

**PILOT: IMPLEMENTATION OF AN ANTI
ABSCONDING INTERVENTION
SOUTH EASTERN HEALTH AND SOCIAL
CARE TRUST**

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Background

Unauthorised absence or more commonly referred to as 'Absent Without Leave' (AWOL), from a psychiatric hospital has potentially serious negative consequences for patients including suicide, homicide, self harm and physical health problems.

Bowers et al (1999) estimated that in the region of 3.6% of absconds result in harm to the patient or to others. The risk of suicide associated with AWOL was highlighted by the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness Northern Ireland (2011). This enquiry identified that there were 35 in-patient suicides in Mental Health facilities in NI during the time frame 2000-2008. Thirteen of these events occurred off the ward by patients having left without staff agreement, that is, they were absent without leave (AWOL); this equated to 37% of inpatient suicides occurring while the patient was AWOL.

In addition to the risk to clients and others presented as a direct result of absconding, an excessive amount of staff time is consumed in searching for the patient, contacting relatives and carers, liaising with the police where appropriate and completing documentation. This is time that would otherwise be spent delivering care to the remaining clients.

In 2012 the PHA, on behalf of the Bamford Taskforce, carried out an audit across the five Health and Social Care Trust areas to establish progress in relation to Recommendation 8 from the National Confidential Enquiry (2011)

'In-patient' services to adapt or strengthen protocols for preventing and responding to absconding'

This audit examined information in relation to absconding activity from Acute Inpatient wards and Psychiatric Intensive Care Units for a 14 month period pre and post publication of the report; that is from April 2010 to September 2012, (inclusive).

In the 14 month period prior to publication of the National Confidential Enquiry report 680 patients absconded in total; in the period post publication 583 patients absconded showing a 14% decrease generally. Three of the patients who absconded post the publication of the report took their lives at the time of the incident.

Whilst the overall reduction in absconding was a welcome and positive outcome, given the associated consequences, including the risk of suicide,

it was felt that additional work was required to further reduce the incidence of AWOL. In light of this the report identified a number of recommendations including the need to explore the reason why patients abscond and to identify and pilot an anti-absconding intervention which would allow staff to put in place appropriate interventions to reduce incidence.

This paper outlines the pilot of an Anti-absconding intervention in an Acute Inpatient Psychiatric unit at the South Eastern Health and Social Care Trust.

Literature Review

Bowers et al (1998) in a study examining absconding incidents from acute admission psychiatric inpatient wards found that absconders are more often:

- Young,
- Male,
- From disadvantaged groups,
- Suffering from schizophrenia,
- Have had a number of transfers between wards,
- Have refusals of medication,
- Involvement in officially reported ward incidents in the previous week,
- Have absconded during previous admissions,
- Have had previous contact with the police.

They also found that absconders in general are considered by nursing staff to be a risk to self or others.

In relation to reasons for absconding Bowers et al (1998) identified a variety including;

- Bored on the ward,
- To get alcohol,
- Frightened of other patients,
- Feeling trapped and confined,
- Not wanting to be there,
- Having household responsibilities the patient feels they must fulfil,
- Feeling cut off from relatives and friends,
- Worried about the security of their home and property,
- Lack of clarity around the rules in relation to leaving the ward.

The PHA (2013) carried out a snap shot review of why patients absconded from acute inpatient mental health wards in Northern Ireland. All patients

who absconded over the identified period, on their return to the ward, were interviewed by staff in relation to their reason for leaving the ward. The key reasons identified were boredom, did not want to be in hospital, to get drugs or alcohol and misinterpretation of 'rules' in relation to leaving the ward. These reasons were consistent with the evidence from Bowers study (1998).

The evidence gathered by Bowers et al (1998) in relation to absconding, including the characteristics of absconders, the reasons for absconding and staff experience of absconding, informed the development of an anti-absconding intervention encapsulated in a self-training work book called the '**East London and City Mental Health NHS Trust 'Anti-Absconding Work Book'**' (Bowers et al 2003). This intervention, (appendix1), draws on the empirical research into staff and patient experiences of absconding as an effective, practise based intervention.

The elements of the intervention include:

1. Rule clarity: use of a signing in and out book
2. Identification of those at high risk of absconding
3. Targeted nursing time for those at high risk
 - Dealing with home worries
 - Promotion of controlled access to home
 - Promoting contact with family and friends
4. Careful breaking of bad news
5. Post-incident debriefing
6. Multi-disciplinary-team (MDT) review following two absconds

The work book contains reflective tools that enable nurses to understand and draw upon key components of evidenced based practise of the key interventions, so that subtle changes in practises may prevent or reduce the likelihood of patients absconding. It also provides;

- Background,
- Principles and importance of the intervention,
- How to implement the intervention
- Expected benefits
- Questions to help staff work through the material reflectively through the use of case examples

As part of the intervention package Bowers produced a **Handbook for Ward Managers** (appendix 2). This hand book provides guidance in relation to staff education and support as well as direction in terms of monitoring implementation and effectiveness of the intervention.

Bowers et al tested this intervention in two exploratory studies (2003; 2005). In these studies, the anti-absconding intervention was offered to a number of acute admission psychiatric wards across the UK, who agreed to implement it and audit the results. Five wards participated in the first study and fifteen wards in the second study.

Absconding reduced by 25% overall during the intervention period, a fall which was statistically significant, with some areas showing a 50% reduction. The results from both these studies support the efficacy of the intervention, and indicate that significant reductions can be made in absconding rates.

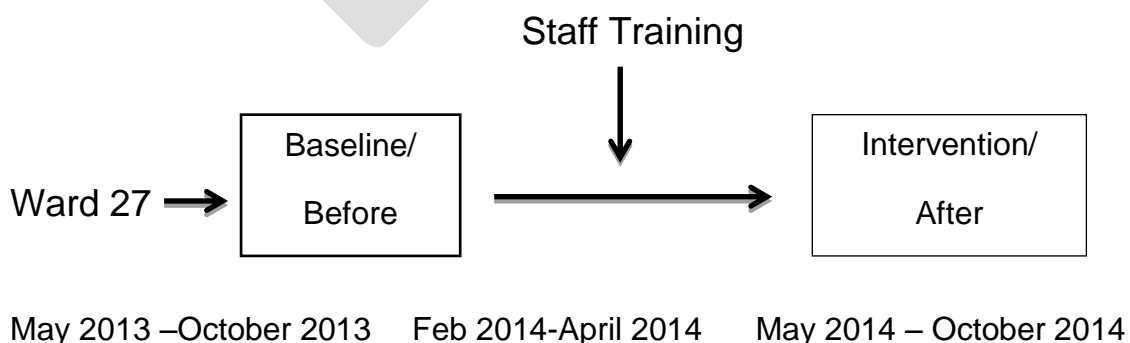
In order to test the continued relevance of the original evidence Bowers and Stewart (2010) carried out an extensive literature review (75 empirical papers), looking at the incidence, duration, and outcomes as well as the demographic and clinical characteristics of absconding patients; this indicated that the evidence remained consistent with the original study (1998).

Aim of the Study

The aim of this study was to evaluate the implementation of the ‘**East London and City Mental Health NHS Trust ‘Anti-Absconding Work Book’**’ (Bowers et al 2003), as an intervention to reduce patient absconding rates within ward 27 at the Ulster Hospital Dundonald; ward 27 is an acute psychiatric inpatient ward.

Methodology

The study involved a before-and-after trial examining the period May 2013 to October 2014 inclusive. The base line and post intervention measure was recorded for the same months to rule out seasonal variations.



Outcome measures

The primary outcome measure was absconding rates; absconding was defined as follows;

'Inpatients either detained or voluntary will be defined as Absent Without Leave (AWOL), if they leave any of the Trusts' Mental Health or Learning Disability facilities without the agreement or knowledge of staff or fail to return from escorted or unescorted leave'.

Analysis

Assessment of change was performed using the one-way Fisher's exact test.

Procedure

Pilot Site

It was initially decided to pilot the intervention in one acute ward per Trust area but in light of a number of limitations the intervention was piloted in one area; ward 27 at the Ulster Hospital Dundonald.

Ward 27 is a busy, mixed gender 24 bedded acute admission psychiatry ward caring for individuals aged from eighteen years upwards. The patient population of the ward varies between young physically fit individuals to a frail elderly population.

As in all acute inpatient psychiatric facilities across Northern Ireland, ward 27 has significant challenges in relation to patients leaving the ward without the knowledge of staff. In September 2013, a patient who had absconded from the ward subsequently died by suicide.

A senior nurse was identified as the lead to take forward and develop the anti-absconding pilot.

The definition used for AWOL was as follows:

'Inpatients either detained or voluntary will be defined as Absent Without Leave (AWOL), if they leave any of the Trusts' Mental Health or Learning Disability facilities without the agreement or knowledge of staff or fail to return from escorted or unescorted leave'.

A base line retrospective audit was carried out of all the AWOLs from ward 27 Ulster Hospital from the 1st May 2013 to the 31st October 2013 to use as a comparative for the intervention period.

Staff Training

The anti-absconding intervention (appendix 1) which is encapsulated in a self-training package/workbook was initially discussed at the weekly mental health hospital services managers meeting of which ward 27 interim charge nurse and newly appointed ward sister attends. These initial meetings were the catalyst for the dissemination of information to ward staff.

The Ward Managers Handbook (appendix 2) which is part of the tool kit was used to guide and inform staff education in relation to the intervention. This tool provides step by step guidance in relation to staff motivation, education, maintaining momentum and monitoring and evaluation of impact.

The workbook and information was circulated to all staff from ward 27 in late January 2014. The intervention was subsequently discussed at length in staff meetings in terms of the pilot and the rationale including the success of its implementation in London in relation to the significant reduction in patient absconding rates.

Staff were given protected time, incorporated into their on-going mandatory training requirements, over a specified period of eight weeks to enable individual completion of the workbook and full compliance by all staff. This enabled staff to have an opportunity to raise potential concerns or questions and to provide clarity. Time to complete the booklet took on average 2 hours. This process was further facilitated through a high visibility approach adopted by the newly appointed ward sister, regular staff meetings and individual 1:1/operational supervision. All staff completed the anti-absconding workbook by April 2014, pre the commencement of the pending audit in May 2014.

The anti-absconding pilot was also discussed at the Trust's Mental Health Acute Care Forum. This forum is a monthly meeting attended by acute hospital inpatient consultants, senior managers and acute inpatient ward managers. The purpose of the forum is to discuss and debate current trends, significant practise issues and service improvement issues within hospital services.

The pilot was given full support and endorsement from all staff and the Mental Health Acute Care Forum.

Patient Engagement

The anti-absconding project was discussed at the ward Patient Forum. This is a specific service user engagement process which occurs on a weekly/bi-weekly basis across the acute inpatient wards. These forums are chaired by nursing staff and voluntary peer advocates. The anti-absconding pilot and subsequent practise was agreed as a standing item on the weekly forum agenda. The pilot was given full support and endorsement from this forum.

Intervention

The anti-absconding intervention was initiated on the 1st of May 2014 and consisted of the package of measures described in Figure 2 below. All patients on the ward on the 1st of May 2014 and those admitted thereafter had the Anti-absconding Intervention discussed with them by their named nurse and their risk of absconding assessed as a score. Patients assessed as 'high' risk, that is a score of 7 and above, had the anti-absconding interventions included as part of their care plan and were actively engaged in discussions and decisions in relation to addressing this risk. Families and carers were also made aware of the appropriate elements of the intervention including the need to complete the signing in/out book and the risk assessment. When availing of planned leave, the intervention was again re-enforced with patients and, where relevant, their careers.

Figure 2: Anti-Absconding Intervention

Identification of patients at high risk of absconding, and associated updating of care plan.

Use of a signing in and out book for patients, thereby clarifying responsibilities and rules around leaving the ward.

Careful and supportive breaking of bad news to patients, for example following refused requests for leave, or disappointing outcome of Mental Health Review Tribunals.

Post ward incident debriefing of patients, following any aggressive or noisy altercation, with explanation and reassurance, especially at night.

Targeted nursing time daily for those high absconding risk patients, for the discussion of worries/concerns about home, family and

friends, followed by practical attempts to address those needs.

Facilitated social contact for those at high risk of absconding, via phone contact, encouraging visiting, or using all available resources to enable supervised temporary leave.

Post AWOL intervention:

- Discussion with the patient as to why they left the ward and how to prevent this happening in the future
- Agreeing therapeutic interventions to prevent further episodes and updating the patients care plan

Multidisciplinary review, usually but not necessarily via the ward round, of patients who had absconded more than once.

To assist with implementation, a senior nurse on the ward developed a **score me on admission** poster diagram as a prompt and reminder for all staff which was displayed in a central position at the staff base. This was to act as an aide-mémoire to staff to carry out the anti-absconding interventions on admission, to score the individuals risk and then to evidence the anti-absconding conversation in the individual patient's records.

If a patient was assessed as at risk of absconding this was recorded in their care plan as a risk and it was further evidenced through their daily 1:1 therapeutic interactions with staff, where interventions to reduce risk were discussed and implemented.

Throughout the pilot period the Lead Nurse continued to monitor patient notes to ensure the intervention was being used with all patients on the ward and provided support and encouragement to staff as appropriate.

The number of AWOLS was recorded for the period 1st May 2014 to the 31st of October 2014 inclusive. The baseline audit was completed for the same months in 2013 to use as a comparison that addressed the potential for seasonal variation.

Findings

Absconding rates fell by a statistically significant 70% during the intervention period, as compared to the base line period (see Table 1).

The difference was tested and found to be statistically significant (Z test for population proportions, $p < 0.05$)

Table 1 Number of AWOLS from Ward 27

Month	Base Line: May – Oct 2013 (Number of AWOLS)	Intervention: May – Oct 2014 (Number of AWOLS)
May	4	0
June	5	2
July	9	2
August	3	0
September	0	2
October	3	1
Total	24	7

For the period May to October 2013 **4** patients were responsible for 9 incidents; that is 19 patients went AWOL; for the intervention period May 2014 to October 2014 **2** patients were responsible for 5 incidents; that is 4 patients went AWOL

A number of additional observations were made by staff during the intervention period including; a perceived reduction in aggressive outbursts, a reduction in complaints and a reported improvement in the therapeutic relationship between patients and staff. When the numbers of complaints were reviewed it was found that there were 5 complaints during the base line period and 2 during the intervention period.

Discussion

As discussed in the background to this paper unauthorised absence from a psychiatric inpatient setting, more commonly referred to as 'Absent Without Leave' (AWOL), has potentially serious negative consequences for patients including suicide, homicide, self harm and physical health problems.

The results from this pilot which tested implementation of the '**East London and City Mental Health NHS Trust 'Anti-Absconding Work Book'**' (Bowers et al 2003) on an acute inpatient mental health ward, have been extremely encouraging, showing a reduction in absconding rates of 70% as compared to the base line audit .

This reduction has been shown to be statistically significant and exceeds the results from Bowers studies (2003, 2005), where the reduction in AWOL varied from 25% to 50%.

The interventions within the work book are focused and specific. They are based on academic evidence collated by Bowers et al (1998) in relation to the reasons why patients abscond and what can help address these.

Staff on the pilot ward found the tool for identification of patients at high risk of absconding particularly useful. The evidence clearly identifies factors that increase the risk of patients absconding including previous episodes; access to a tool to score risk allowed staff to proactively put in place strategies and interventions, agreed with the patient, with a view to reducing the likelihood of the patient absconding. This supported a more therapeutic relationship between the patient and staff in that interventions were agreed collectively with the patient who was as a result more likely to co-operate and engage in their care in a positive manner. This supports a proactive person-centred approach to the prevention of absconding as opposed to a reactive and procedurally focused response.

A further significant intervention was the introduction of the signing in and out book. This has reportedly created a more vigilant and engaging team across the ward. This includes not only the nursing staff but the other members of the multi-disciplinary team, including patient experience staff, who frequently enquire of patients who they see leaving the ward, if they have "signed out". There have also been occasions, when individual patients have approached staff asking them to sign the signing in and out book to allow them to avail of prescribed leave. This process reinforces to staff the need to engage patients and carers, and clarify expectation and rules that enables patients and carers to commit to an expected time of return. It focuses very much on a partnership approach to care encouraging patients to take responsibility and allowing them to retain some element of control in their care.

Generally feedback from staff suggests that implementation of the intervention has contributed to a more therapeutic relationship with patients, which ultimately impacts on the quality of care and patient outcomes. Moreover, staff anxiety about patients who have left the ward without staff knowledge, and the administrative burden of locating and returning them to hospital (both by nursing staff and the PSNI) has reduced significantly freeing up staff time to spend in more therapeutic interactions with patients.

In addition to the outcomes related specifically to absconding rates, discussion with ward staff, the ward manager and the Senior Lead Nurse, identified a number of further incidental, but none the less very important outcomes which staff linked directly with the intervention. These outcomes included:

- **Reduction in complaints;** When records for complaints were reviewed it was noted that there were 5 complaints for ward 27 throughout the base line audit and 2 complaints for the intervention period. Although not statistically tested, this was noted by staff as significant from the point of view of patient satisfaction.
- **Reduction in aggressive outbursts;** Again although not statistically tested, staff noted a calmer more therapeutic relationship between staff and patients. It was suggested that this was because patient's were feeling more in control in that they understood and were clear in relation to the rules about leaving the ward; also risks for absconding were identified on admission with the patient and addressed through therapeutic interventions.

Throughout the Pilot, the anti-absconding intervention was discussed at the ward Patient Forum meeting as a standing item agenda. The forum fully supported and endorsed the intervention as a positive change in practice. On-going feedback from patients indicates that the intervention has provided improved understanding and increased clarity of the importance of informing staff when seeking to avail of time off the ward; this in turn has encouraged a more collaborative and therapeutic partnership in care. The anti-absconding intervention remains an agenda item at the patient forum meetings.

Fundamental to the success of this intervention was the guidance and support provided through the work book. The Lead nurse and manager from ward 27 highlighted that the significant evidence based and reflective learning from the work book allowed individual practitioners to have a greater insight into the challenges faced by patients including conflicting concerns and worries about their life and personal situation. These reflections helped to promote a more person centred culture as opposed to an institutional model of care, facilitating more specific meaningful and focused interventions with individual patients and their families/carers. This is in keeping with the ethos of ImROC and increased autonomy and shared decision making with patients.

Protected time for staff to complete the work book was essential in supporting the successful role out of this intervention as was the support of clinical and senior management. The Lead Nurse and Ward Manager dedicated considerable time to supporting staff and checking that the interventions were being implemented and embedded in day to day practice. This point was highlighted by Bowers (2003) during testing of the interventions; in areas with poor leadership and lack of commitment to staff education and support the impact of the intervention was significantly lower. On average the time taken to complete the work book was 2 hours; this time was incorporated into staff on-going mandatory training requirements.

The Handbook for Ward Managers was viewed as invaluable as it provides detailed guidance on how best to introduce the anti-absconding intervention to ensure its successful implementation. This includes guidance on stimulating and maintaining staff interest, monitoring and evaluation and on-going staff training and support. This work book recognises and supports the concept of continuous learning through supervision and case analysis providing the ward manager with all the relevant tools to deliver.

Conclusion

This study, coupled with previous research conducted by Bowers et al (1998, 2003 and 2005), provides strong support for the efficacy of the intervention contained within the **'East London and City Mental Health NHS Trust 'Anti-Absconding Work Book'** in reducing absconding rates within Acute Inpatient Psychiatric wards.

The 70% reduction realised in absconding incidents in ward 27 at the Ulster Hospital represents an appreciable clinical effect.

Previous research (Bowers et al 1999) has shown that 3.6% of absconds have a negative outcome for the patient; the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness Northern Ireland (2011) found that 37% of inpatient suicides over the time period studied (2000-2008) occurred while the patient was AWOL. To this end it is probable that a percentage of patients on the pilot ward throughout the intervention were protected from putting themselves or others at risk because of the anti-absconding intervention.

In light of the outcome from this pilot study, the South Eastern Trust have implemented the **'East London and City Mental Health NHS Trust 'Anti-Absconding Work Book'** intervention across all acute inpatient mental

health wards across the Trust as well as the Psychiatric Intensive Care Unit.

An on-going scrutiny and audit of incident recording forms against the anti-absconding intervention has also been put in place to ensure that the intervention is sustained and that the reduced levels of absconding across all acute inpatient wards is maintained.

The Trust has also completed a range of other measures to reinforce and reflect the success of the anti-absconding pilot. These include:

- Updating of the acute inpatient integrated admission care pathway to include the anti-absconding interventions,
- Updating of respective GRA2 risk assessments for each ward to reflect the anti-absconding interventions as a specific control measure for the potential risk of an individual going AWOL.
- Updating the Risk register for the Trust identifying the anti-absconding work as a control measure.

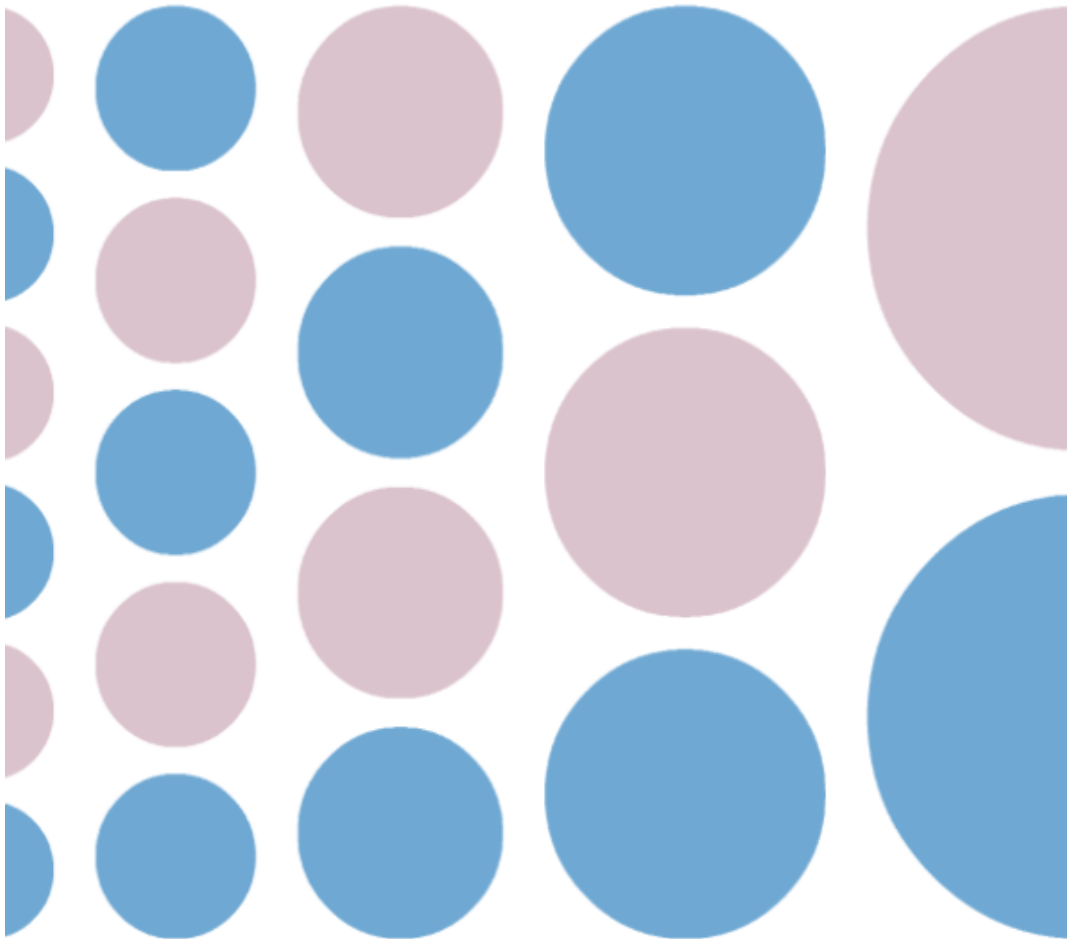
Regional Recommendations

- All patients should be assessed for the risk of AWOL on admission
- Risk Assessment for AWOL to be included in the Regional Care Pathway
- Evidence based Anti-absconding interventions should be implemented in all Acute Adult Mental Health and Learning Disability Inpatient Units
- Consideration to be given to the development of a Key Performance Indicator (KPI) for the reduction in AWOL incidents

Appendix 1

The Anti-Absconding Workbook

Department of Mental Health
and Learning Disability



THE ANTI- ABSCONDING WORKBOOK



Written and produced by Len Bowers, Jane Alexander & Alan Simpson
Design by jerometurner.co.uk
Illustrations by Geoff Brennan
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East London and The City 
Mental Health NHS Trust

All the researchers behind the work described in this book would like to acknowledge the support and assistance they have received from staff in East London and the City Mental Health NHS Trust in carrying out the research on which this workbook is based.

THE ANTI-ABSCONDING INTERVENTION

INTRODUCTION

Since 1998 in the East End of London we've been conducting research on absconding by patients on acute psychiatric wards. That research has enabled us to find out how to reduce absconding rates by at least a quarter. In this workbook, we have summarized what we have learnt, and devised some material for you to work through, so that you, too, can use this method to reduce the rate of absconding from your ward.

We're confident that you can do this because of the findings from our three studies of absconding (if you want to read about these in detail, the references are at the end of the workbook). In the first exploratory study of absconding, we looked at all absconders from 12 acute psychiatric wards over a period of five months. This is the largest

study of absconding that has ever been conducted anywhere in the world. We logged 498 absconders by 175 absconders. We interviewed 62 absconders on their return, 24 nurses on the topic of absconding, and 6 carers or relatives. In a subsequent study we examined the relationship of absconding to other difficult behaviours (e.g. aggression) in 238 two-week admissions during 2001. Then last year we tested the intervention described in this book, to see if it really made a difference. That test took place on five acute psychiatric wards, and we demonstrated a 25% reduction in absconding rates.

WHY IS REDUCING ABSCONDING IMPORTANT?

When patients abscond we spend a great deal of our nursing time worrying about them, completing paperwork, making phone calls, and trying to get absconders back to hospital. That's not just nurses, but often doctors and administrators too. Valuable time that we could all make better use of. Much police time is also taken up with processing paperwork, and going out to find absconders. In our part of London, police are notified of absconds over 500 times a year. But all this time taken up by patients who run away pales into insignificance when we think of the potential negative consequences of absconding. A small number of absconds (3.6%) result in harm to the patient or to others. In fact we know from other research that about a quarter of inpatients that commit suicide do so after absconding from the ward. On very rare

occasions there have been homicides by absconders. Absconding more frequently results in interrupted treatment, and often, prolonged hospital stays. In some cases patients travel so far that they are lost to psychiatric follow up entirely. This is not to speak of the loss of confidence by relatives in us, when they discover that we have not kept their loved one safe.

All the above are really good reasons for tackling absconding. If we can reduce absconding by 25%, then we can reduce the anxiety by 25%, and our absconding paperwork time, police time, carer worry, and negative outcomes. Work carefully through the contents of this book, and that is what you have to gain.

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KEY ELEMENTS

The key elements of the intervention that you will learn about are:

1. Rule clarity: use of a signing in and out book
2. Identification of those at high risk of absconding
3. Targeted nursing time for those at high risk
 - Dealing with home worries
 - Promotion of controlled access to home
 - Promoting contact with family and friends
4. Careful breaking of bad news
5. Post-incident debriefing
6. Multi-disciplinary-team (MDT) review following two absconds

These are not the only ways to reduce absconding, but they are the ones that we put to the test. Not only did they reduce our absconding rates by 25%, but also at the same time we were able to reduce the number of daytime hours during which the ward doors were locked. However locking the ward door, or the use of special observation, can still be measures that are necessary from time to time.

WHAT THE WORKBOOK CONTAINS

The workbook contains reflective tools that will help you to understand the evidence base for the intervention, so that you can implement the changes in your practice that may prevent the patients in your care from absconding. This list is by no means an exhaustive account of every fundamental aspect of the intervention, but it represents those elements identified as crucial to the prevention of absconding. This workbook provides:

- Background, principles and importance of the intervention
- How to implement the intervention
- Expected benefits
- Questions to help you work through the material reflectively

EVIDENCE-BASED PRACTICE

By working through the exercises in this book, and reflecting on your own practice, you will be drawing on key components of evidence-based practice as recommended under clinical governance guidelines aimed at improving the quality of patient care. The workbook draws on empirical research into patient and staff experiences of absconding, and of an effective practice-based intervention. The emphasis on work-based learning also meets the requirements for continuing professional development (CPD) (Department of Health, 1998: ie May, 1999)

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RULE CLARITY: USE OF A SIGNING IN AND OUT BOOK

BACKGROUND AND RATIONALE

In our interviews of patients in many research studies, we have found that patients are not always clear about the rules for leaving the ward. Perhaps these were never explained or communicated to them, because sometimes it was assumed that people would know, or that patients would tell each other. Sometimes, when they are explained on admission, the patient has not been in a suitable state to absorb them. Often people need to have things repeated before they truly learn or absorb them.

Staff can also be confused about who is allowed to leave the ward, on what basis, for how long, to go where. And about who has to stay. That confusion and lack of clarity is easily conveyed to patients in the way we answer their questions. These sorts of

confusions can lead to patients unwittingly getting into trouble and conflict with staff, including about leaving the ward and absconding.

Use of a signing in and out book clarifies expectations, and provides a leaving ritual during which nurses can explain the rules and patients can make a commitment about when they are coming back. The presence of the book also makes more visible the process of trying to leave without permission.

HOW TO DO IT

Obtain a good quality, hardbound book for the ward. A nice book, clearly labelled, will inculcate respect, whereas use of a scrap of paper or a clipboard invites instant dismissal by patients. Find a location on your ward where it can be kept, preferably in full view. A table near the door is ideal, and a pen for signing in and out should always be available. Appropriate locations vary because ward layouts differ. Inside the book columns should be neatly drawn using the following headings:

Date, Patient's name, Amount of leave, Time left ward, Time of return, Sign out, Nurse Countersignature, Sign in, Time of return

Part of the absconding intervention involves asking the patients to sign in and out as they leave the ward AT ANY TIME. This has proved very popular amongst patients and staff, as well as reducing absconding because the book jogs memory about keeping to time.

- Make it clear to ALL the patients on the ward what the rules are regarding leaving the ward (patients often do not know)
- When leave is agreed, establish how long they are allowed to be out for (don't assume that they know or understand)
- On leaving, ask the patient to sign the book, reminding them of the time they are due back.



EXERCISE TO WORK THROUGH

MAKING THE RULES CLEAR

The following list contains examples of vague/clear instructions. Communication is a two way process, and it is important to know if the patient has interpreted and understood the rules. Try to identify which of the following examples are clear. Place a tick beside those that are clear, and a cross besides those that could be better. Compare your results with our comments afterwards - found at the back of this workbook on page 40.

	Example interaction	✓ or ✗
1	Patient: Can I go to the shops? Nurse: Yes, of course, see you later.	
2	Nurse: Dr X says that you can have two hours of unescorted leave per day, but it is up to us to decide whether you are well enough to go out. Patient: Can I go out today? Nurse: Yes, but don't forget to sign the book, and remember to come back on time otherwise you will be grounded again.	
3	Patient: I am allowed out now aren't I? Nurse: Yes Dr X says that you can go out for 1 hour in the morning and 1 hour in the afternoon. Patient: Okay I think I'll go out for a walk now. Nurse: So do you remember how much time you have got? Patient: Two hours. Nurse: One hour now and one hour this afternoon. Patient: Can't I take them both together I'm tired in the afternoon? Nurse: No sorry not at the moment. You are getting better that's why you are allowed out for 1 hour at a time, and that will be increased again by Doctor X if he sees that you are benefiting from it. Its 20 past 10 now so what time are you due back? Patient: At 20 past 11. Nurse: Right so that's clear. Now I have written the time you left and when you are due back. Please sign out against your name, and when you come back tell one of us so that you can sign in. Then we will know that you have returned safely.	
4	Patient: I'm just going down the road to get some fags, OK? Nurse: Sure, How long will you be? Patient: Not long, I'll be back before tea. Do you want anything? Nurse: No, thanks, See you at tea then don't be late Patient: No, don't worry, six at the latest.	
5	Nurse: John, I see in your care plan you can go out for the morning if you fancy it. How about getting out for some air today? Patient: Nice idea I'll do that. How long have I got? Nurse: Three hours. So, if you go in the next half hour, you will have to be back by twelve. Okay? Patient: Yeah, I'll do that, I'll go for a walk by the canal Nurse: OK, when you are ready to go can you come in and see me and sign the signing-out book. And let me know when you are back at twelve, so we can sign you in again. Thanks John.	
6	Patient: The doctor said I could go home and pay some bills and stuff today. I'll sign the book and everything. Nurse: Yes, I heard about the ward round. Good, yeah, just sign the book. See you later. Make sure you get back in time. Patient: No problem.	
7	Nurse: So, Ghazala, you are going out for the afternoon till 5.30. Can you sign the book before you go? Patient: I don't have to do it? That's what the Doctor said; I could just go as long as I come back on time. Nurse: Yes it's important to come back on time, so we know everything is ok, and we ask everyone to sign the book before they leave. Patient: But I thought I didn't have to? Nurse: Yes, we ask everybody to. So can you let me know when you are going and sign the book? Patient: Oh all right if I have to.	



IDENTIFICATION OF THOSE AT HIGH RISK OF ABSCONDING

BACKGROUND AND RATIONALE

When we conducted the first exploratory study of absconding we compared 175 absconders to 159 patients on the same wards who did not abscond. We then examined how these two groups differed on over 30 different characteristics. Many of these we found were associated with absconding in some way. In other words, the absconders had a profile that was different from that of patients who did not abscond. We then used a special statistical technique to discover which of these differences were the most important and most highly predictive of absconding.

The patient group who are most likely to abscond may have all or some of the following characteristics or behaviours:

- Absconded during a previous admission 9 times more likely to abscond
- Refusal of medication in previous 48 hours 3 times more likely to abscond
- 35 years or under 3 times more likely to abscond
- Male 2 times more likely to abscond
- Diagnosis of schizophrenia 2 times more likely to abscond

You can weight each of these risk components, and total the score. Possession of all five characteristics means that the patient is 19 times more likely to abscond than the patient who possesses none of these characteristics. There is no magic cut off point, but the score is an indicator of risk, and alerts you to target the patients' who fit the profile of a potential absconder.

HOW TO DO IT

Administer the profile when reviewing existing patients, as well as with new admissions, totalling the risk score in your head. A score of 7 or above is a rough guide, but also use your clinical judgement and what the patient says to reach a decision. When you have identified a patient at high risk of absconding, place a symbol on the ward board against the person's name. This will remind you, and the rest of the team that the intervention should be implemented with this patient. Make sure that the symbol is different from those that are in use for other purposes. We found some of the wards we have worked with like to use a green spot, indicating that the patient is likely to 'go'.

CLINICAL JUDGEMENT

It is important to remember that the total score according to the risk factors outlined above, provides an indicator of risk but it is still important to use your clinical experience and judgement. If someone scores a low total but you have good reason to think the patient is at risk of absconding, it will still be good practice to carry out the procedures recommended in this workbook anyway.

EXERCISE TO WORK THROUGH

IDENTIFYING POTENTIAL ABSCONDERS

Eight case examples are described. After reading and reflecting on each one score the risk factors accompanying each case. Then total them to assess the risk odds ratio, and complete the section on the scoring sheet. For example, a diagnosis of schizophrenia would score 2 and absconding on a previous admission scores 9. This would total 11. Write the total score under the 'Risk' column.

The patient group who are most likely to abscond may have all or some of the following characteristics or behaviours:

- Absconded during a previous admission 9 times more likely to abscond
- Refusal of medication in previous 48 hours 3 times more likely to abscond
- 35 years or under 3 times more likely to abscond
- Male 2 times more likely to abscond
- Diagnosis of schizophrenia 2 times more likely to abscond



Case	Risk
1 Christine is 29 years old, and a single parent. Her Mother is looking after her child, but Christine misses her and is worried that she is not being looked after properly. Christine lives in a high-rise building, and she has been burgled several times in the past. She is worried that that this will happen again whilst she is in hospital. She suffers from bipolar affective disorder, and has absconded during previous admissions. She believes that she should not be in hospital, and has refused to accept medication since she was admitted to the ward 48 hours ago.	
2 Vincent is 32 years old, and lives with his Father with whom he has a difficult relationship. Vincent developed symptoms of schizophrenia when he was at university, and has made several serious suicide attempts. He dislikes hospital and is anxious to leave, but cannot do so until a suitable placement is found for him. Vincent has had frequent admissions to hospital, and has never absconded. He is accepting medication now, but refused it when he was first admitted because he disliked the side effects.	
3 This is Peter's first admission to hospital. He is 18 years old, and has been prescribed anti-psychotic medication. Initially he accepted the medication, but during the past 24 hours he has refused stating that it slows him down. Peter has a history of substance misuse, and has been found in possession of cannabis on several occasions during admission. He lives with his Mother who does not agree that he should be compulsorily detained or medicated. Peter constantly states that he misses his girlfriend and friends. He has tried to abscond on several occasions.	
4 Brenda is 34 years old and has been diagnosed as borderline personality disorder. She was admitted following an overdose of paracetamol, and has made several self-harm attempts since then. She has absconded during previous admissions, and constantly requests increased doses of minor tranquillisers. Brenda has a very stormy relationship with her partner, and they each have two children from previous marriages. The children are on the social services at risk register, and Brenda is very worried about the safety of her own children in particular as she maintains that her partner treats them differently from his own, and is too strict with them.	
5 Jacob is 35 years old, and lives in supported accommodation. He suffers from paranoid psychosis, and relapsed prior to admission because he had stopped taking his medication. Jacob is extremely suspicious of the staff and patients. Apart from mealtimes he refuses to come out of his room, and has had several altercations with staff when they try to stop him smoking in bed. He has had several admissions, but has never absconded from hospital. Jacob is extremely suspicious of his medication, and started to refuse it 24 hours ago. He has been told that if he continues to be non-compliant it will be given intramuscularly.	
6 Victor is 51 years old, and has a long-term drink problem. He has absconded during previous admissions, and usually returned to the ward in an inebriated dishevelled state. Victor's partner is a recovering drug addict. She suffers from pancreatitis, and is very dependent on him. He is very worried about her ability to cope on her own, and has been unable to contact her because the telephone was disconnected recently, and she has run out of credit for her mobile phone.	
7 Roy, 52, is homeless and regularly sleeps rough or in hostels. He hates psychiatric hospitals and avoids meeting the CPN when he visits the local day centre for homeless people. Roy was recently admitted under a section of the Mental Health Act and has been very quiet and withdrawn since. It is thought that he might suffer from chronic schizophrenia, but he also drinks heavily. He has no family in the area.	
8 Olinda is 53. She has suffered from an extreme anxiety disorder for most of her life, and used to take high levels of benzodiazepines. These have recently been reduced under the supervision of her psychiatrist, which led to her admission following a suspected suicide attempt at the local railway line. Her 27 year old daughter who brings her food and magazines to read visits Olinda regularly. She has never been in a psychiatric hospital before.	

TARGETED NURSING TIME FOR THOSE AT HIGH RISK OF ABSCONDING

BACKGROUND AND RATIONALE

Our interviews of 62 returned absconders showed us that there was no single reason why they did so. Instead patients have a range of reasons as to why they abscond. Although we found evidence that psychiatric symptoms contribute to the decision to leave, in nearly every case patients we interviewed gave additional and rational reasons for absconding. Highly prominent among reasons for absconding were:

- Home related concerns (bills, pets, plants, neighbours, washing, clothes, security and burglary, etc.)
- Homesickness (wanting to be in comfortable own territory)
- Missing friends and relatives

A quarter of absconding patients we interviewed mentioned feeling isolated from friends and family, and nearly half felt homesick. Not all absconders had these feelings. Some were visited frequently and others did not desire any contact with their family. However for those that wanted more contact and did not get it, being in the acute psychiatric ward could be a lonely experience. Hence most absconders went home or to family and friends on leaving the ward, and many gave social contact as a reason for leaving the ward. The patient's home (when they had one) was a source of worry and preoccupation for absconding patients. This and other everyday responsibilities created reasons for patients to need to leave the ward without permission. So some patients left the ward to obtain personal property from home,

others left to deal with unpaid bills, keep the home clean, or just to check on the house in case of burglary. Other patients worry more about their responsibilities to others, with children and elderly relatives both being mentioned as in need of care and attention from the patient.

Admission to hospital is a profoundly socially isolating experience. Many of the absconders we interviewed complained they did not see enough of their family and friends, and worried about how they were getting along or managing whilst the patient was in hospital. The social and family networks of psychiatric patients tend to be restricted and frail. Admission to hospital places a further stress upon these networks, which may be highly prized by the patient. It is particularly striking

how one in three male patients went directly to visit friends or seek friendly companionship on absconding from the ward. It is all too easy for us to have a rosy view of the nature of the acute psychiatric ward as a friendly community of people. Just because people are severely mentally ill does not mean they have so much in common that they must be friendly, understanding and supportive to each other. In fact, they're more likely to be like any other random group of people temporarily gathered together: superficially polite towards each other with the blossoming of friendship comparatively rare. For the patient with defective social skills, making and securing friendships on the ward may be difficult or impossible. Thus, even in the midst of people with similar difficulties, being a patient can be a lonely experience.

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RATIONALE

Patients also worry a great deal about their house or flat while they are in hospital and are quite literally homesick. Many have not travelled a great deal and may not be used to being away from home. Many are relatively poor and may have taken a long time to accumulate property or arrange their home in the way they wish. It is sobering to think of the elaborate preparations made by any person before they leave home to go on holiday: unplugging appliances, emptying the refrigerator, making arrangements with neighbours to collect mail, giving a key to a friend and asking them to check every so often, setting a burglar alarm, etc. For the psychiatric patient admitted to hospital there is little time, ability or resources for this preparation. Everything happens in a hurry, if not as a surprise to the patient. Little wonder that

they worry about their home, about bills being paid or their electricity being cut off, and most of all about being burgled. This is a serious and rational worry, as many patients live in areas where burglary is very likely to befall any unoccupied property. Two absconders in our study had their flats burgled while they were in hospital. Crudely extrapolated, this suggests that one out of 26 patients admitted will have their homes broken into while they are in hospital. Other absconders related how this had happened to them on previous admissions, and how they worried about it happening again. Little surprise, then, that worry about their homes and the practical affairs related to their upkeep leads some patients to abscond.

HOW TO DO IT

Nursing time of at least 15 minutes per day should be targeted at those patients identified at risk of absconding. In order to make this happen, responsibility for carrying it out needs to be allocated at the beginning of the shift. Towards the end of the shift, the shift co-ordinator should check with others on duty that the task has been carried out for all the patients at high risk of absconding. Preferably the patient's named nurse should give this time, but a substitute should be nominated if the named nurse is not on duty.

During those 15 minutes, the patient should be encouraged to share their worries and concerns about hospitalisation, their homes, property, and their social networks. Once the patient concerns have been identified, creative means should be found to address them where possible. These should not be done 'off the cuff' or alone, but as part of a good risk assessment, multidisciplinary discussion and decision making.

- Can someone (friend, neighbour, worker)
 - go round and check the property?
 - bring things (clothes/paperwork) in?
- Can you help the patient deal with bills/money from hospital?
- Get patients home more often:
 - Are there other people who could help the patient visit home?
 - Support workers, social workers, CMHT care co-ordinators, hostel workers, student nurses, church workers
 - Friends and relatives as escorts and guarantors
- Make compromises – be more prepared to agree limited leave rather than risk absconding
- Promote telephone, text message, mail contact
- Facilitate contact, make it easy for the patient
- Get to know about patients' social networks/contacts/employers/colleagues, etc., make it easy for them to be in touch
- Welcome visitors to the ward



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EXERCISES TO WORK THROUGH

FACILITATING HOME AND SOCIAL CONTACT

The following exercises will help you appreciate more fully what it is like to be a patient on your ward.

1. List the comforts of your home. What is important to you? What would you miss most if admitted to hospital?

2. List the preparations you make before leaving your home and going on holiday.

4. List the things that affect maintaining contact, e.g. visiting hours, access to phone, limited public transport, relatives looking after children/elderly, etc

3. Consider your social network – who you would miss if admitted to hospital and why – list your top five and say how you would try to maintain contact

5. Interview a patient for 15 minutes about their home and social concerns, and write down what you found out (do not identify the patient by name):

See page 41 at the back of the workbook for some of the things we would miss when in hospital.

ANTI-ABSCONDING INTERVENTION - 4

CAREFUL AND PLANNED BREAKING OF BAD NEWS

BACKGROUND AND RATIONALE

In our previous research, we found that some patients leave impulsively and in anger following unwelcome news. About one in four absconders left in anger at their treatment. Some of these had long term dissatisfactions with psychiatry, but others left impulsively 'in a huff' following unwelcome events, such as refused requests for leave, discharge, or negative outcomes of Mental Health Review Tribunal hearings.

For example one patient told us "the night before I didn't sleep at all because of my tribunal and, my tribunal wasn't successful, that's why I left the ward without saying anything to anybody. Well I got my letter from the tribunal and when I looked at it, it said cannot be discharged, yeah, so I felt very angry and then I just left the ward.

Basically then I just ran away, because I know if somebody wants to catch me then they can yeah, then I took a black cab to my home." Another described how he had taken great pains to prepare himself for the ward round to present his request for leave, having a bath, putting on his best clothes, only to have his request summarily rejected. Perhaps we don't always realise how emotive and how important it is to the patient to get a positive response to their requests. To the staff, refusal is no more than a trivial delay in the patient's orderly progression towards discharge. To the patient, emotionally and practically, it might be considered a disaster - a crisis that may be further complicated and exacerbated by their mental state.

HOW TO DO IT

Be aware of occasions and events that might generate these angry reactions. Either work with the multidisciplinary team in the ward round to express the bad news sympathetically, or intercept the patient after it has happened. Then find a quiet place and give them time to express their feelings, acknowledge their frustration, express sympathy and empathy, perhaps make a friendly gesture like providing a cup of tea, or snack. Answer any questions honestly, giving the patient time, attention, and respect. Showing that you are receptive to patients' concerns can be achieved by some simple listening techniques such as making eye contact, asking about their worries, and using open ended questions, such as "Tell me more about it".

It is important to find out how much patients understand about the decision. This will allow you to correct any misconceptions that they have, frame treatment in as positive a way as possible. Patients may not be able to absorb all the information they have been given at the ward round for example. Following them up is a good way to assess their emotional state and understanding of the situation. However the shock and angry emotion accompanying bad news can create confusion or hinder understanding. This may be compounded by the patient's illness or the medication they are taking. Making sure that patients understand the decision and acknowledging their feelings can improve the relationship and will make absconding less likely.

EXERCISES TO WORK THROUGH

DEALING WITH PATIENT DISSAPOINTMENT

DISAPPOINTED PATIENTS

Identify three examples where patients have been disappointed or frustrated by the decisions of the treatment team recently on your own ward.

1	
2	
3	

THE FEELING OF DISAPPOINTMENT

Give three examples of when you have been disappointed over decisions that have affected you, or that you felt were unfair or unreasonable. Such examples might be things like:

- Had been acting up, and expected to be appointed to the post, but someone else was successful
- Had been looking forward to spending Christmas with the family, but the ward manager told you that you had to be on duty
- Had received a poor mark for a piece of academic work that you thought was good.

Example	Describe feelings and thoughts
1	
2	
3	

WORDS THAT MAKE THINGS BETTER OR WORSE

A series of words and phrases follows. They include words that might exacerbate or calm patients down during and after the receipt of bad news. Please read through the list and consider which are the more positive items and the best ways of responding to the patient. Which are least helpful? Consider situations where some of these responses may make things worse rather than better. As you go through the list, score each phrase with 1 for the more effective responses, 2 for the least useful ones, and 3 for those about which you are uncertain.

Never mind. Tell me more about it You will prolong your stay if you continue to argue about your treatment. Do you understand the news that was given to you? I am only telling you what the Doctor decided. What aspect of the news makes you most fed up? No I can't change the rules A few more days won't make any difference What did you think was going on with you when you were admitted? How many times do I have to tell you? Do you worry about being in hospital? What have you been told about your treatment so far? You can't go out until the Doctor says so Hearing that your section has been renewed is clearly a major shock to you	It's for your own good How does that make you feel? You can't be trusted Are you worried that you haven't been told everything? I'll talk to you after the handover. I wish the news were better The sooner you settle down the sooner you will be allowed out. What do you think about what you've just been told? It's not that bad is it? Obviously this piece of news is very upsetting. There is nothing to worry about, just try to relax. Clearly this is very distressing. Look at the information sheet that I gave you about your section. That's not what you wanted to hear, I know. Whatever.
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ANTI-ABSCONDING INTERVENTION - 5

POST-INCIDENT DEBRIEFING

BACKGROUND AND RATIONALE

Patients react with fear after ward events or episodes. Events such as violence, absconding, the admission of disturbed patients, arguments and containment measures like physical restraint. Even relatively minor events might be frightening in certain contexts. An example given by a patient during our research described how a newly admitted patient grabbed her arm. In itself the event was not particularly aggressive or threatening, but in the context of an acute ward it was enough to frighten the woman so much that she left. Night time may be particularly frightening for patients particularly if they are unused to the environment where they may be sharing a sleeping area with other people that they do not know, and illness may make them particularly vulnerable to additional stress. Patients may wake to the sound

of shouting in the middle of the night, and lie awake fearfully imagining what might be going on. One patient in our research described being terrified in these circumstances, and absconded the next morning.

Patients are also affected by the stereotypes and the stigma attached to mentally ill patients as portrayed in the media. They too may perceive their fellow patients as strange or frightening. The commonplace media picture of madness as uncontrolled violence also permeates the patients' views of each other. They may be sure that they themselves pose no threat to others, but they are by no means sure about the other patients on the ward not posing a threat to them. Occasionally these fears are overlaid with paranoid ideation or

delusions, producing a powerful motivation to abscond or leave. More frequently, just plain unembellished fear of assault is motivation enough. Any confrontation between patients, or between patients and staff, even if only verbal, can raise the anxiety of patients to unbearable levels. Of course patients' fear of assault is not entirely groundless. Violent events do happen on psychiatric wards, and they are sometimes, albeit rarely, very serious. Nearly a half of the absconders in our research expressed fears of other patients.

HOW TO DO IT

Of course our first concern when an incident occurs is to deal with it in a way that prevents injury to the patient concerned or us. Often our next action is to care for the victim if there is one, or to discuss the event with the rest of the team, in order to both ventilate feelings and learn from each other how to manage better next time. Last on the list, and often ignored, are the other patients on the ward, who may be completely unsettled without having their feelings and fears dealt with.

So after any incident, however small, especially at night:

- Assess the impact on all patients, including those at high risk of absconding.
- Defuse the situation by allowing them to ventilate thoughts, emotions, and experiences associated with the event and provide "validation" of possible reactions.
- Predict events and reactions to come in the aftermath of the event.
- Look for maladaptive behaviours or responses to the crisis or trauma, e.g. Patients hiding in their rooms
- Look out for patients, and be aware of how they are responding, ask them if they are worried, listen to them, reassure them, for example by saying that the staff are here to manage incidents like that and to keep everyone safe.
- After any event check out with people what the effect has been.
- Facilitate open discussion amongst patients after an event
- Bring "closure" to the incident "anchor" or "ground" patients, and start the rebuilding process (i.e., help identify possible positive experiences from the event).
- Debriefing assists in the "re-entry" process back into the ward community. Debriefing can be done in large or small groups or one-to-one depending on the situation.

There are several over-arching goals, including: being responsive to an urgent situation, assuring safety, using the ward setting to discuss events that are ongoing, providing an outlet for discussing thoughts, feelings and reactions to the event. Make sure patients feel safe and do what is necessary to guarantee safety:

- Maintaining structure and the usual daily routine is reassuring.
- Try to allow some focused time each day to spend on discussion of ward events and debriefing of patients - perhaps in a community meeting or other consistent and appropriate place in the daily schedule
- Keep open channels of communication so that patients feel safe to tell staff about their concerns. Remember that they may be traumatised in other ways by other patients who bully, intimidate or sexually harass them.

What to say to your patients and how to say it

- Let your patients know that you (and other staff) are there to LISTEN and to answer questions
- Let your patients know that it is normal to experience many different thoughts and feelings after experiencing an event
- Let your patients know that you and they will find ways to cope with the event
- Use your judgment as to how much factual information is appropriate following individual patient's cues as to how much is enough
- Use words that your patients will understand
- Allow your patients to tell you what they understand about the event
- Allow some opportunity for patients to say how they feel
- You CAN share your concerns about the event with patients, but try to leave them feeling safe at the end of the conversation



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EXERCISES TO WORK THROUGH

ENSURING SAFETY AND UNDERSTANDING

HELPFUL AND UNHELPFUL RESPONSES

A list of positive and negative responses to ward events follows. Tick the positive responses.

Oh you don't want to worry about Jim - he's always like that

Are you worried about your safety?

Are you worried about the safety of other patients or the nurses?

Everything is all right. Jim has had an injection, and we have taken him to his room.

I know Jim sounded upset, but it is just his illness. Don't think about it anymore, go and have a cigarette.

Jim wouldn't hurt a fly really

God! We get worse things than that happen here. Last time he kicked off it took seven of us to get him into seclusion.

Shall we put the telly on? It's Countdown in a minute.

That was a bit scary wasn't it? How are you feeling now?

Are you shaking or is that just your medication? No, only joking love.

OK. Judith is being looked after by two of the nurses now. She's a lot calmer. How are you feeling? Oh you don't want to worry about Jim- he's always like that

STRANGE PLACES

Recall a time in your life when you were in a strange and alien environment. For example your first day at school, or in a new job, or your first day on the wards as a student nurse. Describe what this experience felt like. What were your first impressions of people, and how did these differ from your later experience of them?

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MULTI-DISCIPLINARY TEAM REVIEW FOLLOWING TWO ABSCONDS

BACKGROUND AND RATIONALE

A small minority of patients abscond repeatedly. In fact our studies have shown that one in four absconders do so more than twice, and they account for 67% of all absconds. In other words, one quarter of all the absconders account for two thirds of absconds.

HOW TO DO IT

When a patient returns or is returned following an abscond, check to see if they have absconded during this admission before. Try to discover the reasons for their absconding by asking them. If they have absconded two or more times, initiate a multi-disciplinary discussion and decide upon an action. This discussion may be fairly informal and just be a discussion with the doctor on call, nurses and the patient, or if convenient, the full ward round may be used. During that meeting, review options and decide upon action plan that is related to the reasons identified for the absconding, and the risk assessment of the patient concerned.

Possible options might be:

- Re-negotiate care with the patient to include more planned leave – compromise with the patient
- Find alternative ways to meet the patients needs – supervised access to home or other things described previously in this workbook
- Find ways to deal with their fears or worries of other patients
- Transfer to a locked ward
- Put on special observations at an appropriate level and intensity

• Lock the ward door

- Set up activities – give them something to do (boredom is a big reason for absconding)

A repetition of an abscond is also an indication that the patient's risk assessment should be reviewed and updated.

EXERCISES TO WORK THROUGH

PROVIDING A TEAM RESPONSE TO REPEAT ABSCONDERS

What questions would you ask a patient when they return / are returned from absconding?

What factors might lead you to suggest transferring a repeat absconder to Psychiatric Intensive Care?

A MULTIDISCIPLINARY REVIEW

A simulated transcript of a multi-disciplinary review follows. You can critically analyse this, and write down anti-absconding points that were missed or aspects of the review that could have been handled better.

Background: Jim has absconded on two occasions. On the first occasion he was persuaded to return to the ward by his partner, she was very distressed when he came home unexpectedly. The children were upset because Jim was shouting that he was not ill, and said that his wife was in league with the doctors. When Jim returned to the ward Nurse X asked him why he had absconded, and Jim said that he missed his children, but his wife would not let them visit the ward because she thought that they were too young to understand

what was wrong with him and the other patients. The second abscond occurred after Jim had been told that he could not use the office telephone until the staff meeting was over. Jim went home again, but his wife was picking up the children from school. Jim went to find her, and she was embarrassed because he got down on his knees, and pleaded with her to let him come home in front of the other parents. As per the anti-absconding intervention the staff organised a Multidisciplinary Review.

Consultant Now Jim the staff has told me that you have left the ward twice. Do you remember what I told you last week?

Jim What do you mean Doctor?

Consultant About us wanting you to stay on the ward until you are well enough to go out.

Jim I am well enough. I've just been a bit upset and mixed up, and no one told me that I wasn't allowed to go out at all

Nurse Jim you were told, and you went out without asking us or signing the book

Jim The office door was shut, and I knocked but you told me to come back later. What book I haven't seen any book.

Consultant Okay Jim lets start again. You are on a section 3, and that means that you are only allowed out if I sign a form, and then it is up to the nurses whether they think you are well enough to go.

Nurse The staff have been talking to Jim every day, and he has told us that he misses his family really badly, and is worried that his wife won't have him back when he is better.

Consultant Is that right Jim? You know that your illness makes you think these things sometimes.

Jim She is fed up with me Doctor, and she keeps telling me that I have to stay in hospital.

Nurse We have been thinking about this, and maybe we could arrange to book a room for this weekend so that Mrs X and the children can see Jim off the ward.

Consultant What if that could be arranged would you stay on the ward?

Jim I don't like being shut up in here with no fresh air it's making me worse.

Consultant Okay you can go out in the grounds with a nurse for 15 minutes in the morning and 15 minutes in the afternoon, as long as you don't leave the ward again without permission. Then if that goes all right we will gradually let you go out for longer periods.

Jim Can I go to the shops as well?

Nurse No Jim we will take you out into the grounds, and arrange for your wife to visit, and then we will see how that goes because we want to make sure that you are safe. Do you remember what happened before you came into hospital?

Jim I stopped taking my tablets because they weren't doing me any good, and the people in the flat downstairs started to follow us about. They were going to do something to the children so I kept us all indoors.

Consultant Well Jim your wife and children have been all right since you were admitted haven't they?

Nurse You can telephone again after this, and see them at the weekend. We will ask your wife to bring plenty of change so that you can use the public phone. Or is there anyone else who could bring some money in.

Nurse [To Assertive Outreach Worker (AOW)] Could you pop in and see Jim's wife, and get some money?

AOW Yes I can do that later today, and bring it in tomorrow. Is there anything else you want from home Jim?

Jim I need my other jeans and a few tee shirts and underwear. Oh and a photograph of the kids

Consultant Right Jim so we have made a plan. Nurse X will go over it again, and then you tell us if you understand everything.

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Nurse Okay Jim you are allowed out into the grounds with one of the nurses for 15 minutes in the morning and 15 minutes in the afternoon.

Jim Only in the grounds. Not to the shops?

Nurse No Jim, not yet we will see how you get on in the grounds first with a nurse for fifteen minutes in the morning and fifteen minutes in the afternoon.

Jim Okay only in the grounds, not on my own and only for fifteen minutes

Nurse Twice a day

Jim Yes twice a day with a nurse

Nurse We will let you use the office phone to talk to your wife, and you can ask her to give the AOW some money and clothes for you

Jim Can I go and phone her now?

Nurse Let's just finish talking about the plan. We will try to get a room so that you can see your wife and children off the ward at the weekend.

Jim I really want to see my kids.

Consultant I know Jim, but can you wait for a couple more days?

Jim I suppose so as long as I can talk to them on the phone. They keep on asking where I am.

Nurse Right Jim I have written down what we have agreed for you so that you won't forget. I will come with you to the office and explain to nurse X what we have said. She will talk to you about it, and arrange for you to use the phone as soon as possible.

What do you think about the review above? What was good? Was anything missed out?

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ANTI-ABSCONDING INTERVENTION

THE FINAL TEST

Now that you have worked through the material you can test yourself with the following multiple-choice questions. Tick the correct answer that appears after the following statements:

1. Which of the following is a risk factor for identifying patients at most risk of absconding?

- a) Over 40
- b) Dislikes medication
- c) Absconded on previous admissions
- d) Suffering from depression
- e) Vegetarian

2. Someone who has absconded before is:

- a) Just trying to get some attention
- b) Probably claustrophobic and needs some medication
- c) Confused
- d) Going to waste a lot of our precious time
- e) More likely to abscond again

3. What is the primary aim of targeted nursing time with patients at most risk of absconding?

- a) To persuade them to go to occupational therapy
- b) To ask them if their medication is working
- c) To talk to them about getting a job
- d) To distract them by talking about what is in the news
- e) To encourage them to talk about social concerns

4. Patients at most risk of absconding tend to worry about which of the following things?

- a) Gaining weight
- b) Home security
- c) Never getting out of hospital
- d) Being given the wrong medication
- e) Ward rounds

5. If a patient is concerned that his/her flat might be burgled, it is best to:

- a) Reassure the patient it is probably OK
- b) Try to make arrangements for family or friends to go and check on the flat
- c) Arrange for qualified staff to accompany the patient home
- d) Reassure them that you have never been burgled
- e) Initiate a multi-disciplinary review

6. The signing in and out book is used in which of the following ways?

- a) Patients only have to sign in and out if they are leaving the grounds
- b) Patients don't have to sign in and out when they go to occupational therapy
- c) Patients do not have to sign in and out if they go to the hospital shop
- d) Patients sign in and out as they leave the ward at any time
- e) Nurses sign patients out after they have left the ward

7. Where should the signing in and out book be kept?

- a) In the nurses' office next to the kettle
- b) In the nurses' office in a clearly marked place
- c) Near the ward door visible to all
- d) In the patient's lounge
- e) In the doctor's office

8. When is the best time to break bad news to patients?

- a) During the ward round
- b) After patients have had their medication
- c) When the patient asks about the rules
- d) When you have made enough time to talk to the patient in private
- e) When the patient is in a bad mood

9. When patients become upset by bad news you should:

- a) Give them your full attention
- b) Try and divert them by getting them to talk about something else
- c) Stop them from getting angry or upset
- d) Give them PRN medication
- e) Provide diversionary activities e.g. table tennis

10. Following difficult incidents on the ward, it is best that:

- a) They are forgotten about as soon as possible
- b) They are not be talked about too much otherwise patients will worry
- c) Patients should be given an opportunity to say how they feel
- d) Patients should be encouraged to go to their rooms until they feel less anxious
- e) They are quickly smoothed over so that patients can settle down

11. Patients who abscond more than twice should be:

- a) Grounded
- b) Transferred to a locked ward
- c) Given one more chance
- d) Told that if it happens again their leave will be stopped
- e) Given a multi-disciplinary review

How did you get on? The answers are on the next page of this workbook.

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MARKING

INTERVENTION 2 - IDENTIFICATION OF THOSE AT HIGH RISK OF ABSCONDING (from page 15)

THINKING POINTS

Example 1: This was far too vague. We suspect the nurse didn't check the patient was allowed out, nor did they ask the patient to sign the book, or define an expected time of return. Not only that, but this is the type of passing agreement and conversation that gets so easily forgotten during a busy shift on the ward.

Example 2: This was very vague the leave amount was unspecified nor was the time that the patient planned to leave or return.

Example 3: The rules were made clear and the agreed amount of leave was consistently enforced with the aid of the signing in and out book.

Example 4: The nurse did not check the patient's leave status, clarify the amount or use the signing in and out book.

Example 5: The exact amount of leave was not communicated clearly.

Example 6: Far too vague with no clarification of the exact amount of leave, and a casual approach to signing in and out.

Example 7: The nurse did not check the exact time of departure, but the response was positive in that she/ he did not give in to pressure, and showed a consistent approach to the use of the signing in and out book.

MARKING

Communication we thought was 'good enough': examples 3, 7.

Communication we thought should have been clearer: examples 1, 2, 3, 4, 5.

INTERVENTION 3 - TARGETED NURSING TIME FOR THOSE AT HIGH RISK OF ABSCONDING (from page 21)

Do these things appear on the list of things you'd miss in hospital?

- Pubs and clubs
- Social networks
- Girl/boyfriend partner or spouse
- Mother, father children
- The family
- Your own bedroom/bed
- Bathroom/ lavatory
- Own safe storage space
- Eat and drink when you like, and have what you want
- Go out, and come in when you feel like it
- Own personal space - no need to talk if you don't want to
- Wear what you like
- Bath/shower in private and as often as you like
- Your garden
- Relax with a drink
- Smoke whenever you like
- Put your feet up in front of the TV
- Listen to the radio, and play music when you like
- Read in bed
- Watch TV in bed
- Take the dog for a walk or play with the cat
- Cuddle your children whenever you like
- Cuddle your partner whenever you like

THE FINAL TEST

- 1. c
- 2. e
- 3. e
- 4. b
- 5. b
- 6. d
- 7. c
- 8. d
- 9. a
- 10. c
- 11. e

I confirm that this workbook has been successfully completed by:

Name

.....

Nurse's signature

.....

Ward Manager's signature

.....

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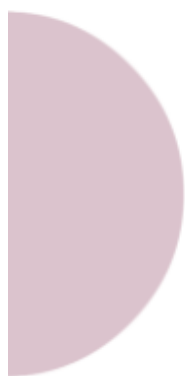
Appendix 2



The University for business and the professions

The Anti-Absconding Intervention:
A Handbook for Ward Managers

Department of Mental Health
and Learning Disability



THE ANTI- ABSCONDING INTERVENTION A HANDBOOK FOR WARD MANAGERS



Written and produced by Alan Simpson, Jane Alexander & Len Bowers
Design by jerometurner.co.uk
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All the researchers behind the work described in this book would like to acknowledge the support and assistance they have received from staff in East London and the City Mental Health NHS Trust in carrying out the research on which this handbook is based.

East London and The City 
Mental Health NHS Trust

THE ANTI-ABSCONDING INTERVENTION



BACKGROUND

Since 1998 in the East End of London we've been conducting research on absconding by patients on acute psychiatric wards. That research has enabled us to find out how to reduce absconding rates by at least a quarter. In the accompanying **Workbook**, we have summarized what we have learnt, and devised some material for your staff to work through, so that you can use this method to reduce the rate of absconding from your ward. This **Handbook for Ward Managers** provides some guidance, built on our own experiences, on how best to introduce and review the anti-absconding intervention to ensure its successful implementation.

We're confident that you can reduce the rate of absconding on your ward because of the findings from our three studies of absconding (if you want to read about these in detail, the references are at the end of the workbook). In the first exploratory study of absconding, we looked at all absconders from 12 acute psychiatric wards over a period of five months. This is the largest study of absconding that has ever been conducted anywhere in the world. We logged 498 absconders by 175 absconders. We interviewed 62 absconders on their return, 24 nurses on the topic of absconding, and 6 carers or relatives. In a subsequent study we examined the relationship of absconding to other difficult behaviours (e.g. aggression) in 238 two-week admissions during 2001. Then, in 2002, we tested the intervention described in the workbook, to see if it really made a difference. That test took place on five acute psychiatric wards, and we demonstrated a 25% reduction in absconding rates.

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WHY IS REDUCING ABSCONDING IMPORTANT?

When patients abscond we spend a great deal of our nursing time worrying about them, completing paperwork, making phone calls, and trying to get absconders back to hospital. That's not just nurses and ward managers, but often doctors and administrators too. Valuable time that we could all make better use of. Much police time is also taken up with processing paperwork, and going out to find absconders. In our part of London, police are notified of absconds over 500 times a year. But all this time taken up by patients who run away pales into insignificance when we think of the potential negative consequences of absconding. A small number of absconds (3.6%) result in harm to the patient or to others. In fact we know from other research that about a quarter of inpatients that commit suicide do so after absconding from the ward.

On very rare occasions there have been homicides by absconders. Absconding more frequently results in interrupted treatment, and often, prolonged hospital stays. In some cases patients travel so far that they are lost to psychiatric follow up entirely. This is not to speak of the loss of confidence by relatives in us, when they discover that we have not kept their loved one safe.

All the above are really good reasons for tackling absconding. If we can reduce absconding by 25%, then we can reduce the anxiety by 25%, and our absconding paperwork time, police time, carer worry, and negative outcomes. By following the guidelines in this handbook and introducing this intervention - and encouraging your staff to use the workbook - that is what you have to gain.

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THE ANTI-ABSCONDING INTERVENTION

1. Rule clarity: use of a signing in and out book
2. Identification of those at high risk of absconding
3. Targeted nursing time for those at high risk
 - Dealing with home worries
 - Promotion of controlled access to home
 - Promoting contact with family and friends
4. Careful breaking of bad news
5. Post-incident debriefing
6. Multi-disciplinary-team (MDT) review following two absconds

These are not the only ways to reduce absconding, but they are the ones that we put to the test. Not only did they reduce our absconding rates by 25%, but also at the same time we were able to reduce the number of daytime hours during which the ward doors were locked. However locking the ward door, or the use of special observation, can still be measures that are necessary from time to time.

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PREPARATION AND INTRODUCTION

The success of any new procedure or intervention will be largely determined by people's first impressions of it. The **Anti-Abscending Intervention** is a positive change for good that will benefit patients, staff and relatives and should be seen as such. To that end, it is important to prepare fully and to think about the best way to introduce the new intervention.

- Read through the workbook yourself and complete the exercises to ensure you fully understand each component of the intervention.

- Ensure you have the necessary resources (workbooks, table, book, pens, forms, poster) before starting.

- Distribute a letter or memo to staff stating the commitment of the ward to the reduction of absconding on the basis that this will improve patient care and reduce staff stress.

The letter should include a statement regarding the aims of the anti-absconding intervention that emphasises an improved quality of care and patient safety. It should also stress the detrimental effects and risks associated with absconding. Use the information contained in the workbook.

The letter needs to assure staff that they will not be held responsible for patients absconding

during the transition phase as long as they are doing their job, and not being neglectful.

- Provide all ward staff with copies of the **Anti-Abscending Workbook**. Agree a timescale for completion of the books and sign each one off on completion on the appropriate page in the workbook. Encourage all staff to complete the workbook.

- Provide each member of staff with a laminated **Anti-Abscending Intervention reminder card**.

- Put up the **Anti-Abscending Intervention poster** in a prominent position.

- Communicate with colleagues (e.g. consultant psychiatrists, senior managers) to enlist their support and ensure a consistent approach to leave and absconding. Outline the gains for the multidisciplinary team.

- Hold team meeting(s) to discuss the aims of the intervention and set a start date for its implementation. Ensure all staff on all shifts are informed and involved. Concentrate on the positive aspects and avoid attempts to list all the reasons it will not work. It does work!

- Identify and select members of your nursing team who will help you to introduce and monitor the intervention. Try to choose those staff members who seem most supportive of the aims. Allocate specific tasks to particular people.

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IMPLEMENTATION

1) RULE CLARITY AND USE OF THE 'SIGNING IN AND OUT' BOOK

Check that all members of staff are aware of each patient's leave status, and that this is documented clearly in the notes. Make sure that the amount of leave is written beside the patient's name on the white board in the staff office, and that the details are correct. Make sure that staff communicate this information unambiguously to patients during the admission process, and as leave status changes for the duration of their stay. Informing patients should be seen in the context of ensuring clear communication and reducing the chances of patients leaving the ward through misunderstanding or confusion.

Use of the signing in and out book is a key component of the intervention and helps clarify rules regarding leave to patients and staff. Discuss the best place to position the book so that patients and staff can have easy access to it, and so patients cannot leave or return to the ward without signing out or in. For example, place the book on a small table opposite the office door, and put a sign above this reminding all patients to follow the procedure. Ensure a pen is always available with the book. If the book is placed on a shelf in the office or on the desk it may not be used effectively. Remind staff of the importance of using the book and make regular spot checks.

2) IDENTIFICATION OF PATIENTS AT MOST RISK OF ABSCONDING

Identify the high-risk absconding group. Actively involve day and night nurses and health care assistants in this process. Ensure the process is systematic and methodical. Focus on one patient at a time and leave sufficient space for team discussion and collaboration. Make sure that staff document the process in the patient's notes, and that they place an appropriate symbol on the ward white board beside high-risk patients' names.

Keep a record of absconding. Accurate records help identify the time and circumstances around absconding, and highlight those patients at most risk of absconding again.

3) TARGETED NURSING TIME AND CONTROLLED ACCESS TO HOME

Ensure that the patients identified to receive targeted nursing time receive that time each shift. Encourage staff to use the targeted time to help patients identify concerns and potential problems and negotiate plans that will address and resolve these problems. The content of these contacts and outcomes should be recorded in nursing notes. Care plans might need to be updated in light of discussions. Patients that are receiving the intervention should be reviewed at handovers and ward rounds. Should a problem arise, the team should assess needs and seek suitable alternatives or adaptations as per the intervention.

Gather ideas from staff on how best to help patients arrange controlled access to home. Ensure that the issue of arranging controlled access to home is addressed in ward rounds. Promote the use of innovative approaches, e.g. encourage staff to involve relations, neighbours, friends and other members of the multi-disciplinary team. Ask members of the CMHT how they can help your team realise this.

4) CAREFUL AND PLANNED BREAKING OF BAD NEWS

Ensure that staff demonstrate an awareness of the possible reactions of patients at most risk of absconding when they receive unpalatable news. This may occur during ward rounds, Mental Health Act tribunals, following particular visits or telephone calls. Make sure that staff understand that they must accompany the patient out of the room, and either deal with the situation themselves or hand them over to another member of staff who can spend time with them.

5) DEBRIEFING FOLLOWING WARD INCIDENTS

During handovers ask the day and night staff if any incidents occurred on the ward. These might include someone being aggressive or violent, or someone absconding or attempting to abscond. Patients might be unsettled by the admission of a disturbed or loud patient. Ask them to recall the incident and specific aspects of debriefing. Have they spoken with the patients at risk of absconding? When did they speak to the patient? What can you tell you about what the patient said?

If an incident occurs during a shift, once the incident has been satisfactorily managed, ensure that one or more staff are deployed to speak with the patients and to encourage them to talk about how they feel.

6) MULTI-DISCIPLINARY REVIEW FOLLOWING MORE THAN TWO ABSCONDS

The multi-disciplinary team should review patients who have absconded on more than two occasions. Ensure that all staff institute this process. Continually raise the issue at handover. If someone has absconded, ask how many times and whether the person is due for a review by the team.

In meetings with other members of the MDT, take the opportunity to remind them of the benefits of the anti-absconding intervention and encourage them to support the review of patients who have absconded on two or more occasions.

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STIMULATING AND MAINTAINING INTEREST



Once you and your team have decided to start implementing the intervention it will be important to stimulate and maintain interest in order to maximise the success of the new policy. Ensure the anti-absconding intervention poster is in a key location. Consider moving it to a new location after a few weeks so people notice it again. Discuss the use of the workbooks in staff supervision sessions and during handovers. Keep the anti-absconding intervention at the front of everyone's minds.

Continually observe, monitor and feedback to staff the progress of the intervention. Review and reinforce understanding of the intervention and its aims in handovers, at team meetings and during ward rounds. Regularly encourage discussion of the use of the intervention. Employ case studies or examples from actual practice but ensure these sessions are used to improve practice. Remind people what they could and should be doing, rather than apportion blame or highlight failures. When a patient has absconded, use that as an opportunity to discuss and reflect on absconding and use the methods in the anti-absconding intervention to identify what might have been done to reduce the chances of absconding taking place. Again, avoid any blame.

Employ spot checks and regular reminders on the use of the signing in and out book. Remind staff to identify at risk patients and encourage them to debrief patients after all disturbing incidents on the ward. Use handovers and ward rounds to encourage the use of controlled access to home. If it helps, use a list to remind your self of the things you want to encourage and keep a check on.

Conduct regular reviews that the intervention is being used – is there mention of it in nursing notes, care plans, ward rounds and team discussions? Ask staff to tell each other examples of ways they have helped patients manage domestic difficulties that were worrying them. Share examples of how leave arrangements were used imaginatively and productively. Encourage discussion of episodes that staff found difficult and help the identification of options and solutions. Document the interventions that worked and those that were less successful. Remember that each patient is an individual and what does not work for one person might work well for another.

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MONITORING AND EVALUATION

Once the anti-absconding intervention is up and running it will be important to monitor and evaluate its implementation regularly to ensure that all components are being deployed. This will also allow you to intervene swiftly should you detect any difficulties. The following includes suggestions on monitoring and evaluating and some strategies that you can use should you encounter any problems. Look for evidence of anti-absconding intervention measures being used. This will include:

- Completed workbooks
- Poster in prominent position
- Signing in and out book and pen in right place
- Use of signing in and out book
- Patient care plans include anti-absconding measures
- Risk assessments include anti-absconding interventions
- Symbols on the white board in the office to denote patients at most risk of absconding
- Frequent discussion of anti-absconding measures undertaken
- Plans for controlled access to home discussed and arranged
- Multi-disciplinary team discussions of frequent absconders

Each part of the intervention is important. If any of these is not being fully followed, re-motivate staff by reminding them what the intervention will achieve and of the benefits for both patients and staff. Discuss any difficulties faced and encourage the identification of solutions. Make clear statements to people that you want these interventions done, or that you will be looking to see that they are done. This intervention is important and it will make a difference. Review its implementation during handovers, in community groups and in ward rounds. Use regular reminders and spot checks to keep the intervention at the front of people's minds.

Discuss use of the intervention with staff and patients and consider using the following suggestions.

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ON BREAKING BAD NEWS

Interview staff and ask about the breaking of bad news. Encourage them to identify times when patients received bad news and explore their responses. Help them consider alternative responses.

"How did you speak with the patient after they had received bad news?"
"How often did you speak to the patients? What did you say?"
"What can you tell me about what the patient said to you?"
"On reflection, can you think of another way you might have responded to their fears?"

Speak with patients and ask them about their experiences after they had received bad news:
"What did the staff talk to you about?"
"Did you find this helpful?"
"What was agreed?"
"Was this implemented?"

Consider feeding back patients' positive experiences to your staff as models of good practice. Explore less positive experiences as a chance to reflect, learn and improve. Avoid identifying individuals if possible.

ON WARD INCIDENTS

Interview staff and ask about how they responded after incidents on the ward. Identify the different kinds of bad news patients receive and help staff explore a range of responses.

"What did you do after a particular incident on the ward?"
"How did they respond to the patients' concerns?"
"What did they say?"
"How did the patients respond?"
"On reflection, how could you have handled that differently?"

Speak with patients and ask them about their experiences after a ward incident:
"How did they feel during and after the incident?"
"How did the ward staff respond?"
"What did the staff say? Did this help?"
"Would you have liked something different to have happened? If so, what?"

Again, try and use the experiences and viewpoints of the patients to inform staff reflection on how best to respond in these situations.

ON FREQUENT ABSCONDING

Interview staff about those patients at most risk of absconding. Find out how much they know about each patient and whether they can identify those who have absconded before. Ask them whether a multi-disciplinary review has been arranged where appropriate. Interview patients who have absconded before and find out the reasons for them absconding. Ask patients:

"Was there anything that could have been done to remove the need for absconding?"
"What can we do to reduce the risk of you absconding again?"
"How can we help?"

Use this valuable patient feedback to inform that individual's care plan and multi-disciplinary review but also to stimulate discussion and understanding of the reasons why people abscond and the measures that can be taken to reduce further absconding.

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ONGOING STAFF TRAINING AND SUPPORT

Education regarding the effects of absconding and prevention should be ongoing for staff. Mini-absconding reduction sessions lasting 15-20 minutes can occur on the ward, and are a valuable educational opportunity that will have benefits beyond the anti-absconding intervention. They could include case studies and problem solving sessions.

KNOWLEDGE AND UNDERSTANDING

Are the staff able to identify patients at most risk of absconding? Do they understand how to calculate a risk score for each patient? Use examples from patients on the ward so that the theory of the intervention becomes a practical reality. Explore with staff how they communicate their findings? Are 'at risk' patients being clearly identified in the ward amongst all staff?

Once patients have been identified as at risk of absconding, are staff spending sufficient time with those patients in order to find out what concerns and worries they may have? Are they formulating interventions satisfactorily following targeted nursing time with high-risk patients? Are they able to give or obtain help for patients who have domestic or other worries? Look out for barriers that may make it difficult for staff to successfully meet the needs of patients and help them identify solutions. You may need to discuss the intervention again with colleagues in community mental health teams or with medical or other staff to enlist their support in helping patients' access home or deal with domestic worries. You may have to help your nursing staff deal with conflicting demands.

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CASE STUDIES

Use the case studies from the learning activities in the workbook or write your own. Even better, encourage staff to develop scenarios based on their 'real life' experiences with patients on the ward. One way to make it even more interesting is to use a round where each nurse adds a piece of information to generate a case study. Use these cases to generate whole group discussions and problem solving. Role play common scenarios and identify useful responses. Encourage staff during handover to identify one thing that they learnt about absconding or preventing absconding and discuss it amongst the team.

Use the case studies to identify risk assessment skills and deficits. Encourage staff to think about what choices patients have when faced with their concerns, fears and upsets. What are the risks, what is likely to happen? What would be the best thing for the patient to do in order to solve their problem and what would be the worst? What factors might prevent the patient from doing the best thing? Encourage staff to empathise, to think about how the patient might be feeling. How could they get help, who could they go to for help? Why might they not seek help? How could the patient know what help was available from the staff, from the team, from friends or family? Are there measures the staff can take to increase patient awareness of more positive responses than absconding?? What might they do or not do to stop them absconding? What would they need to do to stop them from absconding?

QUIZZES USING THE WORKBOOK

Use quick-fire fun quizzes to remind staff of key aspects of the risk factors and interventions to reduce absconding. Use some of the questions in the back of the workbook or make up some of your own. Ask another member of the team to do this so they are encouraged to look at the workbook again.

DEVELOP SKILLS AND SENSITIVITY

How would you react if you had to leave home suddenly, and had no time to make arrangements or say goodbye to friends and family? How would you feel if you knew there were people at home dependent on you to pay bills, to sort out problems, to take children to school? Help staff to develop their listening and problem-solving skills. Use role play with one person playing the talker and another the listener – see how hard we often find it to listen and not immediately step in with reassurances. Listen to how patients feel. Encourage them to get help, to keep calm and look for solutions. Promote autonomy and encourage them to feel that they can do something about it. Why might the patient abscond? How might they be feeling? Why might it be difficult to help them? Seek to understand different social and cultural attitudes towards absconding. Encouraging patients to take responsibility for their own actions.

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FINALLY

We know from the research we have carried out that this anti-absconding intervention works. By following the measures outlined, you and your staff can reduce the likelihood of patients needing to abscond from your ward. By reducing absconding you and your team will have more time for other activities. All of this increases the amount of time staff can spend with patients and improves the patient experience. It is also likely to improve staff morale. Good luck.

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