

PROTOCOL

Departure Prior to Completion of Treatment

Process:

1. Patient or Power of Attorney states intention to leave prior to completion of treatment plan
2. Nursing supervisor/DON or Healthcare Professional Investigates cause for early departure
 - a. Determine if patient has uncontrolled symptoms
 - b. Determine if patient has pressing outside responsibilities
 - c. Address those possible causes of early departure if possible
3. Healthcare Professional (Physician, PA or NP) Assesses capacity
 - a. Patient or POA is able to understand treatment plan and consequences of refusal
 - b. Patient or POA is not found to be incapacitated by mental illness
4. Healthcare professional devises alternative plan to Mitigate any possible harm to patient
 - a. Offer maximal necessary treatment acceptable to patient
 - b. Provide prescriptions or call in prescriptions to pharmacy
 - c. Provide discharge instructions and follow up plan
5. Social worker or unit clerk will make follow up appointment with Primary Care Provider
6. Healthcare Professional Explains treatment plan and alternatives
 - a. Original treatment plan explained
 - b. Dangers of failure to follow treatment plan explained
 - c. Alternative plan explained
7. Administrator or Admissions office details options regarding return to facility if possible
8. Patient or POA signs "Departure Prior to Completion of Treatment" form
9. Documentation:
 - a. Healthcare Professional will document
 - i. Medical capacity evaluation
 - ii. Discussion regarding initial treatment plan, alternative plan and possible consequences of refusal.
 - iii. Efforts to convince patient and/or POA to complete treatment
 - iv. Patient reason for refusal
 - v. Departure instructions
 - b. Unit Supervisor will document
 - i. Investigation as to cause of early departure
 - ii. Efforts to convince patient or POA to continue with proposed treatment
10. Checklist will be completed by DON
 - a. DON will ensure that all involved parties have completed and signed checklist