Recognising & Managing

the Risk of Absconding from Wards / Units

An absconding incident refers to *any absence without leave of a person detained or liable to be detained under the Mental Health Act 1983 (for example: on Section 17 leave of absence from hospital, or held under short-term powers of Section 5, 135 or 136)* (CQC Definition). This includes a failure to return from authorised leave, absenting self from hospital, or absenting self during escorted leave.

However, it is also important to consider vulnerable informal patients who go missing: *a person receiving treatment and care who has left the hospital ward / premises without going through normal leave or discharge processes, whose whereabouts are unknown, and who presents a risk of danger to self / others or is susceptible to being abused by others, whether due to medical or psychiatric problems, or problems related to learning disability.*

PRACTICE GUIDELINE

Assessing the Risk:

consider, identify, record and communicate known risk factors associated with the individual's risk of absconding (Bowers et al 2003; Simpson et al 2003), *including*:

- HISTORY: absconded during this or a previous admission = *9x more likely to abscond*
- COMPLIANCE: refusing medication in the previous 48 hours = *3x more likely to abscond*
- AGE: aged 35 years and under = *3x more likely to abscond*
- GENDER: being male = *2x more likely to abscond*
- DIAGNOSIS: having a diagnosis of schizophrenia = *2x more likely to abscond*

though the above risk indicators may help in identifying those who present a high risk for absconding, it is clearly important to consider the person's circumstances

- ADMISSION: risk of absconding is often higher in the first 2 – 3 weeks from admission
- BEHAVIOUR: consider behavioural indicators or subtle changes in the person's behaviour
- REASONS: for those who do not wish to stay in hospital, have absconded or have a history of absconding, it is very important to explore their reasons for not wishing to stay / absconding – *for example*: concerns and worries about hospitalisation, their home, property and family / social networks; substance use; frustration or distress; issues related to feeling safe in the ward; self-harm / suicide risk issues

Managing the Risk

upon developing a personalised care plan with the individual, consider, discuss and agree specific practical interventions that are likely to help in minimising and managing the individual's risk of absconding – *consider the following examples* (Bowers et al 2003; Simpson et al 2003; Bartholomew 2009)

a. informing the patient of the entrance and exit policy upon admission to the ward
b. the use of a signing in and signing out book by the patient in confirming their whereabouts and the use of leave
c. providing frequent opportunities to actively involve the patient in the development and review of their care-plan
d. the daily review of their risk of absconding / risk status
e. providing therapeutic observation through a care engagement approach
f. targeting therapeutic time to those at risk as part of the shift allocation process, offering at least 15-minutes of nursing time, during which time the patient should be encouraged to share their concerns and worries about hospitalisation, their home, property and family / social networks
g. providing swipe cards / other methods for managing access to bedrooms / areas of the ward
h. engaging the patient within therapeutic interventions and activity programmes, with special attention to times when there are fewer staff around
i. involving the patient in setting personal goals and planning their day / week
j. tailoring activities to meet the patient's needs and interests
k. ensuring the availability of activities during the evening and at weekends
l. encouraging the patient's feedback on activities and groups
m. promoting controlled access to the home environment
n. promoting telephone, e-mail and face to face contact with family and friends
o. providing family-members and carers with information about how to contact the ward, the named nurse etc…
p. involving the patient and family-members in decisions about their treatment and care
q. the careful and sympathetic breaking of bad news – finding a quiet place; giving time to express their feelings, acknowledging frustration, expressing sympathy and empathy; answering any questions honestly, giving attention and showing respect; explaining decisions about their care and promoting understanding
r. exploring reasons / triggers for absconding
s. after two incidents of absconding, initiating a multi-disciplinary discussion, reviewing options and deciding upon a course of action that clearly addresses the reason identified for absconding and the risk of the patient, updating the risk assessment and care plan