

Missing Resident Policy

Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as 'we statements', they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for:

Learning culture

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Safeguarding

We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Involving people to manage risks

We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Safe environments

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Safe and effective staffing

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

Independence, choice and control

We promote people's independence, so they know their rights and have choice and control over their own care, treatment and well-being.

Responding to people's immediate needs

We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Person-centred care

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

Governance, management and sustainability

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Learning, improvement and innovation

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Scope

Residents may be frail, infirm and limited in their mobility. Some may also be confused or disoriented and become easily lost. Therefore, a resident going 'missing' constitutes a cause for concern for their safety.

This policy sets out EFH approach to minimising the risk of a resident going missing and the actions staff should take in the event of a resident reported missing.

This policy and procedure are provided for the regulated activity of accommodation for persons who require nursing or personal care.

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Policy Statement

Residents may have limits in their mobility, others may be confused or easily disoriented and therefore become easily lost.

Staff must be vigilant at all times as to the whereabouts of people in the service.

They should also be aware of the current risk assessments and care planning arrangements in place to minimise these risks and any legal orders that may be in place.

A missing person could constitute an emergency situation and needs immediate action.

A Herbert Protocol form (missing person form) should be completed and retained on file in circumstances where a risk has been identified of a person going missing. Access and Clinical Form 6.01

The Herbert Protocol is a scheme adopted by several police forces within England and Wales in partnership with Local Authorities and other agencies. It is a simple risk reduction tool to be used in the event that an adult with care and support is reported missing.

It contains a list of information to help the police if the person goes missing, including:

- Medication required
- Mobile numbers
- Places previously located
- A recent photograph
- Details of friends and relatives

Keeping a completed protocol saves the worry of trying to recall the information during the stressful time of someone going missing. It also saves time for the police, allowing the search to start sooner.

Staff need to check the home and grounds to ensure the resident has not fallen or is incapacitated before raising a missing person alarm.

Staff need to follow the procedure specified in the policy and ensure the alarm is raised as soon as possible once they have identified the resident is missing.

This policy must be read and followed by all staff working with residents and the management team.

The policy has been developed to address a situation when a resident is 'missing' from the service, raising concerns for their safety, which could constitute an emergency situation.

This policy links to the Reportable Incidents CQC Policy and the Safeguarding Adults and Children in an Adult setting Policy. In the event of a resident going missing, to comply with the requirements of these policies, staff must also:

Report serious incidents to CQC using their notification procedures, and make referrals to the local Adults Safeguarding Team in the event of a resident being at risk or suffering harm or abuse.

The Policy

EFH aims to ensure the safety of residents while delivering a high-quality service that meets their care and support needs. This will be achieved through policies, procedures, training, competency assessment, quality assurance, audit, and staff supervision.

Staff must always remain vigilant and be aware of where residents are at any given time. Those residents who are prone to walking around the home, gardens, community or are at risk of getting lost or disorientated due to their mental state, will have an identified risk assessment and a suitable plan of care to keep them safe and minimise risks.

Residents should be kept under observation as appropriate to the level of identified risk and their needs, i.e. the least restrictive practice possible to keep them safe and maintain their independence.

Staff must comply with the Mental Capacity Act 2005 and its codes of practice to act in the best interests of the resident.

Those with a mental impairment and/or acquired brain injury who staff believe lack capacity to make a decision regarding leaving the residence, and are at a high risk of getting lost, should have a mental capacity assessment and if required a deprivation of liberty safeguard application appropriate to meet their needs.

Any restrictions applied, e.g. to limit the residents egress from the building, will be the least restrictive practice to meet their person-centred needs.

To avoid false alarms, residents, their relatives and visitors are required to inform a member of staff when they are leaving the service on an outing or a walk and to sign out of the visitors and residents' logbook to ensure an accurate roll call can be taken in the event of a fire or other emergency.

Where possible, residents and/or family members should give both a time they expect to return and a contact name and telephone number. All such arrangements should be entered in the person's daily record.

The Herbert Protocol

The Herbert Protocol is a national scheme that encourages care providers, carers, family and friends to provide and put together useful information, which can then be used in the event of an adult at risk going missing.

A form is completed in advance, including important information about the missing resident such as the contact numbers, medication needed, locations the person was last seen, and a photograph can be provided.

The form can be sent or handed to the police in the event of a resident going missing.

The scheme is designed to help those caring for someone with dementia, or similar conditions, to ensure that, in the event a person going missing, the police have access to essential information promptly.

Remembering all sorts of information at times like this can be very distressing for those involved and when being asked by a police officer, adds to the stress and upset caused. The information contained within these forms aims to relieve some of that stress.

The Herbert Protocol initiative is named after George Herbert, a War veteran of the Normandy landings, who had dementia and sadly died while he was 'missing' on his way to his childhood home.

EFH will work with residents and families of people with a history of going missing or with symptoms which may predispose them to getting lost to complete a Herbert Protocol form which will be kept with their care and support notes. This will be completed at the same time as the care and support plan and will be reviewed quarterly with the care and support plan or as needs change.

Raising the alarm

Situations where a missing person's report may be indicated include the following:

- Where a resident has not returned from an arranged outing, activity or walk.
- Where a resident cannot be found in the home or grounds and no arrangements have been made for an outing, activity or walk.

Staff Member Procedure

As soon as it is suspected that a resident may be missing, staff should:

- Check the resident's care notes and the visitors and residents' logbook to make sure they have not gone out to a planned activity or outing with relatives.
- Initiate an immediate search of the premises and its immediate surroundings or garden to ensure the resident has not fallen or is incapacitated.
- If they have a mobile phone, try to contact them on their mobile number to ensure they are not running late or there is a mundane reason for their absence.
- Contact relatives, or friends, other obvious places where the resident may have gone or has been known to go in the past.
- Once you're sure they are not in the premises or the grounds, cannot be raised by phone, inform the Registered Manager or senior person in charge.
- Pass on all relevant information, such as the full details of the person and the Herbert Protocol and the incident. This should include when and where the person was last seen, by whom, and what the person was wearing.

Registered Manager's/ Registered Nurse /Senior's Procedure

On receiving a missing person's alert, the Registered Manager or senior in charge should:

- Make immediate efforts to contact the resident's relative, if not already done so, and to inform them of the situation, gather information and receive advice.
- Make immediate efforts to contact the Senior Manager on call, or contact a Director of EFH.

- Contact the police and give full details about the resident, including when and where they were last seen, by whom, what they were wearing and provide the Herbert Protocol information.
- Co-operate fully with any police search.
- A Care Quality Commission (CQC) notification must also be submitted.
- The Registered Manager will consider the need to make a referral to the local authority Safeguarding Team if there are any concerns regarding neglect or harm to the resident.
- Where the police are involved, the service's directors/owners should be informed as soon as possible, as should members of the missing person's family if they have not already been contacted.
- Families should be requested to telephone the office or police if the resident contacts them, and relatives should be kept informed.
- The Registered Manager or senior person in charge, at the earliest opportunity, should complete a significant incident form and ensure that a full note of events has been made in the resident's care notes.
- A contemporaneous record must be maintained including, times of actions and decisions, this will be stored with the significant incident form.

On finding the missing person

Once the resident has been found, it is essential that all the parties who were advised of the emergency are contacted again and informed that the search has been concluded, including relatives, other staff, CQC and the police.

The resident's GP should be contacted to undertake any required health assessments and reviews. If the person has any injury, they should be taken to minor injury or accident and emergency services.

On conclusion of the incident, staff involved should be asked to write their statements of fact which will be stored with the significant incident form.

The resident's risk assessment and care and support plans should be reviewed, and any changes made.

At all stages the line manager should be sensitive to the needs of other persons, staff and relatives and should provide or arrange any support that they may require.

Once the missing service user has resettled back into the residence, the Registered Manager will undertake an investigation of the significant incident, identify lessons to be learnt, develop an action plan, and any improvements that are indicated. Continuous improvement activities and actions will be implemented, and staff updated and trained on new systems of work, policies and procedures and learnings from the incident.

The incident will be reviewed against the Duty of candour regulation and policy and procedure. Where there has been failure by the organisation that has led to a breach of the harm threshold, then the organisation will comply with Regulation 20, including notifying CQC.

Training

Care staff are provided with an awareness of our EFH commitment to resident safety at all suitable stages of their employment from induction onwards.

Seeking Feedback about

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of improvements made to resident safety where it is appropriate to do so. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

References

<https://www.met.police.uk/SysSiteAssets/media/downloads/central/advice/met/herbert-protocol/herbert-protocol-form-editable.pdf>

Review date	Next Review Date
May 2024	May 2027