Standard operating procedure (SOP) · ED-SOP-003 · Version 1.0 · Approved by the ASF Expert Committee

Supports: 36.5

At a glance

- Each patient who leaves before assessment is recorded in the register (ED-REG-002).
- The department makes reasonable attempts to follow up each patient by phone or letter.
- The attempts and their dates are recorded.
- The rate and reasons are reviewed at the set interval.
- Stop and get help straight away if: a patient leaves before assessment and is not recorded.

1. Purpose

To make sure patients who leave before being seen are known about and followed up (36.5).

2. Scope

Applies to	Clinical and support staff in the hospital
Locations	All wards, clinics and departments of the facility
When	Whenever the activity described is carried out
Does not apply to	Activities covered by another document listed in section 15

3. Definitions

Term	Meaning
Clinical lead	The doctor or nurse in charge of the area at the time

4. Background

Patients who leave before they are seen may be seriously unwell, and the department must know who they are to follow them up. Recording and following up those patients is part of safe care.

5. Responsibilities

Role	Responsibility	Competence
Nurse in charge of the shift	Records each departure and starts follow-up	Emergency department lead
Emergency department lead	Reviews the rate and reasons	Clinical director

6. Materials and equipment

Item	Requirement	Condition
Records and forms named in this document	Current version	Checked before use

7. Safety

- Stop and call for help if a patient is at immediate risk. Do not delay urgent care to complete paperwork.

8. Before you start

- Confirm the forms and equipment named in this document are available and current.

9. Procedure

Step 1. Record.

- Record each patient who leaves before assessment, with the time and any reason given (ED-REG-002).

Key point: Recorded.

Step 2. Follow up.

- Make reasonable attempts to follow up by phone or letter and record each attempt.

Key point: Followed up.

Step 3. Review.

- Review the rate and the reasons at the set interval.

Key point: Reviewed.

10. Decision points

- No decision points in this procedure.

11. Special situations

Situation	Action
Out of hours	Follow the same steps. Use the on-call contact on the wall of the area.

12. Escalation

- Any serious problem goes to the duty clinical lead at once and to the clinical director the same day.

13. Monitoring

Measure	Target	Frequency	Owner	If not met
Departures recorded with follow-up attempts	100%	Monthly	Emergency department lead	Escalate to the clinical director

14. Records

Record	Kept in	Retention
Record named in this document	Patient record or the area file	the period set by the facility’s records policy years

15. Training

- Staff are trained in this document at induction and refreshed each year, with a recorded competency check.

16. Related documents

ID	Title	Use
ED-REG-002	Left-before-assessment register	Register

17. Evidence

Reference	Note
E-009	Based on the WHO Emergency Care Systems framework and the Emergency Triage Assessment and Treatment guidance, the WHO Global Patient Safety Action Plan 2021–2030 for handover, and the ASF Hospital standard for senior clinician responsibility.
E-006	ASF Policy Framework v1.2. Adapted.
E-009	ASF Expert Committee consensus.

18. Change history

Version	Date	What changed	Approval
1.0	the date of approval	First version	set Expert Committee approval

E-learning for this document

- **Safety & Emergency Preparedness** (H-05)

References

- Accréditation Sans Frontières (2026). ASF Policy Framework v1.2. (E-006)
- Accréditation Sans Frontières (2026). ASF Expert Committee consensus on Standard 1. (E-009)

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