

# CLINICAL GUIDELINES FOR MANAGING LEAVE FOR INFORMAL PATIENTS AND PATIENTS DETAINED UNDER THE MHA

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## SCOPE

Services	Applicable	Comments
Trustwide	✓	

**The Director responsible for monitoring and reviewing this Clinical Guideline is the Executive Medical Director**

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**CLINICAL GUIDELINES FOR MANAGING LEAVE WITH INFORMAL PATIENTS  
AND PATIENTS DETAINED UNDER THE MHA**

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<p align="center"><b>CLINICAL GUIDELINES FOR MANAGING LEAVE WITH INFORMAL PATIENTS AND PATIENTS DETAINED UNDER THE MHA</b></p>
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<p align="center"><b><u>Assurance Statement</u></b></p>
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<p>This clinical guideline is required in order to ensure that decisions surrounding leave are made within a framework of clinical robustness for patients who are voluntarily in an inpatient setting and also patients detained under the Mental Health Act.</p>
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<p><b>1.0 PURPOSE</b></p>
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- 1.1 This policy aims to ensure that our Trust safeguards the rights of informal patients and patients detained under the Mental Health Act 1983 amended in 2007. It aims to give assurance that patients who are admitted to an in-patient unit informally receive protection of their Article 5 (Right to Liberty) rights under the Human Rights Act (HRA). Also, the same protection is afforded for detained patients regarding their Article 2 (Right to Life) rights under the HRA. Both the patient and, where appropriate, their carer and advocate should be made aware of these rights with information being provided in a format and language that the patient understands. Patients detained under the MHA refer to the Trust MHAPG1A Procedural Guideline for the Administration of the Mental Health Act 1983.
- 1.2 Patients and carers have the right to expect that appropriate arrangements are in place in granting periods of leave from the hospital. Although informal patients have the right to leave the ward (unless the patient satisfies the criteria for an assessment under the Mental Health Act) at any time, the Trust has a duty of care towards them including responsibility for their safety and wellbeing. These guidelines provide a framework for the provision of safe and appropriate leave. Each Inpatient Service will display these rights at the entrance and exit points of each ward.
- 1.3 The term informal is in reference to the Mental Health Act 1983, amended 2007, and refers to patients who are not detained under the Act and have capacity to give an informed consent to hospital admission and treatment.
- 1.4 For patients detained under the MHA refer to the Trust MHAPG1A Procedural Guideline for the Administration of the Mental Health Act 1983.

<p><b>2.0 GUIDING PRINCIPLES</b></p>
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- 2.1 Leave from an inpatient area is defined as any period of time spent by an inpatient outside of the inpatient area, with or without an escort
- 2.2 The Consultant/Responsible Clinician for detained Patients (RC) has an overall responsibility for care and treatment of the patient on the unit, including granting of appropriate leave. The Consultant/RC and multi-disciplinary team (MDT) together with the patient and/or relatives/carers will discuss leave as part of the individual patient treatment programme.

- 2.3 In line with the principles of managing patients in least restrictive environment, while granting leave, the inpatient team should consider if the patient can be safely treated in the community by the Home Treatment Team. In such a situation, the care should be transferred to the Home Treatment Team, following appropriate discharge procedure.
- 2.4 Where the Consultant/RC and MDT have not agreed that the patient be absent the patient is absent without leave (AWOL see Trust CLP34).
- 2.5 Extended leave from the hospital would not normally be agreed in lieu of self-discharge.
- 2.6 The purpose of the leave should be clearly documented in the notes. Requests for leave soon after admission need a very careful review and an assessment of potential risk undertaken. The reasons for such leave along with risks and risk management plan should be clearly documented. Such practice may not in effect be safe or therapeutic and should take into account the view of the carers.
- 2.7 Some patients might leave the ward without identifying their intention to any doctor or nurse. Unless this is subsequently agreed by the consultant (and if necessary, Ministry of Justice in the case of patients on restricted sections of the MHA). These patients are not “on leave” and are considered absent without leave (AWOL). Staff must notify the Head of Patient Safety Incidents and Quality or the Integrated Risk Team of any informal patients who are missing and are considered to pose a risk to themselves or others. Please refer to CPG3 the Adverse Incident Reporting Procedure and CLP34 Absent without Leave and Missing Patients Procedure.

### **Informal Patients**

- 2.8 An informal patient may wish to take their discharge against medical advice. In this instance, every opportunity will be taken to ensure safety of the patient and others. A thorough assessment of the person’s mental state and a risk assessment must be conducted and clearly documented by a member of the MDT who knows the patient. This assessment will be recorded in the patient’s notes. The assessment should take into account the need to consider detention under the Mental Health Act 1983. All patients discharged against medical advice must have an aftercare plan including 7-day follow up and a discharge summary to the patient’s GP.

### **Patients Detained under the MHA**

- 2.9 Leave for patients detained under the MHA, this must be referred to the Trust MHAPG1A Procedural Guideline for the Administration of the Mental Health Act 1983.

<b>3.0 AGREEMENT OF LEAVE</b>
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- 3.1 Leave from hospital for patients will be seen as part of the care and treatment programme and will be planned with a specified duration and purpose. Leave allows the patient, any carer and the Hospital team to assess progress made and their ability to cope outside of the Hospital environment.
- 3.2 A comprehensive risk assessment must be undertaken and documented prior to the commencement of leave.
- 3.3 Any overnight or long period of leave for an informal patient must be agreed with the consultant or his deputy. A plan of leave should include the following:
  - Period of leave and return date and time
  - Contact details of the service user and carer
  - Contingency plan if the patient fails to return from leave
  - A risk assessment (including risk of absconding, risk of failure to return, risk to self or other whilst on leave and safeguarding risks) should form part of the leave plan.
  - 3.3.1 In cases of those under 16 years of age, the person who has parental responsibility for the young person must be informed and be part of the agreement process.
  - 3.3.2 For those over 16 years, but under 18 years of age, the adult with legal parental responsibility must be made aware of leave plans.
- 3.4 A Ward or Duty Doctor, Nurse in Charge, Consultant in charge of care are the only people who can agree leave from the ward for an informal patient (except for planned overnight leave, which must be agreed with the Consultant). The Nurse in Charge needs to be a regular member of staff who is familiar with the patient and the clinical area.
- 3.5 If a regular member of staff is not available and no decision has been previously agreed, contact needs to be made with a regular member of the MDT to provide advice.
- 3.6 Where a patient is being closely observed by the ward staff on an increased level of observation, they can only be agreed leave from the ward if a member of staff is able to supervise them as per CLPG8 Engagement & Supportive Observation Procedure.
- 3.7 Consideration must always be given to the patient's need for support and/or monitoring whilst they are on leave, whether for a day or longer. It is not appropriate that patients would be expected to manage their time on leave without prior discussion and planning. The level of support and who will provide it must be agreed prior to commencement of leave, i.e. Home visit, or telephone contact.
- 3.8 Any period of leave of for a detained patient (which the exception leave for urgent medical care) must be authorised the RC. Refer to the Administration of the Mental Health Act 1983 Procedural Guidelines
- 3.9 When leave is being considered patients, every effort must be made to contact the patient's relative(s). If the patient is living with their relative or carer and the patient has consented for the relatives to be contacted, the leave must be

discussed with the relative. This discussion must be recorded in the medical or nursing notes.

- 3.10 In the event that staff have any concerns in relation to the patient's clinical presentation or risk, the leave should be suspended for a review by the patient's Consultant/RC or the MDT. The reasons for suspending the leave must be documented in the records. In case the patient is unwilling to wait, the nurse in charge or the ward doctor should consider the holding powers under the Mental Health Act until a review is undertaken by the Consultant.
- 3.11 Where a community mental health team is involved in the care, the inpatient staff should involve the community team, particularly when granting overnight leave. If the community team agrees to support the patient during the leave, the nature and frequency of the support must be agreed and clearly documented in the notes.
- 3.12 Where a patient is receiving medication, a supply of the prescribed medication with the necessary advice must be given to the patient to cover the period of leave. Nursing staff must check the TTA's against the patient's drug administration card to ensure correct medication and dosage has been dispensed.
  - 3.12.1 In cases of those under 16 years of age, ALL medications MUST be given to a responsible adult. It would be preferable if it were the person who has 'parental responsibility'.
  - 3.12.2 For those over 16 years of age but under 18 years of age the adult with parental responsibility needs to be made aware of ALL medication in the possession by the young person.

<b>4.0 DURING LEAVE</b>
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- 4.1 Any patient on leave is still subject to inpatient care and any concerns expressed by patient/carers must be taken seriously and fully explored. If the patient needs to return to the ward, arrangements must be made for safe return of the patient to the ward.
- 4.2 If the concerns have been raised by someone other than the patient, the patient must be contacted and their mental state explored. In case the patient refuses to return or communicate, ascertain the location of the patient, review the risk and contact the patient's consultant/ward doctor, who can then make a decision whether if the patient is informal an assessment under the Mental Health Act needs to be arranged. The staff should inform the Police if there are significant concerns for the patient's wellbeing and safety.
- 4.3 The legal status and the concerns must be shared with the police and clearly documented in the clinical records. The staff must complete a Datix form if the patient has been identified as AWOL. Please refer to CLP34 - Missing Person Procedure for further information
- 4.4 When a patient is on extended leave and the care coordinator or HTT makes a home visit, they will liaise with the ward and medical staff and advise of on-going progress, giving recommendations with regard to further leave and/or discharge.

All professionals involved will write their observations in the relevant patient's notes.

<b>5.0 ON RETURN FROM LEAVE</b>
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- 5.1 When a patient returns from leave, the nursing staff on the ward should discuss the leave with the patient. The staff should explore clinical presentation during the leave period, any risks noted by the patient/carer, any use of alcohol or illicit drugs and compliance with medication. An assessment of mental state and review of risk must be undertaken on return from leave must be documented in the notes.

<b>END</b>
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