Protocol for the Management of Informal Patient's Leave from Adult Acute Mental Health In-patient Wards

Document Summary

This policy outlines the procedures to be followed during the co-ordination and implementation of periods of leave for patients from adult acute in-patient mental health wards within the Cumbria Partnership NHS Foundation Trust to help ensure the safety of the service user, their families and the general public.

POLICY NUMBER	POL/001/057
DATE RATIFIED	June 2017
DATE IMPLEMENTED	June 2017
NEXT REVIEW DATE	August 2019
ACCOUNTABLE DIRECTOR	Director of Quality and Nursing
POLICY AUTHOR	Associate Director of Nursing, Mental Health

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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1 SCOPE

This policy is to be used by all care co-ordinators, adult acute inpatient and ALIS and Home Treatment staff when co-ordinating and implementing leave for patients for periods of leave from an adult acute in-patient mental health ward within Cumbria Partnership NHS Foundation Trust.

2 INTRODUCTION

2.1 This policy is to ensure that all staff are aware of their responsibilities prior to the granting of leave for informal patients, during periods of leave and on return from leave.

2.2. Leave is described as any agreed or authorised period of absence from the ward and is an essential part of an individual patient's treatment plan and recovery. Whilst on leave patients remain under the care of Cumbria Partnership NHS Foundation Trust. As such, all leave should be planned by the clinical team (except in emergency situations) in conjunction with the patient, relatives and carers. The benefits of leave must be weighed up against the risks in each individual case prior to any decision.

2.3 All patients' leave will be fully operated in accordance with Cumbria Partnership NHS Foundation Trust Care Co-ordination Policy POL 001/001.

3 STATEMENT OF INTENT

This policy provides for leave in relation to informal patients and intends:

- To ensure the proper provision of leave for each individual patient
- To provide staff with a framework for the use of leave; and
- To clarify the role and responsibilities of clinical staff (inpatient and community).

4 DEFINITIONS

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

Care Co-ordinator: Term used in this policy to describe the qualified professional responsible for coordinating a patient's care on a day-to-day basis.

ALIS (Assessment and Liaison Integrated Service) and Home Treatment Team who are responsible for the monitoring of the patients mental health and risks during a period of home leave and during 48 hour follow up on discharge from hospital.

Named Nurse: The inpatient nurse who is responsible for collaborating with patients and carers in the development 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/ family or friend) or unescorted (on their own).

Responsible Clinician (RC): Under the terms of the MHA this means the Approved Clinician (AC) in charge of a patient's treatment. The role of the RC pertains only to patients who are formally detained or subject to Community Treatment Orders (CTO) under the Act. The term "Responsible Clinician" should be used in respect of informal patients on leave from hospital, meaning a clinician with responsibility for the patient's day to day care, or a deputy acting in their place.

Risk Assessment: The systematic collection of information to determine the degree to which risk is present, or is likely to pose problems at some point in the future, for the patient, relative(s), carer(s) or the public.

5 DUTIES, ROLES AND RESPONSIBILITIES FOR THIS POLICY

The Director of Quality and Nursing is the accountable Director for this policy.

Network Manager: Each Network Manager is responsible for ensuring that the policies and procedures are adhered to within their area of accountability.

Senior Staff: All ward managers, medical staff, nurse consultants, Allied Health Professional (AHP), Team Manager is responsible for ensuring that the policies and procedures are adhered to within their area of accountability.

All Staff: All staff within the scope of the policies and procedures are responsible for the implementation of the policy within their own area of accountability

6 PROCEDURE / PROCESS FOR AGREEING LEAVE WITH INFORMAL PATIENTS

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

- The clinical presentation and nature of the disorder;
- Risk factors;
- Information from relevant others (carers, other professionals eg GP, Care Co-ordinator);
- The social circumstances of the patient (condition at home/available support).

The risk assessment should be recorded in the appropriate risk assessment and management documentation specific to each specialist service on RiO and should include clear advice on the appropriateness of off ward activities/leave. The care co-ordinator should negotiate this agreed plan with the patient in the context of the therapeutic aims of the admission.

The risk assessment will be informed by the Pre Leave assessment Form (Appendix 1) and reviewed by the MDT when making a decision about home leave.

The risk management plan including the provisions for off ward activities including leave should be reviewed and revised at the first multi-disciplinary team meeting and at each multi-disciplinary team meeting thereafter with changes to the plan being negotiated with the patient (and where appropriate relatives, with the consent of the patient, and other professionals). The outcome of these reviews should be clearly documented in the progress notes on RiO and regularly updated.

Prior to any decision for leave, consultation will take place with the patient; their relatives and carers (where appropriate and with the patient's consent) to ascertain their views. The key worker (or other relevant clinician) should ensure that these views are communicated to the MDT to inform the decision making process.

The Responsible Clinician has a statutory responsibility for the proper care of all informal patients admitted under their care. This should include negotiating off ward activities and home leave with informal patients in consultation with the MDT. In order to allow maximum freedom for the patient when this plan has been agreed and documented, other members of the MDT will be authorised to act within this agreed framework, varying the agreed leave plan if the patient (or their carers) wishes to. This ability to vary leave within an agreed framework exists only in relation to informal patients.

Preparation for Leave: The named nurse will, in collaboration with the Care Co-ordinator, Adult Social Care, Home Treatment Team, the patient, relatives and/or carers (if appropriate, and with the patient's consent), discuss the activities and goals that the patient should be aiming to achieve during their period of leave. Such goals and activities will form part of the patients planned care and be recorded in the RiO care record.

In the case of home leave the named nurse, Care Co-ordinator, Adult Social Care or Home Treatment Team should ensure that the patient has the necessary practical requirements to provide day-to-day care for themselves and that any necessary support (emotional/practical) has been arranged. The key worker should ensure that leave arrangements are clearly understood by the patient and communicated to relatives (with consent) and to any other relevant professionals.

Prior to the patient going on leave, the nurse in charge/named nurse should satisfy themselves that earlier risk assessments remain valid. Where there is cause for concern, the nurse in charge/ named nurse will implement any necessary risk management strategies, such as offering escorted leave for example. The concerns and strategies should be documented in the progress notes and leave care plan on RiO.

If any clinician becomes concerned that an informal patient would be at significant risk due to their mental disorder if allowed to leave the ward, an attempt should be made to persuade the patient to remain as part of a revised agreed risk management plan. If this is unsuccessful and the patient wishes to leave consideration should be given to the use of holding powers under Section 5 Mental Health Act 1983.

The named nurse in consultation with the Care Co-ordinator, Adult Social Care and/or Home Treatment Team worker will discuss risk and coping strategies with the patient and their carers prior to leave (with the consent of the patient having been obtained). Any support needs will be fully assessed prior to leave and arrangements put in place and communicated to the patient and relatives. Where the patient is going on home leave, the clinical team should be satisfied:

- That the patient's home destination is habitable with all services, i.e. heating, water, power, sanitation;
- That the patient has access to the premises.
- That arrangements have been made for the patient to obtain any groceries etc.
- There are no immediate risks which could compromise the safety of the service user.

A contingency plan will be developed in collaboration with the patient and where appropriate their carer and the Home Treatment Team early discharge worker will take responsibility for this and will document this in the clinical record. A copy of this can be found in Appendix 2.

The named nurse/ shift co-ordinator will detail the requirements for leave and will document this within the clinical record and this will include:

- Date, time and location of leave
- Date and time of return from leave
- Involvement of carers
- Any actions to be undertaken by ward staff during the leave

Where an informal patient declines offered community support or refuses to accept the advice of the Team to delay leave until any social problems can be resolved and there are no grounds for compulsory detention on the basis of their mental disorder, the advice given should be documented in the case notes and on RiO.

Any medication required by the patient during leave will be issued immediately prior to the patient going on leave. The key worker/named nurse should ensure that the patient understands how and when to take their medication and also explain 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.

The patient, relatives and carers, should be informed that if there are any problems, they can either contact the ward via telephone or return early from leave to discuss any issues arising with a member of staff. Contact details of the ward and the Care Co-ordinator will be issued to the patient and relatives prior to commencement of leave.

The ward staff shall ensure there is a verbal handover to anyone who arrives to accompany the patient from the ward on commencement of the period of leave, that the standard processes are completed and a record of information shared is recorded.

An accurate record of all patients on leave from the ward should be maintained at all times.

When an informal patient is on leave overnight or longer, this should be recorded RiO in addition to an entry in the progress notes on RiO.

Adequate feedback of progress when on leave is crucial for informing further intervention, timing of discharge and in reviewing risk. The relevant professional should ensure that structured feedback from the patient is always obtained and where possible gathered from all other relevant individuals. The standard process should be followed when a patient returns from leave, where the patient and anyone accompanying them verbally feedback any issues/concerns to the ward staff and a record on RiO is made of who the patient and anyone accompanying them spoke to and what information was shared.

All professionals need to be aware of the need for regular review of the mental state of the patient both before and after leave. Any changes should lead to a review of the risk management plan pertaining to leave.

On return from leave, the key worker will discuss with the patient, relatives and carers events during the leave in order to assess achievements and/or any incidents that may have occurred. Where community support services are involved then contact must be made to establish their views of the leave. The outcomes of these discussions should be recorded in the Progress notes on RiO and used as part of the ongoing review of care within the MDT.

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 progress notes on RiO.

Patients and carers should be encourage to take all the patient's belongings whilst they are on leave. Although every effort will be made, Patients and carers should be informed by ward staff that the patient may not return to the same bed and only in exceptional circumstances, the same ward.

Management of Informal patients who do not attend pre-arranged appointments with the Care coordinator or Home Treatment Team worker during leave: In the event that the patient does not answer their door during a pre-arranged visit with the Care Coordinator or Home Treatment Team to monitor home leave, the care coordinator or Home Treatment Team worker should follow the flow chart in appendix 3. This will involve undertaking an environmental check to illicit any signs of suspicion i.e. mail not been collected, curtains drawn, animals in distress, signs of habitation etc. Attempts will be made to contact the carers, other relative sources of support and the patient and a card dropped through the letter box with the Care Coordinator's/Home Treatment Team contact details. If the Care Coordinator/Home Treatment Team worker is unable to ascertain the patient's whereabouts after 30 minutes then the ward should be contacted and the trust policy *POL 001/009 Management of Service Users Missing or Absent without Official Leave* should be

initiated. Ward staff will need to inform the Police outlining the procedures in trust policy *POL 001/005/002 Joint Operational Protocol for Inter-Agency Assistance - Mental Health.* Ward staff will inform the ALIS/ Home treatment Team of the escalation and the time to meet the police at the agreed address to provide ongoing support.

7 TRAINING

Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis. Management of training will be in accordance with the Trust's Learning and Development Policy.

8 MONITORING COMPLIANCE WITH THIS POLICY

All procedural documents will include a section on how they will be monitored, using the following table. Monitoring of this specific procedural document will be overseen by the Risk Management Committee. See detail in the attached table:

Aspect of compliance or effectiveness being monitored	**Monitoring method**	**Individual responsible for the monitoring**	**Frequency of the monitoring activity**	**Group/ committee which will receive the findings/ monitoring report**	**Group/ committee/ individual responsible for ensuring that the actions are completed**
The management of informal patients' leave is in accordance with this policy in relation to: - Duties. - Procedures use when an informal patient cannot be contacted for an agreed visit. - Procedures used to escalate concerns to Police, senior clincian's and managers.	An audit of 5 sets of clinical records per year of informal patients who go on leave.	Associate Director of Nursing.	Annual	Care Group Governance Committee	Associate Director of Nursing.

9 REFERENCES/ BIBLIOGRAPHY

The Mental Health Act 1983 Reference Guide paragraphs 12.39-12.56, TSO, 2008

The Code of Practice Mental Health Act 1983 Chapter 21, TSO, 2008

The Quality Care Commission Guidance Note 18

Transition between inpatient mental health settings and community or care home settings: NICE 53 (August 2016)

10 RELATED TRUST POLICIES/ PROCEDURES

POL 001/001 *Care Co-ordination Policy*

POL 001/009 *Policy for the Management of Service Users Missing or Absent Without Official Leave.*

POL 001/005/002 *Joint Operational Policy for Inter-Agency Assistance.*

POL 001/045 *Non Attendance/ Did not attend policy*

11 APPENDIX 1 - PRE LEAVE ASSESSMENT

Name:	**DOB:**
Date of Assessment:	**Care Coordinator:**
Proposed Leave Plan (when, where, how long, transport to / from, planned activities, support available: family / friends / services, planned visits / telephone calls, emergency contacts etc)**:**	
Carers perspective (concerns / issues highlighted, level of contact)**:**	
Accommodation (flat / house / bungalow)**:**	**Tenure** (rented / privately owned)**:**
Home Environment (habitable)**:**	**Location / Local Facilities:**
Mobility (transfers, stairs, internal / external)**:**	**Heating** (gas / electric, smoke / carbon monoxide alarms)**:**
Cooking Facilities (cooker, microwave, fridge, freezer, kettle, basic ingredients)**:**	**ADL Function** (ability to utilise kitchen appliances, food preparation, hot drinks / snacks)**:**
Medication Issues (depot / medication regime / medication dose)**:**	**Finance Issues** (money for essentials gas, electric, food etc)**:**
Mental State (mood, orientation, appearance, behaviour, speech, thought content, perception, attention, concentration, memory, insight, judgement)**:**	
Risk Issues:	
Contingency Plan in Event of non-contact by Patient on Leave:	

12 APPENDIX 2 - SAMPLE CONTINGENCY PLAN

Identified needs	Actions
I was admitted to the inpatient unit (name) due to low mood and suicidal ideation intent and plans. At the time I had thoughts of taking an overdose and could not guarantee my safety. After a period of time on the ward I recognise that my mood has improved and I have only fleeting suicidal ideation which I can control. I currently rate my mood as 5/10 I have now been granted a period of home leave to prepare me for discharge.	It was discussed in the MDT and I have agreed that whilst I am on leave the ALIS/Home Treatment Team (community mental health team etc) will visit me at home on ***Dates to be inserted.*** I would prefer a morning/afternoon visit. I will be contacted at either between 9.30 and 10.00 hrs for the morning visit or 14.30 and 15.00 hrs for the afternoon visit. If I am going out I will contact the crisis team to let them know. At these visits I will explore coping strategies and the effectiveness of these during my leave. ***List coping strategies used here.*** I will also discuss how I am managing at home and whether there is any further support I require or whether things are going well. The risks and my relapse signatures will also be reviewed and changes made to my plan in response to these.
Medication Whilst I am on leave I understand the importance of taking my medication. I have been given leaflets to explain my medication.	I have been given …… days of medication. I have been prescribed (list medication, dose, and when to take). I have agreed that my family can look after my medication. I am aware of side effects of medication and will inform either ALIS/Home Treatment Team or the consultant if I experience any of
Risk Management I was admitted to hospital due to suicidal ideation, intent and plans. In the past I have taken …….. overdoses and made other attempts on my life. On each occasion I have accessed help by…… I recognise that I usually feel like this	I or my family can contact ALIS/Home Treatment Team anytime whilst I am active with them on 01946 63791. I or my family can talk to the team and if we agree I need a visit they will visit me. This number can be used 24/7,if it

after I have had a lot to drink if my family have seen me and I am safe the team will request that I contact them to arrange a time for the visit. My mood has been low and I recognise that when I am not able to sleep and my concentration gets worse that this means my mood is deteriorating. My family (whoever) say that I sometimes stare into space and become quiet before this happens.	message and the team will get back in touch with me. I can be contacted on ……. If the team cannot contact me then they can contact my …….. on …….. If my family have seen me and I am safe the team will request that I contact them to arrange a time for the visit. If my family have not seen me I will then receive a cold call (this means that the team will call at my house). If there is no answer the team will phone the ward who will activate the absent without leave policy and request a police assist visit. The CRHT will then visit with the police to ensure my safety.

This care plan will be personalised to the risks identified and to the triggers and coping strategies of the service user.

13 APPENDIX 3 - FLOW CHART TO MANAGE HOME LEAVE

MDT Review to consider Leave with patient, carer where appropriate.

GRIST risk assessment reviewed by MDT and updated by named nurse/ associate nurse

Home leave assessment completed by care co-ordinator and/or Home Treatment Team early discharge worker

Leave Care Plan completed by named/associate nurse and Contingency Plan completed by Home Treatment Team early discharge worker

Appointment arranged with patient, carer and Home Treatment Team worker for first visit on leave.

Patient Attends Appointment

Review with patient and carer:

- mental state
- risk management plan
- Coping strategies
- Additional support required
- Contingency plan
- Return date and time to ward

Document in clinical record.

Patient does not attend appointment

- Undertake environmental check of accommodation
- Contact relatives./ carers and patient
- If no contact within 30 minutes and unable to ascertain patient's whereabouts contact ward to activate Missing Person's policy.
- Ward staff contact police and activate Police Assistance Protocol.
- Ward Staff contact CRHT to meet police at patient's home.
- Inform Bronze manager on call