### BOX 1

**Capacity assessment to be completed if patient requests self discharge from hospital against medical advice**

- Can the patient understand the information relevant to this decision?
- Can the patient retain that information?
- Can the patient use or weigh that information as part of the process of making the decision?
- Can the patient communicate his/her decision?

If YES to all 4 criteria above the patient has capacity. Complete BOX 2

If NO to ANY of the 4 criteria above the patient lacks capacity and must be prevented from leaving hospital. Complete BOX 3

### BOX 2

To be completed when the patient has been assessed as HAVING CAPACITY to decide to self discharge against medical advice

- Explanation of the necessary treatment required and the consequence of the patient refusing the treatment have been given and are understood
- Other options which may be acceptable to both the clinicians and the patient have been explored with the patient
- Where the consequences of refusing treatment are serious or life threatening discussion and assistance has been sought from the consultant and other relevant professionals such as the Psychiatric Liaison Service

The self discharge release from responsibility for discharge form overleaf is completed by the patient **whenever possible** and retained in their medical record

### BOX 3

To be completed when the patient has been assessed as LACKING CAPACITY to decide to self discharge against medical advice

- Staff utilise persuasion, calming and de-escalation techniques
- Referral to the Psychiatric Liaison team is considered as appropriate
- Referral to the IMCA Service and DOLS is considered as appropriate
- If the patient has left the ward staff utilise the RCHT Missing Persons Policy

### Outcome

- Patient with capacity self discharged
- Patient with capacity decided to remain in hospital
- Patient without capacity decided to remain in hospital
- Patient without capacity is detained
- Datix completed

**Signed:** ______________________  **Print name:** ______________________  **Designation:** ______________________  **Time:** ______________________
To be completed with the patient whenever possible prior to the patient taking his/her self discharge from this hospital

I, the undersigned hereby declare that I am discharging myself from this hospital and that I understand the consequences of failing to follow the medical advice given to me which might result in significant disability or even death.

I understand I can change my mind at anytime and return for treatment.

Patient’s signature: ____________________________________________________________

Witness: ______________________________________________________________________

Designation of witness: _________________________________________________________

Date: ___________________________ Time: ___________________________

This form when completed must be retained in the patient’s medical record and a DATIX of the SELF DISCHARGE event completed in every case by the relevant involved multi-disciplinary team member.