NHS GG&C Mental Health Service

Advance Statement Guidance for Staff

Important Note:
The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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MHS 29 - Advance Statement Guidance for Staff

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date	Brief Summary of Changes	Author(s)
1.0	26/07/2017	First Draft Inclusion of health records procedure for recording statement on EMIS and completion of ADV 1 form for MWC. Typo and spelling amendments	A Strachan
2.0	Dec 2020	References to changes made to the act in 2017 updated	S McCulloch

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1. Introduction

"An Advance Statement is a statement specifying the ways the person making it wishes to be treated for mental disorder; the ways the person wishes not to be so treated".

Mental Health (Care and Treatment) (Scotland) Act, 2003

1.1 In NHSGG&C, the number of service users developing an advance statement remains low although there has been notable progress in some areas. Whilst it is recognised that there are many contributing factors to this, two of the main issues appears to be the lack of awareness in some service providers and the absence of a clear structure to the process of engaging with the service user from the outset.

1.2 The expectation of the Act is that all service users are informed of their right to make an Advance Statement. There is no clear responsibility placed upon any specific organisation or staff group to ensure this happens at present. It is therefore incumbent upon all staff working in mental health to attempt to put in place processes, opportunities and resources to ensure that service user is aware of their rights.

1.3 The legislation specifies:

- The person must have the capacity of properly intending the wishes specified in the Advance Statement.
- The Advance Statement is in writing
- The Advance Statement is subscribed (signed) by the person making it
- The Advance Statement is witnessed by a person who is in the class of persons prescribed by regulations
- The witness certifies in writing on the document that, in their opinion, the person has the capacity to make the statement.

1.4 The Advance Statement does not replace consent to treatment for a capable patient and therefore has no legal authority where a patient can consent. However all staff must take into account the Advance Statement when reaching treatment decisions for patients who are detained and should be used for treatment decisions under the principle of "Taking into account the present and past wishes and feelings of the patient" for patients who are not detained but may be unable to consent.

1.5 Staff need to be aware of any other decision makers such as welfare attorneys and guardians where a patient is an Adult with Incapacity and a valid Advance Statement is in place.

2. Operational Issues

2.1 The expected minimum standard for each service user still open to any service is that they have their right to make an Advance Statement explained to them **at least once within every 12 month period**. Where a patient has an existing advance statement a review of this must also be offered **within every 12 month period**.

2.2 Where a service user has been admitted into hospital their right to make an Advance Statement explained to them **at least once during the admission** preferably as part of discharge planning.

2.3 There should be documented evidence that the service user has been informed of their right to make an Advance Statement, which can be accessed for the purposes of reporting and audit.

2.4 Progress on the promotion of Advance Statements will be made via local Care Governance groups with HSCPs.

2.5 There are several different types of approach that can be adopted within teams such as identified patients invited along to workshops delivered by staff or by the service user network or information leaflets devolved for a specific client group. The important aspect is that this activity is followed up by staff until completion and that activity is recorded.

3. Awareness Raising

All disciplines and personnel in the multi-disciplinary care team need to recognise their role in promoting advance statements. This could take the form of Named Nurse engagement, multidisciplinary meetings, care or case management and should include an awareness of the very significant contribution made by Voluntary services and Advocacy. The support and encouragement of the Management team and senior clinicians are crucial to the successful engagement with service users.

As services strive towards shorter admission episodes and ward and community staff work more collaboratively, it is essential that inpatient staff are not only aware of the significance and value of an advance statement for service users, but also understand their role in providing information to the service user on how their Community Mental Health Team will be encouraging them to participate.

Inpatient settings can display posters and leaflets, hold informal information groups and collaborate with their community colleagues in describing the benefits to patients prior to discharge. It is also imperative that Inpatient staff know when a patient has written an Advance Statement and its significance when admitting, assessing and planning the patients care.

Information to support the promotion off Advance statements can accessed at the mental welfare commission website:

http://www.mwcscot.org.uk/get-help/getting-treatment/advance-statements/

In order to maximise the opportunities for engagement with service users, teams need to employ as many formats as available, including:

- 1:1s with Named Nurse or key worker
- Meetings between the service user and Consultant or RMO
- Meetings between the service user and MHO
- Multidisciplinary team meetings
- Posters
- Leaflets
- Information “coffee mornings”
- Local service user networks
- Patient focus, Public involvement groups
- Advocacy staff and meetings
- Peer support workers (where available).
- Advance statement Champions group – patients who have already developed statements and are willing to meet with other service users to share the experience.

4. Personal Statements

A Personal Statement is a document which contains a service user's instructions and wishes regarding other aspects of their lives, for example

- Who has agreed to look after their pet if they need to go into Hospital,
- Who will be informed that they have been admitted with regards to looking after their house or garden
- Who will hold another set of keys
- What arrangements are already in place for looking after children or elderly dependants
- What they wish their children or other family members to be told
- What their religious beliefs and needs might be
- If they have a lawyer, name and address
- Dietary needs
- Physical health
- Communication needs

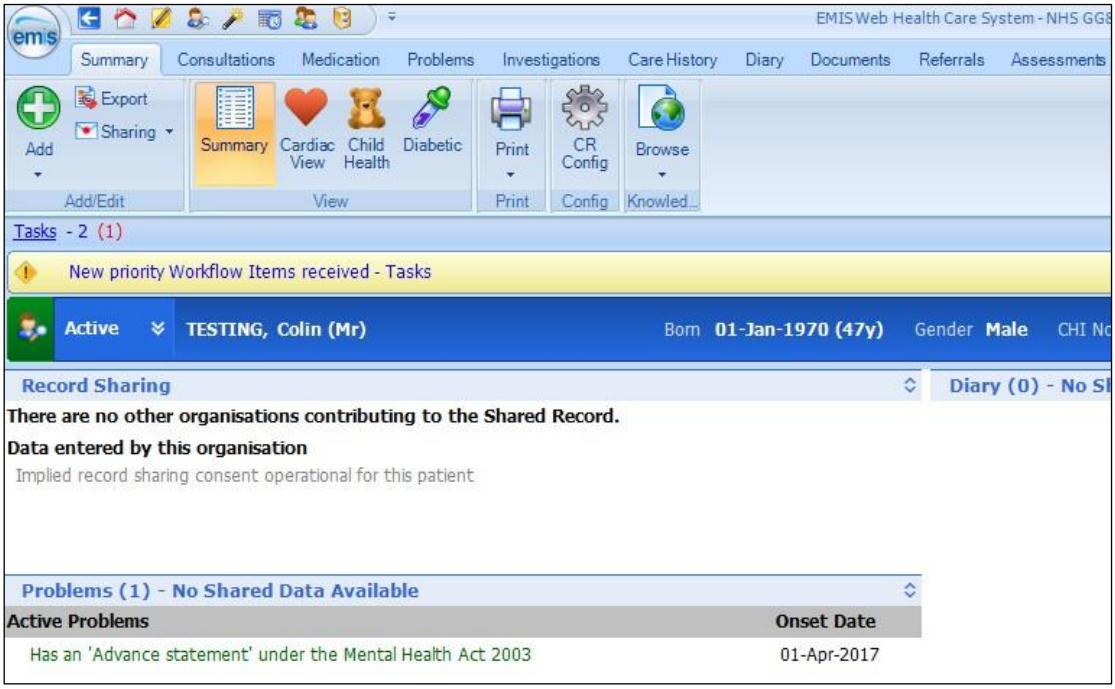
5. Procedure for Recording Advance Statement Activity

Introduction

Changes to the Mental Health (Care & Treatment) Act 2003 came into force on 1 July 2017. One of the changes requires boards to notify the Mental Welfare Commission when a patient makes and provides an Advance Statement. At present, practice around the recording of Advance Statements varies, however when Health Records Departments are made aware of these they will record them locally and ensure that a copy is placed in the patient's health record.

Procedure adopted under the new legislation

1. All Health Care Professionals who are either involved in helping a patient prepare an Advance Statement or are given a Statement by a patient must forward this to their local Mental Health Records Department.
2. Health Records staff will ensure that the appropriate MWC Form (ADV1) is completed and forwarded to the MWC to inform them that an Advance Statement exists for a particular patient.
3. Health Records staff will record in the patient's EMIS Care Record that the patient has an advance statement and record the date this was made. This will be done by selecting Add a Code in the **Care History Tab** and searching for "Has an Advance Statement under Mental Health Care & Treatment Act" (Code EMISNQHA20).
4. This Entry will be visible in the Active Problems section of the Summary Tab in the patient's EMIS Care Record.



5. Health Records staff will also scan upload the Advance Statement into the Documents Tab in the patient's EMIS Care Record.
6. While we are still using paper records, a copy will be filed in the patient's red Integrated Record Folder behind the Mental Health Act divider.

Withdrawal of an Advance Statement

1. Health Records staff will ensure that the appropriate MWC Form (ADV1) is completed and forwarded to the MWC to inform them that an Advance Statement has been withdrawn for a particular patient.
2. Health Records staff will record in the patient's EMIS Care Record that the patient does not have an advance statement under the Mental Health (Care & Treatment) Act and record the date the statement was withdrawn. This will be done by selecting Add a Code in the Care History Tab and searching for "Patient does not have an Advance Statement under MHA 2003 (Code EMISNQPA22).
3. While we are still using paper records, a copy of the MWC Notification in the patient's red Integrated Record Folder behind the Mental Health Act divider beside the original statement to clearly indicate that is no longer valid.

6. Procedure for Recording Withdrawal of Advance Statement

A withdrawal of an advance statement document may be received at any hospital department or outpatient location. It is the responsibility of the member of staff who receives this statement to ensure that it is filed in the patient's medical record.

The document must be checked to ensure it is valid. For the withdrawal of an advance statement document to be valid:

- It must be signed and dated by the person withdrawing it.

- It must be witnessed by a prescribed person and dated. A prescribed person is a suitably qualified person such as a doctor, clinical psychologist, registered nurse, qualified social worker, occupational therapist, solicitor or social service worker (e.g. supervisor or manager of a care service).
- The witness must state in writing that in their opinion the person withdrawing the advance statement has the capacity of properly intending their wishes.

The patient's medical record should be retrieved.

The advance statement document should be cancelled and the word **"WITHDRAWN"** and the date written across the page.

The withdrawal of advance statement document should be filed, behind the pink divider, on top of the advance statement document in the medical record.

7. Procedure for Recording Decisions Made Which Conflict With Advance Statement

The document explaining decisions made which conflict with Advance Statement should be sent to the Medical Records Department.

The Medical Records administrator should send a copy of the document to:

- The person who made the Advance Statement
- The patient's named person
- Any guardian or welfare attorney of the patient
- The Mental Welfare Commission

A copy of the document should also be filed behind pink divider in medical record.

Advance Statement Flowchart – Preparation and Storage