Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Missing Patient Policy

This procedural document supersedes: PAT/PS 1 v.5 - Missing Patient Policy

Policy to be used in conjunction with:

- PAT/PS 19 – Abduction or Suspected Abduction of an Infant/Child Policy
- Doncaster & Nottinghamshire Local Safeguarding Board Guidelines
- PAT/PS 8 - Safeguarding Adults Policy
- PAT/PS 10 - Safeguarding Children Policy
- PAT/PA 10 – Concordat for the care of prisoners admitted to DBTH
- PAT/PA 19 – Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)
- CORP/ICT 7 - Data Protection Policy

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The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Executive Sponsor(s)	David Purdue Director of Nursing, Midwifery and AHP
Author/reviewer: (this version)	Kate Carville Associate Director of Nursing (in consultation with Nottinghamshire Police and South Yorkshire Police)
Date revised:	January 2020
Approved by:	Policy Approval and Compliance Group
Date of approval:	12 February 2020
Date issued:	18 February 2020
Next review date:	July 2023
Target audience:	All staff, Trust-wide

Amendment Form

Please record brief details of the changes made alongside the next version number.

If the APD has been reviewed without change, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 6	18 February 2020	• Revised in line with South Yorkshire Police to include their escalation and assessment criteria • Updated missing person risk definitions • New missing/ absent patient flow chart • New action card , escalation process for missing person	Kate Carville
Version 5	23 May 2016	• Revised in line with requirements of both Nottinghamshire and South Yorkshire Police to include their standard risk assessment criteria and standardised flow chart to enable the policy to be in line with other Acute Trusts in South Yorkshire and Nottinghamshire. • Updated in line with 2014 reorganizational structure. • Inclusion of updated Site Security presence at Bassetlaw Hospital. • Updated safeguarding considerations • Updated templates and addition of Action Card and added requirement to produce post incident report.	David Purdue
Version 4	May 2013	• Updated to reflect CSU structure and role of Director of Communications. • Documentation process amended to include need for wards and departments to stock WPR.	Mandy Dalton
Version 3	May 2012	• Minor changes to further clarify categories of patients, escalation levels and actions. • Updating to reflect change to Clinical Service Units.	Chris Beattie/ Deborah Oughtibridge
Version 2	April 2010	Substantial changes, please read whole document.	Mandy Dalton

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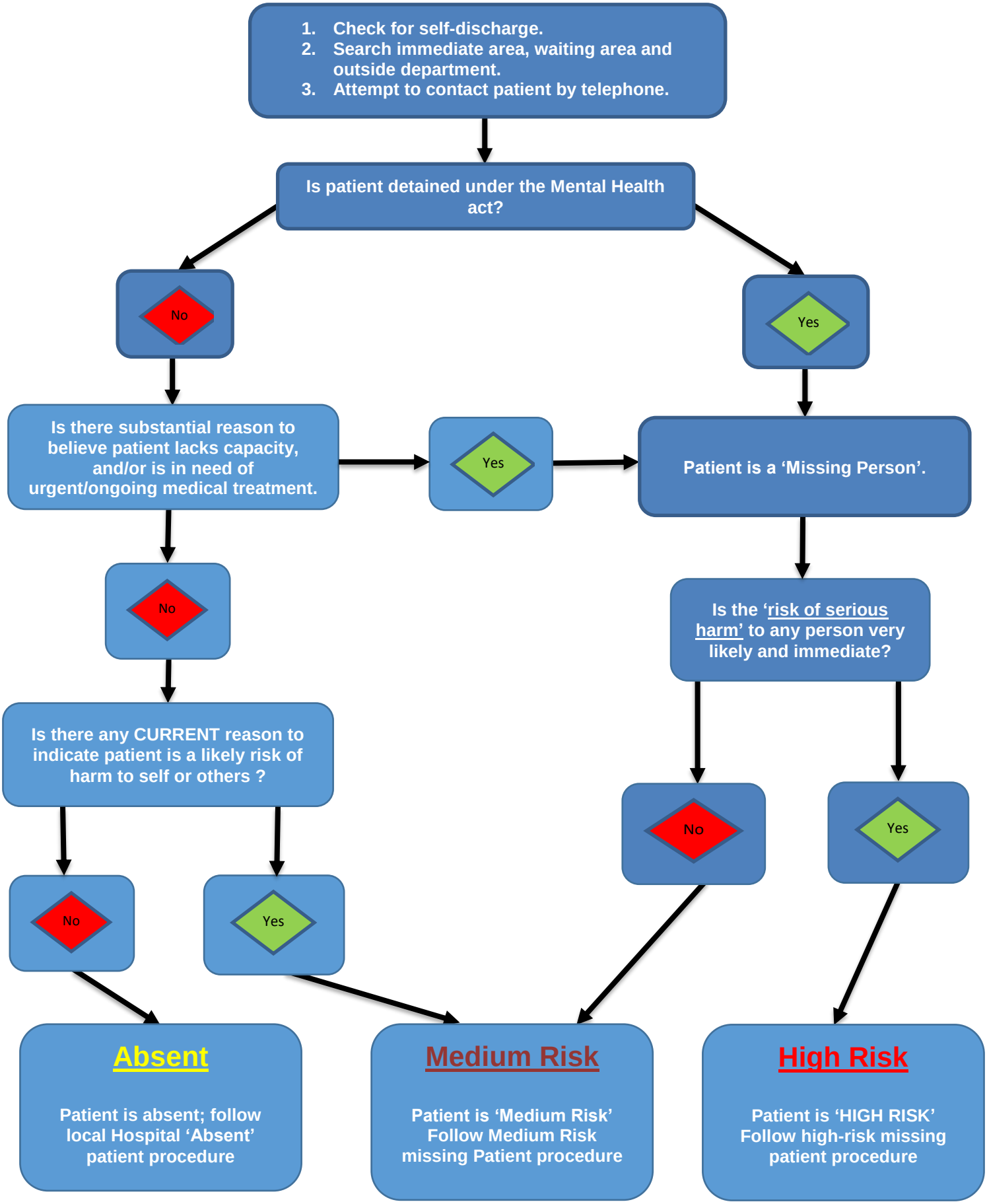
APPENDIX 1 – MISSING/ABSENT PATIENT FLOW CHART



APPENDIX 2 - ACTION CARD – ESCALATION PROCESS – MISSING PATIENT

WARD/DEPARTMENT - On being alerted that a patient is missing from the ward or department, the Nurse in Charge will take the following action:

1.	Organise an immediate search of ward/department and surrounding areas
2.	If the patient is NOT found, activate Missing Patient Procedure: • Undertake the Risk assessment algorithm at Appendix 1 to determine the Category and level of risk • HIGH/MEDIUM/LOW risk • Commence the Incident Log Appendix 4 • Complete the Missing Patient information sheet at Appendix 2 for ADULTS and Appendix 3A AND 3B for CHILDREN • COMMENCE ESCALATION PROCESS
3.	**Escalation Level 1** • High risk and missing for 1 hour - ESCALATE to Divisional bleep Holder, Matron or CSM (Consider immediate Police involvement with this category if HIGH risk) • Medium risk and missing 1-2 hours, ESCALATE to Divisional bleep holder, Matron or CSM • Low risk/Absent - If a patient is deemed low risk/absent based on their medical needs, circumstances around whereabouts being unknown and risks assessed then this does not need reporting to Police. This must be a reasoned grading based on all information known. If there is any risk identified then a report to the Police on 101 should be made. Escalate to Divisional bleep holder, CSM or Matron
4.	**Escalation Level 2** • High risk missing 1-2 hours • Medium risk missing 2-3 hours • Low risk missing 3 -4 hours Divisional bleep holder/Matron/ Clinical Site Manager to coordinate a team to conduct a wider Hospital/buildings/grounds search and instigate the relevant family member, community team, GP to visit the patients home address, and: **Liaise with** • Service Supervisor • Security staff • Estates Manager • Communications Team to distribute Missing Patient email alert In the absence of a Senior Manager, the CSM will adopt the role of Search Co-ordinator.

5.	**Escalation level 3** • High risk missing 2 hours • Medium risk missing 4 hours Divisional Bleep Holder hands over responsibility for on-going search to CG Manager, who will take on the Search Co-ordinator role and will: • Inform the Police - Medium risk - enquiries at home address to take place first. • Inform the Chief Executive or Deputy in hours • Inform On Call Director out of hours • Inform the Head of Communications and Engagement and assist with the preparation of media and other communiqués. • Inform Patient Advice and Liaison Service (PALS)
6.	**OUTCOME:** • Patient found – arrange for medical check to ensure safe and well. Police alone are not trained/qualified to establish if the patient is safe and well and thus they should be seen by the appropriate healthcare professional. • If the patient is found dead, or is suspiciously injured, inform the police immediately. Do not move the deceased and prevent further intervention at the scene. • In all cases ensure all relevant staff and family are informed of the outcome (liaise with police re: deceased or injured) • In all cases, ensure that relevant documentation is completed fully within patient's notes and retained in case of future inquiry. This includes the incident log and any other documentation completed at the time of the incident.

1. INTRODUCTION

The Trust has a duty of care for the safety of its patients. At the same time, patients have a legal right to leave the hospital unless they are detained under the Mental Health Act 2007 or Mental Capacity Act 2005

The Trust is committed to ensuring the safety, welfare and well-being of all patients whilst receiving direct care and treatment, as such it will have systems and reporting mechanisms in place to ensure a comprehensive search is undertaken should a patient be shown to be missing from any of the Trust's in-patient facilities. It is reasonable for patients to leave the ward for a specified and agreed period of time if they are medically stable. However, patients must be advised to check with the ward staff first that there are no clinical restrictions, ensuring staff are aware of where they are intending to go and for how long.

Staff must ensure they do not infringe on the liberty of patients known to use substances such as alcohol, drugs, nicotine and who have the mental capacity to make the specific decision to leave the clinical area. The needs and decisions of such patients should be respected and safeguarded.

Where patients leave hospital premises without the conclusion of treatment and there is a concern for the patient, then there is a National Initiative that the police will only respond to adults at risk where there is a real and immediate threat to life and limb of the adult. Where this threat does not exist then the Trust should look to use health/social care to check on the medical welfare of the patient. The policy is aligned with both Nottinghamshire and South Yorkshire Police requirements in risk assessment and notification of missing persons/patients.
Staff should be aware that in the event that where there is a concern that an infant or child has been ABDUCTED, then the appropriate policy, PAT/PS 19 "Abduction or Suspected Abduction of an Infant/Child Policy" should be followed.

2. PURPOSE OF THIS POLICY

The purpose of this policy is to:

2.1 Identify where possible the location of a missing patient and ensure their safe return in a timely manner if necessary

2.2 Ensure a dynamic risk assessment, using agreed criteria, is undertaken as soon as it is realised a patient is missing.

2.3 Ensure the incident is fully documented and that there are clear lines of responsibility for co-ordinating the necessary procedures and actions.

2.4 To determine an appropriate course of action in the co-ordination and escalation of a search for a missing patient.

2.5 To identify roles and responsibilities of staff members in the event of a missing patient incident.

2.6 To provide a framework for communication and liaison regarding the missing patient including information and updates to the patient's family.

2.7 To ensure that all relevant parties are informed immediately when the patient is found.

2.8 To undertake a post incident internal investigation and produce a report identifying the key issues, actions and learning outcomes, and implement any changes identified.

3. DEFINITIONS

3.1 Patient

A patient can be regarded as a person who has been documented as being an in-patient in a ward or department, or an outpatient who is receiving treatment within Trust premises. Most of these patients have come to be on Trust premises as a result of planned or emergency admission or appointment.

3.2 'Missing person'

For the purpose of this plan and to aid partnership working with South Yorkshire Police (SYP), Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBTH) will use the Police definition of a Missing person, which is "Anyone whose whereabouts cannot be established and where the circumstances are out of character or the context suggests the persons may be the subject of crime or at risk of harm to themselves or others". To be a missing patient, a person must have been receiving care or treatment under the NHS and who has left the NHS premises without going through normal leave or discharge processes and whose whereabouts is unknown

The Police Categories of Missing Persons are

- High Risk - Risk is immediate and there are substantial grounds for believing the subject/public is in danger due to vulnerabilities, threats, risk of danger (risk of harm should be 'here and now' immediate action required)
- Medium risk- The risk posed is likely to place the subject in danger or they may be a threat to themselves/others (active measured response)
- Low Risk – no apparent threat or danger to the subject or public (not for juveniles)
- Absent – a person not at a place where they are expected or required to be and there is no apparent risk.

A patient should be considered missing if:

(a) They leave the ward without notifying staff and there has been no contact or agreement made with staff.

(b) They fail to return within one hour of agreed leave and there is not adequate contact or agreement made with staff. (**NB**: for vulnerable patients, children and babies, the term missing should be applied as soon as their absence is noted).

If a patient's whereabouts is known, but they are refusing to return to the hospital and there is no immediate risk to themselves or others, they are not missing. Options that should be considered include the involvement of community staff, friends and families. Patient, Advice and Liaison Service (PALS) staff can be contacted and may be able to assist the ward staff (if appropriate) to encourage the patient to return to continue care and treatment. In the event where someone who is missing but there is no real or immediate threat to their life or limb friends, family, local GP's and community staff should first visit the patients home address or locations they are known to frequent prior to informing the police. This will be a clinical decision from the care team involved with the patient.

Implementation of this policy requires a degree of latitude in some departments such as the Emergency Department (ED), where patients may book in and then leave without notifying a member of staff, or a patient may be triaged and then leave before seeing a doctor. The policy would be implemented if staff have concern for the patient's safety, (clinical, physical, mental or social). If there is an element of doubt it is advisable to implement the policy by reporting to the Matron, General Manager or Clinical Site Manager and seeking advice, there is always a senior manager available to advise staff.

Nottinghamshire Police have agreed a joint protocol with Trusts, covering the Nottinghamshire force area, regarding the response to adults at risk and will only respond to adults at risk where there is a real and immediate threat to life and limb. Patients who self-discharge from accident and emergency will be required to meet this criteria based upon credible information or intelligence before a police resource will attend. In the event where someone who is missing but there is no real or immediate threat to their life or limb friends, family, East Midlands Ambulance Service (EMAS), local GP's and community staff should first visit the patients home address or locations they are known to frequent prior to contacting the Police. During these enquiries a constant review of the risk should be in place, taking into account any time related risks associated with the patient's health issue.

Any member of staff who finds a patient wandering in or out of hospital grounds, and who do not know which ward they belong to, should attempt to escort the patient back to the nearest phone and contact bleep 1393 via switchboard who will be able to advise or direct to a senior manager.

4. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 5)

5. ROLES AND RESPONSIBILITIES

In the first instance, it is the responsibility of the nurse in charge of the ward to initiate and co-ordinate the search, identify the risk category as Appendix 1, then to hand over to the appropriate member of staff identified at the escalation process. *Appendix 2 Action Card – Escalation Process* identifies the responsible roles and actions that need to be taken and by whom at each level.

5.1 Staff member in charge of clinical area

The nurse in charge will organise the local search for the patient; undertake a risk assessment and determine the risk level; begin documenting the incident and escalate as set out in Appendix 2.

5.2 Divisional bleep holder/Matron/Clinical Site Manager (CSM)

The search for a missing patient will inevitably involve a multi-disciplinary team of people within the Trust, and possibly from external agencies. The Matron/Manager/Clinical Site Manager/department bleep holder is responsible for gathering together a search team, and in collaboration with facilities staff, organising any searches in a systematic way. An incident/search control room will be established on the ward/department from which the patient went missing. Other departments/professionals may be called upon to provide intelligence, equipment and expertise in conducting the search. In the absence of a Senior Manager, the CSM will adopt the role of Search Co-ordinator until a Senior Manager relieves the CSM. Their roles are outlined as follows:

5.2.1 Patient Advice and Liaison Service (PALS)

It is good practice (during daytime hours) to inform the PALS, of any patient reported missing on any site. This would be for information only, to increase their awareness, rather than for their assistance initially.

5.2.2 Service Department

The role of service department staff is to support the search as directed by the search co-ordinator. Service assistants (normally the Central Services Team) will be responsible for gaining access to locked areas and stairwells. This will be via the supervisor during the day and out of hours via the shift leader at DRI and via switchboard at BDGH and Montagu.

5.2.3 Security Staff

The role of security staff is to support the search as directed by the search co-ordinator and to provide escort to nursing staff if the missing patient is considered to be a risk to others. Security staff will provide assistance to the search team whenever possible and when not dealing with other more serious security calls. CCTV images, where available, may be used at escalation level 3 and can be accessed via the Security Manager. Please see Appendix 2 for escalation process.

5.2.4 Estates Department

It is anticipated that the Estates department becomes involved at escalation level 2, where a whole search of the hospital/building/ grounds is required. The Estates department will provide access to high-risk areas, e.g. roof, plant rooms, and ducts. They will ensure that relevant equipment for searching is available from the *Missing person* incident box situated in:

- **Doncaster Royal Infirmary:** Security Office
- **Montagu Hospital:** Wards Rehab 1 and Rehab 2
- **Bassetlaw Hospital:** Security Office

The boxes will contain maps, torches, blue chalk and high visibility clothing for outdoor searchers. All rooms/areas searched should be marked with blue chalk to avoid confusion and duplication. The Missing Person boxes should be checked to ensure complete and equipment in working order on a monthly basis by:

- **Doncaster Royal Infirmary:** Security
- **Montagu Hospital:** General Office staff
- **Bassetlaw Hospital:** Security

5.2.5 Head of Communications and Engagement

The Head of Communications and Engagement will address any organisational alerts required and media requests for information. Requests for Trust-wide communication or media alerts should go through the Head of Communications and Engagement (or nominated deputy) during working hours or the senior manager on call out of hours. The Head of Communications and Engagement should be informed of any cases where a missing patient may result in interest from the media or other external stakeholders.

5.2.6 Police

The police should be informed immediately if the patient is categorised as “high risk” or at escalation level 3. Information should be given to the police regarding the likelihood of the missing patient coming to harm or harming others. If the patient is assessed as “high risk” clear instructions must be given to the police requesting the patient returns to the hospital. The police will then co-ordinate a wider neighbourhood search (if considered appropriate).

Where the patient is deemed to be medium risk, the nurse in charge is responsible for instructing the relevant healthcare/social care professional to visit the patient’s home address to check on their welfare. If the relevant professional encounters, or there is credible information to suggest the patient may present a risk to the relevant professional, the police should be contacted to provide support to the visiting professional. If the patient is not at their home address and the next of kin and phone enquiries do not locate the patient, then report to the police as a medium risk missing person.

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

6. THE PREVENTION OF A MISSING PATIENT INCIDENT

It is important that all staff take measures to prevent a missing patient incident with the following actions:

6.1 As a routine admission procedure, patients will be advised of the need to inform staff when they plan to leave the ward and the time of their expected return. The person should also be advised that their details may be passed to the police if they fail to return from leave or if they leave without informing staff.

6.2 As part of the routine admission procedure next of kin contact details will be regularly updated and the patient's mobile phone number will be recorded.

6.3 Risk assessments should be undertaken if a patient is known to be vulnerable, such as confused or suicidal, or if they are a child with safeguarding issues. The risk to themselves and others, should they absent themselves from the ward/ department, should be explained. This should be continually reviewed throughout the care episode.

6.4 It is important that a risk assessment of the patient environment is also undertaken, especially where there is easy access out of the ward through windows, fire doors etc.

6.5 If a patient is assessed by a trained nurse as being at risk of going missing, and it is known that a patient requires close supervision, the nurse in charge of the ward should follow PAT/PS 20 – Enhanced Patient Supervision and Engagement Policy. Where this course of action is difficult or impossible, due to staffing resources, the Matron/Head of Nursing should be made aware of the situation to discuss all options for undertaking adequate supervision. In some circumstances, the patients' family/carer may be able to contribute to the supervision process. Arrangements should be made in consultation with the family/carer.

6.6 Patients requiring close supervision should have a record (in the nursing notes) of their clothing kept and updated as necessary each shift.

6.7 All other ward staff should be aware that there is such a patient on the ward, in order to be vigilant and observe the patient's movements.

6.8 Information concerning such patients should be communicated via nursing handover/report.

6.9 Should the named individual responsible be called to other duties that make it impossible for them to observe the patient, then responsibility must be passed to someone else for that period of time.

6.10 If a patient is seen 'wandering' they should be approached and enquiries made.

6.11 Individual care plans should identify any triggers or particular needs that may result in the patient leaving the ward.

7. MISSING PATIENT PROCEDURE

7.1 Category of Patients:

High risk patients

The risk is immediate and there are substantial grounds for believing the subject/public is in danger due to vulnerabilities, threats, risk of danger (risk of harm should be 'here and now' immediate action required) examples would be:

- The patient is a baby/child or young person up to the age of 16.
- The patient is in need of regular medication, absence of which may cause threat to health (e.g. insulin dependent diabetic patient).
- The patient has expressed suicidal thoughts or has made previous suicide attempts.
- The patient lacks mental capacity as well as confused and is unable to care for themselves or protect themselves from danger.
- The patient may be a risk to others due to violent or unpredictable behaviour.
- The patient is subject to the Mental Health Act (2007). This refers to patients who are subject to the Mental Health Act, but are being treated for an unrelated medical condition.

Medium risk patients

The risk to the patient is likely to place the subject in danger or they may be a threat to themselves or others (active measured response)

Low risk patients

There is no apparent threat or danger to the subject or public (not for juveniles) however the length of time they have been away from the ward causes a concern:

- Children who are known to be with their parents/guardian and there are no safeguarding concerns and/or no immediate clinical risk.
- Patients with no mental impairment and low clinical risk.
- Need to establish contact for minor intervention i.e. removal of intravenous cannula or to communicate follow up arrangements
- Medical and nursing assessment may identify that the patient is considered a self-discharge and does not require follow up.

Absent patients

A person not at a place where they are expected or required to be and there is no apparent risk to them or others.

7.2 Immediate Action

If a patient is found to be missing from an Area/Ward and there are concerns that the person could be at risk to themselves or others, the following actions must be taken **immediately** and should take no more than 15 minutes:

- Staff will make an initial search of the immediate and surrounding areas (adjacent wards, office accommodation, stairwells one floor up and one floor down).
- Ascertain whether the person has previously signalled their intention to leave the hospital
- Check to see if anyone saw the person leave.
- Check patient's locker to see if property has been taken.
- Check if the person has arrived at their home address.
- If abduction involving a baby or child is suspected, implement PAT/PS 19 "Abduction or Suspected Abduction of an Infant/Child Policy".
- Check if the patient is in possession of a Mobile Phone and if you have the number attempt to make contact and leave an answer phone message if the call is not answered.

7.3 Escalating the Search

If the person is not found and is still giving cause for concern the missing/absent patient flow chart at Appendix 1, should be reviewed.

The level of risk (table below) should reflect the **Current and On-Going** risk presented, given the circumstances of the disappearance or non-appearance. This will be informed by various factors,

including previous missing behaviours. It should be borne in mind that any risk assessment is on-going. Any new information or changes in circumstances may require a new review or review of current risks.

Once a patient has been reported missing, the level and timing of escalation will depend on the level of risk attributed to the patient, and the professional judgement of the clinical care team. In all cases, a risk assessment to determine whether the patient meets the risk definitions on Table 1 will be undertaken and actions executed accordingly.

Where a patient has been categorised as **high risk, or medium risk,** the actions set out in Appendix 2 should be executed swiftly, aiming to implement actions. The police should be informed following the initial search. It is accepted that some actions in level 2 will be ongoing and concurrent to actions in level 3.

For **low risk,** the actions set out in Appendix 2, should be executed within a three to four hour period. If level 3 is reached, communication with the police will enable both Trust staff and the police to decide upon the most appropriate course of action.

Table 1. Risk Definitions

HIGH RISK
Definition: The risk is **immediate** and there are **substantial** grounds for believing that the individual may suffer death or serious injury. or The risk posed is **immediate** and there are **substantial** grounds for believing that the individual may cause death or serious injury to another. or It is suspected that the individual has been the victim of a serious crime.
MEDIUM RISK
Definition: There is an **apparent risk** that the individual may be exposed to significant harm. or There is an **apparent risk** that the individual poses a risk of significant harm to another person.
LOW RISK
Definition: There is **no apparent risk** that the individual may be exposed to significant harm. or There is **no apparent risk** that the individual poses a risk of significant harm to another person.

The information recorded on the Missing Patients Information sheet, Appendix 3 and also 3A if a child or young person is involved, must be shared with the Police and Site Security and will include, as a minimum, the following information**:**

- Person's name, age and address
- Person's mobile phone number if they have one and what messages have been left.
- Full description of the person, to include any distinguishing features.

- Full description of the clothing being worn and any property in their possession.
- Time and location last seen along with their mental state at that time.
- Any preparations they had made to leave i.e. packing their locker.
- If the patient has been discharged with a cannula or other medical device fitted then an assessment of the risk to the patient should be undertaken.
- A description of whether the person is at risk to themselves or to others.
- Whether the person is known to be a smoker, have substance misuse issues or alcohol abuse issues.
- A Point of Contact for the Police /Security to further communicate and the appropriate contact number.

7.4 Escalation and Timing of the Search

The action card at Appendix 2 outlines the escalation process and the actions to take by relevant key staff at each escalation level. It is better to escalate to the senior manager and executive on call, earlier in the proceedings rather than later.

7.5 Out of Hours

If a patient should be reported missing out of hours, the procedure for escalation is through the Clinical Site Management Team.

8. SAFEGUARDING CONSIDERATIONS

Safeguarding adults

If a patient who goes missing is known to have safeguarding issues, it is important to let the corporate Safeguarding Team know.

Out of hours if there is immediate risk to the adult telephone the Emergency Duty Team:

- **Doncaster:** 01302 796000
- **Bassetlaw:** 0300 4564546

Please refer to Safeguarding Adults Policy/local safeguarding board policies.

Please contact the corporate safeguarding team within hours to update them/for advice.

For patients subject to a Deprivation of Liberty Safeguard (DoLS) authorisation, the Police must be informed. Once found the patient must be returned to the relevant hospital as this is their lawful place of detention.

Safeguarding children /young people

When a child/young person goes missing they are at potential risk and therefore safeguarding should be considered. There is a responsibility on all relevant agencies to work together when a child/ young person goes missing. Going missing can be a symptom of something going wrong in a child or young person's life. Children, who go missing for the first time, or for short periods of time, can still face a number of risks and dangers which can impact on their life.

If a child/young person goes missing and you believe the child to be at risk of significant harm complete a referral to children's social care as policy.

Out of hours if there is immediate risk to the child telephone the police and the Emergency Duty Team:

- **Doncaster:** 01302 796000
- **Bassetlaw:** 0300 4564546

Please Refer to Safeguarding Children Policy /local safeguarding children partnership policies .

Please contact the corporate safeguarding team within hours to update them/for advice.

9. COMMUNICATION/DOCUMENTATION AND RECORD KEEPING

The Search Co-ordinator is responsible for ensuring that all relevant documentation and record keeping is completed. Once the search has concluded, all documentation completed should be kept in the patient's clinical records. Each area should keep a supply of the missing patient information sheets. All documentation generated must be retained safely in case of a public, judicial, or coronial inquiry.

9.1 Missing patient information sheet

Appendix 3 - Adult or 3A and 3B if a child or young person up to age 16yrs should be completed as soon as it is established that the patient is missing. This should be circulated to all relevant staff participating in search activity, and shared with the police as appropriate.

The Children's Act (1989) defines a child as from birth up to the age of 18 years so the Safeguarding Children Policy would apply in these cases.

Please note that the police define a child as anyone 17 yrs. and younger and will apply police policies for children to anyone who is 17 years and younger.

9.2 Patient's Nursing/Medical records

A record of the patient going missing should be made in the clinical records and log of events *(Appendix 4).*

9.3 Log of events

The purpose of the log of events (Appendix 4 and also required Appendix 3b Checklist if a child or young person up to age 16yrs * please see note in red box above) is to provide a contemporaneous record of actions, decisions and communications made during the course of the search. This should be initiated as soon as it is established that the patient is missing and maintained until the patient is located.

9.4 Information technology and email

During day time hours, the use of email to alert other wards/departments/staff needs to be considered carefully in relation to data protection and patient confidentiality. The Head of Communications and Engagement will address ongoing communication methods.

10. DE-ESCALATION & CONCLUSION OF INCIDENT

The Incident is concluded when all areas of the hospital – both internal and external have been searched, relevant enquiries through community teams, GP, Social Services, next of kin and family have been completed or when the missing patient has been located. In the event of a missing patient not being located the police will implement their own Missing Person Procedure/ Joint protocol regarding the response to children at risk of harm and adults at risk. In all other circumstances the police will risk assess the seriousness of the incident and make a decision on what further action is to be taken.

10.1 The Search Co-ordinator

Once the patient has been located the Search Co-ordinator will notify all appropriate personnel. If the Missing Patient has been located 'off site' joint decisions between the Hospital and Police must be agreed regarding the management of the person and safe return to the hospital.

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has responsibility for ensuring the return of patients who have been located, or to document the reasons why not.

Transport to hospital will normally be by ambulance/car if the patient has an unstable medical condition that may require attention or medication. Ambulance assistance can be requested by 999 or police control.

<u>Police transport or escort will only be used in circumstances where the patient:</u>

- Is violent at the time of return.
- Is likely to be an immediate danger to themselves or the public.
- Is suspected of being involved in the commission of a criminal offence during the period of absence.
- Is located in such circumstances as would trigger a consideration under section 136 of the Mental Health Act. In these circumstances an ambulance should still be used to transport unless the patient is unmanageably violent. The police will however travel with the ambulance.

Police transport will **not** be used to convey people who have been sedated as they will require constant clinical supervision from a medical practitioner or a nurse. The police and ambulance service have to consider the question of consent from a patient. It should be remembered that unless these services can point to a statutory requirement to detain and transport a patient, the police and ambulance service will refuse to provide transport if a patient does not consent.

10.2 The patient

The patient should be encouraged to return to the ward and be medically examined. The patient should not be forced to return. If he/she is subject to the Mental Health Act (1983), the police/mental health services may be required to assist. The police have powers under S18 Mental Health Act (1983) to return patients to hospital where they are absent without leave whilst under Section 2 and Section 3 Mental Health Act. (**Please note** Police Officers do not have a power of entry under this section).

Further risk assessments should be undertaken and the patient observed appropriately in an effort to avoid a repeat incident.

10.3 Further Action

The incident must be reported through the Trust adverse incident reporting system and investigation undertaken within the Division. In the event of the incident being assessed as a Serious Incident (SI), the Incident Controller's Line Manager is to ensure that the Hospital Director on Call is informed.

A post incident investigation and report will be undertaken to determine the key issues, actions and learning outcomes and implement any changes identified. Following review, action plans and policy amendments should be made appropriately.

All documentation generated must be retained safely in case of a public, judicial, or coronial inquiry.

11. TRAINING/EDUCATION

There is no educational/ training plan for this policy. Awareness and support with Policy is through line management and the local induction training.

12. MONITORING COMPLIANCE AND EFFECTIVENESS OF THIS POLICY

When a missing person incident results in a serious outcome (Serious Incident escalation) the management of that case will be assessed against the procedure laid down in this policy and the relevant Divisional management and governance arrangements.

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
Missing patients are monitored through the Datix information system	Department leads and ward managers	When the incident occurs	Patient Safety Review Group Clinical Governance Group Risk Management report
The items in the missing persons boxes	Security team	Following an incident	Head of Security

13. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

- PAT/PA 10 – Concordant for the care of prisoners admitted to DBTH
- Doncaster & Nottinghamshire Local Safeguarding Board Guidelines
- PAT/PS 20 – Enhanced Patient Supervision and Engagement Policy
- PAT/PS 10 - Safeguarding Children Policy
- PAT/PS 8 - Safeguarding Adults Policy
- PAT/PS 19 – Abduction or Suspected Abduction of an Infant/Child Policy
- PAT/PA 19 – Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS)
- CORP/EMP 4 – Fair treatment for all
- CORP/EMP 27 – Equality Analysis Policy

14. DATA PROTECTION

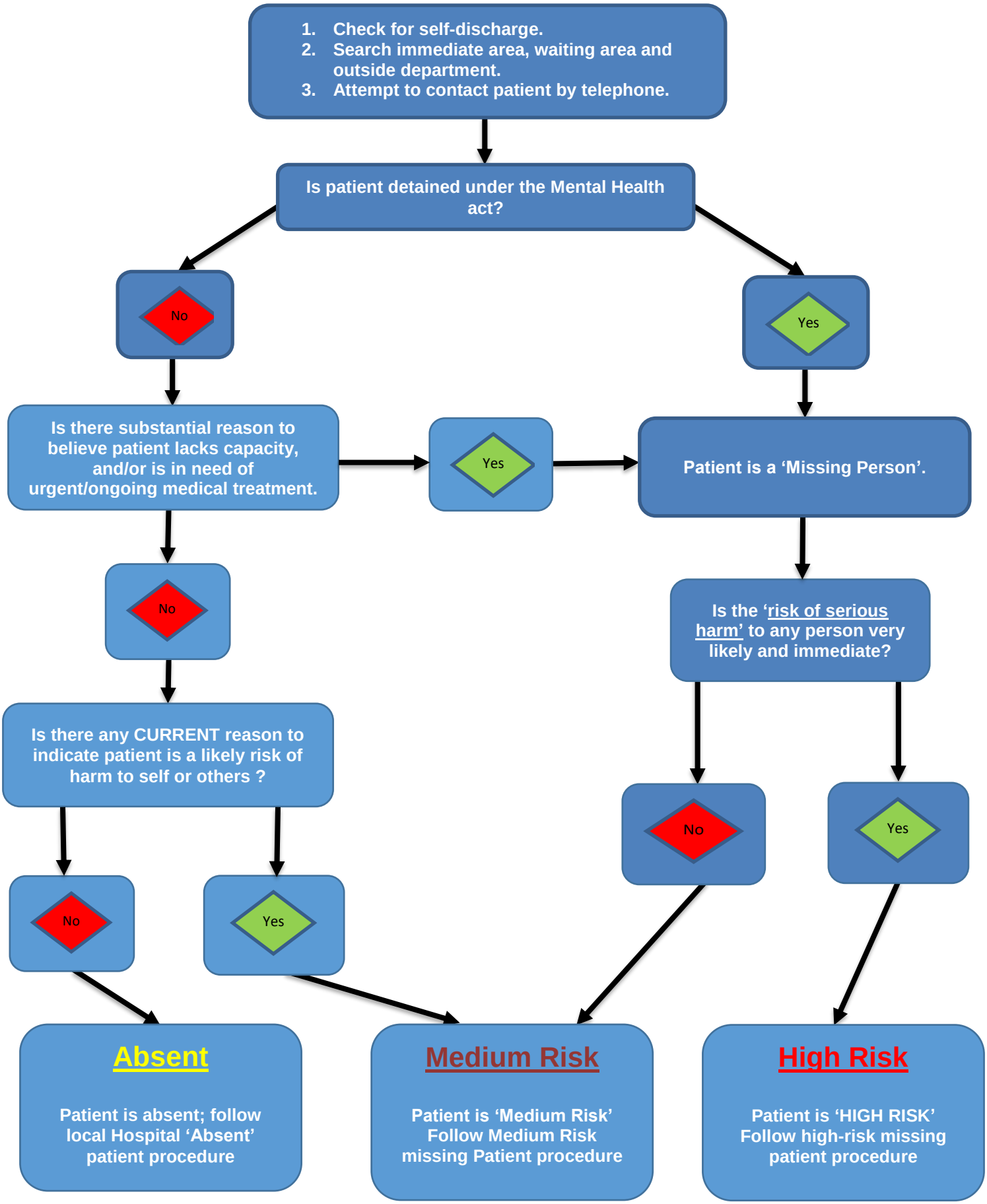
Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/uk-data-protection-legislation-eu-general-data-protection-regulation-gdpr/

15. REFERENCES

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

APPENDIX 1 – MISSING/ABSENT PATIENT FLOW CHART



APPENDIX 2 - ACTION CARD – ESCALATION PROCESS – MISSING PATIENT

WARD/DEPARTMENT - On being alerted that a patient is missing from the ward or department, the Nurse in Charge will take the following action:

1.	Organise an immediate search of ward/department and surrounding areas
2.	If the patient is NOT found, activate Missing Patient Procedure: • Undertake the Risk assessment algorithm at Appendix 1 to determine the Category and level of risk • HIGH/MEDIUM/LOW risk • Commence the Incident Log Appendix 4 • Complete the Missing Patient information sheet at Appendix 2 for ADULTS and Appendix 3A AND 3B for CHILDREN • COMMENCE ESCALATION PROCESS
3.	**Escalation Level 1** • High risk and missing for 1 hour - ESCALATE to Divisional bleep Holder, Matron or CSM (Consider immediate Police involvement with this category if HIGH risk) • Medium risk and missing 1-2 hours, ESCALATE to Divisional bleep holder, Matron or CSM • Low risk/Absent - If a patient is deemed low risk/absent based on their medical needs, circumstances around whereabouts being unknown and risks assessed then this does not need reporting to Police. This must be a reasoned grading based on all information known. If there is any risk identified then a report to the Police on 101 should be made. Escalate to Divisional bleep holder, CSM or Matron
4.	**Escalation Level 2** • High risk missing 1-2 hours • Medium risk missing 2-3 hours • Low risk missing 3 -4 hours Divisional bleep holder/Matron/ Clinical Site Manager to coordinate a team to conduct a wider Hospital/buildings/grounds search and instigate the relevant family member, community team, GP to visit the patients home address, and: **Liaise with** • Service Supervisor • Security staff • Estates Manager • Communications Team to distribute Missing Patient email alert In the absence of a Senior Manager, the CSM will adopt the role of Search Co-ordinator.

5.	**Escalation level 3** • High risk missing 2 hours • Medium risk missing 4 hours Divisional Bleep Holder hands over responsibility for on-going search to CG Manager, who will take on the Search Co-ordinator role and will: • Inform the Police - Medium risk - enquiries at home address to take place first. • Inform the Chief Executive or Deputy in hours • Inform On Call Director out of hours • Inform the Head of Communications and Engagement and assist with the preparation of media and other communiqués. • Inform Patient Advice and Liaison Service (PALS)
6.	**OUTCOME:** • Patient found – arrange for medical check to ensure safe and well. Police alone are not trained/qualified to establish if the patient is safe and well and thus they should be seen by the appropriate healthcare professional. • If the patient is found dead, or is suspiciously injured, inform the police immediately. Do not move the deceased and prevent further intervention at the scene. • In all cases ensure all relevant staff and family are informed of the outcome (liaise with police re: deceased or injured) • In all cases, ensure that relevant documentation is completed fully within patient's notes and retained in case of future inquiry. This includes the incident log and any other documentation completed at the time of the incident.

APPENDIX 3 - MISSING PATIENT INFORMATION SHEET

Name & Address of patient: **Include mobile and landline numbers**		**Include known alias if used:**
Date of Birth & Age:		
Next of Kin: Address and contact number:		**Police Incident Number :**
General Practitioner		**Contact details:**

Risk Level:		**Date and Time last seen:**
Ward/department		**contact number:**
Medical Condition:		**Length of time missing:**

Height:		**Weight:**
Build:		**Hair Colour and style:**
Complexion:		**Skin colour:**
Eye colour:		**Facial hair:**
Distinguishing features (Include tattoos; scars; plaster cast etc.):		**Hospital ID band on?**

Access to a vehicle:		**Cash, clothing etc. missing from locker:**
Places frequented:		**Where have you searched:**
If patient has gone missing before, where found:		
Known friends' contact details:		

Additional Information: Reasons for reporting missing: include mental state, special concerns or risks about patient's health, medication needs, suspicious circumstances and any known reasons for leaving:

Date & Time……

Completed by……**PRINT**……

Contact details……

APPENDIX 3A - MISSING CHILD & YOUNG PERSON INFORMATION SHEET

PLEASE COMPLETE AND RETURN TO: Head of Nursing (Paediatrics) /General Manager Children's & Families Division

Ward/Department		**Contact Number:**
Name & Address of Child:		**Hospital Number & Consultant:**
Date of Birth & Age:		**Police Incident Number:**
Name and address parents/guardians: **Contact number: Include Mobile numbers:**		**Who does the Child usually live with:**
General Practitioner		**Contact details:**

Date and time last seen:		**Where:**
By whom:		**With anyone?**

Male/Female:		**Height:**
Weight		**Complexion:**
Hair colour and style:		**Eye colour:**
What was the Child wearing when last seen?		

Distinguishing Features e.g. scars birthmarks etc:		**Is the Child under the care of CAMHS**:
Physical condition, including capabilities:		
Special Concerns – e.g. epilepsy, diabetes; developmental etc.		
If previously missing, where were they found?		**Hospital ID Badge in place?**
Additional Information:		

Date & Time……..

Completed by…….**PRINT**……

Contact details……..

APPENDIX 3B- CHECKLIST FOR STAFF REPORTING A MISSING CHILD/YOUNG PERSON

	Date	Time	Who was informed	Signature	Title
Reported to Children's Services bleep holder					
In Hours Reported to Matron/Head of Nursing and Quality (Paediatrics)					
Out of Hours Reported to Clinical Site Manager					
Search Initiated					
Parent/ Guardian informed					
Police informed					
Social Services informed (if appropriate)					
Safeguarding Team informed (if applicable)					

Outcome: **Was the Child found safe and well:** **If no, explain:** **What further action needs to be taken:**	

Date & Time……

Completed by……PRINT……

Contact details……..

APPENDIX 4 - MISSING PATIENT INCIDENT LOG

Name of patient:		**Hospital Number:** **Police Incident Number:**
Ward/Department:		**Time reported missing:**
Risk level:	**HIGH** **MEDIUM** **LOW**	
Log Commenced:	**Date:** **Time:** **By:**	**Print Name and Designation**

Action	Time	By whom	Notes/comments
1. Immediate search of Ward and surrounding areas (Specify)			
2. *Assessment of risk category Category 1 Category 2 *See page 9 of policy			For category 1 patient consider informing police immediately (see Action 14)
3. Missing patient information sheet completed			

4. Matron/Clinical Site Manager informed			
5. Manager on Call Informed (Out of hours)			
6. Patient's consultant informed (Day time only)			
7. Consider contacting patient's relatives/carer if appropriate.			
8. Estates department notified			
9. Service assistants/porters notified and wider building search initiated:			
10. Hospital wide search commenced			
11. Grounds search commenced			

12. Patient's relatives/carer notified			
13. Patient GP notified			
14. Police notified Category 1 patient: request the patient returns (see page 13 of Policy for Police limitations) Further advice on CAT 2 sought (police no longer do routine 'safe and well' checks			
15. Director of Nursing, Midwifery and Quality (or deputy) informed (day time only)			
16 Patient Advice & Liaison service notified			
17. Social services/emergency duty team notified (if appropriate)			
18. Executive on call notified			
19. Chief Executive briefed			
20. Missing Patient Email Alert sent to Head of Communications and Engagement (in hours)			

21. Head of Communications and Engagement to prepare statement for media at request of CE or Executive on Call.			
22. Patient Found			
23. Medical examination of patient			
24. Incident form completed			
25. All Documentation safely retained in case of inquiry			

Any further action required or add any additional information that may be useful here:

List of staff involved in the search, including designation and contact details	Names:	Designation	Contact details

APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Missing Patient Policy PAT/PS 1 v.6	Corporate	Kate Carville	Existing	27 January 2020

1) Who is responsible for this policy? David Purdue, Director Of Nursing, Midwifery and AHP, Kate Carville, Associate Director of Nursing, Division of Medicine

2) Describe the purpose of the service / function / policy / project/ strategy? Missing patients from the Trust

3) Are there any associated objectives? Nottinghamshire and South Yorkshire Police partnership agreements.

4) What factors contribute or detract from achieving intended outcomes? – None

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/beliefs - No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality?

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	
b) Disability	No	
c) Gender	No	
d) Gender Reassignment	No	
e) Marriage/Civil Partnership	No	
f) Maternity/Pregnancy	No	
g) Race	No	
h) Religion/Belief	No	
i) Sexual Orientation	No	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 √	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: January 2023

Checked by: Marie Hardacre **Date: 27 January 2020**