POLICY TITLE: Time Away From the Ward (Inpatients)

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Policy Owner:	Dr Pradeep Pasupuleti, Clinical Director, Priory Healthcare
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Outcome:	This policy: • Standardises definitions, practice and responsibilities for supporting periods of time away from the ward (time away from the ward) during inpatient admissions including Section 17 of the Mental Health Act • Ensures that staff support patients to plan time away from the ward, by co-producing and creating individualised care and contingency plans • Establishes Priory standards, processes and documentation to ensure best practice and meet statute and guidance
Cross Reference:	H02 Admission, Transfer and Discharge H11 Informed Consent H126 Patients who are Missing or AWOL H34 Care Programme Approach – Care Treatment Planning H35 Clinical Risk Assessment and Management H86 Locked Door Policy H97 Searching Patients and Visitors OP03 Complaints and Concerns OP05 Mental Capacity OP05.2 MCA DoLS England and Wales OP05.5 Deprivation of Liberty OP29 Service User and Carer Involvement OP054 Community Treatment Orders H62 Healthcare Records HG12 Guidance for the completion of 5 point risk assessment form-signing in & out

EQUALITY AND DIVERSITY STATEMENT

Priory is committed to the fair treatment of all in line with the Equality Act 2010. An equality impact assessment has been completed on this policy to ensure that it can be implemented consistently regardless of any protected characteristics (age, disability, gender identity and expression, marriage or civil partnership, pregnancy or maternity, race, religion or beliefs, sex, sexual orientation), and all will be treated with dignity and respect.

In order to ensure that this policy is relevant and up to date, comments and suggestions for additions or amendments are sought from users of this document. To contribute towards the process of review, email LegalandComplianceHelpdesk@priorygroup.com

TIME AWAY FROM THE WARD ARRANGEMENTS (INPATIENTS)

CONTENTS

1 SCOPE

1.1 This policy applies to all Healthcare sites with inpatient services. This includes Priory sites in England, Scotland, and Wales. Where there are differences between nations, this will be clearly highlighted.

1.2 The policy applies to all service types and patient populations. This includes NHS and private patients. This policy also applies to all patients who have agreed to come into hospital voluntarily or where Mental Health Legislation has been necessary to authorise their admission, care and treatment.

1.3 The policy establishes Priory's expectations for collaborating, empowering and involving patients and, where appropriate, their families, carers and loved ones when planning safe, effective and therapeutic time away from our hospital.

2 INTRODUCTION

2.1 Supporting patients to spend time away from hospital as part of their recovery or rehabilitation goals, is core to our commitment to help people live their lives, protect their autonomy and independent and their right to liberty. Any time away from hospital during an inpatient admission also needs to be facilitated in a way that balances freedom and autonomy with our duty of care, protecting patients who may be vulnerable and at risk of harm to themselves or others.

2.2 Decisions regarding time away from the ward require our teams to consider and balance people's Human Rights (Article 2, right to life, Article 5, right to liberty, and Article 8, right to private and family life). When making decisions with patients, or in their best interests, following this policy, processes and documentation will help staff to minimise unnecessary restrictions for individuals, remain compliant with legislation, and support high-quality, safe, effective care while safeguarding people in their service.

2.3 For all services, it is critical that we help patients to understand their rights and freedom to take time away from the ward at any time, or why restrictions are in place and how they can raise a concern or complain. Particularly when they feel their liberties or freedoms have been overly restricted or may have been deprived of their liberty. All staff are encouraged to invite challenge and debate for individual time away from the ward arrangements and care plans or

relating to our organisational frameworks, which will help us to avoid harm and promote choice and autonomy.

2.4 Within this policy, information that **MUST** be shared with patients and, as appropriate, other individuals have been highlighted. Applying these standards will ensure staff are transparent with patients, explaining any concerns and reasons for restrictions to be in place, and what authority we are using to do this if the patient does not, or cannot, agree to this. The standards in this policy have also been created to apply learning from the rare but significant tragedies that have occurred in our services and others. To ensure that information and expectations are shared with patients the Time Away from the Ward - Mutual expectation booklet must be offered to both patients and family or carers (subject to the patients consent to share information).

3 DEFINITIONS

3.1 In hospital settings, the correct terminology for 'time away from the ward' can vary depending on the person, service and the legal frameworks or the purpose of time away from the ward. The reasons for planning and supporting time away from the ward may include;

- Enabling people to live their lives, as part of their individual treatment, rehabilitation and recovery plans
- Pre-transfer or discharge visits to other settings and providers
- Compassionate visits to maintain and support private and family life
- Emergency or planned treatment to other hospitals or services
- Attendance at court or other mandatory activities

3.2 This section of the policy is not exhaustive and all staff should be alert to any other terms that may risk confusion or reduce clarity, during discussions with patients, the Multi-Disciplinary Team (MDT) or others involved in the planning and facilitating of time away from the ward.

3.3 **Identifying the legal status of patients**

<table>
<tr><th>Informal</th><th>Detained</th><th>Community Treatment Order (CTO) or Conditional Discharge (CD)</th><th>Deprivation of Liberty Safeguards (DOLS)</th></tr>
<tr><td rowspan="2">A patient who has consented to the admission, care and treatment. Includes NHS or Private patients.

The patient must have the capacity to agree to their admission, care and treatment and not be deprived of (or at risk of) being deprived of their liberty.

May also be referred to as a 'voluntary patient'.</td><td rowspan="2">This applies when patients are subject to the Mental Health Act (MHA) in England and Wales, or Mental Health (Care and Treatment) (Scotland) Act (MHSA).

Dependent on the type of Section or Detention, different rules regarding time away from the ward will apply e.g. for restricted patients additional authorisation is required</td><td>Voluntary patients who are subject to
• Community Treatment Order (CTO, Section 17A of MHA), but have accepted informal admission, or
• Have been conditionally discharged</td><td>Patient whose inpatient stay is authorised using a Deprivation of Liberty Safeguards (DoLS).

The authorisation may include specific arrangements e.g. restrictions on time away from the ward conditions and limits to where the person may go.</td></tr>
<tr><td colspan="2">England and Wales only</td></tr>
</table>

3.4 **Informal patient** They may also be referred to as a 'voluntary patient'. This can apply to NHS funded patients or Private patients. To be compliant with the Human Rights Act, we must be able to demonstrate that informal patients;

- Are deemed to have capacity to make a decision about the admission, care and treatment during the inpatient stay
- Understand their right to time away from the ward the hospital at any time, but have agreed to discuss time away from the ward and care planning with their clinical team when they would like to take time away from the hospital and grounds. For example, we may ask them to stay on the ward during their initial assessment period or we may need staff to arrange exit from our buildings, or grounds at all times due to the ward or site environment.
- Where applicable, they understand that any clinical concerns regarding risks to their health and safety may lead to consideration of using Mental Health Legislation to prevent them leaving while assessments can be completed.

3.5 **Detained Patient** Patients who are subject to the Mental Health Act (MHA) in England and Wales or Mental Health (Care and Treatment) (Scotland) Act (MHSA). Dependent on the type of Section or Detention, different rules regarding leave will apply. This includes;

- Short-term powers (72 hours or less e.g. s.299 Scotland or s.5(4) England and Wales) – There are no powers to authorise any period of leave from the hospital and grounds.
- Assessment and Treatment Civil Sections – Statutory leave may only be granted by the Responsible Clinician. Leave within the hospital site does not need statutory authorisation but risk assessments and care planning arrangements are required in Priory policy
- Restricted Sections – where there is any restriction in place (s.41, 49 or Sections 221-226 in Scotland) then Statutory Leave from the hospital and grounds may only be granted within boundaries set and approved by the Secretary of State for Justice (via Ministry of Justice) or Scottish Ministers.

3.6 **Community Treatment Orders or Conditionally Discharged** This applies to patients who are subject to Community Treatment Order (CTO, Section 17A of MHA) arrangements (England and Wales only) or patients that have been Conditionally Discharged (CD) to the community and remain liable for recall due to restrictions. The arrangements must be clear for both patients and staff, but will typically include;

- Voluntary CTO/CD inpatient – this may apply when a patient has agreed to an inpatient stay and not been recalled by their Responsible Clinician (Community Team consultant unless the CTO has been transferred to Priory) or the Ministry of Justice. Their Leave will be arranged as per an informal patient with the exception that any decision to prevent them taking leave can only be authorised by recall procedures. This is because holding powers (Section 5 of MHA) **DO NOT** apply to CTO or CD inpatients in England and Wales
- Recalled CTO inpatient – During the 72 hours of recall, there are no powers to grant statutory leave away from the hospital. They may be supported to take grounds leave but this must be agreed with the clinical team and clearly documented.
- Recalled CD patient – will be treated as a detained restricted patient from the point of the recall

3.7 **Deprivation of Liberty Patient** This includes any patient whose inpatient stay is authorised using the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The authorisation may include specific arrangements e.g. restrictions on leave conditions and limits to where the person may go.

3.8 Patients on DoLS have been assessed as lacking capacity for decisions relating to their accommodation in our sites, but may still have capacity to inform decisions relating to leave and activities. This **MUST** be considered by their clinical team and their choices and wishes should be supported as appropriate.

3.9 **Note: Throughout this policy, we refer to 'time away from the ward' and 'all patients'. Where there are additional considerations or requirements, this will be specified and will typically include 'informal' meaning voluntary, CTO and DoLS patients or "detained" meaning all people subject to detention powers.**

3.10 **Types of Time away from the ward**

Grounds Time away from the ward	Community Time away from the ward	Overnight Time away from the ward	Unplanned Time away from the ward
Time away from the ward in grounds of hospital Grounds must be defined and understood by patients and staff This includes garden time away from the ward. The boundaries of which must be discussed, agreed with the patient and MDT, and recorded clearly e.g. if agreement is to a secure garden only and not all grounds	Any period away from the hospital and grounds. This must be recorded and planned with the patient and MDT, including any details agreed or authorised e.g. duration, return time, escorted, frequency.	Applies when a patient is not expected to return overnight. This may be in any setting (home, community provider, other hospital). This may also be called 'extended time away from the ward'.	In the event an urgent or emergency situation arises, then colleagues must ensure the circumstances are considered by the most senior clinician available and robust records are made of the decision and rationale for any action. Where this involves a medical emergency, verbal confirmation from the senior clinician will be adequate to avoid any delay.

3.11 **Grounds time away from the ward** This includes any period spent off the ward that the person has been admitted to, but does not include exit from the boundary of the hospital grounds.

3.12 While no legal authority is needed for any patient to access grounds time away from the ward, there must be agreement with the patient and the clinical team including risk assessments, care plans to inform checks or observations e.g. clarity on accompanied, escorted, unescorted and expected return times or checks.

3.13 This will include garden time away from the ward. The boundaries of which must be discussed, agreed with the patient and MDT, and recorded clearly e.g. if agreement is to a secure garden only and not all grounds

3.14 **Community time away from the ward** Any period away from the hospital and grounds. This must recorded and planned with the patient and MDT, including any details agreed or authorised e.g. duration, return time, escorted, frequency.

3.15 **Overnight time away from the ward** This will apply when the person is not expected to return from time away from the ward for any period that includes overnight stays. This may be overnight in any setting – home, other provider placement, with family.

3.16 **Unplanned time away from the ward** In all services, there will be situations where time away from the ward is immediately necessary or requested by patients. The response will be dependent on the individual facts but general principles are;

- Any refusal to grant unplanned time away from the ward to a patient will need to be clinically justifiable and confirm the correct legal authority for doing so e.g. holding powers may be necessary for informal patients
- Emergency medical treatment **MUST** not be delayed due to documentation not being available. Verbal confirmation from the most senior clinician will be adequate to support immediate action, and then clearly documented in the notes when practicable
- Police removal of a patient without the agreement of the clinical team should always be recorded as an incident. Police powers will override the hospitals authority in urgent situations, however attending police officers should be asked to delay to allow a support plan to be in place if appropriate e.g. consider any medication needed, escort from clinical team, information that may need to be known to custody sergeant
- Situations that arise which are unrelated to the patients reason for being in hospital e.g. medical situation for a family member, should always be seen as a priority and appropriate support offered to facilitate a safe plan of time away from the ward without delay

3.17 **Time away from the ward criteria and conditions -** For all patients, the time away from the ward criteria and conditions **MUST** be clearly set out and agreed with the patient (applies to all patients) and authorised by their RC or RMO (detained patients only). Plans will need to include specific considerations such as the length of time, the limitations of time e.g. not between the hours of 10pm and 6am or any other condition felt to be necessary in the interests of the patient or protection of others (including other people on the ward).

Unescorted	Escorted
Any type of time away from the ward without any member of Priory staff being present during the time away from the ward. The person may be accompanied by others e.g. family or carers, but the time away from the ward would still be considered 'unescorted' if there will be no member of Priory staff available during the time away from the ward period.	Any type of time away from the ward with any member of Priory staff or any other professional authorised in writing by the hospital director e.g. ambulance staff, community nurse or secure transport staff. This could include more than one member of staff and may be different depending on the type of time away from the ward e.g. unescorted in grounds but escorted in community

3.18 **Unescorted -** Patients who spend time away from the ward hospital without any member of Priory staff. This needs to be reflected in the plan for time away from the ward. The legal responsibility and duty of care to ensure the time away from the ward is safely planned, communicated to patient or others, and effectively facilitated remains with the Priory team alone e.g. is not the responsibility of families or others.

3.19 The person may still be accompanied by others e.g. family or carers, but the time away from the ward would still be considered 'unescorted' if there will be no member of Priory staff available during the time away from the ward period. Details of other people may be included in the time away from the ward documentation, reflecting the expected plan, but the terminology used and risk assessments would remain 'unescorted'. For example, if the plan is for the person to go out for the day with their father then they are taking "unescorted community time away from the ward with their father".

3.20 **Escorted -** Patients who may only take time away from the ward hospital with a member of Priory staff. This may be by agreement or request for informal patients or it may be a condition of statutory time away from the ward for detained patients.

3.21 Where this applies to detained patients, they remain 'in custody' while they are on time away from the ward if accompanied by any officer on the staff of the hospital or any other professional authorised in writing by the hospital director e.g. ambulance staff, community nurse or secure transport staff.

3.22 To avoid any confusion, there are no circumstances where it would be appropriate to describe family or carers as 'escorting' the person. This is because the term 'escort' implies additional legal responsibilities that any person 'escorting' a patient would need to understand and accept their consequent responsibilities for. This can create a risk of misinterpretation and cause undue pressure for friends and relatives, therefore this practice is not supported in Priory services.

4 LEGAL CONSIDERATIONS

4.1 **Duty of care** All staff working in healthcare settings have a duty of care to protect patients. This includes their emotional and physical wellbeing and ensuring their safety. Doctors have a duty to ensure ethical and legal obligations are met and that their decisions are informed by what they believe is clinically best for their patients.

4.2 All staff need to ensure decisions reflect the balancing of this duty of care with and the provision of therapeutic care that promotes recovery, autonomy and helps progress discharge. Plans for time away from ward will need to reflect the challenge of promoting autonomy and choice while managing risk.

4.3 **De facto detention -** All staff must be alert to the risks of 'de facto detention' and the risk of an unlawful deprivation of a persons liberty. Appropriate action to avoid this for any informal patient must be taken.

4.4 The term reflects a situation where an informal patient wishes to time away from the ward the hospital but feels they must agree purely because of a perceived or actual threat of detention. It is important when we become aware that this may apply, clinical teams offer support;

- to explain the patients rights,
- their access to other support e.g. advocacy or,
- if restrictions are needed, clarify whether an assessment under the relevant legislation should be arranged without delay.

4.5 It is important to recognise that, even where the clinical view is that detention is not necessary or expected, it is the patients perception of this that is the important factor. Staff **must** explore this with informal patients and offer any support to help them understand their legal position and avoid any risk of them being subject to 'de facto detention'. Staff must ensure there is continued valid informed consent for their inpatient admission and any plans for taking time away from the ward.

4.6 **Absent without agreed time away from the ward/Missing Person** Legally, the term is 'absent without leave' (AWOL) and only applies for detained patients when the time away from the ward has not been authorised by their RC. This will include when the authority for time away from the ward granted to the person has expired, they have not met conditions stated and they have not returned to the ward.

For informal, CTO or DoLS patients, they would be classed as 'missing' from the point of time that they were expected to return to the ward. The response to this situation will depend on the risks and individual patients. To confirm actions needed, including where contact has been

made with the 'missing' patient by the ward, all staff **MUST** refer to **H126** Patients who are Missing or Absent without agreed Time Away From the Ward for more information.

5 SITE REQUIREMENTS FOR SUPPORTING EFFECTIVE TIME AWAY FROM THE WARD PLANNING (ALL PATIENTS)

5.1 **Robust, Supportive Referral and Admission Process** Information to inform time away from the ward planning begins from the point of referral and assessment. This would include contacts and phone numbers, patient photo if they consent.

5.2 Information should also be provided about the typical time away from the ward procedures or seeking information from stakeholders to inform time away from the ward and clinical risk assessment on arrival.

5.3 For all patients, site teams **MUST** ensure there is a robust local system for explaining rights relating to time away from the ward, access and freedoms on arrival to the ward. This equally applies to all categories of patients, ages and services. The information may be included in pre-admission packs, welcome packs and displayed in community areas. A Time Away from the Ward - Mutual expectation booklet in regards to leave was devised and must be given to the patients and careers based of patient consent at the admission This **MUST** include;

- Their rights regarding leaving the ward, building or hospital site and how this may change in the first day, week and beyond.
- How they can raise any questions regarding conditions or boundaries agreed with the team
- When time away from the ward planning will usually be reviewed and how to ask for this to be done at an earlier stage
- Understand our duty of care and how this may be applied when planning and supporting any time away from the ward from the ward area (this should be normal practice, helping sites to meet requirements for fire safety, safeguarding etc)
- How they may seek external support with time away from the ward arrangements e.g. advocacy, legal representatives
- Discuss preferred communication and options to request Accessible Information for them or family and carers
- The need to agree contingency plans relating to time away from the ward and involve family and carers and others

5.4 **Clearly identifying "Hospital" and "Grounds"** All services must have information for staff and patients that clearly establishes the grounds and perimeters. In some services, this may be a perimeter wall but for other sites, this may need additional discussion and review of boundaries e.g. if a site does not have a fence and grounds end at a public highway or path. Services should ensure this information is accessible and consider a pictorial map that would be available to staff and patients.

5.5 **Supporting a Culture of Care** Site teams should continuously seek to embed and improve the culture of care for patients and staff on their sites. By applying the principles of involvement, working together to meet this policy and ensuring that any restrictions on freedom or liberty are clearly agreed and understood, we can offer safe, therapeutic and equitable places to be cared for, and fulfilling places to work. Evidence of how this is done should be routinely monitored and discussed in site forums and team meetings, examples would be;

- Demonstrating that time away from the ward planning is co-produced with patients, families and carers
- Considering any concerns or complaints relating to time away from the ward arrangements and acting to resolve (individual plans or informing policy and process change)
- Actively supporting staff to seek feedback from patients and carers – direct, through quality walk rounds – on their experiences of time away from the ward and ways that the site team can encourage and facilitate time away from the ward

- Encouraging all patients and staff to be involved in challenging any rules for time away from the ward that may be managed in a different way e.g. environmental changes that could support greater grounds access, sharing positive experiences of time away from the ward in community settings that may be considered for other patients in the unit

5.6 **Suicide prevention strategies** In healthcare, the potential of adverse consequences of planned, therapeutic time away from the ward can be irreversible. With a fifth of all inpatient suicides, occurring during authorised, planned time away from the ward (Hunt et al 2013). However, the importance of autonomy and freedom, to avoid risk-aversive or coercive environments, means that any restrictions on time away from the ward **MUST** be clinically justified and proportionate to the risks for the individual person.

5.7 During formation of risk assessment, it will be especially important to explain any reasons for requested or directed restrictions to the person. Ensuring any necessary support is available to empower the patients and others to contribute or challenge the MDT view. Following this, it will remain critical that all members of the ward team report any changes in presentation immediately and seek support and advice if there are any concerns regarding the time away from the ward arrangements in place.

6 INDIVIDUAL TIME AWAY FROM THE WARD PLANNING

6.1 **Before time away from the ward takes place -** Referral and assessment should include an initial plan for supporting time away from the ward once admitted to the ward. This will reflect the circumstances of the admission and the patient's capacity to understand the expectations or processes in place for the site.

6.2 On admission, it **MUST** be explained that less time away from the hospital may be necessary while an assessment is completed. The reasons and process for this should be explained, including the requirement for developing their care and treatment plan which will support discharge planning.

6.3 For some patients, particularly when transferred from other services who may know them well, this can and will feel restrictive. It is critically important that they understand our reasons for any planned time away from the ward, when this will be reviewed, and they know how to raise any concerns or request an earlier review.

6.4 Staff **MUST** negotiate, encourage and agree time away from the ward and care arrangements with individuals. This includes jointly developing care plans and risk assessments (including contingency plans) throughout their admission.

6.5 When considering and planning any time away from the ward, MDTs **MUST** take into account;

- Patients wishes and those of carers, friends and others who may be involved
- Consider the benefits and risks to the patients health, safety and wellbeing
- Consider how time away from the ward may assist the patients recovery and/or maintenance of independence
- Balance these benefits against any known risks and consider any safeguarding risk and actions that may need to be taken
- Consider support that may be needed during time away from the ward and any resources needed
- Seek and clarify the views of any community services that are or may provide support during time away from the ward, particularly for any community time away from the ward
- Ensure the patient is aware of plans put in place for their support, including what they should do if they think they need to return to hospital early from community time away from the ward

- **For mentally disordered offender patients:** Consider any relevant issues relating to victims that may impact on time away from the ward, conditions and who needs to be informed
- **For restricted patients:** confirm approval from the MoJ or Scottish Ministers has been confirmed

6.6 All time away from the ward related documentation **MUST** be recorded on CareNotes, and **MUST** include:

- The agreed or authorised amount of time away from the ward, duration, frequency, and location (grounds time away from the ward, community time away from the ward, home time away from the ward etc.)
- Patient's/carers' understanding of time away from the ward, their views, wishes or preferences regarding time away from the ward,
- Any assessments of capacity relating to time away from the ward arrangements
- Subject to the patient's consent, any consultation or information that may be needed before they take time away from the ward e.g. home circumstances or risk assessments for home time away from the ward or contact with relatives, friends or others
- Any circumstances in which time away from the ward should not go ahead,
    - For example signs of deterioration or distress that may prevent the time away from the ward from taking place until further assessment has been completed
- Contingency plan if patient does not return at the time agreed (this is the time they **MUST** be considered missing from H Form:38).
    - Including who we may contact and information that may be shared. Patients **MUST** be informed that confidentiality rules will still apply, unless there is a real and immediate risk that would justify overriding this
- When their time away from the ward will next be reviewed and how this can be brought forward at request of patient or others

6.7 Consideration of observation levels must be included in planned time away from the ward arrangements. This **MUST** ensure any contradictions are clearly resolved and clarity offered to patients and staff e.g. up to one hour unescorted grounds time away from the ward if the patient is on 30 minute observations, this would mean the time away from the ward needs to be reduced or the observation levels reviewed.

6.8 **Ward Teams** must

- Communicate clearly with patients and explain any changes to facilitating time away from the ward e.g. a patient may be asked to wait to time away from the ward the ward due to a safety concern for other patients or fire procedures
- Ensure all staff on shift understand who is responsible for planned time away from the ward that day and who can be approached to check time away from the ward e.g. if asked to open a door for an informal patient, who would be able to confirm this is part of an agreed plan with the patient
- All sites **MUST** have a single arrangement that documents who is on time away from the ward at any one time e.g. whiteboards (able to be covered for confidentiality)
- It is suggested that the following information is captured as a minimum:
    - Patient Name
    - Informal / Detained status
    - Time away from the ward Keeping Safe Care plan agreed by MDT (Date)
    - Contingency plan within the Time away from the ward form complete
    - 5 Point risk assessment complete
    - Discussed with NiC
    - Time OUT / Time DUE to Return / Time RETURNED
    - Contact Number
- The NiC is responsible on shift for monitoring the 'at a glance' and observations systems with clear instructions for sharing information.

- Provide clear instructions about the immediate action to be taken by the colleague responsible for identifying that the person has not returned at the correct time
- All staff to be supported in knowing the action that needs to be taken to locate patients taking grounds time away from the ward and the process for this e.g. the nurse in charge may include the return time for the person taking ground time away from the ward on a whiteboard and repeat this in the observations form to prompt immediate reporting if they fail to return to the ward.
- Ask patients about their plans for any time away from ward,

6.9 Copies of the information regarding the time away from ward agreed by the RC and any conditions attached **MUST** be offered to the patient, carers, professionals and other people in the community who may need to know. See English Code of Practice paragraph 27.22 / Welsh Code of Practice paragraphs 27.17 – 27.22).

7 RISK ASSESSMENT

7.1 Risk assessments **MUST** be completed in accordance with the H35 Clinical Risk Assessment and Management Policy. This requires;

- MDT to assess risks for all planned time away from the ward and this to be done by nurses for each period of time away from the ward. Please note, this assessment is covered by Five Point Risk Assessment which needs to be completed before first episode of leave for the day
- Risk assessments and time away from the ward plans are supported by a clear risk formulation
- All to be documented clearly within the Keeping Safe care plan or risk management plan

7.2 The risks must be reviewed for each type of time away from the ward agreed or authorised. Where this includes home time away from the ward or time away from the ward without staff (unescorted), the risk assessment must reflect a clear and robust plan. As appropriate, this should include;

- Informing the NHS community team and clarifying any community support that may be available or accessed
- The specific date and time for return
- Who will be contacting the patient during time away from the ward and how often
- **The medication they will be taking (if overnight or longer term time away from the ward)**

7.3 The Five Point Risk Assessment (H Form 128) **MUST** be completed prior to time away from the ward for all patients. This **MUST** include time due to return~~return time~~ from time away from the ward and **MUST** be signed by a Nurse. All patients taking time away from the ward from the ward require a time away from the ward contingency plan that sets out what to do if late returning or fail to return. Further information on the H Form 128 can be found in the HG12 Guidance for the completion of the 5-Point Risk Assessment.

7.4 During each day, the first part of H Form 128 (Five point risk assessment) **MUST** be completed prior to the <u>first period of time away from the ward</u>. It should then be revisited and re-done if there are reasons to think that patient's mental state or risks have changed during the day.

7.5 In all risk assessments, it must be clear that any 'real' risk (substantial, significant and known – or ought to be known - to the MDT) is considered and a plan to support is in place. This includes any risks that are not considered imminent or immediate, but are believe to be present and continuing e.g. a patient with a known history of significant self-harm would need to be reflected in a robust risk assessment, even if that hasn't been observed or acted upon during the current admission. Please also consider potential safeguarding risks within assessment.

7.6 Risk assessments should include consideration of any additional information needed before agreeing time away from the ward. For example, supporting any time away from the ward home may require additional information from the patient, family/carers or community services. The reason for this should be clearly explained to the patient and their agreement sought for seeking information. In some cases, this may also require a venue risk assessment of the home or location and details of this **MUST** be recorded in care and contingency plans. For CAMHS services which are collocated with adult mental health services consideration must be given to potential related risks.

7.7 In recording time away from the ward an up-to-date clothing description of the patient should be captured in H Form 128: Five point risk assessment.
In addition, a photograph of the patient should also be included in their notes, with the patient's consent (or if the patient lacks capacity to decide whether a photograph is taken, refer to OP05 Mental Capacity). (See English Code of Practice paragraph 27.22 / Welsh Code of Practice paragraphs 27.17 – 27.22).

7.8 There must be a record in the patient's healthcare records of the contact number and address of the place where the patient is staying whilst on time away from the ward.

7.9 **In sites/services where electronic forms are used for managing Section 17 Leave / time away from the ward:**

(a) Prior to time away from the ward being authorised RC MUST complete a Priory Risk assessment.
(b) Any trained member of staff can complete the Time away from the ward form available under the leave tab) and must ensure the contingency plan within this form has been completed.
(c) For restricted patients - Details of the leave authorised by MoJ should also be recorded on this form.
(d) A Venue Risk Assessment Form should be completed if required (this will not be required in all cases).

8 CONTINGENCY PLAN

8.1 Contingency plans **MUST** be available for all periods of time away from the ward ~~from the ward.~~ This includes all types of time away from the ward e.g. ground time away from the ward or long-term time away from the ward. Patients should be involved in developing the plan and invited to suggest or question actions we will take if they do not return at the agreed time.

8.2 The contingency plan can be completed by any member of the MDT but must be agreed with the lead clinician. All contingency plans **MUST** be kept with the Time away from the ward Authorisation Form in CareNotes and reviewed by MDTs when any changes are made to planned time away from the ward conditions or risk assessments.

8.3 Contingency plans may contain a wide range of information that can help the patient and staff understand the response and escalation when a person fails to return to the ward. As a minimum, this **MUST** include;

- The parameters of the time away from the ward e.g. where, what, why, who with.
- Duration of the time away from the ward e.g. overnight and specific return time
- Any contact expected during time away from the ward between site team and patient or others e.g. checks, calls, other
- Confirmation that the AWOL or missing patient procedures will be implemented at the expected return time and factors to take into consideration to support the processes e.g. who to call, what may indicate a need to call the police
- Information for the patient if they feel they need assistance during time away from the ward or actions they can take if they know they will not be able to return at the agreed time

8.4 **Informing others -** Time away from the ward arrangements allowing the patient to return home for a day or longer should be communicated to the local commissioning team, community team and the GP in case the patient needs to access services locally, as well as to ensure good communication with colleagues external to site. This is particularly important for patients who are travelling some distance home.

8.5 **Informing family and carers -** Prior to the patient leaving the ward staff should seek the persons consent to provide a verbal update to any member of the persons family or carers who may need to be involved in the time away from the ward arrangements and seek their views.

8.6 If patients do not consent to carers or other people who would normally be involved in their care being consulted about their time away from the ward, RCs should consider whether this has any bearing on the plan or risk assessment for the time away from the ward.

8.7 The patient, their relative or carer or any person accompanying them whilst on time away from the ward should be provided with a contact number of the hospital and be informed that the patient can return and/or be bought back early if necessary before the end of their time away from the ward period. This should be recorded on the personalised risk management plan, **MHA Form: 01B**.

8.8 **Additional considerations for Informal Patients -** Informal patients have a right to time away from the ward at any time they choose to do so. It is important that informal patients understand this right and their responsibilities in working with their clinical team to plan time away from the ward arrangements during their stay. They must also be supported in understanding there may be circumstances in which they could be prevented from leaving e.g. if we have concerns and may need to use the Mental Health Act while further assessments are completed. All time away from the ward arrangements **MUST** be recorded in the Time Away from the Ward (Leave) form on CareNotes. The contingency plans section within this form must be completed.

8.9 The right to time away from the ward does not mean 'immediately or without any reasonable delay' and this will need to be explained clearly to patients throughout admission. Staff will need to ensure there is a balance between respecting the rights of our informal patients (protecting their right to liberty within the meaning of the Human Rights Act) and our need to protect people who may be vulnerable and at risk of harm to themselves or others (Article 2 and right to life)

8.10 For example, if a ward is locked and patients need to request doors to be open then this may mean a short delay. If the patient has agreed to particular information being collected such as clothes they are wearing that day, then they may be asked to delay leaving if staff are attending to an emergency. In all cases, communication – prior to time away from the ward and during the delay – is critical to maintaining therapeutic, collaborative care environments and protecting the informal patients rights. Local systems and processes must regularly review the access and egress arrangements for their sites to ensure any undue delays are minimised.

8.11 If the patient informs the ward team that they would like to take time away from the ward that hasn't previously been discussed with their MDT, this must not be refused unless;

- Their care plan states they have previously agreed to time away from the ward and, to meet our duty of care, assessment is now necessary to explore their withdrawn agreement. This must be done as soon as practicable and the patient engaged fully while wait for the clinicians to arrive
- The situation indicates that a holding power using Mental Health Law is necessary, to prevent them from leaving due to concerns for their health, safety or that of others.
- The concern is not related to their mental health but another power to prevent them from leaving may be necessary. For example, a patient awaiting discharge with no mental health symptoms becomes violent and is threatening to carry out a serious

criminal act when they time away from the ward the site. Police would need to be informed and the MDT may need to take steps to manage the situation until they arrive.

8.12 **Additional Considerations for Detained Patients -** Only the patient's responsible clinician (RC) can grant leave of absence to a patient detained under the Mental Health Act. The RC cannot delegate the decision to grant leave of absence to anyone else, except in the absence of the usual RC due to sickness or annual leave. In these circumstances leave can be granted by the approved clinician, who for the time being is acting as the patient's RC (English Code of Practice paragraph 27.8/ Welsh Code of Practice paragraphs 27.35-27.38).

8.13 Documentation **MUST** be checked and confirmed prior to leave for detained patients. This includes;

- Section 17 Leave Authorisation Form (England and Wales)
- Suspension of Detention certificate (Scotland)

8.14 For all detained patients, once leave has been authorised by the RC, it will be for nursing staff to manage the leave within the parameters set. This may be using information provided by the RC, for example the time of the day the leave should take place or circumstances in which the leave should not go ahead. Nursing colleagues **MUST** communicate their reasons for reducing or refusing leave with the patient and ensure information is shared with the RC for them to review the implications on the leave authorised. (English Code of Practice paragraph 27.15-17/ Welsh Code of Practice paragraphs 27.12-27.13).

8.15 **Additional Considerations for Restricted Patients -** If the patient is subject to special restrictions (a 'Restricted Patient') in accordance with Section 41, 45B or 49, the RC MUST also obtain written authorisation from the Ministry of Justice (MoJ) to grant leave. The RC must ensure that all leave granted complies with time limitations and all other conditions stipulated by the MoJ. The RC's Section 17 Leave form must be kept in the clinical area with a copy of the MoJ's letter of authorisation.

8.16 The approval from Ministry of Justice or Scottish Ministers (**MUST** be reviewed before each period of leave to be taken, this can be once per day if multiple leave periods are agreed daily)

8.17 Where the patient must be taken for urgent physical treatment, the MoJ states that authority can be assumed but they must be notified of the action taken as soon as possible.

8.18 In England and Wales, if the patient is being granted Section 17 leave for seven consecutive nights or more, then the Responsible Clinician must consider if the person could be on a Community Treatment Order instead. This does not apply to restricted patients, nor, in practice, to patients detained for assessment under Section 2 of the Act, as they are not eligible for CTO.

9 DURING TIME AWAY FROM THE WARD

9.1 Maintain any agreed support/contact while the patient is away from the ward and that this is clearly documented in CareNotes including contingency plans which are required to be clearly communicated to all on shift during the time away from the ward period.

9.2 If during time away from the ward, the patient needs to return to the hospital then responsibility for the safe return of the patient rests with the hospital team. The contingency plan **MUST** be followed and support may be requested from others as appropriate e.g. community team, family. However, this does not replace any legal responsibility for the site team to ensure appropriate action is taken to return the patient.

9.3 **High Risk Response when fail to return** In all cases, patients are deemed to be 'high risk' when they have not returned from time away from the ward, their whereabouts is unknown

and they are uncontactable. Immediate action and escalation **MUST** be applied until there is any confirmation of their location, safety and plans have commenced for return. All staff **MUST** refer to **H126** Patients who are Missing or Absent without agreed Time Away From the Ward for more information

9.4 **Considerations for Detained patients**

9.5 **Recall -** The RC (or, in the case of restricted patients, the Secretary of State or Scottish Ministers) may revoke leave if they consider it necessary in the interests of the patient's health or safety, or for the protection of others. RCs must be satisfied that these criteria have been met and should consider what effect being recalled from leave may have on the patient. A refusal to take medication would not on its own be a reason for revocation, although it would almost always be a reason to consider revocation.

9.6 The RC must consider seriously the reasons for recalling the patient and the effects this will have and must be satisfied that it is necessary in the patient's interests, or the safety of others.

9.7 The RC must complete **MHA Form: 01A** - Recall from Section 17 leave of Absence

9.8 The RC must arrange for the notice in writing, notice of revoking leave (**MHA Form: 01A**) to be served on the patient or on the person for the time being in charge of the patient. Hospitals should always know the address of patients who are on leave of absence and anyone with responsibility for them whilst on leave. (English and Welsh Codes of Practice paragraph 27.33).

9.9 The reasons for recall should be fully explained to the patient and a record of explanation entered in the patient's healthcare record.

9.10 It is essential that any appropriate relatives and friends, especially if the patient is residing with them whilst on leave , and any other professional in the community who needs to know, should have easy access to the patient's RC, if they feel consideration should be given to the return of the patient to the hospital, before their leave is due to end.

10 FOLLOWING TIME AWAY FROM THE WARD

10.1 CareNotes **must** be updated when the patient returns from overnight time away from the ward. Staff **MUST** capture the time of return and ensure this is recorded in the Five Point Risk Assessment and any other supporting documentation e.g. if sign in/out sheets are in use on the ward.

10.2 Each ward **MUST** have a process in place to monitor return times, to mitigate against this being missed during busy times on a ward.

10.3 Staff must be clear on who is responsible on that shift for confirming and closing any time away from the ward documentation, discussing and checking in with the returning patient and recording any return on observation forms, white boards or other procedure.

10.4 Risk assessments or care plans **MUST** be updated if there has been any concerns or issues identified during the time away from the ward or communicated on the persons return to the ward.

10.5 Any searches will need to be completed in line with the policy on searching and in accordance with the banned and restricted item procedures.

10.6 **Outcomes of time away from the ward** all patients **MUST** be asked for their feedback on (See English Code of Practice paragraph 27.23 / Welsh Code of Practice paragraphs 27.17 – 27.22).;

- How the time away from the ward went,

- Any issues, problems or concerns
- Positives and benefits to time away from the ward
- Anything they would like to change about the next time away from the ward that is taken, for example the need for an individual search / Banned and restricted items.

10.7 They can refuse to engage with any 'debrief' or share any information, in which case this should be recorded and respected.

10.8 Any information provided by the patient during a debrief or through observations by staff, **MUST** be captured in CareNotes. This will help inform the MDT and updates to care plans or risk assessments. The formality and detail of this can be adapted to the patient and time away from the ward type e.g. grounds time away from the ward may be a short check in with the patient, whereas an overnight with family would generate a more detailed discussion.

10.9 Patients must be asked if they are happy for us to actively seek feedback from carers, family or friends. This should have been discussed and agreed prior to time away from the ward, but the patient should be asked again before following up.

10.10 If the ward team are contacted by others to share any information regarding any unescorted or accompanied time away from the ward taken, this can be received and recorded. Information should not be shared in return without consent from patient or, if they lack capacity, if there is evidence that this is appropriate and in their best interests to facilitate future time away from the ward.

10.11 **Review** Information gathered during and following time away from the ward must be reviewed at each MDT meeting, or sooner if required or requested. This must be used to inform planning for future time away from the ward and keeping any conditions or restrictions on time away from the ward under review.

11 REFERENCES

11.1 Human Rights Act 1983
Mental Health Act 1983
Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
NG225 Self-harm: assessment, management and preventing recurrence | Guidance | NICE
DH (2015) Reference Guide to the Mental Health Act 1983
DH (2015) Mental Health Act 1983: Code of Practice
Welsh Assembly Government (2016) Mental Health Act 1983 Code of Practice for Wales Review
DCA (2007) Mental Capacity Act 2005 Code of Practice
The Deprivation of Liberty Safeguards 2007 and Code of Practice

11.2 **CASE LAW**
HL v UK 45508/99 [2004] ECHR 471Savage v South Essex Partnership NHS Foundation Trust [2010] EWHC 865 (QB)
Rabone v Pennine Care NHS Foundation Trust [2012] UKSC 2
Fernandes de Oliveira v. Portugal (no. 78103/14)

12 ASSOCIATED FORMS

12.1

H Form: 99A	Observation and Engagement Record Top Sheet
H Form: 99F	Observation and Engagement Record Continuation Sheet
H Form: 128	Five Point Risk Assessment - Leave Signing In and Out Form
MHA Form: 01	Mental Health Act 1983 Section 17 Leave of Absence from Hospital
MHA Form: 01A	Recall from Section 17 Leave of Absence
MHA Form: 01B	Risk Management Plan

MHA Form: 01C	Checklist for Granting Section 17 Leave of Absence from Hospital for Under 18 Year Olds
HG12	Guidance for the completion of the 5-Point Risk Assessment
HG12.1	Guidance for the completion of the 5-Point Risk Assessment (Scotland)
HG25	Time Away From The Ward Patient Leaflet
HG26	Time Away From The Ward Patient Leaflet (Easy Read)
HG27	Time Away From The Ward - FAQs1
HG27.1	Time Away From The Ward - FAQs2
HSOP29	Time away from the ward (Detained and Informal Patients)

13 EQUALITY IMPACT ASSESSMENT

13.1

How is the policy likely to affect the promotion of equality and the elimination of discrimination in each of the groups?			
Protected Characteristic (Equality Act 2021)	**Impact** Positive/ Negative/ None	**Reason/ Evidence of Impact**	**Actions Taken** (if impact assessed as Negative)
Age	None		
Disability	None		
Gender re-assignment	None		
Marriage or civil partnership	None		
Pregnancy or maternity	None		
Race	None		
Religion or beliefs	None		
Sex	None		
Sexual orientation	None		
Other, please state:	None		
EIA completed by:			
Name: **Role/Job Title:**	Kim Forrester, Head of MHA and MCA Operations		
Date completed:	29/10/2024		