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