The Patient Safety Education Program™
CANADA

Module 13b: Mental Health Care: Preventing and Responding to Absconding and Missing Patients

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Module 13b Mental Health Care: Preventing and Responding to Absconding and Missing Patients

PSEP – Canada Objectives	Related CPSI Safety Competencies
The knowledge elements include an understanding of: • what constitutes absconding; • the personal, clinical, and treatment factors associated with absconding; • the practices and procedures for preventing absconding; • the importance of trust and having a therapeutic care setting; and • the incident response process The performance requirements include the ability to: • carry out a review of an absconding incident for quality improvement purposes.	**Domain: Contribute to a Culture of Patient Safety** *1. Health care professionals who commit to patient and provider safety through safe, competent, high-quality daily practice:* 1.1. Are able to articulate their role as individuals, as professionals, and as health care system employees in providing safe patient care 1.4. Demonstrate knowledge of policies and procedures as they relate to patient and provider safety, including disclosure 1.6. Participate actively in event and close call reporting, event analyses and process improvement initiatives 1.9. Recognize clinical situations that may be unsafe and support the empowerment of all staff to resolve unsafe situations 1.10. Demonstrate a commitment to a just culture, promoting fair approaches to dealing with adverse events 1.11. Advocate for improvements in system processes to support professional practice standards and the best patient care *2. Health care professionals who are able to describe the fundamental elements of patient safety, understand:* 2.1. Core theories and terminology of patient safety and the epidemiology of unsafe practices 2.2. The characteristics and capacities of organizations with respect to patient safety, namely: 2.2.1. A commitment to patient safety as a major organizational or institutional goal demonstrated at the most senior levels

	2.2.2. The establishment and maintenance of a just culture 2.2.3. The implementation of patient safety best practices 2.2.4. The conduct of adverse event and incident (e.g., close call) analysis 2.2.5. The involvement of patients and their families as key players in patient safety 2.2.6. The provision of an environment of support and safety for health care professionals 2.3. The use of evaluative strategies to promote safety 2.4. The risks posed by personal and professional limitations 2.5. Principles, practices and processes that have been demonstrated to promote patient safety 2.6. The nature of systems and latent failures in the trajectory of adverse events 2.9. The elements of a just culture for patient safety, and the role of professional and organizational Accountabilities 2.10. The concept that health care is a complex adaptive system with many vulnerabilities, (e.g., space or workplace design, staffing, technology) *3. Health care professionals who maintain and enhance patient safety practices through ongoing learning:* 3.1. Identify opportunities for continuous learning and improvement for patient safety 3.3. Analyze a patient safety event and give examples on how future events can be avoided 3.5. Share information on adaptations to practices and procedures that increase safety for specific individuals or situations 3.7. Participate in self- and peer assessments reflecting on practice and patient outcomes *4. Health care professionals who demonstrate a questioning attitude as a fundamental aspect of safe professional practice and patient care:*

	4.1. Recognize that continuous improvement in patient care may require them to challenge existing methods 4.2. Identify existing procedures or policies that may be unsafe or are inconsistent with best practices and take action to address those concerns 4.3. Re-examine simplistic explanations for adverse events to facilitate optimal changes to care 4.4. Demonstrate openness to change **Domain: Work in Teams for Patient Safety** *1. Health care professionals who participate effectively and appropriately in an interprofessional health care team to optimize patient safety are able to:* 1.2. Describe individual and team roles and responsibilities in the context of practice and in the health care system 1.4. Work to develop a shared set of individual and team values, rights and responsibilities 1.5. Identify and act on safety issues, priorities and adverse events in the context of team practice *2. Health care professionals who meaningfully engage patients as the central participants in their health* *care teams:* 2.1. Ensure that patients are at the centre of care 2.2. Engage patients in decision-making and the management of their own health 2.3. Provide appropriate, sufficient and clear information, and teaching to patients to support informed decision-making 2.4. Advocate for individual patients and for the resources to be able to provide patient-centred, high quality

	care 2.5. Respond to individual patient needs and respect cultural and personal health beliefs and practices *3. Health care professionals who appropriately share authority, leadership, and decision-making for safer care:* 3.2. Collaboratively consult with, delegate tasks to, supervise and support team members 3.6. Demonstrate leadership techniques appropriate to clinical situations **Domain: Communicate Effectively for Patient Safety** *1. Health care professionals who demonstrate effective verbal and non-verbal communication abilities to prevent adverse events:* 1.1. Show respect and empathy in communication 1.2. Explain investigations, treatments and protocols clearly and adequately to patients 1.3. Convey information with clarity appropriate to each patient (e.g., by using the Calgary-Cambridge model) 1.4. Convey information in structured communications to team members to promote understanding (e.g. ARC, CHAT, CUS, DESCscript, I'M SAFE, I PASS THE BATON, STAR) 1.5. Communicate in a manner that is sensitive to health literacy needs 1.6. Employ active listening techniques to understand the needs of others 1.7. Communicate in a manner that is respectful of cultural diversity 1.8. Respect privacy and confidentiality 1.9. Use a variety of communication tools and techniques to enhance and assess understanding on the

	part of patients and their families *2. Health care professionals who communicate effectively in special high-risk situations to ensure the safety of patients:* 2.1. Engage patients or substitute decision-makers in a discussion of risks and benefits of investigations and treatments to obtain informed consent 2.2. Provide informed discharge so that patients know when and where to seek care 2.3. Communicate to others the urgency of a clinical situation 2.4. Employ communication techniques to escalate concerns across authority gradients to match the seriousness of the clinical situation 2.5. Employ appropriate communication approaches in high-risk situations, such as in clinical crises, emotional or distressing situations, and conflict 2.6. Use appropriate communication approaches to provide safe transfers, transitions of care and consultations among providers, including between institutions, and on discharge to community care 2.7. Demonstrate insight into their own communication styles with patients and team members in ordinary, crisis and stressful situations and adjust these styles appropriately to provide safe care *3. Health care professionals who use effective written communications for patient safety:* 3.1. Provide appropriately detailed and clear written or electronic entries to the patient health record 3.2. Provide sufficient documentation to facilitate team members' comprehension of the patient's history, physical findings, diagnosis and rationale for the diagnosis, treatment and care plan at any time

	3.4. Write patient care orders and prescriptions to convey the appropriate degree of urgency **Domain: Manage Safety Risks** *1. Health care professionals who recognize routine situations and settings in which safety problems may arise:* 1.1. Demonstrate situational awareness by continually observing the whole environment, thinking ahead and reviewing potential options and consequences 1.2. Recognize safety problems in real-time and respond to correct them, preventing them from reaching the patient 1.3. Employ, as appropriate, techniques such as diligent information-gathering, cross-checking of information using checklists, and investigating mismatches between the current situation and the expected state *2. Health care professionals who systematically identify, implement, and evaluate context-specific safety solutions:* 2.2. Learn from local successes and experiences, assessing their appropriateness to a work setting 2.3. Select the most appropriate solution for a given context, taking into account quality, resources, practicality and patient preferences 2.4. Reflect on the impact of an individual intervention, including the potentially harmful or unintended consequences of a safety intervention 2.5. Evaluate the ongoing success of a safety intervention by incorporating lessons learned 2.6. Adjust policies and procedures to reflect established guidelines, if applicable *3. Health care professionals who anticipate, identify and manage high-risk situations:* 3.1. Recognize health care settings that may lead to high-risk situations

	3.2. Respond effectively by means of efficient task and process management, crisis team functioning, and dynamic decision-making **Domain: Optimize Human and Environmental Factors** *1. Health care professionals who are able to describe the individual and environmental factors that can affect human performance understand:* 1.2. The role of attitude and professional culture in clinical practice 1.5. Understand how to evaluate the impact of organizational resource allocation, policies and procedures and culture *2. Health care professionals who apply techniques in critical thinking to make decisions safely are able to:* 2.1. Describe the common types of cognitive biases **Domain: Recognize, Respond to and Disclose Adverse Events** *2. Health care professionals who mitigate harm and address immediate risks for patients and others affected by adverse events and close calls:* 2.1. Assess the immediate safety and care needs for the physical and emotional well-being of patients and their families, and provide interventions as appropriate 2.2. Reduce or manage the risk of further harm to patients affected by adverse events and close calls *3. Health care professionals who disclose the occurrence of an adverse event to patients and/or their families as appropriate and in keeping with relevant legislation:* 3.1. Understand what information should be disclosed at the initial disclosure stage, the time frame for disclosure, and the relevant documentation, reporting, and analyses

	3.2. Recognize the ethical, professional and legal obligation to disclose and report adverse events 3.3. Differentiate between disclosure and reporting and the inherent processes associated with each concept 3.4. Are aware of existing policies and procedures associated with disclosure and the extent to which these foster a culture of patient safety 3.5. Engage in honest communication and empathic dialogue with respect to disclosure 3.6. Recognize that there are situations that constitute special consideration regarding disclosure, for example, patients in vulnerable situations, patients who have a substitute decision-maker, patients with special communication requirements (e.g., those who are hearing impaired), and patients whose cultural perspective on disclosure differs from the provider's 3.12. Recognize the need for a just culture of safety in supporting disclosure and reporting 3.13. Appreciate the legal implications arising from disclosure *4. Health care professionals who effectively report the occurrence of an adverse event or close call:* 4.1. Recognize that the reporting of adverse events takes place across the continuum of care and includes primary, secondary and tertiary care centres *5. Health care professionals who participate in timely event analysis, reflective practice, and planning for the prevention of recurrence:* 5.1. Engage in personal and professional reflection regarding the adverse event 5.2. Recognize the importance of monitoring the outcome of event analysis 5.3. Apply lessons learned from the event analysis 5.4. Advocate for system change as warranted

Abstract

Absconding is a key patient safety issue for persons with mental illness because of the person's potential increased risk of harm to self or others having left the care environment. Generally, absconding refers to an instance where a person in care cannot be located within the treatment unit and whose whereabouts are unknown. Although absconding can take place in many different care settings, this module will focus on the absconding of individuals under care in a hospital setting and discuss the person, clinical and treatment factors that may contribute to its occurrence.

Keywords

Absconding, elopement, escape, exit-seeking, missing, absent without leave (AWOL)

Teaching methods

Interactive lecture, case study

Objectives

The objective of this module is to provide an overview of absconding and missing patients as a patient safety issue.

Knowledge requirements

The knowledge elements include an understanding of:

- what constitutes absconding;
- the personal, clinical, and treatment factors associated with absconding;
- the practices and procedures for preventing absconding;
- the importance of trust and having a therapeutic care setting; and
- the incident response process

Performance requirements

The performance elements include the ability to:

- carry out a review of an absconding incident for quality improvement purposes

Introduction

Absconding is a significant patient safety concern for persons with mental illness because of the person's increased risk of harm to self or others having left care. The difference

between the person who has absconded and the person who is missing is the person's intent to leave care. So, where absconding is broadly defined to include instances where a patient has chosen to leave the care environment and their whereabouts are unknown, the term "missing patient" describes a person whose whereabouts are unknown but who is assumed to have had no intention to leave care. Often the terms absconding and missing are used interchangeably. Other terms such as "elopement" or being "absent without leave (AWOL)" are also used to describe absconding or missing patients.

Deciding when a person has absconded is not just a matter of discerning the person's intent. It is further complicated by the fact that what it means to "abscond" is contextual and can vary depending on the criteria used. So for example, depending on the person's knowledge about their condition (i.e. their appreciation that they have a form of illness that requires hospitalization) or their legal and/or clinical status, the decision to leave care may or may not be classified as absconding. Similarly, a person's choice to leave care, depending on where the person is located – hospital vs. community setting – is open to interpretation as absconding or not.

Legal and clinical status

The decision to classify a person as having absconded from care must take into account the person's intent (stated or otherwise), their legal (grounded in legislation) and their clinical status. *Intent* refers to whether the person has indicated to the clinical care team that he or she wants to leave care. *Legal status* refers to whether the person is voluntary (i.e. is there under his or her own volition) or involuntary (i.e. the person has been legally forced to be in care). *Clinical status* refers to both the level of risk the person poses to self or others as well as the person's ability to care for his/herself.

For example, an involuntary person who is missing may be considered to have absconded since their legal status as "involuntary" presumes that they do not want to be in care and would choose to be otherwise. Moreover, their legal status implies a clinical status consistent with a high risk for harm to self or others or an inability to care for self which may further validate the decision to classify the person has having absconded.

In contrast, a voluntary person who has made no indication that he or she intends to leave care and whose clinical status is not severe whose whereabouts are unknown is considered missing. If, on the other hand, the voluntary person has stated an intention to leave and subsequently leaves care, the legal status of these persons as "voluntary" means that they will not be classified as having absconded. As voluntary patients, they are free to leave care even against medical advice. It should be kept in mind though that voluntary status does not presume a lack of risk to the person or others. Voluntary patients who have left care may be at the same level of risk of harm to self or others as someone who is said to have absconded.

Location of person under care

This module focuses primarily on the absconding from hospital care. Operationally, a person is considered to have absconded from this treatment setting in the following situations:

- a person who *is otherwise not able* to leave the treatment unit without supervision cannot be located on the treatment unit and whose whereabouts cannot be immediately determined by the unit staff (e.g., the person has not told others about his or her whereabouts);
- a person who *is otherwise able* to leave the treatment unit without supervision and has not expressed their desire to leave and does not return to the treatment unit within a time specified by the care team (e.g., does not return by agreed upon time for bed or meals, does not return from approved leave); or
- a person is not in attendance in a scheduled activity such as a clinical interview or group session and whose whereabouts are unknown and cannot be determined by the care team.

Characterizing behaviour as absconding is more difficult in the community setting. There may be occasions in community health services (e.g., Case Management services) where persons who are under legal community treatment orders fail to show for appointments or whose locations are unknown. These persons may be considered as having absconded from care. However, it is a difficult characterization to make among persons receiving voluntary outpatient care.

Contributing factors to absconding

Many persons who leave care report leaving treatment for the following reasons:

- boredom;
- fear of other patients;
- lack of privacy;
- lack of meaningful recreation and leisure;
- feelings of confinement (which may be related to the quality of the care environment e.g. overcrowding);
- perceived household responsibility i.e., need to get home to finish tasks or take care of a pet – tasks that are perceived to be more important than their care; and
- isolation from relatives and friends.

In addition to these anecdotal reasons for absconding, there are two categories of factors that have been identified that contribute to an increased risk of absconding. The first category of factors is related to the person, such as demographics or prior history of violence and aggression. The second category of factors is external to the person and includes the clinical culture and the treatment provided.

Factors related to the person

Person related factors that may contribute to the risk of absconding include certain demographic characteristics and clinical risk factors.

Demographics

- Younger patients tend to abscond more often than older patients;
- Older adults with cognitive disorders such as dementia are at risk of wandering leading to increased risk of absconding from care;
- Though gender is not associated with absconding generally, men with schizophrenia have been found to abscond more often than women with schizophrenia; and
- Unemployment or homelessness is also associated with increased risk of absconding.

Clinical risk factors

Clinical risk factors related to an increased risk of absconding include the factors listed below.

Diagnosis and symptom severity

While all persons with mental health issues are at risk of absconding, that risk is magnified in persons who have been diagnosed with schizophrenia.

- Schizophrenia tends to be the most common diagnosis associated with the risk of absconding followed by borderline personality disorder;
- Persons with schizophrenia may attempt to abscond because of positive symptoms such as delusional thoughts or command hallucinations; and
- Persons with borderline personality disorders may abscond as an act of defiance against care provision or rules in the treatment environment.

Substance use

A history of substance use, including drugs and alcohol, is also associated with increased risk of absconding behaviour, presumably out of the need to acquire the substance. Perhaps unsurprisingly, people who are daily users of tobacco, but are not able to leave the treatment unit, also abscond for the same reason. This presents a challenge when trying strike a balance among resource allocation (i.e., assigning staff to supervise the person smoking), the potential agitation and disruptive behaviour if the person is not allowed to smoke, and managing the risk of absconding if the person is not allowed to leave the unit to smoke.

Wandering behaviour

Some persons, particularly those with progressive cognitive impairment, exhibit wandering behaviour. Wandering is broadly characterized by purposeful or non-purposeful locomotion. A subset of persons who wander engage in exit-seeking that is characterized by a willful intent to leave a secure treatment unit/ward/facility without permission. This behaviour is characterized by a high level of goal-directed behaviour that includes the capacity to plan and carry out the intentions to leave the treatment setting.

Intent to self-harm and/or commit suicide

Persons truly intent on wanting to die may seek ways to leave treatment to carry out an attempt. This may involve concealing their true intent or plans they have developed to facilitate this attempt.

Medication issues

Absconding is associated with non-compliance with medications which may arise when a person lacks an appreciation for their illness (sometimes referred to as insight). In their view, they are neither ill nor require intervention. Therefore, the introduction of pharmacological or other treatment, particularly if the treatment has side effects or requires hospitalization, will cause the person to seek means of disengaging from the intervention – including absconding. Working with the person to help them develop an appreciation for his or her condition is difficult but important for promoting safety and helping the person in the recovery process.

Clinical and treatment factors

Clinical culture

The attitudes and approaches that clinical staff bring to the care environment may be related to absconding. For instance, nursing styles that are custodial rather than therapeutic may increase the risk of absconding, as well as clinical cultures that focus on blaming others (e.g., person, families, other staff) rather than collaborative care, particularly if the culture leads to conflict and fear. Moreover, these kinds of clinical environments can have an impact on the persons receiving care such that they lose confidence in the management and treatment provided by the hospital or organization and thus leave. More information about clinical culture and patient safety can be obtained from the *PSEP-Canada Module 5: Organization and Culture*.

Treatment issues: transitions and approaches to care

Absconding tends to occur most often early in a person's admission to care, typically prior to or in the early stages of treatment implementation. This correlates to the time

when the therapeutic relationship may be beginning to be established, treatment in not yet in full session, and adjustment to the setting is in active phase. The risk of absconding is also higher during the transitions in care such as transfers and shift changes as well as on Fridays and weekends.

Persons also abscond in response to a disagreement with the nature of treatments offered and the way their problems were perceived by healthcare professionals. Disagreement may stem from the disconnect between the person's attitudes and beliefs and those of the clinical staff. This disagreement may be related to issues such as the person's appreciation for his or her illness as well as cultural differences in beliefs and practices toward mental illness.

These issues underscore the importance of a recovery-oriented and culturally responsive focus of care (outlined in the Mental Health Care: An Introduction to Patient Safety Issues Module) that establishes a strong therapeutic relationship. Failing to take the time to understand the person, establish trust with the person, and include the person in developing goals of care may lead to attempts to abscond from care.

The mental health team

The mental health team plays a crucial role in the assessment, prevention and incident management of absconding. When responding to an incident, each member of the team should know his/her role including organizational procedures for defining when a person is considered missing, search strategies, and contacts outside of the organization.

In addition to the direct care team, other persons within the care setting play a role monitoring and preventing absconding. These persons should be aware of units where persons at risk of absconding are typically admitted as well as all policies and procedures for responding to an incident of absconding or missing patient.

The mental health team and incident response

In response to an incident of absconding or missing persons within the hospital, the mental health team should be mobilized.

If the person is found to be missing from the building and areas immediately surrounding the building, then emergency services such as police as well as family, friends, or other service providers, may have to be engaged along with the mental health team. However, when engaging persons outside of the mental health team, there are a number of very important considerations that must be taken into account. These considerations are outlined further under Step 7 of the Incident Management and Review section that follows further in this module.

Prevention strategies

Important strategies that may help prevent absconding and/or missing persons include:

- establishing strong therapeutic relationships;
- providing care that is culturally responsive;
- using person-centered approaches to care; and
- the minimization of restrictive feel of the care environments.

An example of a prevention strategy is outlined at the end of this section.

Therapeutic relationships and the prevention of absconding

Building rapport and establishing and sustaining a strong therapeutic relationship begin in the first moments of contact between the clinician and the person. It continues throughout the assessment and care process. This rapport is particularly important since most absconding behaviour occurs early in the treatment process, typically in the first few days to weeks of an admission to hospital. Strategies for building rapport can include:

- asking the person how he/she wants to be addressed;
- providing the person with an explanation of your role and the purpose of the assessment which will minimize feelings of uncertainty and anxiety;
- listening empathetically and attempting to understand his or her experience and life goals;
- taking the time to consider the person's story and hear the patient's perspective of his or her needs;
- highlighting the person's strengths; and
- meeting the person in a comfortable and private environment.

Policies and strategies that support safety by preventing absconding need to be implemented and enforced consistently among all persons on the unit. For example, a strategy could be developed to offer nicotine replacement therapy for persons who are not able to leave the treatment unit and threaten to leave. Organizations should take care not to respond to threats in this context with negative responses, punitive actions, or punishment. Instead, these threats should be viewed as an opportunity to discuss with the person his or her reasons for leaving care, possible solutions to help the person remain safely in care, and potential outcomes that the person may encounter upon leaving (e.g., risk of harm to self).

Being culturally responsive

A person is usually deeply connected to the cultures from which he/she comes. It is important for the mental health team to be responsive to the patient's culture. For less familiar cultures, engaging cultural consultants can help the mental health team understand the person's cultural perspective and provide strategies for improving the person's appreciation of and willingness to stay in care.

Adopting a person-centered care approach

It is also vital that the care team work with the person, and whenever possible, the person's family, to develop a person-centered care approach to prevent absconding. A person-centered care approach is one where the team focuses on opportunities to share power and control with the person within the context of the therapeutic relationship.

It must be recognized that for some people the care environment and process of care can be a traumatic experience, particularly for those who have a history of trauma or who have been admitted involuntarily.

- Clinical staff should not use their role to exert control over the person. Instead, staff should contemplate opportunities where power and control could be shared with the person and make him/her feel valued and respected.
- Clinicians must try to understand the experience of being in care from the perspective of the person and use empathy and open communication. In some cases, the experience of being admitted to care may perpetuate a traumatic experience and become associated with feelings of fear and mistrust. Involving the person as a member of the care team and including his or her perspectives in the development of a care plan may help the person engage in the treatment process.

Minimization of restrictive procedures as a prevention strategy

Sometimes restrictive interventions, such as restricting access to exit points, are used as a prevention strategy. However, these strategies are not as effective as might be expected in preventing absconding. Rather, the negative consequences associated with these interventions including agitation, stigma, mistrust, dehumanization, and a perpetuation of feelings of worthlessness and isolation may actually increase absconding as well as incidents of aggressive behaviour.

A balance between patient safety and a person's rights needs to be found. Instituting a tiered approach to restrictions, such as sign-in and sign-out books for lower risk patients and a higher level of safety precaution for higher risk patients, might be more a more nuanced prevention strategy. These precautions should be non-restrictive as possible and attempt to engage the person in positive experiences. For instance, the person could be referred to a leisure activity where a member of the mental health team (e.g., Recreation Therapist) can monitor the person while s/he is engaged in a positive therapeutic experience.

An example prevention strategy: the anti-absconding package

It is hypothesized that clinical interventions directed at reducing risk of absconding may be as effective in preventing absconding as locking units and restricting access. However, few interventions have received formal review or evaluation. One approach that was developed in 2003 by Bowers, Alexander, & Gaskell in inpatient mental health hospitals

in London, UK has been found to reduce absconding by up to 25%. The intervention is called the "Anti-Absconding Package" and includes the following procedures:

- **using a signing in and out book for patients** to clarify the responsibilities and rules for leaving the unit;
- **careful and supportive approaches for breaking bad news** to patients (e.g., following refused requests for leave);
- **post incident unit debriefing for other patients in the unit** following incidents of aggressive or disruptive behaviour with thorough explanation and reassurance to the patients, especially at night when incidents may be particularly frightening for the other patients;
- **multidisciplinary review** of patients who have absconding more than once;
- **identification of patients at high risk of absconding** through careful assessment specifically directed at risk of absconding (refer to the Resource section of module for assessment tools);
- **setting aside daily nursing time to discuss with patients at high risk of absconding** any feelings or worries or distress the patient might have, including concerns about home, family, or friends followed by attempts to address the feelings;
- **facilitated social contact for those at high risk of absconding** including phone contact, encouraged visits, and devote all possible, suitable resources to supervise temporary leaves.

In addition to these interventions, understanding the times at which the risk of absconding is highest should be considered when deploying anti-absconding interventions. For instance, increased supervision may be required during transitions within care (e.g., in-between programs), at night, on weekends and at holidays. These are the times when persons may feel a heightened desire to abscond and when staff may be less vigilant in monitoring due to staffing patterns and distraction, particularly on weekends and holidays.

Incident management and review

Each organization caring for persons with mental illness must have policies in place that clearly outline procedures and responsibilities for responding to incidents of absconding or missing patients.

An example procedure for responding is set out below.

Step 1 – Risk assessment of the immediate situation

The person's most recent clinical assessment such as the one done at admission (with any updated information from the clinical team) can be used to establish the person's potential risk of harm status (to self or others) while missing, and help inform the search

process. (refer to the Tools & Outcome measures and Resource section of the PSEP – Canada Module 13a Mental Health Care: Preventing Suicide and Self- Harm module for assessment tools)

Step 2 – Establish a search plan

The search plan should:

- outline all areas to be checked within the unit and the roles and responsibilities of unit staff for executing the plan (can be captured using a search plan checklist that enumerates all the areas to be checked, and the date, time, and by whom the area was checked), and
- include a strategy for communicating between and among staff as well as other persons in care.

Step 3 – Check the immediate area and determine the level of response

A member of the mental health team, typically the charge nurse, should arrange for staff to search the entire unit and common/public areas using the established search plan and inform security as soon as possible. Information about the person's degree of risk and potential factors contributing to the person's leaving (e.g., intention to die by suicide) should be collected from the care team and, in particular, the attending physician/psychiatrist.

Step 4 – Notify family and substitute decision makers

It is important to notify family or substitute decision makers of persons who have absconded from the treatment setting. In some instances where the person poses a risk of harm but has not provided consent to contact family, it may be necessary to breach confidentiality in favor of safety. The process for breaching confidentiality should adhere to jurisdictional legislation and in consultation with risk management staff. The family or substitute decision makers should be instructed to contact the treatment unit if the person contacts them or arrives home.

Step 5 – Initiate the missing persons emergency code

In this step, the individual in charge of the search, (e.g. the charge nurse, unit manager etc.) should report an emergency code for a missing patient by paging through a central switchboard. This page will include the name of the emergency code (sometimes called a Code Yellow) and the unit from which the person is missing. The organizational policy relating to these kinds of codes should instruct staff as to the appropriate procedures once an emergency code has been called. For instance, a policy could require that once a page has been made over the intercom in the organization, an accompanying email be sent out

to all hospital staff providing further details about the description of the person. If so, these details should include:

- the date, time, and unit from which the person is missing;
- the full name and description of the patient (what the person was wearing, any identifying marks such as tattoos, etc.);
- locations with which the person is familiar and might probably go (e.g., a partner's house, parent's house, etc.); and
- relevant medical information and any cautions on approach (if applicable).

The policy should instruct staff without email access to call the unit to obtain the details. Changes to the status of the code should also be reported as they arise.

Other points to remember when initiating a code are:

- the information about the incident needs to be clearly communicated during shift changes and changes in accountability across the organization; communication should include verbal and written documentation of the details reported in the code;
- the type and nature of a response will be dictated by the circumstance of each case, such as the number of staff available depending on the time of day and nature of programming that is in progress (e.g., staff engaged in group programming, etc.) as well as transitions in staffing (e.g., at shift change or end of the business day there may be less staff available to take part in a search); and
- all other areas in the hospital must then complete a local area search, using their search plan checklists and report the outcome to the unit where the person is missing. The security personnel should coordinate the search of all public and secure areas in the hospital.

Step 6 – Search of the specified hospital area

The decision to conduct a full search of all hospital areas, both inside and out, will be based on the person specific information. For instance, a person with a known addiction is likely to leave the hospital area/property to seek out substances while a person with dementia who wanders may not intentionally leave the grounds.

The decision to search hospital areas should consider not only risks related to the person involved but also risks incurred by units as a result of participation of staff. For example, diverting staff from other places within the organization where they are needed might impact the functioning and safety of other units. The organization should have well established procedures in place for initiating and carrying out a search, as well as for calling local authorities as required. These procedures and the number of staff to engage in a search will depend on the size of the grounds and the availability of staff who can participate. For instance, administrative and support staff (e.g., housekeeping or environmental services) may be able to participate in a search of hospital property so that clinical staff can remain on treatment units. Ideally, security and one other staff member

may perform a limited grounds search – of easily accessed areas, perimeter of building, etc. For persons at high risk for suicide or harm to others, a more urgent search may be needed requiring a greater number of staff or engagement with emergency response (e.g., police).

Step 7 – Initiate police assistance and engage community partners, if necessary

Police assistance may also be requested (in urgent situations) to assist in locating the person, particularly when the person may be under a specific treatment order. Local legislation must dictate when to engage police in a search. In some jurisdictions, when a person absconds, it is permitted to initiate an "Order for Return" and engage police assistance for a patient detained under the provincial *Mental Health Act*. The process of engaging police must be considered very carefully under local legislation with full consideration of the person's level of risk balanced by his or her rights.

Once police are engaged, the responsibility for the search will be assumed by police services. Staff must disclose all relevant information about the person to police. This includes a description of the person, information about where the person might be likely to be found, and information about the person's level of risk. Failure to provide appropriate information may lead to harm to the person or others and the clinical team or hospital could be found to be liable in civil litigation.

Step 8 – Completion and review

In cases where a voluntary person doesn't return to the treatment unit, the person is usually formally discharged from care. If the person returns or is found, all details of the incident should be formally reported to the hospital risk manager. Most hospitals will have formal documentation for reporting incidents. The report should include:

- the date, time, and location of the incident;
- all actions that were taken in response to the missing person;
- the length of time the person was missing;
- the circumstances that the person and staff reported as contributing to the incident of absconding; and
- any other adverse outcomes.

The hospital may have established an emergency code review team who are responsible to review each incident in accordance with hospital policy, local legislation, and patient rights. The emergency review team may initiate a root cause analysis depending on the level of risk and outcome of the absconding incident.

Regardless of the type of outcome, the mental health team overseeing the care of the person in collaboration with the quality and risk management team at the hospital will

debrief to go over the care of the person and circumstances that may have resulted in absconding. This review will answer questions related to:

- the status of the person (e.g., did the person meet the criteria to be treated as involuntary?);
- the care planning process prior to the event (e.g. Were the person's expressed goals of care identified?);
- the safety measures that were put in place (e.g., Was an intent to leave against medical advice identified and, if so, what preventative interventions were established?);
- the incident response (e.g., Did the response follow the procedures outlined in hospital policy? Was appropriate engagement with staff, family, and police established?);
- documentation in the person's health record (e.g., Were all facts related to the event clearly documented in the person's chart, including communication with the person, family, etc.?); and
- the need for a more formal incident review (e.g., Did the event lead to serious harm to the person or others?).

Quality improvement

As outlined in the **Introduction Module**, quality improvement is a process. Specific to the issue of absconding, improving quality of the system means improving the quality of the relationship between the care team and the person. Therefore, quality improvement in this area needs to focus on the development of a culture and set of policies that reinforce a culture of person-centered care.

Similar to other quality improvement reviews, the process related to absconding starts with an evaluation of current organizational policy, practice, and structure. The quality review team within an organization can explore a number of factors to make recommendations for how organizational change can occur.

This evaluation can review the following:

- rates of absconding at the unit and shift levels over different points in time through the year to help identify trends that might be related to specific unit level or time of year issues;
- reasons why persons are absconding, possibly by interviewing persons who absconded but returned as well as care team members;
- locations where persons went when they absconded, so as to inform if persons were focused on returning home, seeking substances, or other factors;
- the policies and procedures in place for preventing and responding to absconding and whether these policies up to date with current legislation and best practice;

- the workload of clinical staff and whether they staff given enough time to focus on direct patient care and, if so, are they following through; and
- the training that has been provided to clinical staff and whether it reinforced techniques for prevention as well as procedures for incident management.

Once the review is complete, recommendations can be discussed with senior leadership within the organization to develop a quality improvement plan. The importance of engaging senior leadership rests on their ability to demonstrate an organizational commitment to quality improvement. If needed, changes to the organizational policy then occur in collaboration with senior leadership, clinical teams, and quality and risk management. Finally, policy roll-out can and should be accompanied by training of clinical staff to ensure procedures are well understood and feasible at the level of care.

Summary

Absconding is a key patient safety incident for persons with mental illness because of the increased risk of harm to self or others having left care. Though absconding may sometimes be difficult to define, understanding the reasons *why* persons leave care is key to reducing these kinds of incidents. Moreover, it is important that all organizations have specific policies and procedures in place that are followed if a person does abscond so that person may be quickly located.

Potential pitfalls

- Failing to understand how personal, clinical and treatment factors contribute to an increased risk of absconding.
- Relying on restrictive interventions, such as restricting access to exits, as a prevention strategy.
- Neglecting to debrief following an absconding event.

Pearls

- Monitoring trends in absconding behaviour at multiple levels and timeframes and adjusting the care process accordingly.
- Carrying out a detailed debriefing and quality review.
- Ensuring that policies and strategies that prevent absconding are enforced consistently among all persons on a unit.

Toolkits & outcome measures

The Anti-Absconding Package: Bowers L, Alexander J, Gaskell C. A trial of an anti-absconding intervention in acute psychiatric wards. *J Psychiatr Ment Health Nurs*. 2003 Aug;10(4):410-6.

Resources

- Bowers L, Jarrett M, Clark N, Kiyimba F, McFarlane L. Absconding: how and when patients leave the ward. *J Psychiatr Ment Health Nurs*. 1999 Jun;6(3):207-11.
- Bowers L, Jarrett M, Clark N, Kiyimba F, McFarlane L. Absconding: outcome and risk. *J Psychiatr Ment Health Nurs*. 1999 Jun;6(3):213-8.

References

Ali A, Maharajh HD. Time of the year and absconding from a psychiatric hospital in Trinidad. *Indian J Psychiatry*. 2003 Jan;45(1):36-9.

Aud MA. Dangerous wandering: elopements of older adults with dementia from long-term care facilities. *Am J Alzheimers Dis Other Demen*. 2004 Nov-Dec;19(6):361-8.

Bowers L, Simpson A, Alexander J. Real world application of an intervention to reduce absconding. *J Psychiatr Ment Health Nurs*. 2005 Oct;12(5):598-602.

Hunt IM, Windfuhr K, Swinson N, Shaw J, Appleby L, Kapur N; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Suicide amongst psychiatric in-patients who abscond from the ward: a national clinical survey. *BMC Psychiatry*. 2010 Feb 3;10:14.

Lai CK, Arthur DG. Wandering behaviour in people with dementia. *J Adv Nurs*. 2003 Oct;44(2):173-82.

Lucero M. Intervention strategies for exit-seeking wandering behavior in dementia residents. *Am J Alzheimers Dis Other Demen*. 2002 Sep-Oct;17(5):277-80.

Mosel KA, Gerace A, Muir-Cochrane E. Retrospective analysis of absconding behaviour by acute care consumers in one psychiatric hospital campus in Australia. *Int J Ment Health Nurs*. 2010 Jun;19(3):177-85.

Muir-Cochrane E, Mosel KA. Absconding: A review of the literature 1996-2008. *Int J Ment Health Nurs*. 2008 Oct;17(5):370-8.

Muir-Cochrane E, Mosel K, Gerace A, Esterman A, Bowers L. The profile of absconding psychiatric inpatients in Australia. *J Clin Nurs*. 2011 Mar;20(5-6):706-13.

Muir-Cochrane E, van der Merwe M, Nijman H, Haglund K, Simpson A, Bowers L. Investigation into the acceptability of door locking to staff, patients, and visitors on acute psychiatric wards. *Int J Ment Health Nurs*. 2012 Feb;21(1):41-9.

Stewart D, Bowers L. Absconding and locking ward doors: evidence from the literature. *J Psychiatr Ment Health Nurs*. 2011 Feb;18(1):89-93.

van der Merwe M, Bowers L, Jones J, Simpson A, Haglund K. Locked doors in acute inpatient psychiatry: a literature review. *J Psychiatr Ment Health Nurs*. 2009 Apr;16(3):293-9.

Yasini M, Sedaghat M, Ghasemi Esfe AR, Tehranidoost M. Epidemiology of absconding from an Iranian psychiatric centre. *J Psychiatr Ment Health Nurs*. 2009 Mar;16(2):153-7.

Module 13b Trainer's Notes

Principal message

The single most important message your audience should come away with is the various factors that impact a person's risk for absconding and that the mental health team should be trained in assessment and prevention of this risk. As a part of this insight, the participant should come away with key elements of a strategy that can be implemented by a unit or organization to promote a safe care environment.

Module overview

Absconding is a key patient safety incident for persons with mental illness because of the increased risk of harm to self or others having left care. Though absconding may sometimes be difficult to define, understanding the reasons *why* persons leave care is key to reducing these kinds of incidents. Moreover, it is important that all organizations have specific policies and procedures in place that are followed if a person does abscond so that person may be quickly located.

This module reviews best practices related to risk assessment and prevention of patients absconding with an emphasis on proactive prevention. Specifically, this module will discuss what constitutes absconding as well as the personal, clinical, and treatment factors associated with absconding. In addition, key practices and procedures for preventing absconding as well as the incident response and review process are discussed. Lastly, strategies to carry out a review of an absconding incident for quality improvement purposes and the importance of trust and having a therapeutic care setting are covered by this module.

Preparing for a presentation

1. Assess the needs of your audience

Choose from the material provided in the syllabus according to the needs of your expected participants. It is better for participants to come away with a few new pieces of information, well learned, than to come away with a deluge of information from which they can remember little or nothing.

2. Presentation timing

Allow sufficient time to collect participants' demographic data and complete the pre-test.

The suggested timing for each part of this module is:

Introduction	2-3 minutes
Presentation	35 minutes

Debrief about teaching methods	5 minutes
Summary	2-3 minutes
Post-test & Evaluation	5 minutes
Total	49-51 minutes

3. Number of slides: 15

4. Preparing your presentation

The text in the syllabus was not designed to be used as a prepared speech. Instead, the text provides material you may want to use. The slides have been designed to trigger your presentation. Although the slides closely follow the text of the syllabus, they do not contain all of the content. Their use presumes that you have mastered the content.

You may want to make notes on the slide summary pages to help you prepare your talk in more detail and provide you with notes to follow during your presentation.

Remember that you can adjust the slides to suit your presentation content, your style, and to make it feel fully familiar and your own.

Practice your presentation using the slides you have chosen, and speaking to yourself in the kind of language you expect to use, until it is smooth and interesting and takes the right amount of time. The most accomplished presenters and teachers still practice prior to a presentation; don't miss this step.

5. Preparing a handout for participants

The syllabus text and slides in the **Participant's Handbook** were designed to be reproduced and provided to participants as a handout. Take the portion you need; they can be used in their entirety, module by module, or for just one specific topic. Please include the following in each set of handouts:

- **PSEP - Canada Front Cover Page**;
- **PSEP - Canada Acknowledgment Pages** (to acknowledge the source of the material);
- syllabus and slides for **your topic**; and
- appendix material as relevant.

6. Equipment needs

- Projector and screen
- Computer and monitor
- Flipchart and markers for recording discussion points

Test your equipment beforehand to ensure that it works.

Review your video segments to assess which trigger tapes or portions you would like to use.

Have a back-up plan so that if there is any equipment failure you can move without panic to your back-up plan. For instance, have in mind that:

- if the video fails, you can read the vignette of the trigger tape story;
- if the slides cannot be shown, you can refer to the hand out slides; and
- if flipcharts and markers are not available, you can have participants list items on their hand outs that you would have written up for all to see.

Making the presentation

1. Introduce yourself

If you have not already done so, introduce yourself. Include your name, title, and the organization(s) you work for. Briefly describe your professional experience related to the information you will be presenting.

2. Introduce the topic

Show the title slide for the module. To establish the context for the session, make a few broad statements about the importance of topic as a patient safety matter. Tell participants the format and time you will take to present the session. Identify the teaching styles that you intend to use.

3. Review the session objectives

Show the slide with the session objectives listed. Read each objective and indicate those that you are planning to emphasize.

4. Present the material

Recommended style: interactive lecture

An interactive lecture will permit you to engage your audience, yet cover your chosen material within the time. You can use as your interactive components the trigger tape stimulated discussion and an interactive exercise. To foster discussion, ask participants for examples from their institutions or experiences. Ideally, the examples could be linked to one of the major teaching points.

Alternative style: case-based teaching

Use a case you are familiar with to include some case-based teaching. To help participants feel involved and invested, you may invite them to give you a case from their institution or experience. However, it is usually best to return to the case you know to

draw out analytic points for teaching since you do not need to ‘think on your feet’ too much.

5. Key take-home points

1. It is important to understand how personal, clinical and treatment factors can contribute to an increased risk of absconding.
2. The mental health team plays a crucial role in the assessment, prevention and incident management of absconding.
3. Anti-absconding interventions/procedures can be effective in reducing rates of absconding.
4. It is important to have specific policies and procedures in place that are understood and followed by staff if a person does abscond so that the person may be quickly located.

6. Summarize the discussion

Briefly, review each part of the presentation. Recap two or three of the most important points that were discussed.

7. Debrief about the teaching method

Tell the group that it is time to consider the teaching method used, how it worked and what its limitations were. Ask them what other methods might work, and what methods would work best *for the topic* in their home institutions. Ask them to consider what method would work best *for themselves as facilitators* and for their *target audience*.

8. Post-test/evaluation

Ask the participants to complete the post-test questions for this module and evaluate the session.