

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Management of Poisoning and Drug Overdose in adult patients admitted to the Royal Victoria Infirmary

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Ratified By:	Directorate of Medicine Clinical Governance Committee

1 Introduction

This document sets out the operational policy for managing adult clinical toxicology patients admitted onto the RVI site. It is intended to guide medical and nursing staff, to provide information on the appropriate pathways of care and to detail the resources available to support management of these patients. It complements and is consistent with other trust policies and procedures that might apply in this setting.

2 Scope

This policy is directed at adult patients being managed by acute and general physicians in the Directorate of Medicine. It does not cover children (<16 y) or the management of patients in the Emergency Department.

3 Aims

The aim of the document is to support appropriate and high quality medical and nursing care that is consistent with NICE guidance.

4 Duties (Roles and responsibilities)

- The Chief Executive has overall responsibility for the implementation, monitoring and review of this policy
- This responsibility is delegated to the Clinical Director, Directorate of Medicine and the Head of Unit, Clinical Pharmacology.
- The Directorate of Medicine Clinical Governance Committee will review the policy and any new evidence base within the time frame set out in the policy
- It is the responsibility of the Trust/line managers and service heads to ensure that access to appropriate education and training is available
- It is the responsibility of all staff to ensure that they understand and implement this policy and attend training sessions as specified in their role

4.1 Nursing Responsibilities

The following principles should be applied, as mandated by NICE guidance. On arrival in the Assessment Suite (AS) the patient will be seen immediately by a nurse and allocated to a suitable bed. Medically unstable patients will be put in the monitored bay. The appropriate AS doctor will be informed of the arrival of the patient and this should be immediately if a patient is unstable or requires immediate treatment (e.g. paracetamol OD, early presentation who may require activated charcoal). A 12-lead ECG should be performed. Nursing staff may document the drugs/toxins involved, the doses and times of exposure and a brief description of the patient, as well as their initial observations (see section 6.4). An ECG should be performed if potentially cardiotoxic substances may be involved (see TOXBASE for details) and the patient should be weighed so that exposures can be calculated in dose/kg and to allow accurate prescription of antidotes (e.g. for paracetamol poisoning).

Some patients admitted with self harm are at risk of further episodes of self harm after admission to hospital and the Trust has a duty of care to minimise risk of this. Nurses admitting patients should ask permission of patients to check their belongings for potential hazards such as unused medicines, blades etc and remove these for safe keeping. A record should be made if the patient refuses to allow this and the case should be discussed with the nurse and doctor in charge of care – consideration of capacity and observation levels should be made and recorded. This information also needs to be handed over when responsible staff change over or when the patient is transferred.

4.2 Junior Doctor Responsibilities

The registrar (DECT 29918) or monitoring bay doctor (DECT 29888) will be informed of the arrival or impending arrival of the patient. It is their responsibility to ensure that review of the patient takes place with a priority that is appropriate to their clinical presentation.

It is the responsibility of the doctor who clerks the patient to ensure that all necessary investigations are done and that the results are chased up when necessary, recorded in the medical records and acted upon appropriately. This includes appropriate hand over of these responsibilities when going off shift.

Laboratory blood tests will be performed by appropriately trained medical staff as recommended on TOXBASE for the specific toxin(s). A record will be made in the multidisciplinary care pathway of the tests done and the time that these were taken. These staff may also insert an intravenous cannula if there is a clinical indication and they have received appropriate training. Further

information on appropriate use of laboratory tests, including access to joint guidance issued by the National Poisons Information Service and the Association for Clinical Biochemistry, is also available via TOXBASE (see below).

The doctor must arrange additional investigations if these are clinically indicated, e.g. blood gases. Note that chest X-rays are not usually required in poisoned patients unless there is a particular clinical indication, e.g. breathlessness, tachypnoea or suspected aspiration pneumonia.

Results of investigations should be entered in the care pathway as soon as they are obtained. It is particularly important to record the times that blood samples were taken, since this is critical for interpretation of plasma drug/toxin concentrations (e.g. paracetamol).

For patients with self-harm, evidence of ongoing or active suicidal thinking and mental capacity to refuse or accept treatment should always be assessed and documented clearly.

4.3 Consultant acute physician responsibilities

Patients with poisoning or drug overdose admitted to the Assessment Suite (AS) initially come under the care of the consultant physician responsible for medical admissions. They should be reviewed by the consultant in the same way as other medical admissions; there is a section of the admission proforma for this consultant assessment to be recorded. This means that patients admitted during the daytime and early evening on weekdays or at any time on weekends or public holidays will be reviewed by an acute medicine consultant. This ensures that, consistent with other medical admissions, these patients are seen by a consultant within 14 h of presentation.

4.4 Consultant clinical toxicologist responsibilities

At 9.00 a.m. on normal working days consultant responsibility for poisoned patients reverts to the clinical toxicology consultant, who conducts a ward round at which all adult toxicology patients in the hospital are reviewed. For patients admitted overnight, this will serve as the post take Ward round and there is no need for these patients to be reviewed routinely by the consultant physician responsible for medical admissions overnight. The consultant clinical toxicologist may be assisted by an advanced clinical fellow in clinical toxicology or SpR in clinical pharmacology, who is responsible for ensuring that an accurate list of patients is available, including patients in Ward 30 and all ITUs and HDUs on the RVI site. Patients for review on the toxicology ward round should be indicated as 'T' on the AS whiteboards so that it is clear who is responsible for the morning consultant review. Junior doctors from AS,

especially those who have managed patients overnight, are encouraged to present their patients on this ward round when possible.

Patients who need specialist toxicology input at other times during normal working hours can be referred to the toxicology SpR or Fellow, when available, via DECT 23709. When there is no response a consultant can be contacted directly (see section 6.2.2). Outside normal working hours responsibility reverts to the on call acute medicine consultant, but specialist consultant advice can be obtained on a 24/7 basis from the national consultant rota provided by the National Poisons Information Service (Tel 0844 892 0111).

Following the clinical toxicology ward round, consultant responsibility remains with the clinical toxicology consultant during normal working hours unless formally handed over to another team. Junior medical support is provided by the team covering the Ward where the patient is located, On AS, this is the F1 doctor looking after patients in the bay that the patient is in. Middle grade support can usually be obtained from the SpR/Fellow covering Toxicology (DECT 23709). Out of hours cover arrangements are as for other medical patients on the ward where the toxicology patient is located.

5 Definitions

Accident and Emergency (A&E)
Assessment Suite (AS)
High Dependency unit (HDU)
Intensive Therapy Unit (ITU)
National Poisons Information Service (NPIS)
Newcastle upon Tyne Hospitals (NUTH)
Nicotine replacement therapy (NRT)
Royal Victoria Infirmary (RVI)

6 Policies and Procedures

6.1 General points

The following principles should be applied, as mandated by NICE guidance.

- Staff should ask patients about specific personal needs, culture, religion, sexual orientation, gender identity, learning disability or other factors that need to be considered when examining or treating them. They should make reasonable efforts to accommodate needs and at an appropriate time let patients know about support available from the chaplaincy team and community organisations Liaison with the Learning Difficulties nurse should be arranged if required.

- If an individual presents to services alone, staff should ask if there is anyone the service user would like to contact, and offer to make contact or provide access to a phone.
- People who self-harm should be given the choice of having a friend, relative or advocate present during assessment and treatment.
- Healthcare professionals should provide emotional support and help if necessary to any relatives/friends/carers present.
- Patients should be provided with clear and understandable information about the care process.
- A member of staff should keep in regular contact with the patient to ensure their safety and to update them on their management and progress.
- When necessary, information should be provided in languages other than English (e.g. via an interpreter), and in an appropriate format for people who are deaf or who have sight, learning or literacy disabilities/ difficulties.
- Confidentiality and its limits should be explained to patients and their relatives/carers, e.g. it is made clear that clinical information is extended beyond the clinical team only if the quality of their care and/or the safety of another depends on this, and then only to those who need to know

6.2 Mental Capacity Act

In law there is a presumption of capacity. Patients who retain mental capacity have the right to refuse treatment or leave hospital if they wish. Further details can be found in the Trust policy document '[Mental Capacity Act 2005 \(including the Deprivation of Liberty Amendment 2009\)](#)', which should always be followed.

Patients who do not have mental capacity (e.g. those who are intoxicated, confused, significantly distressed or angry or psychotic or where a mental disorder is considered to be impairing decision making) are unable to understand and weigh information and are not in a position to make decisions about their care. Medical and nursing staff have a duty of care to the patient who lacks capacity; this includes keeping them in hospital and providing essential treatments if this is considered in their best interest. Advice should be sought from the responsible consultant physician. Assessing capacity is the treating clinician's responsibility, involving the duty psychiatrist or Liaison psychiatry team if there is doubt or a second opinion is required. A decision that a patient does not have mental capacity should be fully documented and justified in the medical notes.

Staff should be aware that according to the Mental Capacity Act (2005), which came into force in April 2007

- a. a person is assumed to have capacity unless it is established that he/she does not

- b. a person should not be treated as unable to make a decision unless all practicable steps to help him/her have been taken without success
- c. a person should not be treated as unable to make a decision merely because he/she makes an unwise decision
- d. Acts done or decisions made under the Mental Capacity Act for or on behalf of a person who lacks capacity must be done or made in his/her best interest
- e. Before such acts / decisions are done /made, regard must be had as to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the persons rights and freedom of choice

6.2.1 Assessment of Mental Capacity

According to the Mental Capacity Act, patients lacking capacity are

- a. unable to understand and retain information relevant to the decision they are being asked to make (e.g. details of the treatment proposed, its indications, main benefits, possible risks, and consequences on non-treatment)
 - b. unable to retain that information
 - c. unable to weigh up that information as part of a process of making a decision,
- or**
- d. unable to communicate their decision (despite all efforts to facilitate communication e.g. via translator, sign language, writing etc)

These questions need to be decided on the *balance of probabilities*.

Note that an assessment of capacity is valid for a specific question at that point in time. Regular re-assessment is needed.

Patients with mental capacity, without evidence of a mental disorder, who have a low risk of suicide but who are at risk from their overdose can be a challenging group to deal with. In law, they are entitled to refuse admission to hospital and/or to refuse lifesaving treatment. However, all steps should be taken to persuade them to have essential treatments and to stay in hospital. Advice of a senior physician and/or psychiatrist should be sought. If these patients refuse treatment or take their own discharge, detailed records of events should be made so that staff can demonstrate that all reasonable and legal steps were taken to persuade the patient to have appropriate treatment.

N.B. Patients under 18 years of age can be treated without their consent if a parent has consented to treatment. The law allows children who are mentally competent to have treatment against their parents' wishes but does not allow the refusal of treatment in these circumstances.

6.3 Mental Health Act

A Mental Health Act Guide for Informal Patients in Hospital is available via the [Trust intranet](#).

Section 5(2) of the Mental Health Act allows a medical practitioner to detain a patient *who has already been admitted* for up to 72 hours until a psychiatric assessment can be obtained but does not permit physical or psychiatric treatment without consent. The appropriate forms must be downloaded from the Trust Intranet and once completed the originals should be submitted to the Mental Health Act Office at St Nicholas Hospital, with copies retained in the medical notes. Anyone considering use of Section 5(2) should seek advice from Liaison psychiatry or on-call psychiatrist before doing so.

6.4 Information and support available to staff

There are three major sources of information that medical and nursing staff can use in guiding their management of poisoned patients.

6.4.1 TOXBASE

TOXBASE is the computer programme of the National Poisons Information Service. It has entries on over 14,000 substances. It is available via the NHS Net and can be accessed in the AS, Ward 43 and Ward 30, using 'Internet Explorer' and the 'National Poisons Information Service' favourite/bookmark. Doctors who wish to access this information on other terminals within the hospital must register to use the service and this can be done via the TOXBASE home page (<http://www.toxbase.org/>).

TOXBASE provides guidance for medical and nursing care of poisoned patients exposed to specific substances. This guidance should always be accessed and followed by medical and nursing staff managing poisoned patients within the Trust unless there is a specific alternative treatment protocol in use.

6.4.2 Clinical toxicology team

The clinical toxicology team can provide advice and if necessary review patients during normal working hours. This service is led by the consultant who performed the toxicology Ward round that morning can usually be accessed by contacting the clinical pharmacology SpR or toxicology fellow (DECT 23709), when there is one available.

Otherwise, contact details for consultants are as follows:

Name	DECT/Extension
Prof Simon Thomas	24642, 20406
Dr Ruben Thanacoody	24642, 24276
Dr Simon Hill	48612 / 26167

6.4.3 National Poisons Information Service (NPIS)

Poisons information is available 24 hours per day via the NPIS, which can be accessed by dialling 0844 892 0111. This number should only be used after consulting TOXBASE. During normal working hours this usually connects the caller with the NPIS (Newcastle) Unit, part of the Regional Drug and Therapeutics Centre located on the RVI site. At times of high call volume or during out of hours periods enquiries may be directed to NPIS Units in Birmingham, Cardiff or Edinburgh. Calls are received by Poisons Information Specialists who may be pharmacologists, nurses, or pharmacists. Medical support up to consultant level is available 24 hours per day if this is required. During normal working hours, the clinical toxicology DECT phone should be used before accessing NPIS.

6.5 Multi-disciplinary care pathway

A pro forma multi-disciplinary care pathway is available for recording salient clinical details of poisoned patients and should always be used by medical and nursing staff. This simplifies the task for admitting staff and prompts them into obtaining the relevant clinical information. It should be filed in the medical notes in chronological order with the other hand-written notes. All fields should be completed. If information is not available (e.g. because the patient is unconscious, this should be recorded and the information recorded by the responsible medical staff when this becomes available.

6.6 Admission observations

A standard AS observation chart should be started. All patients should have the following performed on admission to AS and these should be recorded in their care pathway, together with the time that the observations were made. Pulse and BP should be repeated every 30 min until assessment by a doctor. Patients who are judged to be stable can then revert to 4 hourly observations, unless alternative instructions are given. It is the responsibility of the medical team to give clear instructions about the frequency and type of observations needed.

- Pulse
- BP
- Temperature
- Respiratory rate
- GCS
- Oxygen saturation
- National Early Warning Score (NEWS)

Patients with potential respiratory compromise, e.g. reduced level of consciousness, reduced oxygen saturation or reduced respiratory rate on

admission, should have the following performed half-hourly initially, and continued until they are consistently within the normal range.

- Oxygen saturation
- Respiratory rate
- Neurological observations including GCS, pupil size and response to light

Patients at risk of cardiac arrhythmia, e.g. who have taken drugs with cardiotoxic effects (see TOXBASE), those who have documented arrhythmias, symptoms suggesting arrhythmia or an abnormal 12 lead ECG should be placed on a cardiac monitor. Observation should be continued as recommended in TOXBASE for the specific toxin(s).

Patients with Mental Health Problems and Acute Behavioural Disturbances: Observations should be performed as detailed in the [Enhanced Observation Policy: patients with Mental Health Problems and Acute Behavioural Disturbances](#).

Observations started in the AS should continue when the patient is transferred to any other Ward. The same standard policies for use of [National Early Warning Scores \(NEWS\)](#) apply to clinical toxicology patients as to other acute medical admissions.

6.7 Criteria for hospital admission

Department of Health Guidelines recommend that all patients with drug overdose should be admitted. However, admission may not be necessary following small overdoses / minor self-injury provided a formal psychiatric risk assessment has taken place. Such an assessment should be done by a member of staff who has received appropriate training and should include the following:

- Assessment of level of suicidal intent and any ongoing suicidal thoughts
- Documentation of current mental state and outlook
- Assessment of the level of social support
- Documentation of lack of major mental illness
- Ensuring accessibility of appropriate community follow up

Patients over 65 years old with self-harm or drug overdose should be admitted, unless advised by psychiatry or a senior physician. This is because of a high prevalence of psychiatric disease and high risk of completed suicide.

6.8 Transfers to Ward 30

Patients who are likely to stay in hospital for more than a few hours but who do not need critical care or continuous ECG monitoring are suitable for transfer to the appropriate RVI specialist base ward, which is Ward 30. Transfers should occur as soon as possible so as to reduce the occupancy of AS beds. It is important that as many patients as possible should be managed in the AS or Ward 30 because:

- AS and Ward 30 are the two appropriate environments for managing patients at risk of further self-harm as they have undergone structural adaptation to reduce risks from further attempted self-harm episodes.
- It helps to consolidate the work of the Liaison Psychiatry Team
- The nursing staff have additional training/experience in the care of patients with poisoning and self-harm

It is the responsibility of the AS medical staff to ensure that outstanding results on poisoned patients are chased up and acted on appropriately when this is indicated out of hours and that appropriate hand over of patients to the medical staff taking on responsibility has taken place.

Transfers from other Wards in the Trust, e.g. ITU/HDU, to Ward 30 will usually take place between 8.00 a.m. and 10.00 p.m. If there are no beds on Ward 30, a stable non-toxicology patient can be boarded out to receive the transfer. It is the responsibility of staff on ITU/HDU or other locations transferring patients to Ward 30 to ensure adequate handover to the Ward 30 medical staff.

Patients transferred to Ward 30 out of hours remain the responsibility of the acute medicine consultant until the start of the next normal working day, when consultant responsibility is transferred to one of the consultant clinical toxicologists. Junior medical cover is provided by the doctors covering that Ward.

Referrals for transfer from other hospitals are uncommon. Patients referred from other trusts should be discussed with one of the consultant clinical toxicologists during normal working hours or the admitting consultant physician at other times. The person accepting the patient will be responsible for liaising with the bed bureau and the AS to arrange an appropriate bed and the medical staff who will be responsible for reviewing the patient. The clinical toxicology team will assume responsibility for the patient on the next working day.

On arrival on Ward 30 a brief nursing assessment should be performed (or any earlier assessment reviewed) and recorded in the multi-disciplinary care pathway. Observations started in AS or elsewhere should be continued.

6.9 General issues with overdose patients

6.9.1 Smoking

Many drug overdose patients are smokers and it should be recognised that restriction of smoking may aggravate behavioural problems and/or precipitate self-discharge. There are no facilities within the Trust buildings for patients to smoke and patients have to go outside to do this. For many patients at risk of self-harm, as well as patients sufficiently ill to require ongoing inpatient monitoring or treatment, it is inappropriate for them to go outside the hospital unaccompanied.

Nicotine replacement therapy is available for use by patients within the Trust and can be offered on a temporary basis for patients to help them with tobacco cravings while they are inpatients. Briefly, patients suffering acute nicotine withdrawal can be prescribed NRT using a prescription that states that the NRT is to cover a period of acute nicotine withdrawal. NRT should not be dispensed on discharge.

Patients should only be allowed to leave the Ward unaccompanied when a doctor or senior nurse has considered the individual's circumstances and determined that the risk of medical complications or further self-harm is negligible. This decision should be recorded in the care pathway. The patient should be off the Ward for the shortest period possible.

6.9.2 Opioid dependence

A small but important minority of overdose/poisoned patients are regular users of opioids such as heroin. It is not appropriate for these patients to embark on detoxification regimes during this acute medical admission. However, patients who require prolonged admission to hospital (>24 h) because of their medical problems may have a legitimate need for appropriate pharmacological management of their drug dependence. (

For patients who are already receiving methadone or other agents (including buprenorphine or naltrexone) in the community, it is appropriate to continue their usual prescription and dose provided there is no medical contraindication (e.g. opiate overdose). Their usual prescription should be verified with their original prescriber as soon as possible. Note that a lower methadone dose may be appropriate for patients who have not received their methadone for a few days.

The prescription of methadone to patients who are not receiving methadone in the community should be avoided and should only occur with the authorisation of a consultant. Opiate withdrawal is unpleasant rather than life-threatening in most cases and can be managed symptomatically without opiate replacement.

Discussion with psychiatry or addiction specialists is recommended when there is uncertainty about appropriate management.

Methadone and other related drugs should never be given to patients to take home and should not be prescribed to patients with ongoing features of opiate intoxication. Patients being prescribed methadone and related products should be told that:

- The patient may undergo urinary toxicology screening before and at intervals during treatment to ensure that there is no concomitant consumption of illicit drugs. Patients who use illicitly-obtained drugs while inpatients will be discharged.
- Patients must remain on the Ward unless accompanied by a member of hospital staff, unless agreed by a senior nurse or doctor.
- Patients will abide by the normal rules of the Ward and will not use any sort of threatening or violent behaviour or foul or abusive language.
- Patients will co-operate with any reasonable treatment for their medical condition

Ward staff should treat the patient with courtesy and respect, maintaining their dignity and privacy, insofar as the law allows.

6.9.3 Alcohol-related problems

Chronic excess alcohol consumption is common amongst people presenting with drug overdose and it is important to identify and assess potentially harmful drinking. Patients should be asked about alcohol use as prompted by the clinical toxicology multidisciplinary care pathway and more detailed assessment made should there be a suspicion of alcohol misuse. The AUDIT questionnaire, advocated in NICE Clinical Guideline 115 (*Diagnosis, assessment and management of harmful drinking and alcohol dependence*), may be used for this purpose.

Trust guidance should also be followed for prevention of withdrawal and of Wernicke's encephalopathy ([Alcohol withdrawal – Trust Protocol](#)).

Patients with alcohol or drug related issues should be referred to the Nurse Specialist, Substance Misuse (DECT 29586) who will ensure that an appropriate detoxification regime, including vitamin supplementation, is in place. For those patients with self-harm, longer term issues are considered by the liaison psychiatry team in the first instance.

6.10 Management of Acutely Disturbed Patients

Patients with drug overdose may be acutely disturbed because of an underlying psychiatric disease or personality disorder or because of an acute mental health disturbance induced by the drugs they have taken. Drugs which commonly cause disturbed behaviour include alcohol, tricyclic antidepressants, procyclidine, cocaine, amphetamines, ecstasy, mephedrone and other stimulants or hallucinogens, as well as chronic heavy cannabis use. Management can be difficult but the following points apply:

- NICE guidance is available to support evidence-based management ([NICE Clinical Guideline 25 – Violence; the short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments](#)).
- Staff safety is a priority. Staff should ensure that they have a route of escape if needed (e.g. they should remain between patient and door). They should present a small target (side on). They should not attempt to tackle an escalating situation without adequate back-up.
- Staff should try to guide patient away from dangerous situations (other patients, objects) and into a safe place.
- Staff should call security at an early stage
- Staff should try to talk the patient down. They should remain calm and non-threatening and keep hands in view with open palms
- Restraint may be required and is permitted for patients lacking capacity, provided it is reasonable and proportionate. It should be carried out by staff with appropriate training according to the Trust [Policy on Restraint \(Adults\)](#).
- Drug therapy may be needed in some cases. This should only be used if there is a strong indication since it may worsen features of poisoning, e.g. respiratory depression, cardiac arrhythmias. Reasonable drugs to use, either separately or in combination, are:

Lorazepam 0.5-2 mg oral, i/v or i/m (only use i/m if i/v route unavailable)

Haloperidol 5 mg i/m Consider also using procyclidine 5-10 mg i/m/ or 5 mg i/v to avoid extrapyramidal effects, especially if high doses of haloperidol are used). Avoid in patients at risk of arrhythmia. Lower doses are appropriate in elderly patients.

It is generally appropriate to start with low doses and titrate upwards as required, with appropriate monitoring and nursing supervision. Further advice for managing specific toxins is available via TOXBASE.

6.11 Referral to the Mental Health Team

All patients with self-harm should be referred to the mental health team. For most patients it is appropriate to refer the morning after admission, once the

patient is adequately recovered from their overdose. On weekdays patients admitted through the AS and/or Ward 30 are reviewed automatically by the Liaison Psychiatry Team. At weekends or for urgent out of hours problems a referral must be made to the appropriate duty psychiatrist, depending on the place of residence of the patient:

City sector	Examples	Duty psychiatrist at
Western	Scotswood, Fenham	Newcastle General Hospital
Eastern	Byker, Heaton, Walker	RVI
Northern	Gosforth, Fawdon, North Kenton	St Nicholas' Hospital
Homeless / out of area		St Nicholas' Hospital

(If in doubt call the duty psychiatrist at St Nicholas' Hospital with the patients address / postcode.)

6.12 Discharge Arrangements

Patients with drug overdose in the context of self-harm should only be discharged provided

- a) They are medically fit for discharge, and
- b) They have undergone a risk assessment by the Liaison Psychiatry Team, another mental health practitioner, or another clinician who has undergone appropriate training.

During normal working hours risk assessment and support for medical staff in these circumstances can be obtained from the Liaison Psychiatry Team (LPT). Out of hours, appropriately trained medical or nursing staff must do a risk assessment before patients are discharged. Advice or an opinion can be sought from the Duty Psychiatrist if necessary.

Patients at low medical risk who have psychiatric problems may require urgent psychiatric assessment if their mental health needs outweigh their medical needs.

6.12.1 Self-discharge

Patients who retain mental capacity have the right to leave hospital if they wish (see section 6.2). It is important that the risks of such action are explained to them and they should be asked to sign a self-discharge form. If they decline to do this a detailed record of the circumstances should be made in the care pathway. Consideration should be given for a formal assessment of capacity specific to the decision the patient is being asked to make, especially if there are significant risks to self. Consideration can also be given to use of the Mental Health Act (see section 6.3) if there is a suspected mental

illness. Written information about support available in the community is available from the liaison psychiatry team and should be provided where possible.

6.12.2 Absconding patients

The management of patients who abscond, i.e. leave the hospital without the knowledge of hospital staff, depends on the risk to the patient from their mental and physical state. It is not possible to assess mental capacity under these circumstances. If a high risk to the patient is suspected, reasonable steps should be taken to return the patient to the Ward. Hospital security should be alerted to search the hospital and grounds. Subsequently the police should be contacted to visit the patient at home, although they have limited powers to return patients to hospital. Advice of the responsible consultant should be sought when there is uncertainty about the appropriate response.

On a case by case basis the Liaison Psychiatry Team or Crisis Team can be contacted – it may be possible for them to find further information about the patient and/or to offer out-patient follow-up if the patient has previously consented. They can also provide written information about support available in the community.

6.12.3 Discharge Summaries

As with all other medical discharges, toxicology patients need an INTIME discharge summary completed and finalised on discharge from hospital. INTIME summaries are also needed for patients who abscond or take their own discharge or who die or who are transferred to other hospital trusts (but not for those transferred elsewhere within this Trust). The responsibility for doing the summary rests as follows:

- a. Patients on AS. The F1/F2 doctor responsible for the bay that the patient is in at the time they are discharged.
- b. Patients on Ward 30. The INTIME summary should be done Ward 30 as follows:
 - i) During usual working hours - the Ward 30 F1/F2.
 - ii) At other times - the F1/F2 covering Ward 30INTIME summaries should be finalised and printed before the patient leaves the Ward.

7 Training

It is the responsibility of the Trust/line managers and service heads to ensure that access to appropriate education and training is available to allow staff to implement this policy.

8 Equality and Diversity

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

9 Monitoring compliance

Standard / process / issue	Monitoring and audit			
	Method	By	Committee	Frequency
Monitor completion of assessment documentation	Random audit	Head of Unit	Directorate of Medicine Clinical Governance Committee	Annually

10 Consultation and Review

This policy has been reviewed by the following

- Consultant clinical pharmacologists
- Lead consultant for the Assessment Suite
- Clinical directors, Medicine
- Matron responsible for AS and Ward 30
- Liaison Psychiatry Service
- Equality and Diversity Lead

Guidance provided in this report is not intended to override any policies provided by regulatory bodies such as the Care Quality Commission, the NHS Litigation Authority, Health & Safety Executive or the Department of Health.

This policy will be reviewed every three years by the Head of Unit, Clinical Pharmacology, or as and when significant changes make earlier review necessary.

11 Implementation (including raising awareness)

This policy is an update of procedures previously implemented. Appropriate staff will be made aware of this update when published, and the policy will be discussed during induction of new staff involved in the management of patients with poisoning/drug overdose. The policy is available for staff to access via NUTH intranet (and web site).

12 References

- [\(NICE Clinical Guideline 25 – Violence; the short term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments\)](#)

13 Associated Documentation

- [Mental Capacity Act 2005 \(including the Deprivation of Liberty Amendment 2009\).](#)
- [Enhanced Observation Policy: patients with Mental Health Problems and Acute Behavioural Disturbances](#)
- [National Early Warning Scores \(NEWS\) Policy](#)
- [Alcohol withdrawal – Trust Protocol](#)
- [Policy on Restraint \(Adults\).](#)

SHLT, HKRT, SLH. FINAL

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. **Assessment Date:**

2. **Name of policy / strategy / service:**

3. **Name and designation of Author:**

4. **Names & designations of those involved in the impact analysis screening process:**

5. **Is this a:**
Policy Strategy Service
Is this:
New Revised
Who is affected
Employees Service Users Wider Community

6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*

7. **Does this policy, strategy, or service have any equality implications?** Yes No
If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address <i>(by whom, completion date and review date)</i>	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? <i>(by whom, completion date and review date)</i>
Race / Ethnic origin (including gypsies and travellers)	Provision of Interpreting service- the importance of working with interpreters is mentioned in the policy Mental Health Community Development Worker post for BME communities E&D Training	People from minority ethnic communities are more likely than the general population to be detained under the Mental Health Act. Lack of communication and cultural understanding contribute to this. 6.1 of the policy specifically mentions asking about religious and cultural needs	Staff should be aware of how protected characteristics can impact on behavior and mental health. Action Any training associated with this policy should highlight this risk
Sex (male/ female)	Male and female practitioners are available and there may be occasions when a practitioner of the same sex is required to promote the dignity of patients	Male suicide rates are on average 3-5 times higher than female rates.	As above
Religion and Belief	Chaplaincy service provided with links to leaders of major faiths. 6.1 of the policy specifically mentions asking about religious needs	When in distress patients who have a faith or belief may value support from a minister of religion. Action Add information about this	As above
Sexual orientation including lesbian, gay and bisexual people	Evidence files used to raise awareness of the impact of discrimination on the mental health of LGB people through	In the 2011, three per cent of gay men and five per cent of bisexual men have attempted to take their own life compared to 0.4% of the general population Action Specifically ask the patient about their sexual orientation and let them know about support available in the community.	As above
Age	The policy relates to adults	Men aged 30-44 are the group with the highest rate of suicide. Action Any training associated with this policy should highlight how protected characteristics	As above

		can impact on behavior	
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	<p>Psychiatric services are highlighted in this policy</p> <p>Provision of information in various formats is highlighted in the policy</p> <p>BSL Signers and Deaf Blind Guides are provided in the Trust LD Liason Nurse</p> <p>Consideration of carers is incorporated into the policy</p> <p>Mental Health Observation Policy</p>	<p>The behavior of patients with a learning disability related to pain and distress has been misinterpreted as mental health problems.</p> <p>Lack of communication support for deaf and Deaf blind people can lead to misinterpretation of behavior</p> <p>Over half of all carers have physical and mental health problems of their own. Carers often feel excluded</p> <p>Action 'Deaf' added to 6.1 'liaison with the Learning Difficulties nurse if required' added to 6.1</p> <p>Mental health observation policy now referenced in section 6.6</p>	As above
Gender Re-assignment	Gender Identity sub group to identify and address needs in relation to Gender Identity	<p>Some evidence suggests that lesbian, gay and bisexual and transgender people, who are perhaps more likely than other groups to face hostility and misunderstanding, are all more likely to experience poor mental health</p> <p>Action Ask specifically about gender identity.</p>	As above
Marriage and Civil Partnership	N/A		
Maternity / Pregnancy	Women's Health and Maternity Services provided by the Trust	<p>Post Natal depression may be a cause of self harm</p> <p>?add links to maternity services</p>	As above

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any

significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes No

- 11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)**

No -The policy specifically mentions patients rights under the Mental Health Act and Mental Capacity regulations

PART 2

Name:

Simon Thomas

Date of completion:

27th November 2014

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)