



Admission Guideline

St Giles Hospital



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I **ACRONYMS**

AWOLA	Away without Leave Approval
CPC	Criminal Procedure Code
CWMH	Colonial War memorial Hospital
CPN	Community Psychiatric Nurse
DAMA	Discharge against Medical Advice
DMO	Divisional Medical Officer
MS	Medical Superintendent
MTA	Mental Treatment Act
ROT	Released on trial
PSR	Possible Suicide Risk
SSR	Serious Suicide Risk
SDMO	Sub Divisional Medical Officer
SDHS	Subdivisional Health Sister
WC	Watch Closely
UOR	Unusual Occurrence Report

1. **Introduction**

Admission to an inpatient facility provides the opportunity for a safe and secure environment where direct observation, regular monitoring and continuous therapeutic support are provided.

St Giles Hospital also recognizes that there is a category of patients in the hospital that pose a higher risk than the majority and therefore, require increased levels of security.

In this document those assessed to be “high risk” are those who are at risk of suicide, escape, being assaulted and committing acts of violence or aggression.

The directions of this protocol require that increases in both physical and procedural security be considered for those patients identified as “High Risk”.

The purpose of this document is to describe the procedures whereby these “high risk” patients are identified and the enhanced procedural security arrangements that they may be subjected to. This policy will be applied to all patients, enabling the identification of those who present high levels of risk in specific areas and the safe management of the risks they present to themselves and/or others.

An in-patient unit strives for an appropriate balance between the need to manage the person at risk within a safe and containing environment also the importance of autonomy through the therapeutic relationships and an empowering milieu.

2. **Aim:** The aim of managing a patient in the hospital is to ensure their safety in a supportive and therapeutic environment

3. **Parameters of the protocol:**

Target population: staff handling patients who are admitted to the psychiatric in patient facility.

4. **Types of Admission:**

Admissions to St. Giles Hospital are guided by the Laws of Fiji as outlined in the Mental Treatment Act (MTA: cap 113)(1978); the Criminal Procedure Code (CPC: cap 21) (1978); Prisons Act (cap 86) (1978); and High Court.

a. **Voluntary**

- i. Comes on his/her own with/without family.
- ii. Patient signs himself or herself voluntarily [section 16 Cap 113, MTA
- iii. A voluntary patient can make a written request to the Medical Superintendent requesting his/her discharge from Hospital.
- iv. Patient to be discharged within 72 hours of receiving the request unless not deemed well enough and is admitted involuntarily or under the Medical Superintendent’s urgency order.

b. **Involuntary**

- i. Brought by relatives / guardian / primary care giver.
- ii. Reception order to be signed by the relative/guardian/caregiver [18 years and over] [MTA: Cap 113, sec 15]
- iii. Two medical certificates from 2 medical officers

c. **Court**

- i. Reception order from the Magistrate [MTA: Cap 113 Sec 12, MTA] Committal Order by Magistrate upon the oath of registered medical practitioners [MTA: Cap 113 Sec 9]
 1. Urgency Order by Magistrate [MTA: Cap 113 Sec 13] valid for seven days can ONLY be extended further seven days:
 2. Under the advice of registered medical practitioner or
- ii. (At the request of spouse or relative or police officer of the rank of inspector or above
- iii. Criminal Procedure Code [CPC: cap 21, sec 202]-warrant of committal will be valid until the next court date as indicated on the warrant.

d. **Prison Removal Order** [remand or convicted prisoner]

- i. 1 Prison removal order 14 days duration, can be extended if necessary [Prisons Act: Cap 86 Sec 56(1)]

e. **Other Orders**

- i. President's order-special patients [CPC: cap 21 sec 148]
- ii. Medical Superintendents Urgency order – valid for 24 hours [MTA: Cap113 Sec 20]
- iii. High Court Order

5. ADMISSION PROCEDURES:

a. OUTPATIENT DEPARTMENT/SUPERVISOR'S OFFICE:

Triage nurse will alert the doctors of any emergency according to her/his assessment.

- i. All admissions to be authorized by the doctors
- ii. All patients will be admitted according to the admission criteria.
- iii. Ensure all the necessary papers are filled and signed by relatives/patients, admitting nurse and doctor.
- iv. Physical assessment and mental health assessment are to be carried out in OPD provided patient is cooperative
- v. Doctors to document where patient is supposed to be nursed
- vi. Medication card to accompany patient to the ward
- vii. High Risk patients [suicide, forensic, escapee] (Refer to decision tree for management of high risk patients.
 1. Risk Assessment for suicide, aggression and absconding to be done (i.e level of risk for each to be determined
 2. High risk forms to be completed and to accompany patient to the ward, verbal order is also considered for agitated patients
- viii. Brief summary of the patient's history to be given to the ward staff before patient comes
- ix. Forensic patients to come with proper documents for admission – i.e. the prison removal order, magistrate reception order/committal order, or warrant. The admitting doctor should check the admission order before the patient is taken to the ward. Other documents such as the charge sheet, summary of facts and contacts for relatives should also be available at the time of admission, if not, the forensic nurse should follow up and obtain these documents.
- x. Patient to be accompanied to the ward by at least one staff member but may need more depending on the situation and request of the outpatient staff and/or admitting doctor.
- xi. All patients escorted by police/prison officers need to be handcuffed and to stay with the patient until seen by the doctor or admitted.
- xii. Inpatient checklist to be given to relative.
- xiii. Patients belongings – refer to belonging protocol

b. IN THE WARD:

- i. Patients to be thoroughly checked/searched by two members of the staff as soon he/she enters the ward, if possible depending on their mental state. If a search/check cannot be conducted as soon as the patient enters the ward, it must be done within the first 24 hours of admission while sedated if necessary. If not done within this period, reasons for not doing so must be clearly documented in the patient's folder.
- ii. Aggressive/violent patients to be searched with the presence of police officers. If police are not present, please follow procedure in 5bi
- iii. Patients belonging to be checked, documented and kept in the safe place [refer to belonging protocol]
- iv. Patients to be nursed in the ward according to the doctors and nurses assessments [refer to 1.6].

- v. Explanation of the ward procedures and protocols to be explained to the patient dependent on the patient's mental status.

c. FORENSIC ADMISSIONS:

- i. Forensic cases are those who are admitted through the Prison or court system (i.e. Magistrate court, High Court). These patients may or may not have cases pending in the court. The Hospital has set aside 3 secure rooms in the Men's Ward and 3 secure rooms in the Female Ward to nurse forensic patients.
- ii. Either police should accompany forensic cases to the wards or prison officer as is appropriate.
- iii. They should be nursed as directed by the admitting doctor dependent on admission order and if case is pending.
- iv. They should be nursed keeping in mind the high risk of absconding from the Hospital.
- v. Prison uniform to be given back to the prison officer when admitted.
- vi. Half hourly observation and documentation/checking with the provision in the checklist
- vii. If being nursed in the secure rooms (in separation), they should be allowed to be opened under strict supervision for 1 hour in the morning and 1 hour in the afternoon in addition to time out for personal hygiene depending on the patient's mental status; doctor's instructions; and available staffing per shift.
- viii. Two or more staff must be present and supervise the patient when opened from separation.
- ix. Visitors must be authorized by Medical Superintendent and must be strictly supervised with at least one staff present. Visitations are allowed only during Hospital visiting hours (2-3 pm and 6-7 pm) unless otherwise approved and specified by the Medical Superintendent.
- x. Document important information [e.g. names and contacts for visitors/relatives; patient's behavior when he thinks he is unobserved; etc.]
- xi. Ensure court date and expiry date of order is clearly noted in the supervising office and the ward.
- xii. Remand prisoners admitted are to be escorted by police officers should there be a need to take them to other hospitals or when they are discharged from hospital to prison.
- xiii. Convicted prisoners who are admitted to St. Giles Hospital should also be supervised by a prison officer throughout their admission if Prison staffing available.

6. MANAGEMENT OF HIGH RISK PATIENTS

High-risk patients will be considered under the following categories

- a. Suicide
- b. Aggression
- c. Abscondment

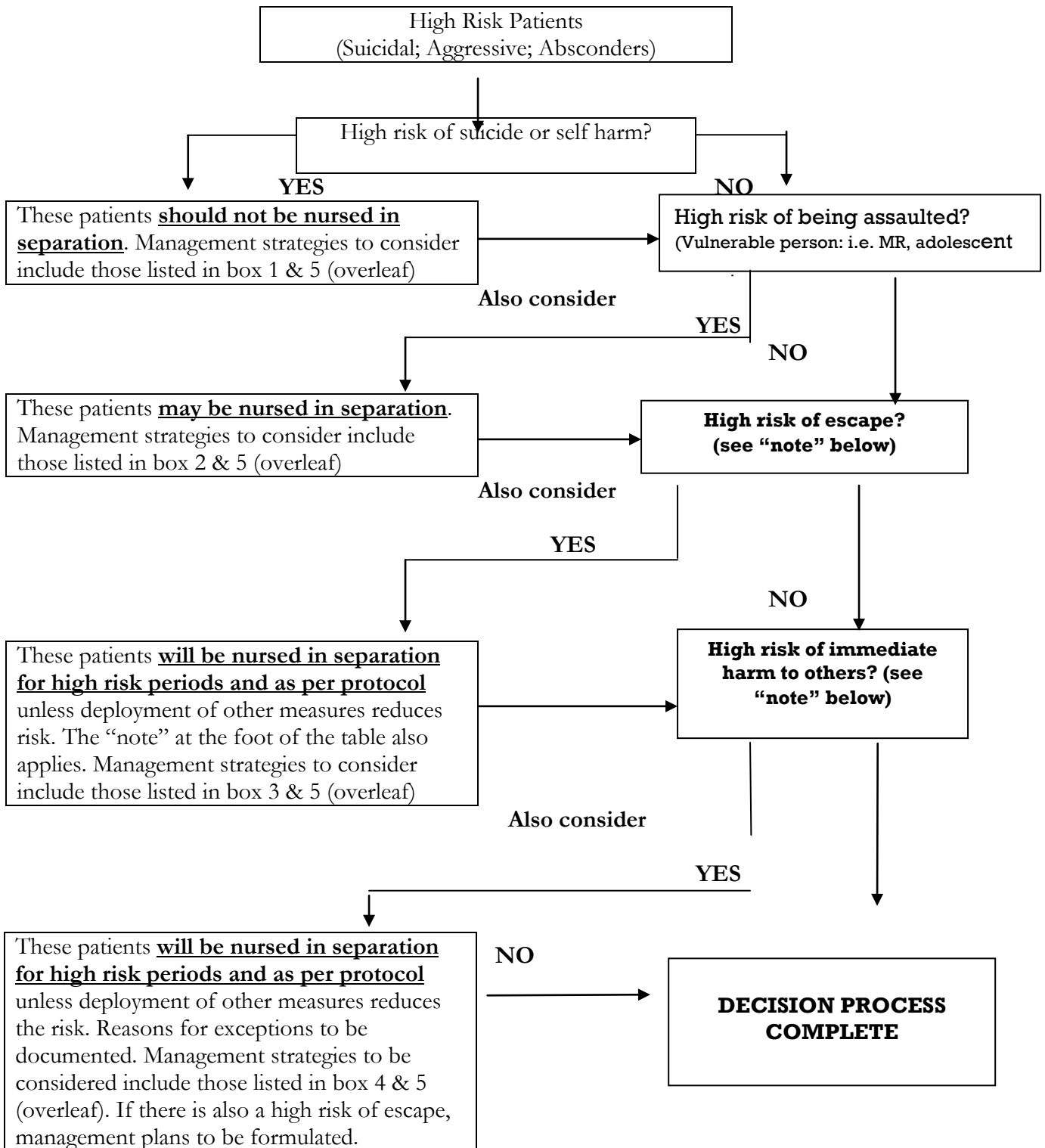
Determination of levels of risk for suicide, abscondment and aggression/violence need to be made before the patient is taken to the ward for admission and if the patient is being returned to the ward from leave or being released on trial (ROT).

- On admission, the admitting doctor will complete the risk assessment forms
- Subsequent re-assessments done in the ward are to be done by both nursing and medical staff; frequency of re-assessments is determined by level of risk. For low risk patients, frequency of re-assessments is determined by length of inpatient stay.
- Before transfer to a less secure ward and prior to leave from Hospital, patients should be assessed to be at “Low Risk” for all the above high risk categories (i.e. suicide, aggression and abscondment) or necessary precautions taken.

Please refer to *Decision Tree for Standardized Risk Management of High Risk Patients & Supporting Strategies* below.

MANAGEMENT OF “HIGH RISK” PATIENTS

a (i) Decision Tree for Standardized Risk Management of “High Risk” Patient Group



Note: if both risk of escape and risk of harm to others occur together, the patient(s) will be nursed in seclusion in accordance with the protocol for “Nursing in Separation”.

MANAGEMENT STRATEGIES SUPPORTING THE DECISION MAKING FOR THE RISK MANAGEMENT OF “HIGH RISK” PATIENTS

Box 1

High Risk of Suicide/Self- Harm

- Specific treatment focused on suicide/ self- harm for the individual
- Reduced access to risk items
- Enhanced levels of observations (refer to suicide watch protocol)
- Enhanced emotional support
- Occasionally a suicidal/ self-harming patient is violent & assaultive, in this situation the patient may be nursed in separation in conjunction with enhanced levels of observation

Box 2

High Risk of being Assaulted

- Enhanced level of observation (refer to suicide watch protocol)
- Geographical manipulation i.e. moving the patient away from person(s) posing a risk or restrict access to such persons, higher staffed location, away from provocation, more confined ward
- Voluntary locking into the room for periods of day or night. Many of these patients will cooperate with measures to enhance their safety, including agreeing to remain in their room for specified periods.

Box 3

High Risk of Escape (As per protocol for high risk of Abscondment)

- All procedures detailed in box 4 to be considered.
- Enhanced monitoring of all visits, belongings/packages and phone calls.
- Enhanced precaution for away without leave from hospital (refer to hospital AWOL procedure).
- Enhanced escorting (to be specified precisely) for movement within the hospital compound.

Box 4

High Risk of Immediate Harm to Others

- Nurse in separation until judged to be safe in accordance with practice guidelines “Nursing in Separation”.
- Nurse in separation for identified high risk periods only (e.g. at night time)
- Geographical manipulation
- Enhanced level of observation (refer to hospital observation procedure)
- Enhanced restriction on access to risk items
- Enhanced search/ drug screening procedures
- Enhanced monitoring of visits, including temporary suspension of visits

* A risk reduction strategy should be considered

Box 5

High Risk of Subverting Security and Safety

High Risk of Organizing Action in Collaboration with Others to Subvert Security and Safety

- All relevant procedures detailed in boxes 3 & 4 to be considered
- Consultation with security liaison Nurse and Security Department about the content of the management plan

NOTE 1: If these measures do not reduce the risk of escape in the view of the clinical team and the security department then nursing in separation for high risk periods will be necessary.

NOTE 2: A decision not to nurse a patient in separation at night in accordance with the protocol should be clearly documented in the staff/doctor's notes

a. Management of Suicidal Patients

Psychiatric inpatient facilities have an essential role in the care of patients presenting with a suicidal risk. The fundamental components needed to reduce suicide risk in inpatient psychiatric facilities are good therapeutic relationships with patients and their families.

It is important that suicide risk assessment is conducted on admission and re-assessed regularly throughout the admission.

Suicidal behaviors are often symptoms of an underlying mental disorder or problem. Thus, it is important that an overall mental health assessment be conducted in an individual presenting with suicide risk. The individual needs to be assessed for depression, schizophrenia, other psychotic illness, bipolar disorder, anxiety disorders, personality/coping style, current and previous drug/alcohol use and organic/physical conditions.

The assessment should also include risk factors associated with suicidal behavior. The most important risk factors for estimating the current and immediate risk for suicide are the personal risk factors such as:

- “At risk” mental states especially hopelessness, despair, agitation, shame, guilt, anger, psychosis
- Recent major life events (especially any involving loss or humiliation)
- Recent suicide attempt
- Personality/vulnerability, e.g. impulsivity

In addition, it is also important to assess environmental factors of the inpatient unit such as ward design, staffing levels, access to means, observation procedures and “busy” times; as well as situational factors such as visitations or lack of; impending stressor (e.g. court appearance; divorce proceedings, etc.); shaming/humiliating experiences; and drug/alcohol use.

Current level of risk of suicide needs to be determined by completing the suicide risk assessment form on admission and as outlined above.

I. LOW RISK: Scores 0-10 on Suicide Risk Assessment

- Routine ward care and observations
- Nurse in area as indicated by doctor.
- Re-assess on a regular basis while patient is admitted:
 - Admission duration 1-4 weeks: assess weekly
 - Admission duration 5-12 weeks: assess fortnightly
 - Admission duration >12 weeks: assess monthly
 - Assess as necessary depending on the circumstances (e.g. death, loss of job relationship breakup, etc.)

ii. **For Those Patients Considered being a Reasonable, Medium or High Risk of Suicide:**

- Re-assessment is done every 24 hours
- All patients are nursed in the emergency room, unless otherwise specified by the admitting doctor (except for remand or convicted prisoners who are nursed as per forensic admission procedures outlined above).
- Forensic cases (remand or convicted prisoners) that are suicidal are to be nursed in separation but follow suicidal protocol relevant to their risk of suicide.
- All written observations to be made on the suicide precaution form during each shift.
- Staff responsible for patient during a shift must handover and sign off on the suicide precaution form to the person who will be responsible for the patient in the following shift. The shift charge should also sign to ensure that patients are handed over at change of shift
- . Vuda Ward patients at risk of suicide are to be transferred to the Men's Ward to be nursed as per suicide precaution protocol.
- The suicide precaution level, its restrictions and rationale should be explained to the patient and their relatives.
- Provide for patient safety by removing potentially harmful objects or contraband from the patient and the environment (e.g. sharp objects, glass items, straps, ties, belts, drugs, purse and cosmetics in glass containers, etc.)
- .All items, objects and packages received by the patient should be screened for any potentially harmful items and these items removed.
- Patients on a suicidal precaution should not leave the ward without a staff escort
- Contact with patient should:
 - a) Be interactive and not just observational.
 - b) Facilitate discussion of factors or events, which precipitated the suicidal thoughts and/or suicidal behavior.
 - c) Refrain from criticizing actions or minimizing patient's feelings and should be non-judgmental.
 - d) Involve active listening, which demonstrates concern
- Increased staff vigilance and extra precautions are necessary in the following situations:
 - e) Staff breaks (e.g. meal and tea) [staff to ensure that patient is handed over to another staff member].
 - f) Patient bathroom and shower time.
 - g) Patient bedtime.
 - h) During shift changes and handing over.
 - i) After the patient has conversed with family members, legal or court officials; during and after visitations.
- Ensure the suicide precaution record sheet is completed for each patient
- Use the appropriate shift sheet to record observations and interactions at the appropriate intervals according to the suicide precaution level.
- Be sure to document every situation in which the patient threatens or attempts suicide, including the clinical intervention undertaken
- All threats and attempts of suicide must be reported to the Ward doctor or Doctor on Call (if after hours). Suicide attempts need to also be reported to the Medical Superintendent.

iii **REASONABLE RISK (WC-Watch closely):**

Scores 11-17 on Suicide Risk Assessment

- Nurse in emergency room (unless otherwise ordered by admitting doctor)
- Observe patient every 30 minutes for patient safety and to initiate frequent verbal contact.
- Patient contact as outlined above
- Written record of interaction with patient to be made every one hour
- .Patient to be re-assessed every 24 hours.

iv. **MEDIUM RISK (PSR-Possible Suicide Risk):**

Scores 18-25 on Suicide Risk Assessment

- Nurse in emergency room (unless otherwise ordered by admitting doctor).
- Observe patient every 15 minutes for patient safety and to initiate frequent verbal contact
- Patient contact as outlined above (4.1.3-11 a-d)
- Written record of interaction with patient to be made every 30 minutes
- .Patient to be re-assessed every 24 hours.

v. **HIGH RISK (SSR-Serious Suicide Risk):**

Scores 26-41 on Suicide Risk Assessment

- Nurse in emergency room.
- Nurse with 1:1 contact at all times (patient must be in view at all times and within arms length; this applies even when the patient is toileting or bathing).
- Patient contact as outlined above (4.1.3-11 a-d)
- Reduced access to risk items.
- Written record of interaction with patient to be made every 15 minutes.
- Patient to be re-assessed every 24 hours.

b. MANAGEMENT OF AGGRESSIVE/VIOLENT PATIENTS

It should be noted that only a small proportion of people exhibiting disturbed or aggressive behavior do so because of a mental illness.

Medical or psychiatric intervention is appropriate only when the disturbed/aggressive behavior is due to an underlying abnormal mental state. Hence, there needs to be careful consideration before it is decided that such intervention is necessary.

However, even if there is an underlying psychiatric disorder causing the disturbance, the dangerousness of the situation, for instance the use of weapons or other forms of physical danger, may make it necessary for the police to take the lead role in subduing the individual and managing the situation.

Individuals with mental illnesses such as delirium or mania may present in acutely disturbed states characterized by confusion, with poor reality testing, marked over activity and disorganized behavior. As a result, they may place themselves or others at risk or react aggressively.

Others with paranoid, schizophrenic or other psychotic illnesses can become acutely disturbed and violent on the basis of their psychosis (i.e. hallucinations and delusions).

Individuals with personality disorders can under stress become extremely distressed and exhibit disturbed behavior, such as loud, dramatic and public threats or verbal abuse. Medical or psychiatric interventions are not always appropriate in these situations; calling the police may be the most suitable action to take.

The important question is whether the available medical and/or nursing staff can manage the situation safely.

It is also important to note that treatment *without consent* can be considered assault of the individual unless undertaken within the provisions the current Mental Treatment Act (1978); Criminal Procedure Code (1978) and Prisons Act (1978).

i. Management of an Aggressive Patient in the Outpatient Department

- **The Patient has been Accompanied to Hospital by Police**

Ensure the Police remain with the patient at all times and must be within arm's length. Handcuffs to remain in place.

Follow the procedure as outlined below.

- **Patient has NOT been Accompanied to Hospital by Police**

a) Alert other Outpatient staff, including doctor-on-call that an aggressive patient is present. If only the supervisor is present he/she is to immediately contact Vuda Ward staff for assistance.

b) Seek assistance from Vuda and Men's Ward staff and also CPN and Police if necessary.

c) Ask any accompanying relatives or persons to remain with the patient while you are waiting for assistance to arrive.

- c) Clear waiting area quietly of bystanders.
- d) Clear away moveable furniture and remove any items of potential risk to be used as a weapon.
- e) Try to “Talk Down” the patient:
 - Do not rush; allow time for the patient to calm down.
 - Engaging patients in conversation and allowing them to air their grievances may be all that is required.
 - Avoid distractions (e.g. mobile phone, pager, etc.)
 - Remain calm and reassuring and try to minimize their fears.
 - Listen and allow patient to talk and avoid interruption.
 - Maintain a relaxed posture with hands visible and body sideways to the patient.
 - Explain any actions you intend to take.
 - Be clear, direct, non-threatening and honest, as this will help confused and aroused patients to calm themselves.
 - Address patient by name and maintain eye contact.

Note: Often it may be not be possible to obtain the disturbed person’s trust and it will be necessary to subdue them.

Sedation

In the majority of cases, the urgent need to achieve sedation in acutely disturbed persons is to:

- Reduce the risk of people harming themselves or others.
- Allow diagnostic assessment to proceed.

Offer oral medication first:

Lorazepam 1-2 mg repeated 4 hourly to a maximum of 8 mg/24 hours

or

Diazepam 10-20 mg orally as a single dose, can be repeated every 2-6 hours, up to 120 mg/24 hours, depending on the response

or

Chlorpromazine 50-100 mg orally, repeated every 2 hours up to a maximum of 300 mg/24 hours

For Specific Cases such as those with Mania or Schizophrenia:

Diazepam 10-20 mg orally, as a single dose repeated every 2-6 hours, up to 120 mg/24 hours

Together With

Haloperidol 5-10 mg orally, every 2-6 hours to a maximum dose of 30 mg/24 hours

If parenteral medication is required, this is to be given in the ward.

- Ensure admission papers are in order (i.e. prison or court orders are valid *or* that a voluntary form is signed *or* reception order signed and at least one medical certificate is completed *or* MS urgency order is to be utilized) before patient is taken to the ward.
- Follow procedures for taking patients to the ward as outlined above.

- Once the patient has been taken to the ward, he/she should be adequately subdued before administering the parenteral medication.
- A team of at least 6 people should be assembled (one for each limb, one for the trunk and one to deliver the injections). The team should proceed with a plan in which, each team member knows what his or her role is.

Parenteral Medication:

- **Diazepam** 5-20 mg as a single dose, titrated to response, by *slow intravenous injection* (given over several minutes to minimize the risk of respiratory depression or arrest); **Diazepam should not be given intramuscularly due to erratic absorption**

or

- **Droperidol** 2.5-10 mg intramuscularly (up to a maximum of 20 mg/24 hours)

PLUS (see next page)

Benztropine 2 mg intramuscularly. Doses may be repeated in 30-60 minutes if required.

or

- **Haloperidol** 5-10 mg intramuscularly (up to a maximum of 30 mg/24 hours).

PLUS Bzotropine 2 mg intramuscularly Dose may be repeated in 30-60 minutes if required.

or

- **Chlorpromazine** 50-100 mg intramuscularly, (up to 8-12 hourly for first 24 hours). Repeated intramuscular doses of chlorpromazine should be avoided if possible as they can cause injection abscesses.
- **NB. For intramuscular doses of Haloperidol and droperidol, Bzotropine 2 mg IM is also given to avoid potentially fatal complication of laryngeal dystonia and other unpleasant extra pyramidal side effects.**
- Vital signs should be monitored before and after injections
- Intramuscular injections should be given in the upper, outer quadrant of the buttock or upper portion of the deltoid muscle (Haloperidol or droperidol only). The site should be rotated for repeated injections.
- The patient should be monitored continuously for adverse effects such as respiratory depression, excessive sedation, hypotension and dystonic reactions (including choking)
- Staff maintaining a calm, supportive presence and speech are important throughout.

ii. **Transfer of Patient to the Ward**

- Patient is to be accompanied to the Ward by hospital staff and/or Police (if present).
- If handcuffs have been used, they are to be removed only when the patient is in the room and parenteral medication has been given.

- Patient to be nursed as a “High Risk” of aggression and follow procedures outlined below.
- Admitting doctor to assess patient in the ward. All patients must be assessed for risk of aggression before being taken to the Ward for admission and as outlined above.

Debriefing of Hospital Staff (Ward and Outpatient Department)

- a) Should take place with Unit Charge and/or shift charge and relevant staff within the unit.
- b) Debriefing should be done before the end of shift.

Low Risk

Scores 0-10 on Aggression/Violence Risk Assessment

- Routine ward care and observations.
- Nurse in area as indicated by doctor.
- Re-assess on a weekly basis while patient is admitted:
 - i. Admission duration 1-4 weeks: assess weekly
 - ii. Admission duration 5-12 weeks: assess fortnightly
 - iii. Admission duration >12 weeks: assess monthly
 - iv. Assess as necessary depending on the circumstances.

Medium Risk:

Scores 11-18 on Aggression/Violence Risk Assessment

- Enhanced level of observation and search procedures.
- Restrictions on access to risk items.
- Restrictions on movement *within* the ward.
- *No movement outside* the ward.
- Nursed in separation at night.
- Re-assess risk of aggression every 48 hours.

High Risk:

Scores 19-36 on Aggression/Violence Risk Assessment

- Patient to be nursed in separation (as per procedures outlined below) in Bua/Moala ward [strong room] or in the side room closed during high risk periods of violence to others (e.g. handing over of staff; visiting hours; night time; etc.).
- Enhanced level of observations (every 15 minutes) and search procedures (each shift).
- Restrictions on access to risk items.
- Patient to be opened with one or more staff present and patient to be strictly supervised at all times while not in separation (within view and within arm’s length).
- Re-assess risk of aggression every 24 hours.

c. **MANAGEMENT OF PATIENTS AT RISK OF ABSCONDING.**

All patients must be assessed for risk of absconding before being taken to the Ward for admission and as outlined above.

Low Risk: Scores 0-4 on Abscondment Risk Assessment

- Routine ward care and observations.
- Nurse in area as indicated by doctor.
- Re-assess on a weekly basis while patient is admitted:
 - Admission duration 1-4 weeks: assess weekly
 - Admission duration 5-12 weeks: assess fortnightly
 - Admission duration >12 weeks: assess monthly
 - Assess as necessary depending on the circumstances.

Medium Risk Scores 4-9 on Abscondment Risk Assessment

- Enhanced level of observation and search procedures.
- Restrictions on access to risk items.
- Restrictions on movement *within* the ward.
- *No movement outside* the ward.
- Nursed in separation at night.
- Re-assess risk of abscondment every 48 hours.

High Risk: Scores 10-14 on Abscondment Risk Assessment

- Patient to be nursed in separation (as per procedures outlined below) in Bua/Moala ward [strong room] or in the side rooms closed during high-risk periods of escape (e.g. handing over of staff, visiting hours; night time, etc.)
- Enhanced level of observations and search procedures.
- Restrictions on access to risk items.
- Restrictions on movement *within* the ward.
- *No movement outside* the ward.
- Nursed in separation at night.
- Patient to be opened with one or more staff present and patient to be strictly supervised at all times while not in separation (nursed within view and within arm's length at all times including patient shower and bathroom time).
- Re-assess risk of abscondment every 24 hours.

It should be noted that “nursed in separation” (seclusion) procedures:

1. May only be used with the MS's authority;
2. Should only be used in exceptional cases to prevent the person causing immediate or imminent harm to the patient or others;
3. Should never be used as a means of punishment or for the convenience of staff.

“Nursed in Separation” (Seclusion) Procedures

- No harmful or dangerous items or any personal belongings to be left in the room with the patient.
- Patient must be checked ***at least every 15-30 minutes*** (as determined by the doctor) and observations documented in appropriate recording sheet.
- Seclusion period to not exceed 4 hours without approval of a doctor and must not follow immediately after another period of seclusion. The exception to the aforementioned is if the person is to be nursed in separation at night due to high risk of abscondment or harm to others, which must be approved by a doctor and checking procedures as above to be followed.
- Time out from separation should be given for personal hygiene and meals, as well as every 2-4 hours, depending on the patient’s mental status; doctor’s instructions; and available staffing per shift. Time outs for the patient should also be closely supervised by nursing staff.
- The use of a bedpan/urinal will need to be decided by medical/nursing staff together and reviewed regularly; bedpans/urinals should be emptied after each use by the nursing staff.
- Ensure proper hydration of the patient while in separation; offer water at regular intervals; water bottles are not to be kept in the room with the patient, unless authorized by the doctor.
- For persons being nursed in separation the following information must be clearly documented in both the patient’s folder as well as a seclusion register: (i) reason for being nursed in separation; (ii) duration; (iii) action taken to minimize seclusion period; and (iii) who authorized it.

7. PROCEDURE TO BE FOLLOWED WHEN A PATIENT ESCAPES FROM THE HOSPITAL

a. All Escapees are to be reported to the Following:

- Ward Charges
- Supervisor
- Ward doctor - working hours
- Doctor on call after working hours, public holidays, and weekends
- Medical Superintendent
- Samabula Police Station; the name of the police officer, his/her rank and number should also be documented.
- Family

b. The Forms to be Filled:

- Abscondment form/UOR forms by staff responsible for patient and ward charge during the shift when patient escaped and handed to supervisors.
- Supervisor to ensure that the forms reach the ward doctor/senior matron and MS within 24hours during weekdays and on the first working day after the weekend.

c. Actions to be Taken:

- Complete UOR/Abscondment forms to be submitted to the Risk Management team for evaluation and filing.
- Risk Management team to give feedback to the ward charges and staff concerned.
- An audit of all patients escaping from seclusion room/area [Bua/Moala/side room closed] will be carried out by MS, Senior Matron, Ward Doctor, Ward Charge and staff concerned within 48 hours during weekdays and by the end of first weekday after weekend.
- Action to be taken depending on the findings.
- Escaped patient to be discharged within one month of the date of escape if they have managed to remain away from hospital.
- Cancellation of the report to the police department when patients are brought back to the ward. The shift/ward charge or supervisor receiving an escaped patient who is being returned to the Hospital should do this.

8. DEATH OF A PATIENT

- All deaths are to be certified by the doctor.
- Police to be notified the hospital [all hospital deaths are classified as police cases]
- Family to be contacted [if no family – hospital is responsible]
- .Death certificate to be completed by the doctor who certified the patient's death. The death certificate should be given to the relative who signed the reception order (if the patient was admitted involuntarily); or to the "legal" next of kin as determined by Police.
- Notification of death to be completed by the shift charge and distributed accordingly [3 copies:](1) Patient's folder;(2) Deceased's body;(3) Relative
- The registered nurse/shift charge must accompany the body with the police officer to the CWMH mortuary in the hospital transport
- Debriefing of staff/family and other patients; counseling to be offered to family members.
- Procedures outlined for reporting of sentinel events to be done as per national guideline on reporting of UORs.

9. PROCEDURES FOR CHECKING AND DOCUMENTING PATIENT BELONGINGS

a. At Outpatients Department:

- Whenever possible all valuable items such as cash, jewellery, and expensive items to be returned to the relatives and signed for by the staff and relative.

b. In the ward:

- Thoroughly check belongings, all valuables to be returned to relatives and to be documented and signed with the particulars of relative receiving the items.
- Any other valuables and cash to be taken to the EO during working hours and supervisor during weekends/public holidays/after hours for safe keeping and a receipt to be issued by the EO and attached into the patient's file.
- Ward/shift charge to be responsible for the above.

- Belongings kept with the patient will be under their own responsibility. This needs to be documented and signed for by the patient.
- Relatives to be informed of the belongings that can be brought to the hospital
- Any belonging given back to the patient/ relatives in the course of his/her admission to be documented and signed by both staff and patient/relative
- Any missing belonging/valuable MUST be reported to your immediate supervisor
- All patients belonging to be returned to the patient/relative when patient goes for leave, ROT or discharge, signed by both the staff on duty and patient/relative [cross check with belonging list on file]
- Document belongings given to other patients by the owner. Patient needs to sign for this.

c. **Discharge to other Hospital (e.g. CWMH):**

- All belongings and valuables to accompany patient to the hospital.

10. **DISCHARGE PROCEDURE FOR PATIENTS:**

- The Medical Superintendent must approve all patients for discharge
- .Pre-discharge planning is to begin once patients are admitted.
- All patients' relatives/carer within the greater Suva area to be involved in the pre-discharge planning and encouraged to have at least weekly meetings with nursing and/or medical staff caring for their relative.
- The Discharge meeting is conducted every Wednesday to discuss patients for leave, release on trial (ROT) or discharge. The Medical Superintendent must approve all patient movement away from hospital
- . Patients who are discharged immediately once they leave hospital are those admitted voluntarily (section 16) or under court orders. Persons who have either escaped or been away without leave approval (AWOLA) and have remained away from Hospital for a continuous one-month period are also discharged. The family and relevant zone nurses should be notified of these patients' discharge from Hospital and procedures
- . A mini discharge summary is to be written by the doctor concerned and given to the patient if they are being discharged while in the ward or from the Outpatient Department.
- Discharge summary for patients discharged or released on trial (ROT), should be completed by the relevant doctor within 2 weeks of the patient leaving hospital.
- Domiciliary medication forms should also be completed if necessary, when the patient leaves hospital or if they are discharge by the doctor and sent to the relevant Sub-divisional Health Sister (SDHS), zone nurse or Sub-divisional Medical Officer (SDMO).

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a. **Away Without Leave Approval [AWOLA]:**

- Ward charges to contact family, zone nurse concerned and CPN to follow up if patient does not attend scheduled clinic dates
- Patients who do not return after one [1] month are to be automatically discharged from the hospital bed state. Procedures outlined in 10.5-10.7 should be followed.

b. **Release on Trial [ROT]:**

- Patients are released on trial for one month, if admitted within this period it is a continuation of the previous admission, not a new admission.
- After one month of ROT, they are automatically discharged from the hospital bed state.
- Staff is to accompany patient when relatives are not available if approval has been given by the Medical Superintendent.
- Patients admitted involuntarily (under section 15 of the MTA) are ROT and not immediately discharged when they leave hospital.

c. **Discharge Against Medical Advice (DAMA):**

- Any request to discharge a patient against medical advice should be discussed with the Medical Superintendent.
- DAMA forms should be completed prior to the patient leaving hospital.

11. **LEAVE:**

- This includes weekend leave, day out and night out
- All medications to be given to the relatives with proper explanations, when they are picking patients from hospital for leave or when patients are dropped home
- Next clinic date to be given.
- Relatives to accompany patients back from leave.
- Before dropping patients at home, relatives should be informed in advance.

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