The Regulation and Quality Improvement Authority

Guidance for the completion of Treatment Plans (Forms 21-23) under the Mental Health (NI) Order 1986

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

Contents

Definitions

Consultant Psychiatrist	A medical practitioner appointed to consultant grade, who specialises in the diagnosis and treatment of mental disorders
Part II Medical Practitioner	Consultant Psychiatrist appointed by RQIA for the purposes of Part II of the Mental Health (Northern Ireland) Order 1986 (MHO)
Part IV Medical Practitioner	Consultant Psychiatrist appointed by RQIA for the purposes of Part IV of the MHO
Psychotropic medicines	Approved drugs that are used to treat psychiatric conditions
Responsible Medical Officer	The Consultant Psychiatrist (usually a Part II doctor) in charge of the patient's assessment or treatment

The Regulation and Quality Improvement Authority

Who We Are

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care services in Northern Ireland.

RQIA was established in 2005 as a non-departmental public body under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to drive continuous improvements in the quality of services, through a programme of inspections and reviews.

The Mental Health and Learning Disability team (MHLD) undertakes a range of responsibilities for people with mental ill health and those with a learning disability under the Mental Health (Northern Ireland) Order 1986 as amended by the Health and Social Care Reform Act (Northern Ireland) 2009. These include:

- preventing ill treatment, remedying any deficiency in care or treatment
- terminating improper detention in a hospital or guardianship by monitoring the appropriateness of all applications forms received from HSC Trusts
- preventing or redressing loss or damage to a patient's property.

The MHLD team talks directly to patients about their experiences. This informs the wider programme of announced and unannounced inspections.

RQIA takes into consideration relevant standards and guidelines, the views of the public, health care experts and current research, in any review of services provided. We highlight areas of good practice and make recommendations for improvements. Inspection report can be viewed on our website at http://www.rqia.org.uk/what_we_do/mental_health_and_learning_disability.cfm

Requirement to seek consent

Part IV of the Mental Health (Northern Ireland) Order 1986 (MHO) sets out the requirements for Consent to Treatment. Under Article 64 of the MHO, the administration of psychotropic medicine three months or more after its first administration, during any continuing period of liability for detention, requires consent or a second opinion. Consent, given by a detained patient, must be validated by the Responsible Medical Officer (Part II Medical Practitioner) or a Part IV Medical Practitioner. If valid consent is not given or cannot be given, a second opinion must be obtained from Part IV Medical Practitioner. Part IV Medical Practitioners are appointed by RQIA and requests for the provision of a second opinion must be made

to RQIA by the Trust. The process for requesting a second opinion is set out in a separate guidance document.

Treatment Plans are recorded on Forms 21, 22 and 23 which require a Part II Medical Practitioner to document the psychotropic medicines which the patient is receiving at that particular time. These prescribed forms used in the processes provision of second opinions for that treatment provide legal justification for staff who take actions under the MHO.

Treatment Plans are referred to in the Mental Health (Northern Ireland) Order 1986 Code of Practice as essential in order to observe the principles set out below and, to ensure that the different elements of patient care are coordinated, as part of an effective treatment programme for each patient.

Treatment Plans should be documented in each patient's clinical notes and incorporate details of the patient's care, supervision and all forms of therapy received by the patient. The medicines for both physical and psychiatric conditions prescribed for the patient are written on their medicine Kardex.

Monitoring of Prescribed Forms by the Mental Health and Learning Disability Directorate

RQIA is required scrutinise all prescribed forms associated with treatment, and advise Health and Social Care Trusts if there are any errors or omissions which may make processes improper.

It is a requirement of the legislation that prescribed forms are forwarded to RQIA by the Trusts. It is important that completed prescribed forms are forwarded to RQIA once they have been completed. These forms should be received by RQIA no later than **four** days following completion.

Standards and General Principles

This document provides guidance and clarity for those completing prescribed forms in terms of the information that must be recorded and the manner in which the forms should be completed.
Supporting guidance and clarity for those completing prescribed forms can be found in the following documents:

- The Mental Health (NI) Order, 1986
- The Mental Health (NI) Order, 1986, A Guide
- The Mental Health (NI) Order, 1986, Code of Practice
- The GAIN Guidelines (October 2011) on the use of the Mental Health (NI) Order, 1986.

The general principles that should be applied to ensure the validity of the documentation include:

- All parts must be completed legibly; it is preferable that the relevant form is typed if possible. Handwritten forms should be written in block capitals.
- All parts must be completed fully
- Full names of patients and all practitioners involved - **NO** use of abbreviations or initials is permitted
- Full names and addresses of Trusts and Hospital – **NO** use of abbreviations is permitted
- Addresses must include postcodes
- Doctors status should be clearly indicated where required
- Forms must be signed, dated (and timed where required) within the timescales required in the MHO

Please note that RQIA cannot accept forms which are illegible, incomplete or include errors.

Form 21

CERTIFICATE OF CONSENT TO TREATMENT AND SECOND OPINION

FORM 21
Mental Health
(Northern Ireland)
Order 1986
Article 63

(TREATMENT REQUIRING CONSENT AND SECOND OPINION)
(Both parts of this certificate must be completed)

(full name and professional address) I _____

Make sure the doctors FULL LEGAL name is used here. No abbreviation or initials to be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. Ensure postcode is included. The name of the Trust is not required here.

, a medical practitioner appointed for the purposes of Part IV of the Mental Health (Northern Ireland) Order 1986 by the Mental Health Commission, and we

(full name, address and status) _____

(full name, address and status) _____

Insert FULL LEGAL name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations to be used. Ensure postcode is included. Ensure that the status of the medical practitioner is recorded here.

, being two persons appointed for the purposes of Article 63(2)(a) of the Order by the Commission, certify that-

(full name and address of patient) _____

Make sure patient's FULL LEGAL name is used here. No abbreviation or initials to be used. Ensure

(a) is capable of understanding the nature, purpose and likely effects of [give description of treatment or plan of treatment];

_____

Ensure LEGIBLE text is written here to provide a detailed description of treatment or plan of treatment

AND

(b) has consented to that treatment

Signed _____

Signed _____

Signed _____

MAKE SURE FORM IS SIGNED AND DATED – date should be within three months of the commencement of treatment.

Please Turn Over

PART II

(full name) I _____ Insert FULL LEGAL name

, a medical practitioner appointed for the purposes of Part IV of the Order by the Commission, have consulted

(Full name, address and status of person or persons consulted)

_____

_____

_____ Insert FULL LEGAL name; address of the Health and Social Care Trust, and status of the medical practitioner her here. No abbreviations to be used.

This will include the RMO, nursing staff and other professional's e.g. psychologist, social worker, occupational therapist etc.who have been involved in the patients treatment

_____

_____

_____ Insert FULL LEGAL name; address of the Health and Social Care Trust, and status of the medical practitioner her here. No abbreviations to be used.

Who appear(s) to me to be principally concerned with the medical treatment of the patient named above and certify that, having regard to the likelihood of the treatment specified above alleviating or preventing a deterioration of the patient's condition, that treatment should be given.

Signed _____ **Date** _____

MAKE SURE FORM IS SIGNED AND DATED

Notes

Information Required	Guidance
Part 1	
Full name and professional address	Make sure the doctors **FULL LEGAL** name is used here. The doctor's address should be that of the hospital to which the patient is admitted or resident in. Ensure postcode is included. The name of the Trust is not required here. Abbreviations or initials will not be accepted.
Full name, address and status (1)	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. Ensure postcode is included. Ensure that the status of the medical practitioner is recorded here. Abbreviations or initials will not be accepted.
Full name, address and status (2)	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here i.e. BELFAST HEALTH AND SOCIAL CARE TRUST. Ensure postcode is included. Ensure that the status of the medical practitioner is recorded here. Abbreviations or initials will not be accepted.
Full name and address of patient	Make sure patient's **FULL LEGAL** name is used here. Ensure name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed. Abbreviations or initials will not be accepted.
Description of treatment or plan of treatment	Ensure **LEGIBLE** text is written here to provide a detailed description of the patient's treatment or plan of treatment. The below information **MUST** be written in **Block Capitals** to ensure legibility.

Sign and date	**MAKE SURE FORM IS SIGNED AND DATED** – date should be within three months of the commencement of treatment.
Part 2	
Full name (Medical Practitioner)	Insert **FULL LEGAL** name Initials will not be accepted.
Full name, address and status of person or persons consulted	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. Ensure postcode is included Ensure that the status of the medical practitioner is recorded here. Abbreviations or initials will not be accepted.
Sign and date	**MAKE SURE FORM IS SIGNED AND DATED -** date should be within three months of the commencement of treatment. ***The 3 month period will run from the day after medicine was first administered as a form of treatment for mental disorder regardless of whether there was an interval during which no medicine was given.***

Form 22

CERTIFICATE OF CONSENT TO TREATMENT

FORM 22
Mental Health
(Northern Ireland)
Order 1986
Article 64(3)(a)

TREATMENT REQUIRING CONSENT OR A SECOND OPINION

Full name and professional address

I,

Make sure the doctors FULL LEGAL name is used here. No abbreviation or initials to be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. Ensure postcode is included.

The name of the Trust is not required here.

*Delete the phrase which does not apply

*The Responsible Medical Officer

*A medical practitioner approved for the purposes of Part IV of the Mental Health (Northern Ireland) Order 1986 by the Mental Health Commission

Please CLEARLY indicate the phrase which does not apply

Full name and address of patient

Certify that

Make sure patient's FULL LEGAL name is used here. No abbreviation or initials to be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

(a) is capable of understanding the nature, purpose and likely effects of (give description of treatment or plan of treatment)

MEDICATIONS

Treatment plans using medications will be assessed with the below criteria:

- **a. Acceptable Medication**
- **b. Dosage within BNF Guidelines**
- **c. Polypharmacy – indications e.g. changeover, treatment resistance etc.**
- **d. Pro Re Nata Medication:**
  - **i. Indications**
  - **ii. Minimum interval between dosages**
  - **iii. Maximum dosage in 24 hours**

Ensure LEGIBLE text is written here to provide a detailed description of treatment or plan of treatment

and

(b) has consented to that treatment.

ELECTROCONVULSIVE THERAPY

If the treatment administered is ECT, include number of treatments per week and maximum number of treatments.

A standard ECT treatment description is given below

"A course of modified bilateral/unilateral electroconvulsive therapy, given up to twice weekly, up to a maximum of twelve treatments, discontinuing earlier if/when improvement is maintained."

Signed

MAKE SURE FORM IS SIGNED AND DATED – date should be within three months of the commencement of treatment.

Notes

Information Required	Guidance
Full name and professional address	Make sure the doctors **FULL LEGAL** name is used here. The doctor's address should be that of the hospital to which the patient is admitted or resident in. Ensure postcode is included. The name of the Trust is not required here. Abbreviations or initials will not be accepted.
Delete which phrase does not apply	Please **CLEARLY** indicate the phrase which does not apply One phase **MUST** be deleted here.
Full name and address of patient	Make sure patient's **FULL LEGAL** name is used here. Ensure this name is consistent with **ALL** other forms completed. Ensure the patient's address is written out in **FULL** including postcode and is consistent with **ALL** other forms completed. Abbreviations or initials will not be accepted.
Description of treatment or plan of treatment	Ensure **LEGIBLE** text is written here to provide a detailed description of the patient's treatment or plan of treatment. The below information **MUST** be written in **Block Capitals** to ensure legibility. ***MEDICATIONS*** Treatment plans using medications will be assessed with the below criteria: a. Acceptable Medication b. Dosage within BNF Guidelines c. Polypharmacy – indications e.g. changeover, treatment resistance etc. d. Pro Re Nata Medication: i. Indications ii. Minimum interval between dosages iii. Maximum dosage in 24 hours ***ELECTROCONVULSIVE THERAPY*** If the treatment administered is ECT, include number of treatments per week and maximum number of treatments.

	A standard ECT treatment description is given below “A course of modified bilateral/unilateral electroconvulsive therapy, given up to twice weekly, up to a maximum of twelve treatments, discontinuing earlier if/when improvement is maintained.”
Sign and date	**MAKE SURE FORM IS SIGNED AND DATED** – date should be within three months of the commencement of treatment. ***The 3 month period will run from the day after medicine was first administered as a form of treatment for mental disorder regardless of whether there was an interval during which no medicine was given.***

Form 23

CERTIFICATE OF SECOND OPINION

FORM 23
Mental Health
(Northern Ireland)
Order 1986
Article 64(3)(b)

TREATMENT REQUIRING CONSENT OR A SECOND OPINION

(full name and professional address) **I,**

Make sure the doctors FULL LEGAL name is used here. No abbreviation or initials to be used. The doctor's address should be that of the hospital to which the patient is admitted or resident in. Ensure postcode is included.

The name of the Trust is not required here.

*(Delete whichever does not apply) am a medical practitioner appointed for the purposes of
*Part II
*Part IV of the Mental Health (Northern Ireland) Order 1986 by the Mental Health Commission

Please CLEARLY indicate the phrase which does not apply

(full name, address and status of person or persons consulted) I have consulted

Insert FULL LEGAL name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. Ensure that the status of the medical practitioner is recorded here.

Insert FULL LEGAL name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. No abbreviations will be accepted. Ensure postcode is included. Ensure that the status of the medical practitioner is recorded here.

who appear(s) to me to be principally concerned with the medical trea

(full name and address of patient)

Make sure patient's FULL LEGAL name is used here. No abbreviation or initials should be used. Ensure this name is consistent with ALL other forms completed. Ensure the patient's address is written out in FULL including postcode and is consistent with ALL other forms completed.

I certify that this patient -

** (Delete if not applicable) ** (a) is not capable of understanding the nature, purpose and likely effects of
OR
** (b) has not consented to

Please CLEARLY indicate the phrase which does not apply

[Give description of treatment or plan of treatment]

Ensure LEGIBLE text is written here to provide a detailed description of treatment or plan of treatment.

MEDICATIONS

Treatment plans using medications will be assessed with the below criteria
:

e. Acceptable Medication
f. Dosage within BNF Guidelines
g. Polypharmacy – indications e.g. changeover, treatment resistance etc.
h. Pro Re Nata Medication:
   i. Indications
   ii. Minimum interval between dosages
   iii. Maximum dosage in 24 hours

ELECTROCONVULSIVE THERAPY

If the treatment administered is ECT, include number of treatments per week and maximum number of treatments.

A standard ECT treatment description is given below

"A course of modified bilateral/unilateral electroconvulsive therapy, given up to twice weekly, up to a maximum of twelve treatments, discontinuing earlier if/when improvement is maintained."

But that, having regard to the likelihood of that treatment alleviating or preventing a deterioration of the patient's condition, it should be given.

I am not the responsible medical officer for this patient.

Signed: _____

MAKE SURE FORM IS SIGNED AND DATED – date should be within three months of the commencement of treatment.

Notes

Information Required	Guidance
Full name and professional address	Make sure the doctors **FULL LEGAL** name is used here. The doctor's address should be that of the hospital to which the patient is admitted or resident in. Ensure postcode is included. The name of the Trust is not required here. Abbreviations or initials will not be accepted.
Delete which phrase does not apply	Please **CLEARLY** indicate the phrase which does not apply One phase **MUST** be deleted here.
Full name, address and status of person or persons consulted	Insert **FULL LEGAL** name and address of the Health and Social Care Trust here. I.e. BELFAST HEALTH AND SOCIAL CARE TRUST. Ensure postcode is included. Ensure that the status of the medical practitioner is recorded here. Abbreviations or initials will not be accepted.
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Delete if not applicable	Please **CLEARLY** indicate the phrase which does not apply If both phases apply there is no need to delete here.
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	: a. Acceptable Medication b. Dosage within BNF Guidelines c. Polypharmacy – indications e.g. changeover, treatment resistance etc. d. Pro Re Nata Medication: i. Indications ii. Minimum interval between dosages iii. Maximum dosage in 24 hours ***<u>ELECTROCONVULSIVE THERAPY</u>*** If the treatment administered is ECT, include number of treatments per week and maximum number of treatments. A standard ECT treatment description is given below "A course of modified bilateral/unilateral electroconvulsive therapy, given up to twice weekly, up to a maximum of twelve treatments, discontinuing earlier if/when improvement is maintained."
Sign and date	**MAKE SURE FORM IS SIGNED AND DATED** – date should be within three months of the commencement of treatment. ***The 3 month period will run from the day after medicine was first administered as a form of treatment for mental disorder regardless of whether there was an interval during which no medicine was given.***

Contact information

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5 Lanyon Place
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BT1 3BT

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Telephone: 028 9051 7500 (Monday to Friday 10am – 4pm)