GUIDANCE FOR THE COMPLETION OF THE 5-POINT RISK ASSESSMENT - LEAVE SIGNING IN AND OUT FORM

This guide must be used in conjunction with H35 Clinical Risk Assessment and Management. The Priory Healthcare clinical risk assessment and management tools must be used for the completion of risk assessments for inpatients (located on the electronic clinical record (Carenotes) and in hard copy (paper) form (the Five Point Risk Assessment (**H Form: 128**)).

Five Point Risk Assessment for leave

This applies to all services that use the supportive observation and engagement policy - The 5-Point Risk Assessment must be completed for any inpatient on any ward (including private wards, excluding brain injury services) who is having escorted/unescorted leave, for the first leave of the day. This includes all leave to therapy units, dining rooms and other rooms/buildings in the grounds. Each unit must have a local protocol to ensure that patients who have unescorted leave that are attending dining rooms/therapy units etc. in the grounds, have arrived at the expected time and arrangements are in place for ward colleagues to be alerted in the event a patient leaves a therapy group prematurely.

- A patient subject to Level 2, 12 in an hour observations and Level 2, 4 in an hour observations, should not generally be granted unescorted leave on/off site. Any unescorted ground leave would be by exception and will require clear justification and a discussion involving the patient's consultant psychiatrist, the multi-disciplinary team and the patient. This must be documented on the informal leave form or the Section 17 leave form under the leave tab in Care Notes and reflected in the risk assessment.
- Patients prescribed Level 2, one or two observations per hour, can be granted unescorted ground leave but similarly a clear justification and contingency plan must be documented on the informal leave form (in the contingency plan section) or the Section 17 leave form (in the Conditions of leave section) by the Responsible Clinician under the leave tab in Care Notes and reflected in the risk assessment.
- Patients subject to Level 3 and 4 enhanced observations must not be granted any leave within the hospital grounds and/or in the community (off site). Only in exceptional circumstances will escorted leave be permitted and will require clear justification and a discussion involving the patient's consultant psychiatrist, the multi-disciplinary team, the patient and where necessary their family. A clear justification and contingency plan must be documented on the informal leave form (in the contingency plan section) or the Section 17 leave form (in the Conditions of leave section) by the Responsible Clinician under the leave tab in Care Notes and reflected in the risk assessment. (Leave from Bespoke therapeutic package (BTP) should be treated as an exceptional circumstance)
- If a patient is being granted leave for fresh air (which may be being used to smoke), they must meet the criteria for unescorted community leave.
- All leave must be prescribed. The informal leave form on Carenotes must be used for informal patients and the Section 17 leave form on Carenotes for all patients who are detained under the Mental Health Act.

Level 1 - General Observations

- It is recognised that patients whose risk level warrants in them being allocated Level 1 General observations should be provided greater autonomy in accessing areas unescorted within the hospital grounds, therefore, a separate sign-in/out process may be used for this.
- Patients on Level 1 Observations accessing areas within the hospital grounds, including therapy rooms/dining rooms, may complete a fire-register sign in/out form that reflects the time they have left the building, the time they are due to return, where they are going and the time they have returned. This may be completed by either the patient themselves or by the ward staff.

- Patients on Level 1 Observations accessing areas within the hospital grounds are still subject to a 5-point risk assessment prior to their first utilisation of this leave.
- Areas within the hospital building itself i.e. dining rooms or therapy rooms, should be subject to a local protocol and take into consideration whether their hospital entrance is restricted and site's ligature audits.
- The expectations and understanding of patients informing ward staff that they are leaving the ward should be documented within their Leave plan on Carenotes.

Care Planning and Recording of Leave on Carenotes

- All leave must be prescribed and planned for.
    - The informal leave form on Carenotes must be used to record the care planned agreement of leave and contingency plans for informal patients,
    - The Section 17 leave form on Carenotes must be used to record the care planned conditions, agreement and contingency plans of leave for all patients who are detained under the Mental Health Act.
- If a S17 venue risk assessment is required (as indicated on the Carenotes S17 leave form), the risk assessment and a S17 leave contingency plan must be completed on under the leave tab on care notes.
    - The S17 leave contingency plan form on care notes is only for use alongside the venue risk assessment.
- Section 17 leave that doesn't require a venue risk assessment, the contingency plans should be included in the 'Conditions of Leave' section and reviewed alongside the Section 17 leave form.
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Completion of H Form: 128 Five Point Risk Assessment – Leave Signing In and Out Form

- Sections 1-5 must be completed for patients in all services, except brain injury, for grounds/access and local leave, overnight leave and return from overnight leave by a registered nurse. (the 5-Point Risk Assessment does not need to be repeated for returning from overnight leave, however, mental state and mood must be assessed and documented when returning from overnight leave i.e. are there any significant changes, which could affect risk management, observation level to be considered.
- This is to establish whether it is safe to allow patient leave, in line with their prior agreed leave arrangements as recorded in Care Notes. Liaison with the patient's Responsible Clinician is required in the event that the findings of the 5-Point Risk Assessment establish a potential risk.
- Sections 1-5 must be completed prior to the first leave of the day for those patients having frequent leave within the same day and at the point of any patient going on overnight leave and needs only to be repeated for subsequent leave if the patient's risk has changed. The Priory risk screen must not be used to assess the patient at the point of leave.
- The name of the registered nurse who completes the 5-Point Risk Assessment should be both printed and signed to indicate that the 5-Point Risk Assessment has been completed.
- Where leave is cancelled/stopped in response to the findings of the 5-Point Risk Assessment, an entry outlining the reasons for the cancellation should be recorded in the contemporaneous record in Carenotes and the patient's general risk assessment must be reviewed, updating the Responsible Clinician of any significant changes at the earliest opportunity. Each ward must have a process in place to ensure that the

cancellation/stopping of leave is communicated to relevant staff (this may include updating the whiteboard and striking through the completed H Form 128.

- Each daily H form 128 is to be held in a folder on the ward to enable easy access for signing in and out.
- H Form 128 must be retained/archived in the patient's records and can be done so either by filing in their paper records, **or** scanned into Carenotes.

Has there been any significant self-harming or aggressive behaviour in the last 24 hours?

- Check MDT notes, handover content and care plan.

Mental State

- Objectively consider the patient's appearance, behaviour, speech content and mood objectively to establish the current risk state of mind. Assess the patient's mood objectively. Is the patient experiencing any suicidal or self-harm thoughts? Is there suicidal intent with plans? Is there a plan to complete suicide? Is the patient feeling troubled e.g. by hallucinations or anxiety? Do they have insight and judgement?

Relational security

- Has there been any change in the patient's interaction with staff and/or others? Have there been any suspicious behaviours?

Compliance with medication in last 48 hours

- Check medication card to establish compliance with prescribed psychotropic medication and/or relevant physical health medication if indicated.

Section 17 status (if applicable)

- Check Section 17 leave prescription for instruction of leave entitlement.

Other matters to consider:

- If a patient is going on unescorted leave for the first time, ensure this has been agreed by the MDT and an appropriate period of leave agreed and understood.
- Are there recent new leave arrangements arising from ward round/MDT meeting – check leave prescription form and/or whiteboard.
- Check when medication is due on the prescription card and respond accordingly.
- Review the patient's access/leave care plan.
- If a therapy/treatment session has just taken place: Speak to the staff member involved to obtain feedback on the patient's presentation.
- Information from 'Anti-absconding Workshop'.

Return from overnight leave

- For return from grounds/access and local leave and overnight leave patients will recommence on level 1 / 2 observations as prescribed. A debrief must be completed where required for example the patient returns late, is in distress or there are other concerns.

Debrief

- Obtain feedback about leave from patient and carer/visitor. **To be completed by a registered nurse**

Mental state

- Mental state and mood to be assessed and documented when returning from overnight leave. Are there any significant changes, which could affect risk management, observation level to be considered **To be completed by a registered nurse**

Restricted items:

- Ask the patient to hand in any banned or restricted items that he/she may have from their leave/access. **This can be completed by a Health Care Assistant**

Search/'pat down or rub down' (Secure only: must be patient-specific and specified and agreed by RC/MDT on an individual risk-assessed basis)

- Gender-specific staff to complete a 'pat down or rub down' search of the patient following consent is documented below.
- If the patient refuses to be searched, the responsible clinician/ on-call doctor to be contacted. The service user should not to enter the main ward until staff are satisfied there are no banned/restricted items present. **May be completed by a Health Care Assistant**

Reporting upwards

- In the event of a serious incident during any period of leave off the ward, ward staff should follow the On-call escalation process and complete **OP Form 46** Upwards Reporting Serious Incident Form and document on Datix.