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<tr>
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<td>Policy, Procedure or Clinical Guideline</td>
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<tr>
<td>DOCUMENT NUMBER</td>
<td>SESLHD PD 2005/06</td>
</tr>
<tr>
<td>DATE OF PUBLICATION</td>
<td>March 2012</td>
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<td>RISK RATING</td>
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</tr>
<tr>
<td>LEVEL OF EVIDENCE</td>
<td>National Standards for Mental Health Services 2010 ACHS – EQuIP5</td>
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<td>January 2014</td>
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<td>FORMER REFERENCE(S)</td>
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<td>Documents that are replaced by this one</td>
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<td>EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR</td>
<td>Mr David Pearce Director Operations, SESLHD Mental Health Service</td>
</tr>
<tr>
<td>AUTHOR</td>
<td>Associate Professor Rajiv Singh</td>
</tr>
<tr>
<td>Position responsible for the document including email address</td>
<td>Clinical Director, Mental Health Service</td>
</tr>
<tr>
<td>KEY TERMS</td>
<td>Leave, inpatient, transfer of care, discharge, risk assessment and management.</td>
</tr>
<tr>
<td>SUMMARY</td>
<td>This policy provides advice to ensure consistent and safe practice in the planning, management and review of inpatient leave across the Mental Health Service.</td>
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1. **POLICY STATEMENT**

   The SESLHD Mental Health Program is a clinical stream within the organisational structure of the South Eastern Sydney Local Health District. This policy has been developed to ensure consistent and safe practice in the planning, management and review of inpatient leave across the Mental Health Program. It has been developed in consultation with the Mental Health Executive of each site/service.

   Transfer of care is a structured, standardised process for ensuring the safe and effective transfer of people with mental health problems between inpatient settings and from hospital to the community. Planned leave is recognised as a transfer of care situation. For many consumers the period after leaving a mental health inpatient unit is a particularly vulnerable time; this includes periods of leave from the inpatient service. Effective leave planning will include responding to consumer needs, in collaboration with other agencies, service providers and carers, as appropriate.

   This policy is consistent with the SESAMH Acute Bed Management Policy, Mental Health Act 2007 (NSW), National Standards for Mental Health Services, Framework for Suicide Risk Assessment and Management for NSW Health Staff, Transfer of Care from Mental Health Inpatient Services (draft policy, replacing PD2008_005 Discharge Planning for Adult Mental Health Inpatient Services) and the Mental Health Outcomes and Assessment Tool (MH-OAT).

2. **AIMS**

   2.1 Granting of leave, including therapeutic leave, helps serve several important functions (NSW Health – Suicide Risk Assessment and Management Protocols: Mental Health In-Patient Unit, 2004):

   - 2.1.1 To offer a patient and his/her carer the opportunity to return to their usual environment for a trial period
   - 2.1.2 To monitor the patient's progress
   - 2.1.3 To be part of an ongoing assessment process
   - 2.1.4 To allow the patient to carry out important activities or business
   - 2.1.5 To ascertain suitability for longer leave
   - 2.1.6 To prepare for discharge

3. **TARGET AUDIENCE**

   3.1 This policy is for all mental health staff who are involved in the assessment and treatment of, and transfer of care for, patients from acute inpatient facilities.

4. **RESPONSIBILITIES**

   4.1 It is the responsibility of the LHD Mental Health office to circulate this policy to the Directors of each site/service and to have it published on the LHD Intranet.

   4.2 It is the responsibility of each site/Service Director to ensure that the policy is circulated and implemented locally.
4 POLICY CONTENT

4.1 General policy components:

4.1.1 Utilisation of the Comprehensive Risk Assessment Framework (Reference: Framework for Suicide Risk Assessment and Management for NSW Health Staff, Sept 2004) must precede any decision to allow a (voluntary or involuntary) patient leave. This risk assessment must include:

4.1.1.1 Risk assessment and status for harm to others (including any risk to children), harm to self, harm from others

4.1.1.2 Risk assessment and status for suicide risk. This will include:

4.1.1.2.1 distress, psychic pain (what is the nature, level and source)
4.1.1.2.2 meaning/motivation (understanding of their predicament, meaning of recent events)
4.1.1.2.3 ‘at risk’ mental status (presence of hopelessness, despair, shame, guilt, psychosis)
4.1.1.2.4 history of suicidal behaviour (past felt experience, previous self harm, previous circumstance, family history)
4.1.1.2.5 current suicidal thoughts (thoughts/feelings present, what are they, frequency, level of thought control, what has stopped acting on thoughts)
4.1.1.2.6 lethality/intent (how determined, level of planning or impulsivity, was ‘rescue’ anticipated, believe they would die, finalised personal business)
4.1.1.2.7 presence of a suicide plan (is there a plan, specific method/place/time, frequency of thoughts, how realistic is the plan)
4.1.1.2.8 access to means and knowledge (access to lethal weapons, firearm available – police to be contacted for possible removal, poisons available, lethal medications available, check with reliable corroborative source, is method irreversible, are these means within the current inpatient environment, have visitors been informed of possible means, type of occupation – police, health worker)
4.1.1.2.9 safety of others (thoughts of harming others, history of harming others, rationale, risk of murder-suicide, evidence of postnatal depression)
4.1.1.2.10 coping potential or capacity (capacity for therapeutic alliance, strengths, coping/problem solving strategies, supports, compliance with treatment, acknowledgement of self-destructive behaviours, abstinence or limit alcohol or drug consumption, history of aggression or impulsivity)

4.1.1.3 Taking and documenting a detailed corroborative history from a variety of sources (to confirm assessment, level of support, accuracy around changeability of risk, opportunity to collaborate around management/leave/discharge planning – consider privacy issues prior to corroborative history taking - Privacy and Personal Information Protection
Act 1998 = disclosure of personal information is permissible provided it is necessary ‘to prevent or lessen a serious and imminent threat to the life or health of the individual to whom the information relates, or another person’).

4.1.1.4 Determination of risk level – high, medium, low, no (foreseeable) risk. This should be consistent with the care level the patient is on at the time (ref: Patient Care Levels for Acute Mental Health Inpatient Units – SESLHNPD/16).

4.1.1.5 It is essential that the Multidisciplinary Team is informed of the patient's history and risk factors. All relevant information should be recorded in the medical record (see Appendix 1 Risk Assessment and Patient Leave Sticker - Protocols) and made immediately known to all staff involved in the management plan and care, then fully discussed at the next available multidisciplinary meeting. ‘ALERTS’ & Flagging risk – identified risk(s) will be recorded clearly in relevant sections of the medical record.

4.1.1.6 Changeability (risk status is dynamic, requires careful re-assessment, high changeability should be identified).

4.1.1.7 Assessment confidence (low level of confidence may include the following factors in the person at risk– impulsivity; likelihood of substance abuse; present intoxication; inability to engage, the social environment e.g. impending court case; isolation; the clinician’s assessment-incomplete; inability to obtain collateral information).

4.1.1.8 Explaining the patient’s condition and treatment to members of their immediate family or other carers.

4.1.1.9 Documentation on the MH-OAT R2 or in progress notes as appropriate (Clinical Review) module of the risk assessment and any relevant issues related to the granting of leave.

4.1.2 Family or carers should be engaged in providing care when a patient is released into the community. Sufficient safeguards are required to ensure the patient’s wellbeing whilst on leave. It is particularly important to ensure that the family or other carers are informed of the issues, are able to agree and accept responsibility within agreed parameters of such responsibility (especially when released to the care of friends) and are able to, and consent to, provide the level of care/support/supervision required. These details are to be recorded in the patient’s medical record.

4.2 Leave under the Mental Health Act (2007)

4.2.1 There are several leave provisions in the Mental Health Act 2007 (Chapter 3, Part 2, Division 4 (sections 46 to 49) – Leave of absence from mental health facilities) that are applicable to involuntary patients detained in a mental health facility. Providing patients with leave is recognised as an important and integral part of the care and rehabilitation process.

4.2.2 Section 47 of the Mental Health Act applies to leave of absence on compassionate grounds, medical grounds or other grounds. In practice this section of the Mental Health Act is used where:

4.2.2.1 The patient is preparing for discharge as a trial
4.2.2.2 The patient is ready for discharge but awaiting a review by the Magistrate or the Mental Health Review Tribunal for a Community Treatment Order

4.2.3 In these circumstances the inpatient bed whilst on leave can be reassigned to another patient requiring acute inpatient care except where specifically ordered to the contrary by the Medical Superintendent/Consultant Psychiatrist.

4.2.4 A similar process of reassignment of bed to another patient can occur in a situation where a patient is absent from the inpatient unit without permission and has not returned or been apprehended within 48 hours.

4.3 Where patients are given leave from hospital:

4.3.1 A comprehensive record of the short leave plan should be provided in the patient's notes. Leave arrangements must be documented in the patient's medical record.

4.3.2 The status of leave authorisation, for each episode of therapeutic leave, must be counter-checked by 2 clinicians prior to the patient being released from an inpatient unit. These 2 clinicians should be the primary nurse allocated to the patient's care and the shift coordinator. In the event that either primary nurse or shift coordinator is not available then the leave status must be counter-checked by another clinician.

4.3.3 Leave should be graduated to minimise risk and allow progressive assessment of the patient's capacity to manage leave (escorted/unescorted, short/overnight or longer).

4.3.4 Protocols for specific criteria for granting leave must be in place and include comprehensive re-assessment of risk prior to granting leave, and before leave is taken.

4.3.5 The Mental Health Acute Care Team (or case manager) should be informed of the patient's overnight leave prior to commencement of leave; current risk status and duration of leave and action required in unforeseeable circumstances.

4.3.6 Patients at high risk are not usually given leave. However, where advisable for therapeutic value, medical staff are to personally inform family/carers for degree of risk and precautions to be taken. Instructions are to be clearly set out for family/carers/NGO in the event of attempted suicidal actions. The level of support required by the Mental Health Acute Care Team is to be specifically determined and communicated to all and documented.

4.3.7 Patients at medium to low risk may be given leave if family or carers understand type and level of leave, agree to continue the management plan and contact the unit or Mental Health Acute Care Team if the patient’s suicidal feelings increase.

4.3.8 Clear arrangements are to be negotiated with a responsible person (family/carer/NGO) in the circumstances in which the inpatient unit or the Acute Care Team should be contacted during the period of leave, for example:

4.3.8.1 failure to take medications
4.3.8.2 time of return from leave
4.3.8.3 notification if return will be delayed
4.3.8.4 'handover' of the patient to inpatient staff upon return;
4.3.8.5 verbal advice on how leave went and if there were any concerns.

4.3.9 Clear, simply written instructions and information about agreed responsibilities must be given to the patient/carer when overnight leave is taken. The patient is
advised in writing of the contact details, procedures and unit phone number. Contact procedures are to be explained to the patient and family/carers.

4.3.10 Responsibilities of leave are to be explained to the patient and family/carers.

4.3.11 Patients on leave contacting the Unit (or Acute Care Team/case manager) with increased suicidal ideation should be assessed over the phone and advised to return as soon as possible for re-assessment, if deemed necessary. If unable to return, increased risk is to be discussed immediately with the patient’s Consultant Psychiatrist or Medical Superintendent (in business hours) or the Registrar/Consultant on-call (after hours), and an appropriate response determined, according to level of risk and per provisions under Chapter 3, Part 2, Division 4 of the Mental Health Act 2007, as applicable.

4.3.12 If the consumer does not return from leave as agreed:

4.3.12.1 For involuntary patients, section 48 of the Mental Health Act 2007 provides for apprehension of persons not permitted to be absent from mental health facility. Under this section, an authorised medical officer of a mental health facility may apprehend, or direct a person to be apprehended if:

   4.3.12.1.1 the person fails to return to the facility on or before the expiry of a permitted period of absence granted under this Part (of the Act) or fails to comply with a condition of the permission

   4.3.12.1.2 the person is absent from the facility otherwise than in accordance with the Act.

   4.3.12.1.3 An authorised medical officer may request police assistance under this Act (section 49), if there are serious concerns relating to the safety of the person or other persons.

4.3.12.2 In all instances, including for voluntary patients who do not return from leave as per agreed plan, the level of risk posed for the patient (and/or for others) would need to be evaluated in each individual case and an appropriate response determined according to the level of risk.

4.3.13 Assessment of how leave went should be conducted upon the patient’s return including information from family/carers and a report from the Acute Care Team/case manager, if they were involved. Post-leave consumer search for potentially dangerous items should also be carried out.

4.3.14 It is the responsibility of the allocated (primary) nurse or shift coordinator to also document in the patient’s medical record: when a patient proceeds on leave, when they return and the outcome of that leave. This documentation should occur for each episode of leave.

4.3.15 The above, inclusive of the arrangements and responsibilities of leave, are to be explained to the patient and family/carers and are to be documented in the patient’s medical record.

4.3.16 A ‘Risk Assessment and Patient Leave’ from Acute Inpatient Unit sticker must be utilised within the medical record to assist staff in their documentation (see Attachment 1).

4.3.17 If the patient is known to have access to a firearm, and there is reason to believe that he or she may pose a threat to the safety of others, or to the person’s own...
safety, staff may be required to complete a Notification to NSW Police and Firearms Registry Form (refer to Appendix 2)

5 REFERENCES & ASSOCIATED POLICIES

5.1 Acute Bed Management & Sustainable Access Operational Guidelines 2008 (SESLHD MHS)
5.2 Mental Health Act 2007 (NSW)
5.3 National Standards for Mental Health Services, Commonwealth of Australia 2010
5.4 Suicidal Behaviour - Management of Patients with Possible Suicidal Behaviour (PD2005_121)
5.5 Suicide Risk Assessment & Management Protocols – Mental Health Inpatient Units, NSW Department of Health 2004
5.6 Framework for Suicide Risk Assessment and Management for NSW Health Staff, NSW Department of Health 2004
5.7 Mental Health Outcomes and Assessment Tools (MH-OAT)
5.8 NSW Firearms Act 1996
5.9 Coronial recommendations
5.10 Patient Care Levels for Acute Inpatient Units 2011 (SESLHNPD/16)

7. REVISION & APPROVAL HISTORY

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<td>Daniella Taylor Patient Flow Manager SESLHD MHS</td>
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<td>Michelle Bradley Clinical Nurse Manager SESLHD MHS</td>
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<tr>
<td>12 Jan 2012</td>
<td>Final Draft</td>
<td>Rajiv Singh Clinical Director SESLHD MHS</td>
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Appendix 1

RISK ASSESSMENT AND PATIENT LEAVE STICKER – PROTOCOLS

For all patients in Acute Inpatient Units a ‘Risk Assessment and Patient Leave Sticker’ is to be utilised within the medical record to assist staff in their documentation of risk assessments and authorised leave.

The ‘Risk Assessment and Patient Leave Sticker’ provides markers for clinical consideration which include:

- Daily risk assessment
- Record of any changes to risk levels, MHA status, care level or leave status
- Conditions under which leave has been approved
- Risk status and rationale considered in approving leave
- The period leave has been approved for
- Consultation with family/carers or social supports who have accepted responsibility for the patient whilst on leave
- Medication arrangements and/or ambulatory mental health service follow up during the leave period
- Authority of person who has approved the leave

Specifically:

- The ‘Risk Assessment and Leave Sticker’ should be completed:
  - Daily as a record of status
  - Whenever the treating team makes a change to risk levels, MHA status, care level or leave status
  - For each episode of leave, except for multiple episodes of leave on the same day in which case a leave sticker is utilised for the first episode of leave and subsequent episodes on the same day will be written in the medical record progress notes.
  - At discharge by the discharging Medical Officer.

- The sticker should be entered in a patient’s medical record and its fields completed by a medical officer, or delegate, when leave and risk domains are initially determined/decided and when the status for risk/care level/MHA status and leave is changed

- All fields should be completed including writing ‘non applicable’ where appropriate

- The protocol should be used for all patient leave irrespective of their voluntary or involuntary status

- Additional details of leave arrangements and conditions should be recorded in the patient’s medical record

- Details of both patient and clinical consultations regarding leave should also be documented in the record

- A written copy of the leave arrangements should be provided to the patient and their family/carer upon initial leave approval and when arrangements are changed.

Please note

- All fields should be completed every time there is an update, to avoid confusion with the need to look at previously recorded stickers.
- When used to document risk/care level/MHA status/leave changes only, the leave section (below risk changeability) should have a line put through it.
- When used to document an episode of leave the whole sticker to be completed.
### Risk Assessment and Patient Leave from Acute Inpatient Unit

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<tr>
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<td>Care Level</td>
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<td>2</td>
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<tr>
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<td>No Leave</td>
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<tr>
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<td>Escorted Leave</td>
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<td>Unescorted Leave</td>
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<td>Abandoning</td>
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<td>Risk Changeability</td>
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<td>Medical Plan</td>
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**Name Medical Officer Approving Leave**

**Rationale for Leave**

**Details of Service Support**

**Name of Other Supports Informed**

**Medication Arrangements**

**Name of Person Responsible for Patient Whilst on Leave**

**Leave Commencement**
- **Date:**
- **Time:**

**Return**
- **Date:**
- **Time:**

**Signature**
- **Date:**
- **Time:**

**Signature**
- **Date:**
- **Time:**
Appendix 2

**NSW POLICE FORCE - FIREARMS REGISTRY**

Disclosure of Information by Health Professionals
Section 79 of the Firearms Act 1996 & section 38 of the Weapons Prohibition Act 1998

Section 79 of the Firearms Act 1996 & section 38 of the Weapons Prohibition Act 1998 protect disclosures of information to the NSW Commissioner of Police by health professionals where they are of the opinion that a person they are treating may pose a risk to public safety or to the person’s own safety if in possession of a firearm or prohibited weapon. Of particular interest are high risk mental health patients known to have access to firearms.

Sections 79 of the Firearms Act 1996 & section 38 of the Weapons Prohibition Act 1998 provide protection from civil or criminal liability, that may otherwise arise including a breach of confidentiality, when disclosing information to the Commissioner of Police.

A health professional is defined in 579 of the Firearms Act 1996 and for the purposes of section 38 of the Weapons Prohibition Act 1998, as any of the following persons: A medical practitioner, psychologist, nurse, social worker or a professional counsellor.

**PROCESS TO FOLLOW**
1. Complete the form and Fax to: 0266 708550 and mark ‘Attention – Team Leader Licensing’, AND
2. Fax this form to the police station nearest the residential address of the patient. If you are unsure of the nearest police station, ring the Police Assistance Line on 131444.

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
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</table>

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>TELEPHONE</th>
</tr>
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**HOME ADDRESS**

<table>
<thead>
<tr>
<th>Where is the patient currently located? eg inpatient, Accident and Emergency, at residential address etc.</th>
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<table>
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<th>DATE OF DISCHARGE</th>
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**ADDRESS WHERE PATIENT WILL BE DISCHARGED** (if different from residential address)

<table>
<thead>
<tr>
<th>If in hospital, anticipated date of discharge. To ensure safety issues can be addressed, please give at least 6 hours notice to Police.</th>
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Describe the circumstances that lead you to believe that the person may pose a threat if in possession of a firearm/prohibited weapon. Include relevant conversation, observations, circumstances, effect of medical condition or treatment on person’s capacity etc.

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<th>UNKNOWN</th>
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<tr>
<td>Does the person have access to other firearms/prohibited weapons?</td>
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<td>NO</td>
<td>UNKNOWN</td>
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If ‘YES’ indicate below the address where the firearms/prohibited weapons are located? For example, with friends, neighbours, spouse or other relative.

**HEALTH PROVIDER INFORMATION**

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<thead>
<tr>
<th>Medical Practitioner</th>
<th>Psychologist</th>
<th>Reg/Enrolled Nurse</th>
<th>Social Worker</th>
<th>Counsellor</th>
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<tr>
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<td>ADMIT NUMBER</td>
<td>CONTACT NUMBER</td>
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**SIGNATURE**

**ALL INFORMATION SUPPLIED IS TREATED IN THE STRICTEST CONFIDENCE**