



Missing Patient Procedure

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Author	Local Security Management Specialist		
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Approved by HMT	Approved by Safeguarding Committee Ratified by Patient Safety Steering Group 16 May 2016		
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1. RATIONALE

- 1.1 The Trust has a duty of care for its patients, however, patients over the age of 18 years have the right to leave the hospital as they please unless they are detained under the Mental Health Act 1983, when they have Deprivation of Liberty Safeguards or they are a prisoner in custody receiving treatment at the Trust.
- 1.2 Patients who are vulnerable and confused may lack the mental capacity to make an informed decision regarding leaving the hospital. Whilst they are in the care of the Trust, patients may occasionally go missing for a variety of reasons, e.g. clinical, medical, emotional, and confusion.
- 1.3 If a patient has left the ward or department without informing staff, they must be assumed as missing and measures must be taken to account for or find that patient immediately.
- 1.4 The procedure supports the [Protecting Patients Who Wander Policy](#).

2. AIM

- 2.1 The aim of this procedure is to enable staff to:
 - Identify when a patient should be regarded as missing
 - To take appropriate action in an effective and timely manner
 - Involve external agencies as appropriate
 - Ensure that the relatives of any missing patient are informed as soon as possible
 - Address any safety issues when engaged in patient searches

3. ROLES AND RESPONSIBILITIES

- 3.1 All staff has a responsibility for ensuring that the principles outlined within this document are universally applied. This policy applies to all members of staff who are involved in any aspect of patient care.
- 3.2 The initial response for the actions lies with the person first discovering the patient to be missing, but should be passed as soon as possible to the person in charge of the area.
- 3.3 The responsibility for the security of prisoners in custody remains at all times with the prison officers, who will contact the police and the site manager immediately if the prisoner absconds. Trust staff should not become involved in the recapture of these patients.

3.4 **Matron / Clinical Site Manager**

The Matron / Clinical Site manager is responsible for:

- ensuring the missing patient procedure is followed (**Annex A**);
- co-ordinating the search for the missing patient, once notified by the ward/department manager/nurse in charge;
- ensuring all relevant documentation is completed during the process, missing person report (**Annex C**)

Contact timings: In Hours Mon-Fri 08:00 - 20:00hrs - **Matron** (for Area/Dept)
Out of Hours Mon-Fri 20:00 - 08:00 and All Weekend - **Clinical Site Manager**

3.5 Ward / Department Nurse in Charge / Department Manager

The Nurse in Charge / Department Manager is responsible for:

- ensuring they and their staff are aware of any vulnerable or '**high risk**' patients in their care and how these patients should be safely 'managed'; Including Mental Health Risk Assessment (**Appendix 1**) if appropriate;
- raising the alert when a patient is identified as 'missing', by adhering to the missing patient procedure (**Annex A**), utilising the Missing Patient Cascade flowchart found at **Annex B**;
- complete the missing patient report using **Annex C** if required to escalate details to the Police;
- ensuring that staff involved in a missing patient incident are offered support post incident if required.

3.6 Ward / Department Staff

Ward staff are responsible for:

- ensuring that all 'vulnerable' patients have been assessed for their 'risk' of wandering from the ward; Including Mental Health Risk Assessment if appropriate;
- ensuring an appropriate action plan has been created when the risk of wandering has been identified which is documented;
- ensuring that staff are aware daily of 'wandering' risk and have recorded patient physical description (including clothing) to assist with search if required
- adhering to and updating, where necessary, the care plan of a patient identified as 'at risk of wandering';
- raising the alert when a patient is identified as 'missing', by adhering to the missing patient procedure (**Annex A**);
- attending and escort any 'found' patient back to the ward;

3.7 Security Staff

Security staff on duty at the time a patient is identified as 'missing' are responsible for:

- once notified of a 'missing' patient, immediately undertaking a co-ordinated search of the site, internal and external grounds;
- keeping a record of all searches undertaken;
- liaising with the Police, where necessary/appropriate;
- notifying the Ward/Dept / Clinical Site Manager / Matron of the outcome of searches; and
- recording actions taken on the security log database.
- Reviewing CCTV footage to inform search efforts

3.8 Porter Staff

Porter staff are responsible for:

- supporting the security team with any search for a missing patient, where necessary within the hospital grounds.

3.9 Switchboard Staff

Switchboard staff are responsible for:

- ensuring the cascade procedure is followed with accurate details and descriptions of missing patient; see **Annex B**;
- notifying the Clinical Site Manager/Matron and ward/department manager of the outcome of the cascade (as per 3.4).

4. RISK CATEGORISATION

4.1 The following categorisation for missing patients ensures a consistent assessment and approach is undertaken. A **Mental Health Risk Assessment (Appendix 1)** should be completed if there is suspicion of mental health concerns at any point which will assist to highlight risk. Patient risk factors should be identified from the patient notes to highlight vulnerability concerns. A decision should be made on risk i.e.

4.2 High Risk

- An extremely young or frail elderly person who is dependent upon the assistance of another responsible person (e.g. parent or carer) and is likely to face immediate and significant harm in the absence of that person.
- A patient, who has been assessed, is likely to attempt significant self-harm or suicide: this assessment will be based on all relevant information indicating the individual's state of mind and includes medical history and any letters, notes or telephone calls made.
- A patient that has been assessed as likely to come to significant harm without medical assistance: also included as high risk are those patients missing without medication, which may make them a significant threat to others and/or themselves.
- Information suggests that the missing person may be of significant risk from others through personal vulnerability or associations with dangerous individuals who may cause them harm.

4.3 Low Risk

- Will include cases where the individual is willingly absent, is able to function adequately without assistance and is unlikely to come to harm under normal circumstances. It would also cover cases where having considered all the risk factors, there are no grounds to believe the missing person is likely to come to harm.

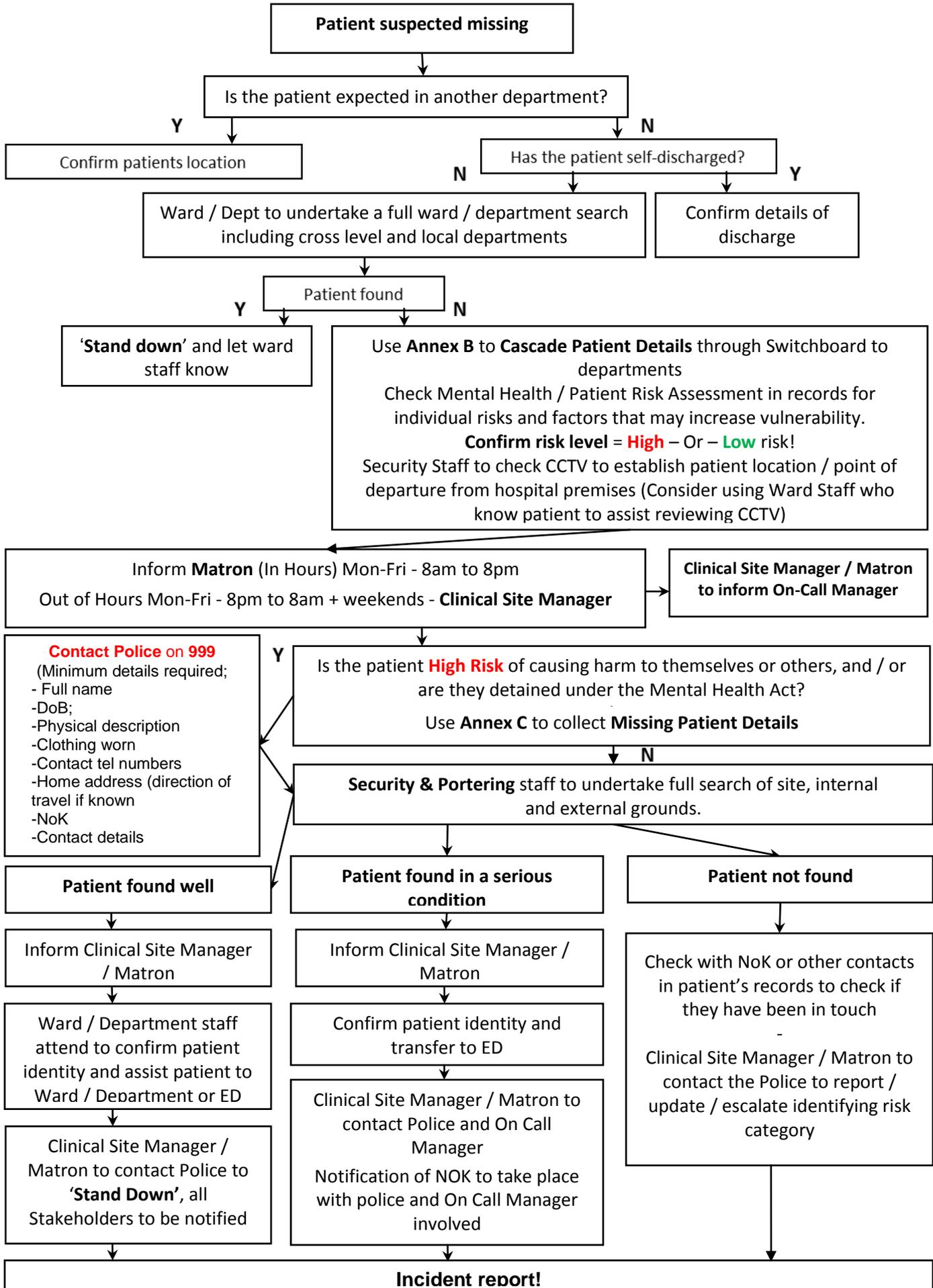
4.4 Patients Detained under the Mental Health Act

- If a patient is detained under the Mental Health Act or a Deprivation of Liberty Authorisation is in place, the patient is not legally allowed to leave the hospital. The police must be informed of this status, if applicable, when a missing patient is reported to them.

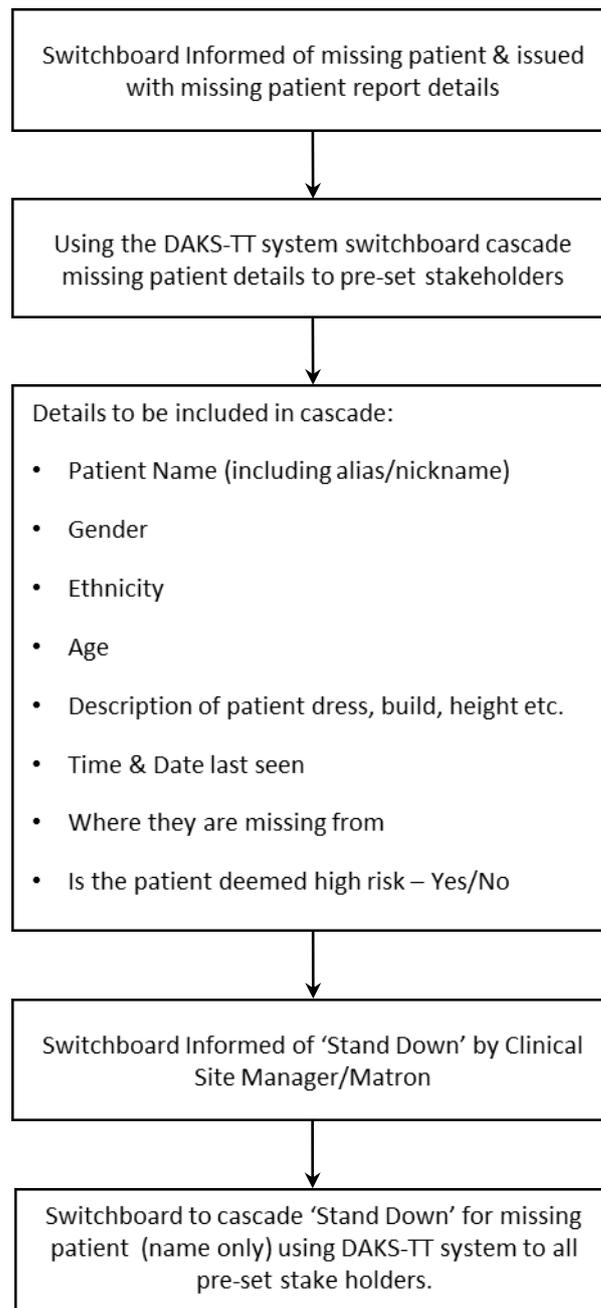
4.5 Wandering Patients

- The [Protecting Patients Who Wander Policy](#) can assist clinical staff to identify wandering patients and identify actions to reduce risks (see the Trust Policy database on YCloud)

ANNEX A: MISSING PATIENT PROCEDURE FLOWCHART



ANNEX B: Missing Patient Cascade Process Flowchart



DETAILS	
Surname: (Alias/Nickname(s))	Forename(s):
Time & Date last seen:	Place last seen:
Ward/Department from which Patient is missing:	Informant:
Have they gone missing before:	If yes give brief details:
Address:	Tel No:
Home Address (if different):	
DOB:	Age:

DESCRIPTION	
Gender:	M F
Ethnicity:	White Euro/Dark Euro/Afro Caribbean/Asian/Oriental/Arab/Other.....
Language:	English /
Build:	Small / Medium / Large
Height:	Tall / Medium / Short (Record height) =
Eyes:	Blue/Brown/Green/Hazel/Other..... Glasses: Y / N
Hair Colour:	Black / Brown/ Fair/ Blonde/ Red/Grey/ Other.....
Hair Style:	Curly/ Wavy / Straight / Permed / Dreadlocks/ Cropped /Wig/ Styled/ Streaked/ Bald/Other.....
Facial Hair:	Moustache/Beard/Sideburns/Stubble/Other.....
Distinguishing Features:	Scar/Tattoo/Other..... Location:.....
Dress:
Jewellery:
<p>Risk Factors: e.g. Confusion / Mobility / Falls Risk / Mental Status / Medical Condition</p>	
<p>Additional Information: e.g. is the patient a risk to themselves or others Likely destination</p>	
<p>Ensure copy is issued to Clinical Site Manager/Matron</p>	

EMERGENCY DEPARTMENT
Mental Health Assessment Matrix

Affix patient label here

Ward:

Patient's Name: Date of Birth:

Tel Number (Home): Mobile:

Next of Kin (Name): Tel Number:

GP: Surgery: Tel Number:

Are there childcare/carer responsibilities? Yes No if yes, steps taken:

Name of assessor(s):

Date: Time:

Steps to be taken when undertaking an initial assessment of a person with a suspected mental health problem:

1. Has a physical cause for the problem(s) been ruled out? Yes No
2. Has drug and/or alcohol intoxication been ruled out as a cause? Yes No
3. Is the person physically well enough (e.g. not sedated, intoxicated, vomiting or in pain) to undertake an interview with mental health staff? Yes No
4. Manage violent and aggressive incidents as per department policy
5. If the person has a known mental health history, always check the Serious Concerns book and/or contact Crisis Team for advice 01935 411605
6. Completed matrix needs to be faxed to 01935 411610 Time faxed
7. Telephone for confirmation that fax has been received



Assessment Categories		
1. Background history and general observations	Yes	No
• Does the person pose an immediate risk to self, you or others?		
• Does the person have any immediate (i.e. within the next few minutes or hours) plans to harm self or others?		
• Is the person aggressive and/or threatening?		
• Is there any suggestion, or does it appear likely that the person may try and abscond?		
• Does he/she have a history of violence?		
• Has the person got a history of self-harm?		
• Does the person have a history of mental health problems or psychiatric illness?		
If yes to any of the above, record details below:		
If previous self-harm: how long ago was the last attempt?		

2. Appearance and behaviour		Yes	No						
• Is the person obviously distressed, markedly anxious or highly aroused?		<input type="checkbox"/>	<input type="checkbox"/>						
• Is the person behaving inappropriately to the situation?		<input type="checkbox"/>	<input type="checkbox"/>						
• Is the person quiet and withdrawn?		<input type="checkbox"/>	<input type="checkbox"/>						
• Is the person inattentive and unco-operative?		<input type="checkbox"/>	<input type="checkbox"/>						
• Does the person appear intoxicated clinically?		<input type="checkbox"/>	<input type="checkbox"/>						
If yes to any of the above, record details below:									
3. Issues to be explored through brief questioning									
Why is the person presenting now? What recent event(s) precipitated or triggered this presentation? Give details below:									
What is the person's level of social support (i.e. partner/significant other, family members, friends)? Give details below:									
		Yes	No						
• Does the person appear to be experiencing any delusions or hallucinations?		<input type="checkbox"/>	<input type="checkbox"/>						
• Does the person feel controlled and influenced by external forces?		<input type="checkbox"/>	<input type="checkbox"/>						
• Is the person quiet and withdrawn?		<input type="checkbox"/>	<input type="checkbox"/>						
If yes to any of the above, record details below:									
4. Suicide risk screen – greater number of positive responses suggests a greater level of risk									
	yes	no	d/k		yes	no	d/k		
Previous self-harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family history of suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Previous use of violent methods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unemployed/retired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Suicide plan/expressed intent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Male gender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Current suicidal thoughts/ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Separated/widowed/divorced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hopelessness/helplessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of social support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family concerned about risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Evidence of psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Disengaged from services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Alcohol and/or drug misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor adherence to psychiatric Tx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic physical illness/pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Access to lethal means of harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Alcohol consumption									
Was alcohol consumed as part of the act or within 6 hours of the act? (please circle): Yes / No / Don't know									
Current contact with psychiatric services									
At the time of attendance, was the patient receiving psychiatric treatment? (please circle): Yes / No / Don't know									
If yes, please ✓ box and name service:									
Inpatient				<input type="checkbox"/>	Community team				<input type="checkbox"/>
(i.e. has been seen by a member of a mental health team and has further appointments)									
Diagnosis (please circle): Yes / No / D/K If yes, diagnosis:									

What category of overall risk have you identified?

Give reasons and rationale for your decision



Action plan and outcomes following initial risk screen:

Describe all actions and interventions following assessment. Include details of referral to other teams(s), telephone calls/advice and discharge/transfer or follow-up plans

Formulation of assessment

Refer to the risk assessment matrix below and summarise:

- What is the key problem?
- What is the level of risk – e.g. low, medium, high? Refer to matrix
- Is referral to the liaison psychiatry team or on-call mental health staff indicated?

Mental Health Risk Assessment Matrix

Level of risk	Key assessment information	Nursing actions	Timescales
LOW RISK	<ul style="list-style-type: none">• Mental health problem may be present, but person has no thoughts or plans regarding harm to self or others• May have already engaged in impulsive self-harming behaviour, but now regrets actions and <i>has no plans or thoughts relating to further self-harming behaviour</i>• Patient is confident about maintaining his/her own safety and relative(s)/significant other(s) are prepared to provide informal support on discharge• No evidence of immediate or short-term physical vulnerability or risk	<ul style="list-style-type: none">• May benefit from referral to primary care services – e.g. GP, practice nurse. Patient can ask GP for relevant services• Consider whether may benefit from mental health promotion/mental health advice – e.g. safe alcohol consumption, information regarding non-statutory agencies• Patients in the ED due to self-harm that are medically ready for discharge can be offered discharge and can be advised to contact their GP for support and advice	<ul style="list-style-type: none">• Referral to liaison team can be arranged if patient prefers to remain in the department for assessment <p><i>or;</i></p> <ul style="list-style-type: none">• Once medically fit, the patient can be discharged at their request with advice to make contact with their own GP

Mental Health Risk Assessment Matrix

Level of risk	Key assessment information	Nursing actions	Timescales
MEDIUM RISK	<ul style="list-style-type: none"> Mental health problem(s) may be present and/or has non-specific thoughts or ideas regarding harm to self or others – e.g. regrets that self-harm failed to lead to death, but no intention to undertake further self-harm There is no plan to act on self-harming or suicidal thoughts However, the person's mental state is at risk of deterioration and they may be physically vulnerable in certain circumstances 	<ul style="list-style-type: none"> Person's agreement to refer to mental health should be sought, but no immediate action required if patient does not wish to engage Advise to seek further assessment and help via primary care If person known to mental health services, inform relevant team of their attendance Provide relevant patient and carer information 	<ul style="list-style-type: none"> Non urgent referral to liaison team Out-of-hours, seek advice from on-call mental health staff
HIGH RISK	<ul style="list-style-type: none"> Serious mental health problem(s) present, including possible features and symptoms of psychosis May well have frank plans to engage in further self-harming behaviour, or harm to others Has clearly identifiable risk characteristics, such as imminent thoughts or plans relating to self-harm (or harm to others) or suicide May have already engaged in self-injurious or self-harming behaviour and <i>on-going suicidal intent remains</i> May lack capacity and competence to consent to or refuse on-going care and treatment Person likely to act upon thoughts of self-harm or injury at the earliest opportunity Mental state will certainly deteriorate without intervention and will almost certainly be physically vulnerable The person has made attempts to leave the department/ward, or you have reason to believe they intend to do so 	<ul style="list-style-type: none"> Urgent mental health assessment required and a risk plan developed to address immediate or short-term risk indicators Mental health assessment required before person can be discharged The person's mental state will deteriorate and increase level of risk if not treated Immediate action required, including urgent mental health assessment and an action plan developed to address risk factors Is likely to require close or one-to-one observation by a member of nursing staff If person is non-compliant, Common Law/Capacity Act should be used to temporarily detain the person pending a full mental health assessment Consider assessment under Mental Health Act, discuss with CSM and senior medical staff 	<ul style="list-style-type: none"> Urgent referral to liaison service or duty mental health staff Seen by mental health staff within 2 hours of referral Police to be informed if absconds Out of hours should be seen by duty mental-health staff All reasonable attempts should be made to stop the person leaving the department before mental-health assessment. The presence of hospital security staff may be required

Signed: Designation:

PRINT name: Date:

APPENDIX 2 – EQUALITY IMPACT ASSESSMENT TOOL

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes / No / N/A	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	N/A	
5.	If so can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Trust's lead for Equality & Diversity, together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the Trust's lead for Equality & Diversity.

Signed – Name: A Pickles (Fire, Health and Safety Manager); Roger Ringham (Local Security Management Specialist)

Dated: 12 May 2016