Solent NHS Trust

MISSING PATIENTS POLICY

Please be aware that this printed version of the Policy may NOT be the latest version. Staff are reminded that they should always refer to the Intranet for the latest version.

Purpose of Agreement	The purpose of this policy is to provide a consistent approach in: • reducing the risk of patients going missing • responding when patients are discovered missing This policy applies to adult mental health, older persons mental health and Kite unit. It only refers to missing patients - the systems for responding to missing staff are set out in the Lone Working Policy.
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MISSING PATIENTS POLICY

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1. INTRODUCTION & PURPOSE

The purpose of this policy is to provide a consistent approach for formal and informal patients in;

- reducing the risk of going missing
- responding when patients are discovered missing

2. SCOPE & DEFINITIONS

2.1 This document applies to all directly and indirectly employed staff within Solent NHS Trust on the clinical areas listed below and other persons working within the organisation in line with Solent NHS Trust's Equal Opportunities Document.

- Adult Mental Health Inpatient services
- Older Person's Mental Health inpatient services
- Kite Unit.
- Adult mental Health community services
- Older Person's Mental Health Community Services

2.2 It only refers to missing patients - the systems for responding to missing staff are set out in the Lone Working Policy.

2.3 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community and our staff

2.4 **Definitions**

A missing person - when their whereabouts are either not known i.e. they are not locatable, or when they have not returned from leave at the agreed time (informal clients).

Absent Without Leave (AWOL) – A formally detained person is considered absent without leave if they are absent from the hospital in any way that is not authorised by s17 leave. This includes patients who have not returned at the time specified in the conditions of their s17 leave.

Absconding - implies that a formally detained patient has actively and overtly left the clinical area.

3. PROCESS/REQUIREMENTS

3.1 **Risk Assessment / Prevention**

All patients should have a Care Program Approach (CPA) or other risk assessment clearly recorded in the appropriate trust system for recording clinical information. This assessment should identify whether there is an active risk that the patient will knowingly and overtly attempt to leave the clinical area or passive risk that the patient may be confused or disorientated and may wander out of the clinical area. The risk assessment should be updated whenever the risks change. The level of risk assessment will clearly vary from patient to patient and from service to service - the key is that staff will have actively considered the possibility of the patient leaving the clinical

area without the knowledge of the staff or having failed to return from authorised leave. This will inform the care plan.

3.1.1 For community patients subject to CPA the care co-ordinator will ensure that the CPA risk assessment is up to date and accessible.

3.2 **Communication**

Each clinical area and community team must have a system which ensures that accurate, current information regarding patients and their risk of absconding/going missing is made available to all staff who are responsible for the care of the patients.

3.3 **Care Planning**

Each patient assessed as being at risk of either actively absconding, passively wandering or going missing from the clinical area, failure to return from leave or going missing in the community should have a care plan which specifically states the actions to be taken in the event of this occurring.

3.4 **Deprivation of Liberty and Best Interest**

A capacity assessment should be carried out for all clients and as appropriate consideration should be given to Deprivation of Liberty and Best Interest assessments. (See; CLS/002 - The Deprivation of Liberty Safeguards and The Mental Capacity Act 2005 Policy)

3.5 **Local Search Procedure - Inpatient services**

As soon as the patient is thought to be missing, the ward manager or person in charge of the ward should be notified and a search of the immediate area should be undertaken. What defines this will be determined by the area the client has gone missing from. However, as a guide in missing from a ward, all areas of the ward must be searched, additional internal areas and if practicable to outside area.

On the St James site consideration should also be given to reviewing the CCTV footage at front hall to determine if the client left the grounds or as a method to identify the area on a the grounds to do a focused search.

If the patient is located and returned to the clinical area, they should be assessed and their care plan and relevant assessments reviewed accordingly. If the patient is not found, please follow guidelines as identified in flow chart in appendix 1.

As indicated by risk assessment; staff to also attend patient's homes or other known haunts within the community if safe to do so.

If staff have been unable to locate patient, the "Missing Person checklist" (Appendix 1) should be completed.

3.6 **Communication with the Police**

If the result of the assessment of risk via the Missing person checklist (Appendix 1) indicates that the patient is a medium or high risk either to themselves or others or is detained Under the 1983 Mental Health Act regardless of risk, the police should be informed. This can be done by telephoning 0845 0454545 as a matter of urgency ensuring all information is available which is necessary for them to act. The ward manager or nurse in

charge of the ward is responsible for ensuring this is done. Low risk patients will be reported to the police at the discretion of the staff. The missing person checklist (Appendix 1) will be ready for the police on their arrival.

3.7 **Communication with Relatives / Next of Kin / Carers**

The nurse in charge of the clinical area should decide at what point the relatives / next of kin should be informed that the patient is missing with consideration for issues surrounding confidentiality. For community patients the care co-ordinator or Lead Professional will make contact. Factors which will influence this will be:

- the relationship between the patient and the family
- Vulnerability of the client
- the potential for the patient to make their way to the family home
- any history of violence or ill-feeling towards family members
- the age / health of the relative / next of kin.

3.8 **Communication with Medical Staff**

The nurse in charge of the clinical area will be required to make the decision as to when the patients Doctor / Consultant will be informed the patient is missing. This will be dependant on the individual patient and should include the overall assessment of risk to the patient, including vulnerability and risk to others. Particular sections of the Mental Health Act will demand the consultant and Ministry of Justice is informed.

3.9 **Reporting and Reviewing the Incident**

The incident should be reported as per the Adverse Event Reporting system. Missing patients ranked as high risk should be considered as a High Risk Incident and communicated via the line management system without delay. A review of the incident should be conducted which is appropriate to the severity rating of the patient.

4. ROLES & RESPONSIBILITIES

All NHS Trust employees are required to comply with this policy.

5. TRAINING

5.1 All staff are required to ensure they know the correct procedure – this will be undertaken as part of their induction.

5.2 Solent NHS Trust recognises the importance of appropriate training for staff. For training requirements and refresher frequencies in relation to this policy subject matter, please refer to the Training Needs Analysis (TNA) on the intranet.'

6. EQUALITY IMPACT ASSESSMENT AND MENTAL CAPACITY

The Equality Impact Assessment and Mental Capacity Act Assessment identified that this policy is unlikely to lead to discrimination against any particular group and that it takes the situations of service users who lack capacity to make decisions into account. The Impact Assessment can be seen in Appendix 3.

7. MENTAL HEALTH ACT

7.1 Patients detained under the Mental Health Act 1983 (the Act) can only leave the hospital when granted leave of absence under s17, by the patient's Responsible Clinician and, in addition, they must comply with any of the conditions of that leave. A person is considered absent without leave if they are absent from the hospital in any way that is not authorised by s17 leave. This includes patients who have not returned at the time specified in the conditions of their s17 leave.

7.2 For restricted patients, leave can only be granted within the limits of the leave agreed by the Ministry of Justice. Responsible Clinicians cannot grant leave of absence from hospital to patients who have been remanded to hospital under sections 35 or 36 of the Act or who are subject to interim hospital orders under section 38, these patients can only be given leave by the court.

7.3 When granting s17 leave the Responsible Clinician may name an escort for the patient. If the escort is not a member of staff of the hospital then this must be in writing, as described in the s17 leave policy. The patient is then considered to be in that person's custody. If they abscond from that person, they are to be considered absent without leave.

7.4 Patients may be granted overnight leave by their Responsible Clinician, with the condition that they reside at a particular place. Patients may be taken into custody and returned to the hospital or that place if they absent themselves from it. The Responsible Clinician may also set conditions that the person remains in the custody of staff at the place at which they must reside. Patients on overnight leave may be recalled to the hospital if the Responsible Clinician believes that it is necessary to do so in the interests of the person's health safety or protection of others. The Responsible Clinician must do this in writing. If this is done and the patient does not return, the patient is considered to be absent without leave.

7.5 An AWOL patient may be taken into custody by any member of staff of the hospital, any Approved Mental Health Professional, any constable or anyone else nominated in writing, as described in the s17 leave policy, and returned to the hospital or any such place that they must reside at as a condition of their s17 leave.

7.6 If a patient has been recalled from a Community Treatment Order and has failed to return, or has absconded whilst a recalled patient, then they are to be considered absent without leave. See The Mental Health Act Policy.

7.7 If any patient that is absent without leave is believed is to be in a residence to which access is blocked or likely to be blocked then s135(2) warrant can be sought from the court. This authorises any constable to enter the premises and return the patient to the hospital in which they are detained or to any place at which they must reside as a condition of their s17 leave. The warrant can be sought by a nurse from the hospital, an AMHP, a constable or any other person authorised to take them into custody. Guidance can be found on the Mental Health Act intranet site.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

See Implementation, Communication, Dissemination & Monitoring Plan (Appendix 3).

If you are unable to comply with this policy you are required inform your immediate line manager and complete a Adverse Risk Event.

8. REVIEW

This document may be reviewed at any time at the request of either at staff side or management, but will automatically be reviewed three years from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 REFERENCES

- Department of Health (1999) – "National Service Framework for Mental Health – Safe sound supportive". London. HMSO.
- European Convention of Human Rights (ECHR) Council of Europe
- Department of Health. 1983. **"Mental Health Act (1983)".** HMSO. London.
- Department of Health. 2008. **"Mental Health Act Code of Practice".** HMSO. London.
- Nursing and Midwifery council. 2008. **"The Code – standards of conduct, performance and ethics for nurses and midwives".** www.nmc-uk.org. London.

Related policies

Mental Health Act Policy

Section 17 Leave Policy

Deprivation of Liberty and Mental Capacity Act Policy

Lone Working Policy

10. GLOSSARY

AWOL Absent without leave

CPA Care Program Approach

APPENDICES

Appendix	Title
Appendix 1:	Missing persons checklist
Appendix 2:	Search and Alert Procedure
Appendix 3:	Implementation, Communication, Dissemination & Monitoring Plan
Appendix 4:	Equality Impact Assessment

Appendix 1

MISSING PERSON CHECKLIST

IMMEDIATE ACTION

Searches	**Comments**	**Initials**	**Time**
Ward searched			
Inform ward manager or person in charge of the ward			
Hospital/Unit searched			
CCTV (if available) reviewed			
Documentation			
Risk Assessment complete			
Police Missing Person form completed and faxed			
Police Incident No:			
Adverse Event Report form completed			
Informing Others			
Duty Senior Nurse (1701 / 1702)			
Medics as appropriate			
Community Care Co-ordinator			
Relatives/significant others			
A&E Dept – QAH			
Home Office (restricted patients only)			
Others (eg Social Services)			
Child Protection Dept.			

Publicity Required?	Yes / No		
Agreed with Consultant Psychiatrist			
Agreed with unit Manager			
Service Manager			
Agreed with relatives			

ACTION AFTER 6 HOURS

	Comments	Initials	Time
Review risk/status			
Update relevant people (as above)			

ACTION AFTER 24 HOURS

	Comments	Initials	Date/ Time
Repeat relevant action taken			
Update relevant people (as above)			
Inform relevant Service Manager			
Inform GP			

ACTION AFTER 48 HOURS

Review	Comments	Initials	Date/Time
Duty Senior Nurse (1701 / 1702)			
Nurse in charge of ward			
Care Co-ordinator			

Medical staff			
Review situation			

ACTION AFTER 96 HOURS

Review	Comments	Initials	Date/ Time
Duty Senior Nurse (1701 / 1702)			
Ward Manager			
Care Co-ordinator			
Service Manager			
Consultant Psychiatrist			

ACTION UPON RETURN

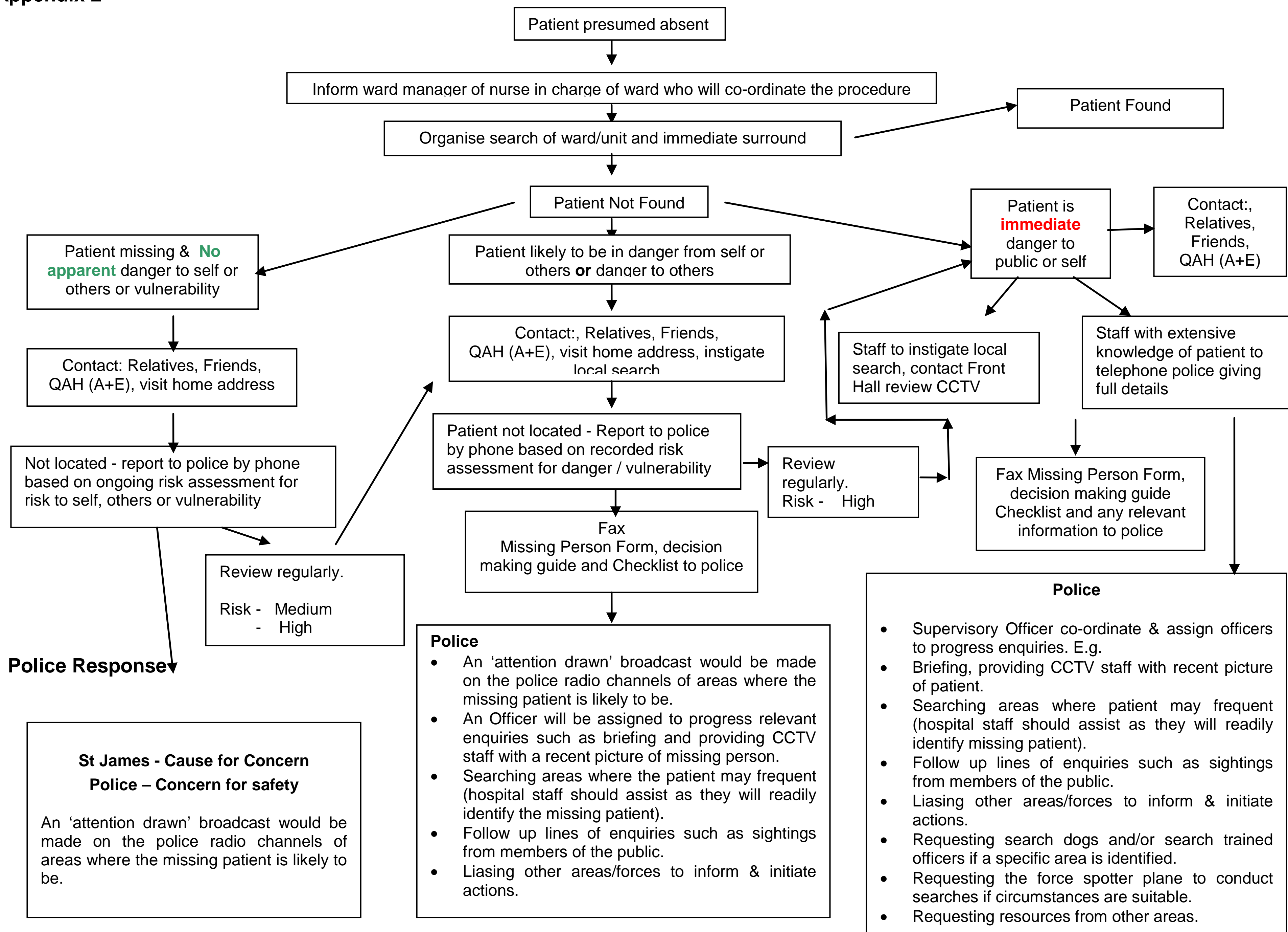
Inform	Comments	Initials	Date/ Time
Duty Senior Nurse (1701 / 1702)			
Medical Team			
Care Co-ordinator			
Police			
Relatives			
A&E Dept QAH			
GP			
Others			

INFORMATION ON RETURN

	Comments	Initials	Date
Where found			
Returned by			
Patient’s reason for			

leaving			
Physical/mental state on return – record in health records			

Appendix 2



St James - Cause for Concern
Police – Concern for safety

An 'attention drawn' broadcast would be made on the police radio channels of areas where the missing patient is likely to be.

Police

- An 'attention drawn' broadcast would be made on the police radio channels of areas where the missing patient is likely to be.
- An Officer will be assigned to progress relevant enquiries such as briefing and providing CCTV staff with a recent picture of missing person.
- Searching areas where the patient may frequent (hospital staff should assist as they will readily identify the missing patient).
- Follow up lines of enquiries such as sightings from members of the public.
- Liasing other areas/forces to inform & initiate actions.

Police

- Supervisory Officer co-ordinate & assign officers to progress enquiries. E.g.
- Briefing, providing CCTV staff with recent picture of patient.
- Searching areas where patient may frequent (hospital staff should assist as they will readily identify missing patient).
- Follow up lines of enquiries such as sightings from members of the public.
- Liasing other areas/forces to inform & initiate actions.
- Requesting search dogs and/or search trained officers if a specific area is identified.
- Requesting the force spotter plane to conduct searches if circumstances are suitable.
- Requesting resources from other areas.

Appendix 3

Missing Patients Policy

Implementation, Communication, Dissemination & Monitoring Plan

WHAT ARE WE TRYING TO ACHIEVE	HOW IS IT TO BE DONE	LEAD	TIMESCALE
Policy approval through assurance route.			TBC
1. To ensure all levels of staff are aware of the policy. 2. To create an understanding of the individual roles and responsibilities.	Information exchange at team weekly business meeting. Inform AD's for distribution at Service Manager cascades.	Chairs of respective Essential Standards Groups AD	TBC
1. To ensure staff aware of the policy. 2. Provide clarity of where policy is to be found and how it may be utilised.	Information exchange at weekly team business meeting. Staff memo via email communications – Service clinical governance meeting agendas Ward meetings	Chair NHSLA Ops Policy and Steering Group Clinical community and Modern Matrons	TBC
To provide training for all appropriate staff on implementation of the policy, as required.	Regular discussion at 'team meetings'	Clinical community and Modern Matrons	
Monitor how the policy is being implemented.	Ongoing incidents reviews Audit compliance activity	Modern Matrons	TBC
Ensure that the policy is effective.	Report to clinical governance meeting when policy due for review.	Chair NHSLA Ops Policy and Steering Group	TBC

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Appendix 4

Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	Answer
1. What are the main aims and objectives of the document?	To support save management of missing persons and AWOL by clarifying the procedure to be followed and roles and responsibilities of staff involved.
2. Who will be affected by it?	Potentially all patients admitted to or cared for by the clinical areas covered by the policy.
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	This is a policy review of current practice. There have been no significant changes as practice is currently in line with this policy.
4. What information do you already have on the equality impact of this document?	There has been some research carried out in relation to client going AWOL, the flow chart has incorporated elements of this that have been suggested to have an effect in reducing this. The policy primarily covers what to do in the event of a missing person / AWOL and the actions are compliant with mental health code of practice and that practice of our partners, eg police.
5. Are there demographic changes or trends locally to be considered?	N/A
6. What other information do you need?	None

Step 2 - Assessing the Impact; consider the data and research	Yes	No	Answer (Evidence)
1. Could the document act unlawfully against any group		x	By having this clear operational policy and ensuring the guidance and practice laid out within it is applied to all patients at all times, it ensures that no group could be unlawfully treated favourably or unfavourably compared to another
2. Can any group benefit or be excluded?		x	As per the answer above
3. Can any group be denied fair & equal access to or treatment as a result of this document?		x	As per the answer above
4. Can this actively promote good relations with and between different groups?	x		It can show parity between different groups and fairness to all
5. Have you carried out any consultation internally/externally with relevant individual groups?	x		All relevant staff have been consulted several times. This has included; • Nursing Staff • Auxiliary Staff • Allied Health Professionals

			• MHA Lead Original policy was agreed with police, as there is no change to the process that was not repeated.
6. Have you used a variety of different methods of consultation/involvement	x		Different methods of consultation have included: • Emails • Discussion in various meetings
Mental Capacity Act implications		X	
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)	x		MCA taken into account in the policy and supports the decision making identified within this policy to ensure patients needs are represented and met

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	**Answer**
1. Is the impact low, medium or high?	Low
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	Ensuring that this policy is followed at all times by staff will eliminate the potential for negative impacts.
3. Are there likely to be different outcomes with any modifications? Explain these?	N/A

Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	Once ratified by Solent NHS Trust, this policy shall be disseminated via the trust intranet. In addition senior clinical staff in affected services will be informed that the policy is operational. Monitoring arrangements are documented within the main body of the text.
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	Support in this process and comments for amendments will be received from significant groups and committees which include, the AMH Essential Standards Group, the Acute Services Operational Meeting, the Acute Care Forum and the Mental Health Act Scrutiny Committee
Step 5 - Publishing the Results	**Answer**
1. How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	Attached to this policy and published as such on the intranet