Informal Patients to take Leave from Adult Mental Health Inpatient Wards

Standard Operating Procedure

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</tr>
<tr>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>1 AIM</td>
<td>3</td>
</tr>
<tr>
<td>2 SCOPE</td>
<td>3</td>
</tr>
<tr>
<td>3 LINK TO OVER ARCHING POLICY</td>
<td>3</td>
</tr>
<tr>
<td>4 PROCEDURE.</td>
<td>3</td>
</tr>
<tr>
<td>4.1 Definitions</td>
<td>3</td>
</tr>
<tr>
<td>4.2 Roles and Responsibilities.</td>
<td>4</td>
</tr>
<tr>
<td>4.3 The Planning of leave.</td>
<td>6</td>
</tr>
<tr>
<td>4.4 Action immediately prior to a period of Leave.</td>
<td>6</td>
</tr>
<tr>
<td>4.5 Action if a period of leave has been agreed but there is a change in the patient's clinical presentation/risk profile.</td>
<td>7</td>
</tr>
<tr>
<td>4.6 Action if an informal patient requests to leave the ward at short notice to attend the shops.</td>
<td>8</td>
</tr>
<tr>
<td>4.7 Support to patients during Leave.</td>
<td>8</td>
</tr>
<tr>
<td>4.8 Return from leave.</td>
<td>9</td>
</tr>
<tr>
<td>4.9 Action if a Patient goes missing whilst on a period of leave from the ward.</td>
<td>10</td>
</tr>
<tr>
<td>4.10 Clinical Record Keeping.</td>
<td>10</td>
</tr>
<tr>
<td>4.11 Involvement of Carers /Relatives</td>
<td>11</td>
</tr>
</tbody>
</table>
1. **AIM**

The services have a responsibility for preparing inpatients for a successful return to the community and periods of leave can form an essential component of this preparation. However any decision to agree a period of leave from a mental health unit has to balance the contribution that leave makes to the patient’s recovery against considerations for the health and well-being of both the patient and others.

Although informal patients have the right to leave the ward at any time, the Trust has a duty of care towards them including responsibility for their safety and well-being. The aim of this standard operating procedure is to set out the specific standards for when an informal patient takes leave from one of the Adult Acute Mental Health Inpatient wards. Additionally it also sets out the responsibilities of clinical staff prior to any period of leave for informal patients, during periods of leave and when a patient returns from leave.

2. **SCOPE**

The contents of this standard operating procedure cover the management of leave for informal patients and apply to all clinical staff working within the Trust’s Adult Acute Mental Health Services.

For patients subject to a period of detention under the Mental Health Act 1983 staff are to refer to the Trust Policy and guidance on the granting of leave for in-patients (including section 17 guidance).

3. **LINK TO OVER ARCHING POLICY**

This standard operating procedure links to the Trust Clinical Risk Assessment and Management Policy.

In addition it is the responsibility of clinical staff to be aware of and adhere to the record keeping standards as set out by the Trust and their respective Professional Regulators.

4. **PROCEDURE**

4.1 **Definitions**

For the purpose of this Standard Operating procedure the following definitions are used;

*Care Programme Approach (CPA):* A framework for multiagency working in mental health services.

*Care Co-ordinator:* A qualified professional from a mental health team in the community responsible for coordinating a patient’s care on a day-to-day basis.

*Lead Professional:* Patients who are on the case load of a community team
for a defined episode of treatment, and do not meet the threshold for CPA will not have an allocated care coordinator. Instead they will have an allocated lead professional who will be responsible for overseeing their episode of treatment and discharge back to primary care.

**CRHT:** Crisis Resolution and Home Treatment Team. In the case of some patients where there is an identified need and agreement with the CRHT they may provide support to patients whilst on a period of leave from the inpatient ward. For any patients they are supporting the team which will be responsible for the care and treatment of the patients' mental health and risks during a period of home leave and during 48 hour follow up on discharge from hospital if part of an early facilitated discharge.

**Named Nurse:** The inpatient nurse who is responsible for collaborating with patients and carers in the development, delivery and monitoring of the care plan.

**Leave from hospital:** The act of a patient leaving the hospital and its grounds either escorted (with a member of staff) or accompanied (with a family or friend) or unescorted (on their own).

### 4.2 Roles and Responsibilities

#### 4.2.1 Consultant Psychiatrist

The Consultant Psychiatrist is the clinician in charge of the patient’s episode of inpatient care and has responsibility for prescribing and overseeing the delivery of treatment for informal patients admitted under their care. This should include negotiating of ward activities and home leave with informal patients in consultation with the MDT and the patients’ carers/relatives.

#### 4.2.2 Admitting Clinician.

On admission, consideration should be given to the potential risks to the patient and/or others of any off ward activities including leave to their home as part of a comprehensive risk assessment. This assessment should also take into consideration:

- The clinical presentation and nature of the disorder.
- Risk factors;
- Information from relevant others (carers, other professionals e.g. GP, Care Co-ordinator);
- The social circumstances of the patient.

#### 4.2.3 Named Nurse.

In liaison with the Community Care Coordinator/ Lead Professional the allocated Named Nurse plays a central role in coordinating patient care and in relation to the planning of leave the Named Nurse must:
- Where appropriate, in conjunction with the multi-disciplinary team encourage the patient to utilise periods of home leave in order to assess their readiness for discharge.
- Ensure that patient has been provided with a copy of leaflet “Legal Rights for Informal Patients”.
- With the patient’s consent liaise with their relatives/ carers about any plans for leave. For guidance on action to take if patient declines to consent staff are to refer to section 4.12 of the Adult Mental Health service Named Nurse Standard Operating procedure.
- Take steps to ascertain that the accommodation at which the patient is taking their leave is accessible.
- Review the patient’s clinical risk assessment and risk management plan to take account of any new or increased risks once the patient leaves the ward.
- Have in place appropriate care plans for any planned periods of leave from the ward.
- Ensure that any required support is in place prior to the patient going on leave, and that the patient and where appropriate relatives /carers are aware of the support arrangements.
- Provide the patient and carers with contact details which can be used in the event of an emergency/crisis arising.
- Make sure the patient has supplies of all their required medication and knows how to administer it.
- When the patient returns from a period of leave:
  - Gain and record in the clinical records the patient’s perspective on the quality of the leave.
  - Gain feedback from the patient’s relatives/ carers as to the quality of the period of leave, and ensure that this is documented in the clinical record. Staff need to be aware that gaining this information from relatives or carers and listening to any concerns they may have does not breach patient confidentiality.

4.2.4 Care Coordinator

It is the responsibility of the patient’s allocated care coordinator to:

- Be involved in the planning of leave for patients they are working with;
- Support patients whilst on leave from the wards;
- Report back to inpatient staff as to the progress of the patient or concerns expressed to them by the patient’s relative/carer following any contact whilst leave is taking place.

4.2.5 Multi-Disciplinary Team

The risk management plan including the provisions for off ward activities such as leave should be reviewed and revised at the first Care Programme Approach (CPA) multi-disciplinary team (MDT) meeting and at each MDT meeting thereafter with changes to the plan being discussed with the patient,
carers (with the consent of the patient) and other professionals. The outcome of these reviews will be clearly documented in the patient’s clinical record.

4.3 The Planning of leave.

Where possible leave should be agreed as part of the patient’s treatment plan and discussed by the MDT involving carers (to discuss progress and ascertain their views), other professionals and / or the Home Treatment Team.

Any MDT support for a patient to have a period of leave from the ward will:

- Be informed by the on-going assessment of clinical risk, taking account of the fact that a patient’s risk profile will change once they are off the ward and no longer under the supervision and care of clinical staff. As part of the risk assessment the following should also be considered:
  - Any issues with treatment adherence;
  - The risk of the patient absconding from the local area;
  - The risk of the patient refusing to return to the ward;
  - Any safeguarding concerns once the patient returns home;
  - In the case of mentally disordered offenders any restrictions to their freedom of movement or risk to victims.

- Consider feedback from any previous periods of leave from the ward.
- Only be supported by the ward MDT if safe and appropriate.
- Involve clear parameters in relation to when, how long for and where leave is to be taken.
- Take account of how any identified support needs will be met.

A leave care plan must be developed which takes account of any identified risks, and the management of these risks, and includes any specific community based support which is needed to safely facilitate the leave.

4.4 Action immediately prior to a period of Leave

Prior to leave each patient will be seen on a 1:1 basis by their named nurse or other allocated staff member who will carry out an assessment of the patient’s mental health presentation and clinical risk profile.

As part of this assessment the named nurse/ staff member should obtain information from the patient as to how they feel about the planned leave and that they clearly understand the arrangements including what to do in the event of them needing advice or assistance.

This discussion will also provide an opportunity to explore with the patient their perception of any identified clinical risk issues and what coping strategies they can utilise.
For any home leave staff should where possible contact the patient’s carers /relative to confirm:

- That there has been no change in circumstances which have a direct impact on the planned leave.
- The address to which leave is to be taken and a contact number for use should the need arise for the ward to contact the patient.
- Any support which is to be provided by the services during the period of leave.
- That they are aware of action to take in the event that they have any concerns during the period of leave.

Where the patient is going on home leave, the inpatient team should also be satisfied:

- That the patient has access to the premises.
- That the patient has (or will have) enough food and beverages for the period of leave.
- That there are no immediate risks which could compromise the safety of the patient.

Any medication required by the patient during leave will be issued immediately prior to the patient leaving the ward. The named nurse /staff member should ensure that the patient understands how and when to take their medication, including any “as required” (PRN) medication if issued. The patient should be reminded of the purpose of the medication and of any side effects they might encounter.

All patients who are having a period of leave from the ward will be provided with a copy of the Adult Mental Health Leave leaflet.

Prior to the patient leaving the ward staff will provide a verbal handover to anyone who arrives to accompany the patient.

**All of the above must be recorded in the electronic patient record.**

**4.5 Action if a period of leave has been agreed but there is a change in the patient’s clinical presentation/risk profile.**

In the event that staff have any concerns in relation to a patient’s clinical presentation/risk profile they are to suspend the professional support for planned leave subject to either a review by the patients Consultant or the MDT.

A full explanation is to be provided to the patient and where relevant their carers/relatives as to why this decision has been made and that arrangements are being made for a review to take place.

Should the patient insist on the leave taking place but it is clear that the risk of harm has increased, the patient should in the first instance be asked to
remain on the ward until seen by one of the medical team. In the event that the patient refuses to wait staff should consider if the criteria for detention under the Mental Health Act 1983 are met.

If the patient does not meet the criteria for detention under the Act and has not had any previous episodes of leave it is essential that a full risk assessment is undertaken before they leave the ward. In these circumstances adequate communication with families and carers is key and there is to be a detailed record made in the patient’s clinical record of all action taken.

4.6 **Action if an informal patient requests to leave the ward at short notice to attend the shops**

Although patients who are not subject to detention under the Mental Health Act 1983 are able to leave the ward area it is not unreasonable for them to be asked to inform a member of staff if they wish to go out for a short period and to give at least an approximate time of return. Any such request should then be considered in relation to the patient’s risk assessment, level of capacity and current presentation.

Any nurse approached by an informal patient who wishes to leave the ward but is unwilling to provide full relevant details of the leave, or the nurse has concerns in relation to their clinical presentation, should request that the patient remains on the ward until seen by a member of the medical team. In the event that the patient refuses to wait staff should consider if the criteria for detention under the Mental Health Act 1983 are met.

If the patient does not meet the criteria for detention under the Act and is insisting on leaving the ward a detailed record is to be made in the patient’s clinical record of all action taken.

4.7 **Support to patients during Leave**

Any patients on leave are still subject to an episode of inpatient care and if ward staff receive communication from either the patient or their carer/relative expressing any concern they should in the first instance ascertain what the concern is and see if there is any advice/practical steps that can be taken to alleviate the concern.

If the call has been made by someone other than the patient, staff should also try to make direct contact with the patient to try and ascertain their perspective as to how they feel the leave is progressing. Following this discussion:

- If it is not felt that the patient needs to immediately return to the ward, the Named Nurse or other allocated professional should contact the relevant community team and request that the patients care co-ordinator undertakes a visit. For patients not under the care of a care co-ordinator the local Access Team should be asked to do an urgent visit.
• If it is felt that the patient needs to return to the ward and they agree, the Named Nurse or other allocated professional should make sure that they have the means to return safely.

In the event that the patient refuses to speak with staff and the situation is felt to warrant the patient returning to the ward staff must:

• Ascertain the patients’ location.

• Assess the level of risk pose to either the patient, and/or others.

• Establish if the patient is willing to return to the ward, and if yes make any necessary arrangements to facilitate their safe return.

• In the event of the patient refusing to return, liaise with the patient’s ward Consultant Psychiatrist in relation to the need for organising an assessment under the Mental Health Act 1983.

4.8 Return from leave

Adequate feedback of progress whilst on leave is crucial for informing future clinical decision making, review of clinical risk, and timing of discharge. In view of this staff on duty at the time of any patient returning to the ward following a period of leave must obtain feedback from the patient and where possible all other relevant individuals including carers/relatives. All feedback and the source of the information is to be fully documented in the patient’s clinical record and the feedback will then be used to determine:

• Any required changes to the patient’s risk assessment and risk management plan.
• The arrangements for any future periods of leave.
• Any additional support which may be required to facilitate any future periods of leave.

There will also be a review of the patient’s mental health presentation on their return to the ward this will also include:

• A review of their adherence with medication.
• A discussion in relation to any side effects they may be experiencing and what action can be taken to manage these.
• Exploration of any issues in relation to the misuse of alcohol or illicit substances.

In addition to this:

• All leave will be reviewed regularly in multi-disciplinary team discussions with the outcome and decisions arising from this review being clearly recorded in the clinical record.
• The Named Nurse or other allocated nurse will contact the carers and any relevant others to invite them to the MDTs to discuss leave and arrangements for any further leave periods.

4.9 Action if a Patient goes missing whilst on a period of leave from the ward.

For full guidance staff are to refer to the Trust Policy for Patients who are Missing or Absent without Leave (AWOL) but in brief for an informal patient who fails to return from an episode of planned leave:

• If the patient has capacity and their whereabouts are known, but they are refusing to return to the ward and there is no immediate risk to themselves or others, then they are not missing. In these circumstances staff should arrange a Multi-Disciplinary Team (MDT) review to agree if discharge is appropriate.
• If the patient's whereabouts are known but there has been a reported deterioration in the patient's mental state an urgent meeting is to be convened to agree what further action is required. This may include a Mental Health Act assessment.
• If the patient's whereabouts are not known:
  o If the patient has a mobile phone an attempt should be made to contact the patient and ascertain where they are and request that they return to the ward.
  o A request is to be made to the care coordinator or the Access team for home visits to be undertaken at different times of the day to see if there is any evidence that the patient has been back to their home address.
  o Contact is to be made with the patient’s carer/relative to see if they have had any contact. A request is to also be made that in the event of the patient establishing contact the ward is informed.
  o If the patient is not located, inform the Consultant Psychiatrist during normal working hours.
  o Inform the Police if there are significant concerns for the patient’s wellbeing and safety to either themselves or others. The legal status of the patients must be fully explained along with the reason for the concerns.

Staff should complete an IR1 to reflect that a patient is missing.

4.10 Clinical Record Keeping.

For full guidance staff should refer to the following Trust policy documents:

• Records Management Policy- Lifecycle of Clinical and Corporate records.
• Adult Mental Health Inpatient services Clinical record Keeping Standard Operating Procedure.

But specific to this Standard Operating Procedure:
- Staff must maintain contemporaneous records of all observations, actions and discussions in relation the planning of and feedback from periods of leave.
- As this information will be used to inform future decision making it is important that all records are factually accurate.
- Any records in relation to leave must include the following:
  - The involvement of any carers /relatives in the planning of leave.
  - Details of 1:1 the conversations with service users.
  - Details of any support to be provided during the period of leave. Including agreed dates and times of any visits.
  - The date, time and location of leave.
  - Details of any contact made by the patient and /or their relative/carer during the leave.
  - Details of any action taken by ward staff in response to any concerns raised by the patient and or their relative/carer during an episode of leave.
  - The agreed contact number for the patient whilst they are on leave.
  - Date and time of return from leave.

4.11 Involvement of Carers /Relatives.

As highlighted throughout this document any carers /relatives who are supporting the patient should be involved in the care planning process throughout the episode of inpatient care, including leave planning. Agreement for this involvement should be sought from the patient at the time of their admission to the ward, and revisited at regular intervals throughout their stay.

In the event that a patient refuses to give consent for any information in relation to their care and treatment to be shared with their relatives /carers, staff must explain this to the relative/carer, but need to be mindful of the fact that seeking information from the carer/relative and listening to any concerns they may have does not breach patient confidentiality.

The relative/carer should also be provided with a copy of the “Information Sharing and Confidentially Guide for carers, family and friends.”

However in circumstances where a failure to disclose information to the relative/carer may put them at serious risk of harm they should be involved at the appropriate level in any decision making in relation to leave even though this does not have the patient’s consent.

Staff are to refer to the “Staff Information Sharing and Confidentiality Guide” or contact the Trust Information Governance Team for detailed guidance and advice. The Caldicott Guardian (the Medical Director) can also be contacted for senior advice, usually by the Consultant Psychiatrist.