General comments:

Whilst we recognize the important human rights implications of "deprivation of liberty" (DoL) our primary concern is the effect any changes in the law might have on patients' chances of recovery. We consider that a patient's "right to life" supercedes any potential, and usually temporary, Deprivation of Liberty while life saving treatment is being provided.

There are several circumstances in which, depending on the new legislation and it's interpretation, whereby DoL might be considered to be occurring in Critical Care units. Some of these circumstances are similar to other acute healthcare settings (e.g. a delirious patient who wishes to leave hospital but is unable to comprehend the consequences of their action). These may be managed in a similar way to other acute settings. Other circumstances may be *unique to the Critical Care environment* and we would strongly encourage the Law Society to consider such cases while drafting this legislation. In our view the particular patient group of concern would be patients who are unconscious or semi conscious and are receiving life sustaining therapies – what we would call "level 3" patients. There are many subtle variations on these patients' circumstances that could affect the assessment of whether they have had their liberty deprived. For example, some patients will have consented verbally to the administration of sedative drugs prior to the initiation of such treatment (similar to the process before anaesthesia for elective surgery) whereas other patients may have become unwell so quickly that no discussion was possible with them. Some patients will be receiving sedative drugs for the sole purpose of administering life sustaining therapies but a side effect of this treatment would effectively be a deprivation of liberty unless specifically excluded by the legislation. Under these circumstances both the sedation or the treatments offered could fall under the

definition of “restrictive care and treatment” e.g. feeding via Nasogastric tube, continuous sedation to tolerate ventilatory support. Cessation of the sedation in an attempt to gain consent would be impractical and could lead to a significant deterioration in condition, grave discomfort and possibly a reduced likelihood of survival. Other patients may have effectively only had their liberty deprived by the disease process – for example a patient with brain injury and so would not fall under the legislation. Other patients may have a mixture of disease and iatrogenic factors leaving them in a position where effectively their liberty may been deprived – not least by the failure of the “free to leave” test and in need of special assessment unless dispensation is made for this very large group of patients. Yet other patients may have regained consciousness and capacity and might wish for their “life sustaining care” to be provided in a “non hospital” environment e.g at home. Patients on long term ventilatory support might fall in this category. In most of these cases the life sustaining therapies can only be provided (at least in the short term) within the confines of a critical care unit. Is it a deprivation of liberty that such provision of such services is not possible outside of hospital? It certainly may limit the patient’s choices about where they can live and remain relatively healthy but the realities of a finite healthcare system is that not all patient wishes can be accommodated where they might wish. A further example of this sort of problem may be many typical “level 2” (High dependency unit) patients who’s care needs cannot be safely met in the normal ward environment e.g. due to excessive sputum production and tracheostomy suction requirement. Have these patients had their liberty deprived? It is certainly true that all critical care unit patients (at both level 2 and 3) are subject to constant supervision. All of these matters require further thought and clarification in our opinion.

It is the agreed view of WICS council (who together have over 150 years of clinical experience to draw upon) that patients and relatives do not see the treatments provided in the critical care environment as anything other than life saving. Not one member of council ever remembers a case where a question of possible “deprivation of liberty” has been raised following the provision of acute care to a “Level 3” patient. As such, even though the definition of DoL as set out in the consultation could apply to such patients we would recommend that the Law Commission consider explicitly excluding such patients on the grounds that it is a temporary situation, that the “right to life” takes precedence. And that assessing all these patients for deprivation of liberty would place an unacceptable and unanticipated burden on the critical care system.

The approach to capacity issues outlined under the Mental Capacity Act has been very successful on critical care units and is well respected as being both practicable and providing necessary safeguards. A similar approach to DoL would be our recommendation, with special consideration as mentioned above to the situation of unconscious patients receiving short term life sustaining treatments. The Welsh Assembly Government have accommodated the existing legislation by recommending operational guidance to DOLS assessors (the “priorities document issued in March 2015”). This guidance balances the need for ICUs to comply with the law with the need to limit the potential workload

and we would recommend that a similar pragmatic approach is adopted in the new legislation.

In the consultation it is suggested that a hospital consultant should prepare a care plan for each patient in whom a potential DoL may occur. If we took the broadest definition of DoL such that all level 3 patients were included (as mooted above), and if we assume that each plan took one hour to write (a conservative estimate) then that could result in a loss of critical care consultant time of some 6,000 hours per year in Wales alone. It is inconceivable that such a large loss of consultant time would not be associated with worsened outcome and some patients not surviving who might otherwise have survived. We accept that this is an "utilitarian" argument but it must be recognized that Critical Care provision in the UK in the 21st century is a "finite" and scarce resource. Any solution to ensure appropriate safeguards must be practical and not place unsustainable burdens on an already stretched healthcare system.

We are also concerned that our members at the end of the consultation should be presented with a practicable solution that they feel they can actually use and contributes constructively to patient care. We do not feel that it is acceptable that any NHS staff could potentially be left open to prosecution for breaches of DoL legislation while performing their day to day work in good conscience. We would also recommend that any solution for safeguarding DoL be flexible enough to take into account the occasionally aggressive nature of some delirious patients. Under both common as well as Health and Safety Law NHS staff as well as other patients and visitors to the hospital have a right to protection from physical injury and this may need to be balanced against DoL in some circumstances.

Response to specific sections and questions:

Chapter 1:

We would welcome clarification on the "devolution" status of DoL and the implications therein. Our recommendation would be a shared "nationwide" (England and Wales) approach to all these issues for the sake of clarity.

Chapter 2:

We would agree that the current system of paperwork for DoL is unfit for purpose, excessively complex and may not provide real safeguards while consuming excess NHS and local authority resource.

We agree strongly with the views set out in 2.29 and 2.30 with regard to critical care practice.

Proposal 1 – Replace DoLs with "protective care" – we have no particular view on this issue.

Proposal 2 – Production of a code of practice – we would welcome a "code of practice" for protective care as long as it addresses adequately the issues faced within Critical Care. We have no objection to a review of the code of practice for Mental Capacity but recommend against significant change as this legislation is working well.

Chapter 3:

We would agree with an approach modeled on Mental Capacity for protection of individual's rights.

Question 3.1 – yes - we agree.

Chapter 4:

Proposal 4.1 – we agree with this statement

Proposal 4.2 – this issue is beyond our remit and so we will not offer a view

Chapter 5:

We agree strongly that the view put forward in 5.4 is correct and highlights the differences that apply to application of DoL safeguards in the acute care environment.

We are unclear however whether this "separate" approach has actually been taken. Unless specifically excluded most treatments provided to critically ill patients would fall under the definition of "restrictive care and treatment" as set out in 5.15-5.17. We would appreciate clarity on this point.

5.25 – A safeguarding solution in acute hospital settings where a DoL based on a doctors report could be authorized for 28 days seems like it might be a practical solution. Further details are required about how exactly it would work. Consideration should be given to the fact that a doctor may sometimes not be the best placed person to make this assessment. Also the nature of critical care – which is often covered on a "shift" basis does not lend itself well to solutions based on the old fashioned model where a patient is under the care of only one consultant. Most commonly in modern critical care in the UK, the care and responsibility for a patient is shared between a team of consultants and may transfer from day to day. We would recommend some flexibility in the legislation regarding who can make the 28 day certification and some provision for delegation in appropriate cases – possibly to more specialized and expert colleagues.

Chapter 6:

This chapter relates to care homes and is outwith of our remit.

Chapter 7:

We are not clear from this section whether "restrictive care and treatment" would apply in acute hospital settings. One the one hand it could be that DoL concerns for the majority of Critically Ill Patients are excluded by their underlying brain disorders. Later on however (section 7.12) a contrary view seems to be taken which would includes such patients. Much more clarity is required here.

Proposal 7.1 - we do not think that "protective care" should apply to patients with disorders of mind due to the therapeutic administration of drugs for the safe provision of life sustaining therapies within the critical care environment

7.21 – It is difficult to comment on the appropriateness of a "list" approach without seeing the list. We have no objection in principle but would worry that the list would not be comprehensive nor could it be updated quickly enough to keep pace with changes in clinical practice. This approach may therefore run into practical difficulties.

Chapter 8:

We agree that the timescales for decisions in acute care settings are shorter and that the effects of DoL much less likely to be long term. These are important observations that need to be borne in mind.

8.6 – We are unclear about the meaning of the phrase "clinical interests over-riding best interests". Does this refer to "organizational" best interests overriding "patient's best interests"? If so this should be made clearer. To healthcare professionals clinical interests and best interest are synonymous terms describing what is best for the patient. Some of our members felt there was an implicit suggestion here that staff might not always do what was best for the patient. The phrasing (and indeed meaning) of this section needs to be considered very carefully if constructive staff engagement with this process is to be retained. In order to avoid such confusion we would suggest that the legislation should stick to the term "patient's best interests" and avoid the introduction of alternate and possibly controversial terms.

Proposal 8.1 – we would agree – a separate scheme is required for acute care settings.

8.19 – We support the notion that immediate provision of life sustaining treatment would not be considered a DoL.

8.21 – This seems an appropriate list for when DoL should be considered but please note our previously expressed concerns about the use of "lists".

8.22 – The "not free to leave" test in the critical care context is particularly difficult. Leaving a critical care unit during treatment would usually result in death and while a patient with adequate capacity may make this decision we would argue that no other person (including family) could make this decision. The application of this test to the critical care environment needs to be elaborated – especially as it is practically impossible to provide critical care therapies in any other environment.

8.24 – We would agree with this general approach as long as it is not overly burdensome on the service. Further clarification will be required on the nature of the care plan, timescale of production etc. It may be more appropriate sometimes for other healthcare professionals (e.g. ward sister) to make the certification to the hospital's managers and the legislation should allow for this delegation where appropriate.

8.25 We do not think it is practical to inform the local authority of all potential cases of DoL at day 1. As the assessment is to be made at day 28, notification at day 21 may be more appropriate and accurate, and reduce the need for the majority of referrals. Most critical care stays are only of only a few days duration.

8.26 We are unclear whether the advocate is required for writing the care plan or for the DoL assessment at 28 days. **We would agree strongly that in highly specialized environments e.g. critical care, a "second opinion" may sometimes be more appropriate than an advocate**

8.29 – We disagree. Issues related to DoL are specialized and time consuming. We feel it may be more appropriate to "concentrate" the experience of making such assessments into a relatively small "pool" of trained staff who's job planning reflects that extra work.

8.30 This arrangement seems excessively complicated and may require dedicated staff to administer the scheme reliably. We advise simplification.

Proposal 8.2 – this seems a reasonable proposal but further details will be needed to ensure this is a practicable system. In particular the scope for appropriate delegation needs to be considered – especially given the "shift" type rotas usually worked by critical care consultant staff.

Proposal 8.3 – we feel a "second opinion" would be more appropriate in some circumstances (e..g. specialized areas such as critical care). This is routine practice already

Chapters 9 to 15:

WICS has no view on these chapters as they are largely outside of our remit.

Summary:

We are of the opinion that in the absence of a valid advance directive the "right to life" should take precedence over any possible short term Deprivation of Liberty. Application of DoL safeguards to Critical Care practice is an area that requires special consideration. Special thought must be given when drafting the new law as to whether or not all "level 3" patients are considered to be subject to DoL by the very nature of the treatments they are receiving. Any safeguarding system put in place must not hinder the provision of life saving treatment nor place such a burden on the system that care suffers. In some circumstances the rights of patients in regard to DoL must be balanced against the rights of others to be protected from physical injury by patients who do not have insight into their actions.

Any new safeguarding system must also be practical, flexible, take account of different hospitals' working arrangements and as well as protecting patients must not leave staff open to potential prosecution for doing their work in a conventional and appropriate manner.

The Welsh Intensive Care Society Council would like to extend an invitation to Law Commission members to visit the University Hospital of Wales in Cardiff in order to see the sorts of challenges that professionals could face in applying replacement DoL legislation. Specifically we would welcome the opportunity to present some critically ill patients' cases along with some of the treatments they are requiring to see whether the Law Commission believes that they could be subject to a deprivation of liberty. Please email the chair (address below) if you would like to take up this offer.

We are also very happy to contribute further to the consultation process to ensure that the final piece of legislation is both workable and provides the required safeguards. Once again please feel free to email the chair if you would like further discussion.

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on behalf of the Welsh Intensive Care Society Council and Membership
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