In-Patient Legal Status Sheet

Guidance For Nurses: This form is used to track the detention and rights of a detained patient and must be kept up to date with the most current information. You may use additional sheets if required.

RECORD OF DETENTION, SECTION 132, TREATMENT CERTIFICATION

Patient Name				Ward		
Section	Start Date	Expiry	Treatment Certificate Due	Current Treatment Certificate	Treatment Certificate Review Date	Name of Nurse (Print Name)

RECORD OF ATTEMPTS TO INFORM PATIENT OF THEIR RIGHTS

N.B. <u>An interpreter must be obtained for any patient who does not speak English as a first language.</u>
Every attempt must be made by nursing staff to ensure that patient understands their rights under the Act. Each attempt should be recorded below and review dates should be indicated in all cases.

Have you informed the patient of their right to an Independent Mental Health Advocate?
Remember to include patients' rights in the Nursing Care Plan.

Date	Did the patient understand? Yes/No (Include in Nursing Care Plan)	Date documented in progress notes	Next date for review. (Whether or not the patient understood)	Print name of nurse reading rights	Copy of Leaflet to Patient Yes/No

Note: This form and the most current section should be transferred into MDT files when a new volume is opened. When this form is completed another form must be attached to this one to continue recording.

Guidance for Nurses:

This form is used to track the powers of detention and rights of a patient subject to powers of the Mental Health Act 1983.

Please file this form at the front of the Mental Health Act section of the patient notes. It must be kept up-to-date with the most current and up-to-date information. You may use additional sheets if required.

All copies of the patients section should be filed in chronological order. The table overleaf should therefore be completed in chronological order to start with and include the date of the original detention.

A record of the patients' current treatment certificate should also be recorded.

It is recommended that papers are filed in the following order:

1. Legal Status Sheet
2. Current section
3. Older sections
4. AMHP Reports
5. Consent to Treatment
6. Capacity and Consent discussions
7. SOAD Consultee Forms
8. RC Discussion with Pt re SOAD
9. Leave Forms (cross through old forms)
10. Appeals/Managers hearings decisions/ reports etc.

- **Consent to Treatment**

If a patient is admitted after recall of their Community Treatment Order, the patient can only be treated if such treatment is specified on either the most recent CTO11 or under section 62A.
After revocation, the patient will need a fresh consent to treatment certificate immediately, ie: either a form T2 or T3 however, a s62 MUST be in place whilst these are being sought.

THE 3 MONTH RULE DOES NOT APPLY AFTER REVOCATION

- **Patients Rights**

Attempts should be made to ensure a patient understands their detention under the Act, their rights of appeal, their treatment requirements, and their rights to an Independent Mental Health Advocate.
The MHA office will inform all patients of their rights under the MHA in writing however, attempts must be documented that the rights of the patient have been discussed verbally with the patient.
This form should contain each attempt made and should include the use of any interpreter.
Its important to ensure that the patient is made aware of their rights at regular intervals when necessary so a date of review must be recorded.

- **Further advice**

Further help and advice can be sought from the MHA administration office.

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