MISSING OR WANDERING PERSON(S) A REPORTABLE INCIDENT

COMMUNITY CARE FACILITIES LICENSING PROGRAM

In both Child Care and Residential Care Facilities, if a person in care goes missing or has wandered away from the care and supervision of the Licensee, this meets the definition of a reportable incident as set out in the provincial legislation and must be reported to Licensing.

Child Care Licensing Regulation Schedule H states:
"missing or wandering person" which means a child who is missing.

Child Care Licensing Regulation Section 55 states:
(2) A licensee must notify the Medical Health Officer within 24 hours' after
(a) a child is involved in, or may have been involved in, a reportable incident described in Schedule H while under the care or supervision of the licensee.

Residential Care Regulation Schedule H states:
"missing or wandering person" means a person in care who is missing.

Residential Care Regulation Section 77 states:
(1) For the purposes of this section, a person in care is involved in a reportable incident, if the person in care
(a) is the subject of
(i) a reportable incident.
(2) Subject to subsection (3) if a person in care is involved in a reportable incident, the licensee must immediately notify
(c) a Medical Health Officer, in the form and in the manner required by the Medical Health Officer.

The purpose of completing the Incident Report form is to inform the Medical Health Officer of a specific reportable event that has occurred. Reporting an incident ensures that an analysis of the event for future planning to ensure health and safety of the individual involved and other persons in care who may be involved in future similar incidents.

What is meant by the term "missing" in the legislation?
Missing means that the person is not in the place that they should be, or is lost, meaning that they have left the care and supervision of the Licensee without a transfer of care to another adult, and/or permission to do so. This would include for example, instances where a person has wandered away from a licensed facility, or into an area of the facility that they should not have access to, or away from the caregiver's care and supervision when outside of the facility (e.g. during a visit to a park or other location). Some examples of reportable "missing or wandering" incidents that must be reported:

- A person in care's care plan indicates that they are not to have independent access to particular areas of the facility, and/or the grounds of the facility, and they are found in those areas off-limits to them, then they have gone "missing" (i.e. away from the area(s) that they should be).
- A search of the premises (building and grounds of a facility) and/or the area beyond the grounds of the facility is necessary to locate a person in care, then that person is considered missing.
- A child leaves the playground (either on the premises of the facility or outside of the facility if the Licensee is using an off-site play area) where the children in care are being supervised by (a) caregiver(s), then that child is considered missing.

A level or reasonableness needs to be applied when determining whether or not to report a "missing" person in care. If the person in care cannot be located on the premises (in the building or on the grounds of the building), or in the area where they should be (e.g. within their secure unit, or within the areas of the building where care is provided, or within the area offsite that they should be), within a reasonable time frame (with consideration given to their cognitive and physical abilities, the size of the building/area and the time needed to complete a search), then the "missing or wandering" incident must be reported. The length of time that the person in missing and the return of the person to care

are not relevant in assessing whether or not the event is reportable to Licensing, instead when determining if a person is “missing” and a reportable incident should be completed, facilities should evaluate if the person was found in any location outside of where they should be. When in doubt, contact your Licensing Officer to discuss the event. They can help you in determining if an Incident Report needs to be submitted.

Safely locating a missing or wandering person in care should be given immediate attention and the highest priority for staff, while still ensuring the health and safety of the other persons in care. Persons in care are vulnerable and at significant risk of harm when they are not under the Licensee’s care and supervision as they should be. Licensees should develop policies and procedures to ensure active supervision is in place at all times and to guide staff in searching the premises, contacting outside authorities (if necessary), and reporting such incidents to Licensing describing the missing event. Each facility is unique and as a result, each facility’s policies and procedures should be developed to address the distinctive characteristics of their location and operations. What may work for one facility or individual event/situation, may not work for another.

What to include in the “missing or wandering person” Incident Report:

1. Any events that led up to the person having gone missing, e.g. a door or gate was left open by a visitor or family member.
2. The measures that were taken by the facility to locate the person. Including any searches that were conducted, who was involved in the search efforts, and who was notified that the person was missing.
3. The time frame between when the person first went missing and when they were located.
4. The location where the person in care was located.
5. Any corrective action taken to ensure that the incident does not happen again (if applicable), which may include for example:
    - The incident may have occurred due to a misunderstanding by the person in care/family member, i.e. they forgot to sign out themselves or their family member, and subsequent discussion that has occurred with those individuals to ensure that a similar incident does not recur.
    - Any modifications to the individual’s care plan that have been put in place, i.e. an ID bracelet may need to be work by the person in care, the person in care has been moved to secure unit, etc.
    - A change in roles and responsibilities for staff at the facility to ensure better supervision of the person in care, etc.