**Medical input to the s136 – analysis over 2 months and trainees’ views**

**Part 1: What are the medical requirements for the s136?**

Data was collected over 2 months to find out:

1) How many patients require medical input.

2) What input do patients require

**Part 2: Doctor survey for on call duties at mental health place of safety**

10 respondents answered a survey sent out via email to understand what the experience of trainees covering the s136 has been like.

1. **What grade are you**

There was an equal response of SHOs covering the senior and junior rota

1. **Who should staff contact first when seeking medical assistance with a detainee on the place of safety?**

This shows a lack of uniform understanding of who the first point of call should be on the s136

1. **The handover I receive from staff is clear and I know precisely what is required of me**

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| Most respondents felt that they were not clear what was being asked of them when they received calls from staff at the s136  [**Comments**](https://www.surveymonkey.com/analyze/VloKlfZNB1dBmctiSmvpIAeljjXv0ejCDSNkjVp2v_2Bg_3D) |
| 1. I contacted the team when on nights because a patient I had assessed twice with the crisis team had been admitted there and I was concerned that she may be lithium toxic and I wanted to review her. The team seemed confused and stated that they had no doctor covering the unit. They were able to give me accurate and detailed information about the SU's physical well being, when I arrived the information all appeared to correlate with what I saw there 2. Staff are often unaware of the medical problems there is no clarity about who should be contacted 3. Often the most confused ward that is dealt with overnight / on call 4. Phone calls are often about abnormal obs, regular medication writing up, benzos, alcohol detox and with no clear guidance as to when we should attend, when we should write up regular meds (ie if section assessment going to be hours to days away), confusion over who nurses should call first (every time) 5. Staff handover as well as they can but often there is insufficient information about PMH and regular medications which causes the most difficulty when patients are admitted. 6. sometimes get different messages from staff and when I arrive it turns out to be a different situation from initially described | |

1. **I feel I know what interventions are and are not appropriate for patients detained on a section 136**

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| Most respondents were unclear about what sort of input is appropriate for patients on the s136  [**Comments**](https://www.surveymonkey.com/analyze/VloKlfZNB1dBmctiSmvpIAeljjXv0ejCDSNkjVp2v_2Bg_3D) |
| 1. I have heard conflicting reports. 2. Sometimes the line between when they should be in A&E and in 136 can be difficult to determine, ie some alcohol withdrawal vs full blown dt 3. Often asked about alcohol withdrawal - not sure sometimes about giving librium and pabrinex, tricky situation surrounding rapid tranq | |

1. **I feel comfortable that I am working within my expertise when providing medical assistance**

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| Most respondents do not feel comfortable that they are working within their expertise.  [**Comments**](https://www.surveymonkey.com/analyze/VloKlfZNB1dBmctiSmvpIAeljjXv0ejCDSNkjVp2v_2Bg_3D) |
| 1. I feel that it would be dangerous to expect us to prescribe regular medications when we can not perform a medical reconciliation, however, it is appropriate for us to to provide urgent advice and to assess patients if they need to be assessed. 2. Concerns about the legal aspect of 136. Disagreements amongst consultants re: who's responsiblity it is to manage these patients mean I would always call the consultant prior to actively managing someone here. 3. Assessing people's medical condition without their past medical history/GP records out of hours often feels extremely unsafe given that nursing staff are not medically trained and therefore not always (not through any fault of their own) confident in when someone should be transferred more urgently. Even if a sensible/ safe-ish plan can be formulated it feels unsafe to implement it in that setting. 4. not clear on all nuances of the law | |

1. **I have a clear understanding of where to get senior support if I need it**

All respondents felt that they knew where to go for senior help.

1. **Please give details about experiences you have had giving assistance to the place of safety. Describe experiences that stand out and if they were difficult please explain why you think this was.**

Showing 8 responses

1. I have been involved as rota rep and so have heard lots of difficult situations arising with lack of clear protocol. I have proposed a protocol along with management which is currently being reviewed. ongoing issues appear to be around alcohol withdrawal prescribing benzos for agitation use of medication against patients will (rapid tranq) "normally" prescribed pt medication (which we cannot verify in the middle of the night. issues arise mainly as a result of patients staying too long in 136 and then subsequently withdrawing/ needing regular meds. difficulties i have suggessted monitoring: • length of stay prior to assessment (and reasons for any delay) • length of stay after assessment awaiting bed • was the on call junior doctor contacted - if so, was it senior SHO (as it should be)? And what was the outcome - phone advice, review, prescription, referral to A&E? • Was any medication prescribed and if so, what and what was the indication. • Any difficult issues arising? Seclusion? Severely agitated or violent behaviour? Alcohol withdrawal? Alcohol intoxication? Medical illness? • Was the consultant contacted for advice/ asked to attend?
2. A patient was on the ward for several days awaiting their MHA withdrawing from alcohol and therefore needing daily review of their cholordizepoxide and vitamin supplementation. His symptoms were bordering on Delirium tremens, he was hallucinating, sweating, with some psychotic symptoms. This would have been more appropriatley managed in a safer environment as DTs is a medical emergency. I am not sure of the MHA outcome, it maybe that they went to A&E but I believe it would have been more appropriate for him to be taken there by police in the first place.
3. I was asked to prescribe anti-epileptics for a patient who did not know what medication she was on or the dose.
4. 1. Delirium tremens/head injury/?Wernicke's -- A&E handover reluctance to take, constant misunderstanding of what we can provide and our role, getting meds from oakwood ooh takes WAY too long 2. Tachycardia 3. Hypotension 4. Bloods needed for ?overdose 5. Chest infection ?antibiotics 6. Seclusion review 7. Write up regular meds 8. Paracetamol
5. Lack of information about background medications etc. Lack of clarity over who should be called to attend and what is appropriate to be given. Have prescribed sleeping tab for known patient, only for her to disclose following morning that she had taken several prior to admission- feels very dodgy. Also asked to prescribe alcohol withdrawal medications 'just in case' for intoxicated patient with no clarity on their alcohol history. Just feels uncomfortable. Also, have only covered at night when also covering other hospitals and there is often a lack of time for getting to the bottom of the situation to make an informed decision
6. The main issue has been the conflicting information we've been receiving about our role at the place of safety, with the offical line seeming to be that cover should eb consultantant led and all calls going via consultants, but then nurses calling consultants saying "X is the problem, shall we call the junior about it?" or some consultants saying they dont want to be called and everything should go through the junior. Personally I don't mind either way whether the work is ours or supervised by consultant but I think we all need to be clear about which this is in order to be safe.
7. Prescription of regular insulin or antiepileptic medications to overtly suicidal patients who are unclear/inconsistent with dose information and no information about doses available on RIO. Review of symptoms of alcohol detox and prescription of chlordiazepoxide Overtly psychotic and violent patients put into seclusion Management of chest pain
8. patient detained, concern about possible PE, refused to attend A&E, seemed to have capacity to refuse, wasn't sure whether she should be taken against her will on the basis of her being detained
9. **Do you feel that additional guidance for medics covering the place of safety would be useful?**

All respondents felt that additional guidance would be helpful.

1. **If yes, what in particular would you like guidance about?**
2. Use of thiamine po/im use of benzos for anxiolytics/hypnotics (pro- helping distressed pt, con-interferes/delays MHA Ax). clear guidelines about not being able to provide meds under mha against will as not detained for treatment, only under mca (so in their patients interest)
3. More clarity about exactly what we should be doing if we are called. Protocol for physical interventions that do not need to be admitted to the general hospital e.g: management of insulin dependent diabetes prevention of acute alcohol withdrawal
4. At times, patients are best seen at A&E and not placed in the 136 suite. I wonder if it would be helpful for this to be anticipated at the time of their admission to 136 with discusison with a medic where appropriate.
5. That if we make decisons on the 136 suite they will be treated like any other ward so I can be sure I am legally covered & would receive support from the consultant if there was a mistake / problem.
6. WHO is ACTUALLY supposed to be called first When nurses should send directly to A&E What we are covered to do medico-legally When to write up regular meds When to prescribe PRN (obviously we use common sense but not under Section 2/3 - what are we allowed to administer under 136)
7. What is ok to prescribe. Common on call scenarios in S136 suite. Clear protocol for nursing staff about who to contact (there was advice to contact consultant or senior registrar, but they would call the junior on call as the senior sho had said it wasn't them... Etc.
8. Accessible information about PMH and regular medications
9. Treating medical conditions in patients refusing to consent, alcohol withdrawal, rapid tranq