

The College of Emergency Medicine

Best Practice Guideline

The patient who absconds



MAY 2013

Summary of recommendations

- Emergency departments should prioritise the clinical assessment of patients at high risk of absconding.
- A key assessment to be performed as soon as risk of absconding has been identified is to undertake a capacity assessment.
- Emergency departments should have written guidance detailing specific measures which may be activated to prevent absconding.
- Emergency departments should have a specific form for detailing a patient's physical features, if at high risk of absconding.
- Emergency departments should have written guidance on when it is appropriate to contact hospital security and the Police Service for patients who abscond.
- Any children who abscond with or without an accompanying adult should trigger local safeguarding procedures.
- Emergency departments should record the number of patients who abscond and those cases in which the Police Service have been contacted.

Scope

This guideline has been developed to assist Emergency Physicians and healthcare managers in the management of patients who abscond from the Emergency Department (ED). The guideline offers recommendations for the prevention and management of absconders in the Emergency Department setting. In this document '*absconding*' is defined as a patient who has left the department unexpectedly with their assessment or treatment only partially completed, without the knowledge of clinical staff. Some patients who abscond may present a risk to themselves whilst others may not. This guideline does not refer to those patients who 'Did Not Wait' or 'Left Without Being Seen' or who take their own 'self-discharge'.

Box 1.

Did Not Wait / Left without being seen- left before assessment by a decision making clinician

Left Before Treatment – left before treatment but has been assessed by a decision making clinician

Self-Discharge – left ED after informing staff

Absconds – left ED at any time without informing ED staff

Reason for development

Patients who abscond from the Emergency Department often pose a dilemma for clinical staff as to what is the most appropriate course of action to take and how far their 'duty of care' extends.

Introduction

The emergency department differs from in-patients wards and psychiatric facilities in that it is a public place. There is little or no evidence in the literature accurately characterising those patients who abscond from the emergency department; however particular patient groups involved may include those with mental health issues and those with a wish to avoid contact with statutory agencies e.g. patients with inflicted injuries. Accurate data characterising and quantifying the numbers of patients who abscond is difficult to find, since these patients are often classified as 'Did Not Wait'.

Predicting who might abscond

Being able to predict who might abscond following initial triage allows measures to be put into place to try to prevent absconding and also prompts planning for the possibility that a patient may abscond. Box 2 Describes factors which may be associated with absconding.^[3]

Box 2.

Verbalising wish to abscond

Previously absconded

Not from locality

Intoxication

Frustration in delay to assessment

Brought to ED against own wishes

Has external commitments/ stressors

Patient / family lack insight into condition

Alcohol or drug dependence

High suicide risk

Quiet / withdrawn Unaccompanied

Not willing to engage with staff

Agitated / angry / distressed

Psychotic symptoms

Lack of insight

Delirium / dementia

Prevention of absconding

It should be assumed that a patient has capacity to leave the emergency department until proven otherwise.

Practical steps which may be possible after identifying a patient who has a high risk of absconding include:

1. Placing the patient in a location which facilitates observation.
2. Prioritising early clinical assessment if they are a potential risk to themselves.
3. Do a capacity assessment; does this patient at this time have the capacity to make a decision to leave the ED without being seen? Be aware that the patient's capacity to decide this may fluctuate.
4. Allocating a member of staff to observe the patient and try to engage with them (this may or may not include security staff).
5. If a patient wishes to leave, establish why the patient wants to leave and try to address their concerns. If the patient is adamant they wish to leave and they have capacity to decide this then they should be managed as per local 'self-discharge' policy.
6. For patients with a high risk of absconding it is recommended that a standard form is used to list a description of the patient's physical features should this be required by the police or hospital security in the eventuality of the patient actually absconding.

What to do if a patient absconds

- If a patient absconds who is felt not to have capacity and is at risk either of self harm or deterioration of their condition then departments should activate a search of hospital premises
- Departments should have a policy for when to call security and what it is expected security will do to search for the patient.
- Security staff can only be asked to restrain or forcibly bring a patient back to the ED if they lack capacity or if it is felt the patient is mentally ill and requires a mental health act assessment. In an emergency where there has been no chance to assess the patient's capacity but there is a significant risk of harm, a patient may be restrained or brought back by force effectively under common law.
- ED staff should try to contact the patient and relatives by phone.

When to contact the Police Service

This guidance does not cover those occasions when the ED has a duty to contact the police service (e.g. knife wounds, gunshot wounds and serious crimes) or when the police service need to be contacted as a result of a criminal act committed in the emergency department or the contact of relatives of seriously ill or injured patients.

The police service do not have the power to bring patients back to the emergency department (ED) against their will unless they are under arrest (i.e. are believed to have committed crime) or unless they place the patient under section 136 (which authorises a police officer to remove a person to a place of safety if he believes that person is suffering from a mental illness). Section 135 allows a police officer to gain access to a patient who is believed to be mentally disordered but who is not in a public place (requires warrant from JP and an Approved Mental Health Professional, AMHP).

Before contacting the police service for patients who have absconded from the ED it is recommended that the following criteria should all be present:

- There exists a real and substantial risk to the patient if they are not brought back to the ED for medical assessment and/or treatment.
- The risk is such that action needs to be taken with urgency.
- Efforts to contact the patient by telephone have failed.
- No other person or service is able to facilitate the return or on-going management of the patient e.g. General Practitioner, Social Worker, Community Psychiatric Nurse or relative.
- Both the nurse in charge and the senior doctor on duty are in agreement that contacting the police is the correct course of action.

In the case of **children** (<18yrs) who have absconded from the ED then the threshold will generally be considered to be lower for calling for help from the police service early. Any children who abscond with or without an accompanying adult should be considered a safeguarding concern unless evidence to the contrary exists; local safeguarding procedures should be followed.

The threshold will also be lower for those patients in whom there is reasonable evidence that they lack capacity or who may be considered vulnerable (e.g. those with dementia).

It is recommended that all cases of patients who abscond and are reported to the police service are subject to local audit or incident reporting.

Patients who return

Patients who have absconded but who either return voluntarily to the emergency department or are brought back by the police service should be considered high risk for further episodes of absconding and their clinical assessment prioritised. Clinicians should be mindful that after a period of absconding the patient's condition may have changed for a variety reasons (e.g. ingestion alcohol or drugs) and previously instituted management plans may need to be reviewed in light of the new clinical assessment following the patient's return. These patients should be seen by the most senior doctor in the emergency department.

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Acknowledgements

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Review

Usually within three years or sooner if important information becomes available.

Conflicts of Interest

None

Disclaimers

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.

Research Recommendations

Risk factors associated with patients absconding from emergency departments and patient outcomes to determine whether any clinical risk exists.

Audit standards

None identified

Key words for search

Abscond, emergency department

References

[1] Clarey AJ, Cooke MW Patients who leave emergency departments without being seen: literature review and English data analysis. *Emerg Med J* 2012; 29: 617-621

[2] O'keeffe F et al Did Not Wait Patient Management Strategy (DNW PMS) Study. *Emerg Med J* 2012; 29: 550-553

[3] Mental Health and Drug and Alcohol Office, *Mental Health for Emergency Departments – A Reference Guide*. NSW Department of Health, Sydney, 2009.

<http://www0.health.nsw.gov.au/resources/mhdao/pdf/mhemergency.pdf>

Appendix 1

Methodology

Where possible, appropriate evidence has been sought and appraised using standard appraisal methods. High quality evidence is not always available to inform recommendations. Best Practice Guidelines rely heavily on the consensus of senior emergency physicians and invited experts.

Evidence Levels

1. Evidence from at least one systematic review of multiple well designed randomised control trials
2. Evidence from at least one published properly designed randomised control trials of appropriate size and setting
3. Evidence from well designed trials without randomisation, single group pre/post, cohort, time series or matched case control studies
4. Evidence from well designed non experimental studies from more than one centre or research group
5. Opinions, respected authority, clinical evidence, descriptive studies or consensus reports.



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