Royal College of Emergency Medicine

Best Practice Guideline

The Patient who Absconds

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Contents

Summary of Recommendations

1. Emergency Departments should prioritise the clinical assessment of patients at high risk of absconding.
2. An essential action to be performed as soon as the risk of absconding has been identified is to assess capacity, ideally as part of a mental health triage tool.
3. Emergency Departments should have a specific form for detailing a patient's physical features, if at risk of absconding.
4. Emergency Departments should have written policy to address management to help prevent absconding when risk has been identified. This should involve capacity assessment, if the patient attempts to leave, and best interest decisions.
5. Emergency Physicians requesting that a patient be restrained must be clear regarding the legal justification of their request and document this in the clinical notes. At all times this must be the least restrictive.
6. Restraint to prevent absconding should be a proportionate response and in the patient's best interest.
7. Acute trusts should have written agreements with the security team regarding when restraint can be applied and how it is applied.
8. Acute trusts should work with local partners to devise pathways and responsibilities as to who should be contacted when patients abscond. This should be based on immediacy of risk of that patient coming to harm. This may be Police, Ambulance, Social Care or mental health services.
9. Any children who abscond with or without an accompanying adult should trigger local safeguarding procedures.
10. Emergency departments should record the number of patients who abscond and those cases in which the Police Service have been contacted in order to facilitate service improvement.

Scope

This guideline has been developed to assist Emergency Physicians in the management of patients who abscond from the Emergency Department (ED). In this document, 'absconding' is defined as a patient who has left the department unexpectedly, without the knowledge of clinical staff, and in whom there remains a potential risk of harm to self or others either through neglect or deliberate means. Some patients who leave without warning may present a risk to themselves whilst others may not.

This guideline does not refer to those patients who 'Did Not Wait', who 'Left without Being Seen', or who 'self-discharge'. The guideline seeks to provide some clarity around the legal basis for decision making in this area, in particular regarding those patients who lack capacity. The Legal Principles apply to patients over the age of 16 years in England and Wales.

Reason for Development

Patients who abscond from the ED cause considerable concern to Emergency Physicians with regards to the most appropriate course of action, how far their 'duty of care' extends and the legal basis of decision making.

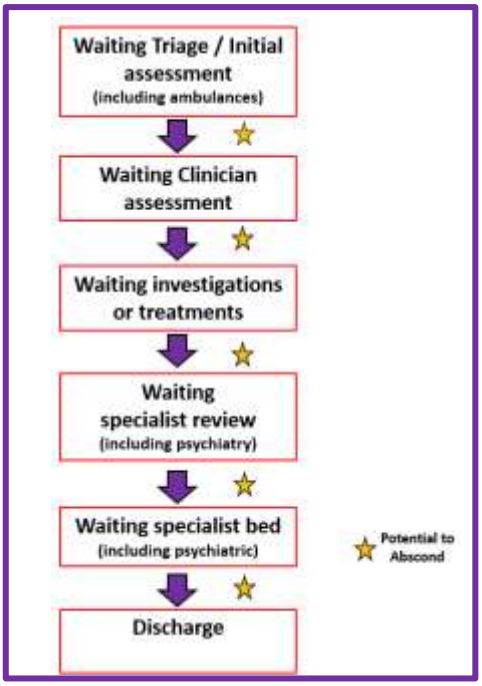
Introduction

Emergency Physicians are frequently posed with the challenge of what action to take when a patient 'absconds'. Central to decision making around what action to take after a patient is discovered to have 'absconded' is whether the patient has capacity. Unfortunately, the 'capacity-status' of a patient who has absconded is not always accurately known. There is a presumption that all patients have capacity unless it can be demonstrated otherwise. Patients who abscond and lack capacity or who potentially lack capacity (formally unassessed but the manner of their presentation causes concern) may be a risk to themselves or others and may be detainable under the Mental Capacity Act (MCA) 2005 or the Mental Health Act (MHA) 1983. Such patients may be, for example, psychotic, suicidal, delirious or intoxicated.

Individuals may lack capacity to decide to leave the ED because

1. they lack capacity to make this decision as formally assessed by the Mental Capacity Act (MCA) 2005 or
2. they are under detention of a mental health 'section', as defined by the Mental Health Act (MHA) 1983

Many emergency departments (EDs) are facing significant issues with 'Exit Block' or achieving significant flows of patients out of the ED in a timely fashion. This has the consequence of increasing the opportunity for patients to abscond from the ED at different stages of their hospital journey (see diagram below).



A Duty of care exists once patients are booked into the Emergency Department. This engages the relevant ethical, legal and professional duties. These duties broadly fall into balancing the need to protect the patient from harm whilst at the same time protecting the patient's liberty. The diagram below, summarises some of the ethical and statutory factors involved in decision making for the clinician.

However, the law can be difficult to navigate in the dynamic and fast paced ED environment. The Emergency Physician (EP) is faced with having to make immediate decisions with incomplete information and often with significant consequences, irrespective of which path is chosen. The EP may find themself in the middle of what might appear to be the conflicting ethical and legal principles of maintaining liberty and the duty to protect life. This has led some to summarise the decision making as choosing between either going to the coroner's court or the High Court.

This guideline has been developed to provide a framework to assist the Emergency Physician in these challenging scenarios.

Legal Principles:

1. A duty of care exists once a patient is booked in. Therefore, active management of any problem is required. Departments should be mindful of patients waiting to be 'off loaded' from ambulances as a consequence of hospital wide capacity issues.

2. A person must be assumed to have capacity unless it is established that they lack capacity. This principle is difficult to apply if the patient has absconded or is attempting to leave before formal assessment has taken place.

3. The decision of a patient who possesses the requisite decision-making capacity (as per MCA 2005) must be respected. If a patient has capacity to act on a decision then – assuming that it does not put others at immediate risk of significant harm – their right to act on that decision must be respected, even if the assessing clinician considers it 'unwise.' However, if the decision to leave ED appears to be unwise, the assessing clinician should be cautious before reaching a conclusion that it is reached with capacity.

3. If a patient's actions put others at immediate risk of significant harm, it is lawful under **common law** to intervene to prevent that harm, irrespective of their capacity.

4. Where the MCA 2005 is engaged, patients who lack capacity to leave can be restrained so long as that restraint is necessary and proportionate to the risk of harm they would suffer otherwise (s6 MCA 2005). However, they are being prevented from leaving ED, then if they are required to remain in ED for more than a short period of time (measured at most in hours) it is likely that the period of time that they will be required to remain there will go beyond mere restraint and will give rise to a deprivation of their liberty.

5. A person can only lawfully be deprived of their liberty where there is formal authority to do so. ED personnel do not have powers to detain under the MHA 1983. Options under the MHA 1983 are limited to requesting the assistance of the police who can use a s136 in the ED. However, even these steps take some time to put into motion.

Practical steps to reduce risks of absconding.

On arrival, patients at risk of absconding should undergo mental health triage, when appropriate, in order to formally assess and document the risk of absconding and self-harm. Each department should have its own processes for mental health triage. Departments should undertake regular audits of their mental health triage processes. Please refer to the RCEM Mental Health Toolkit for more information.[21]

- Part of the initial assessment for patients at risk of absconding should include the assessor making a judgement regarding whether the patient has capacity. Capacity must be assessed for specific decisions. The specific question the triage nurse should be considering is "Do you think this patient has the capacity to decide to leave?". Ask the patient if they understand and agree with the initial treatment plan (provided at triage). Agreement with this initial treatment plan can be used to help assess capacity. If later it is discovered that a patient has left the department without warning, then the nurse's initial assessment of capacity to decide to leave will help inform decision making at this stage.

- It must be noted that distress can impair one's ability to weigh up a decision when capacity is assessed.

- It is important to be empathetic and understanding, this reduces the risk of absconding.

- Consider giving information such as advice leaflets and links to third sector support groups.

- Patients who are at risk of absconding should have their physical description recorded during their initial assessment (triage) to facilitate subsequent identification (e.g., by police) in the event of absconding. It is essential to ensure the patient's contact details are up to date.

- Following triage, they should be informed of the likely time to see a clinician as well as who to contact if they have any questions whilst they are waiting.

- Those patients at risk of absconding should be prioritised for early assessment, e.g. direct streaming to mental health team (where there is no co-existing 'medical' problem) or placed in a priority triage category. Parallel assessment of physical and mental health needs should be standard.

- Patients considered to be at high risk of absconding (or of self-harm) should be observed, either intermittently (e.g. every 15 minutes) or continuously if at very high risk. Training should be given to staff who carry out these observations. There should be documentation of observations in the patient's notes.
- If a patient is threatening to leave, a senior decision-maker should assess the patient whilst at the same time trying to de-escalate the situation, addressing the patient's reasons for wanting to leave and making a rapid determination of the patient's autonomy/capacity.

- If the assessing clinician believes the patient lacks capacity and decides that restraint is appropriate (necessary, proportionate and in the patient's best interests), then this should be clinically led. If restraint is needed for more than 10 minutes, then chemical restraint i.e. Rapid Tranquillisation should be administered. The legal basis for restraint or Rapid Tranquillisation should be recorded in the patient's notes (see box 1).

Box 1. Legal Basis for Restraint in the absence of capacity

MCA 2005:

If they lack capacity, the MCA 2005 powers can be used to restrain the person, and to provide them with treatment including Rapid Tranquilisation in their best interests.

MHA 1983:

If the primary problem is related to mental health, then consider the use of the MHA 1983 and discuss with the mental health liaison service. A patient may benefit from MHA 1983 assessment if they have a severe mental illness, particularly psychosis. If they have already been placed on, or are subject to a Section 2,3 or 136, then restraint can be used under the auspices of the MHA 1983. If they have not been placed on a section, then options are limited to requesting the police to apply s136.

If a patient has a recommendation for a section 2 or 3 this does not apply until the paperwork has been signed when a bed has been identified.

- Acute Trusts should have written agreements between themselves and security teams with regards to what levels of restraint can be provided and under what circumstances. EDs need to be mindful of the importance of documenting both the assessment of capacity and the reason for restraint in the clinical record, without this intention it is unlikely security teams will feel justified in restraining a patient.
- Emergency departments should have a clear policy when a patient is discovered to have absconded. EDs should avoid immediately calling the police but instead undertake a thorough risk assessment. On discovering a patient has absconded, and there is a concern that the patient is at immediate risk of harm to self or others, actions may include:

1. Searching the ED and immediate surrounding area.
2. Contacting security to help with the search as well as using CCTV.
3. Calling the patient's contact number.
4. Consider contacting the next of kin, weighing up the balance of need to ensure safety with patient confidentiality.

- In the event of not being able to find the patient, the senor clinician on duty and the senior nurse should decide whether it is appropriate to contact the police or not. Police should only be contacted if:

  - A real and immediate risk to life exists.

AND

  - Police assistance (requesting that they urgently locate and return the patient to the Emergency Department) represents a proportional response to the identified immediate risk.

AND

  - Individual patient vulnerability (e.g., child, learning disabilities, dementia, etc.) has been considered.

AND

  - Efforts to contact the patient by telephone have failed.

AND

  - No other person or service can facilitate the return of the patient, e.g. GP, SW, parent, relative, paramedics (there may be local agreements regarding appropriate services)

- Staff should be aware of what specific information the police are likely to require, which department you are phoning from, who you are, who you are looking for, why the police need to find them, what steps have been taken so far to locate them and patient description.
- Before contacting the police, it is important to realise that the police do not have the power to bring patients back to the emergency department (ED) against their will unless:

  1. A patient is under arrest (i.e. has committed a crime).

  2. A patient has been placed under section 136 (authorises a police officer to remove a person to a place of safety if he/she/they believe that person is suffering from a mental illness).

  3. A patient is considered to be at risk and vulnerable (for example dementia or a child)

- Once the police have been contacted to locate a patient who has absconded from the ED then an incident form (e.g. DATIX) should be completed. These clinical incidents should ideally be reviewed as part of a rolling governance program with the police service.
- For those patients who have absconded and do not fulfil the criteria for police involvement, other options to consider are:

  1. If there is a mental health concern, inform the Mental health Liaison service

2. Try to contact the patient directly.

3. Contact a friend or relative, if appropriate.

4. Inform the GP including discharge letter.

Local safeguarding procedures (children, vulnerable adults) should be followed.

- When a patient returns or is brought back after absconding, they should be re-triaged, considered high risk for further absconding and be seen promptly, preferably by a senior clinician. Clinicians should be mindful that after a period of absconding, the patient's condition may have changed for several reasons (e.g. ingestion alcohol or drugs). Previously instituted management plans may need to be reviewed considering the new clinical assessment following the patient's return. For those patients brought back to the ED by the police, it is essential to establish whether the patient is on a section 136, under arrest or merely accompanying the patient. The intention or otherwise of the police to remain with the patient needs to be clear.

Revision

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Original

Catherine Hayhurst, James France, May 2013, revised June 2018, revised 2023

Review

Three years or sooner if important information becomes available.

Conflict of interest

None

Disclaimer

The College recognises that patients, their situations, Emergency Departments and staff all vary. This guideline cannot cover all possible scenarios. The ultimate responsibility for the interpretation and application of this guideline, the use of current information and a patient's overall care and wellbeing resides with the treating clinician.

Audit recommendations

Use of Mental Health Triage Tool for qualifying presentations.

Clinical Incident reporting for police involvement in absconded patients; Clinical Note documentation for those patients under-going restraint.

Keywords for search

Abscond, Restraint, Mental Capacity Act, Mental Health Act, Did not Wait.

Relevant references, guidelines and cases of note

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