care inspectorate

Practice note

people leaving care homes undetected and unmonitored – managing risk, health and safety

We have received an increasing number of notifications about people living in care homes having left the building undetected and unbeknown to staff. This has sadly led to fatalities for some people experiencing care and the potential risk of serious injury for others.

Common themes from incidents include:

- regular checks not being carried out throughout each day and night on people and their whereabouts
- door sensors not working
- lack of checks that sensors are working
- people including staff turning off door sensors and not reconnecting them
- alarms not being heard by staff.

People who live in care homes should be able to move around freely and have access to outside space that is safe and suitable for their needs. However, appropriate procedures must be in place to ensure staff know where people are, particularly when they leave the building. Procedures must ensure regular checks are taking place.

The following guidance will help services make proper provision for the health, welfare and safety of people experiencing care in accordance with regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011.

This guidance supports Health and Social Care Standards 5.19: My environment is secure and safe; and 5.11: I can independently access the parts of the premises I use and the environment has been designed to promote this.

Outside spaces in care homes

Access to outside space is important to support people's wellbeing and all people living in care homes must have access to outside space. People must be supported by staff to use outside space, as it is part of the care home environment.

To ensure outside spaces can be used safely, they should have good lighting, be well kept and should have flat and even surfaces. Slabbed areas and paths should not be slippery. Grass and hedge areas should be maintained and not be overgrown or be a barrier to staff being able to see people who need close support when using outside spaces.

Staffing

Decisions on staffing including skills and numbers must be linked to outcomes for people. Further information and guidance on safe staffing can be found at the Safe Staffing Project.

Each shift should have the right numbers of staff with the right skills who are deployed to areas of the care home. Staff should know they are responsible for the care of people including their responsibility to undertake regular checks on individuals. This should be noted on shift plans or allocations.

Personal plans should detail what checks should be in place for individuals. It is important that people in charge of staffing, including on different shifts, have good oversight and quality assurance to ensure the care and support for people is being carried out and take action to rectify any issues identified.

Handovers

At the change of each shift, it is good practice to have a handover from one shift to another. This is important to ensure people receive the right care and that staff coming on shift know the care and support people have received.

All homes must build in handover procedures that include:

- dedicated time for handover
- discussion of the known whereabouts of all those living in the care home
- attendance of all the staff who are coming on shift
- appropriate staffing in place to support people while the handover is taking place.

Technology

Care homes for adults and older people are increasingly relying on technology to support people's wellbeing, independence and safety. There are excellent examples of how technology is used to support good outcomes that are person-centred and embedded within human rights principles. Practice should maximise people's independence while keeping them safe.

Technology should not replace the need for appropriate staffing within services. It should be there to support and provide safe, effective care, linked to people's assessed needs. However, where this is used, it is important that any technology is included in maintenance checks and regular reviews are carried out by the service to ensure it is working well and meeting the needs of people. Read our Technology good practice guide for more information.

The use of door codes

Care homes should consider how to balance risk while supporting meaningful connection. People living in care homes and their families benefit from positive family inclusion. This helps improve emotional, mental, and physical wellbeing by ensuring people feel welcomed and able to maintain meaningful connections. The default position should be that family carers are given the code. In normal circumstances, regular visitors should be able to come and go freely, with clear, proportionate risk assessments guiding any local considerations if this is not the case. The starting point is inclusion whilst balancing and considering risk.

Good practice expectations

To ensure people receive high-quality care that supports their wellbeing in a safe environment that promotes their independence, we expect care homes to do these things.

- Develop a policy to set out staff roles and responsibilities in relation to people leaving care homes undetected or unmonitored. This should reflect timely actions in line with the National Missing Persons Framework for Scotland (2025) and Police Scotland Risk and Concern Hubs.
- A Herbert Protocol should be in place for people living with dementia or a cognitive impairment, although it is beneficial to consider this for everyone.
- All personal plans must detail the support people need including the monitoring of their location across the 24-hour period. This is based on risk assessment, be person-centred and agreed with the individual and/or their representatives.
- All homes must have in place robust assessment of individual needs and how this is used to inform staffing numbers and skills. This must take account of the setting and the needs of people living in the home.
- All parts of the care home must allow freedom of movement and promote people's independence while keeping them safe and free from harm. The Mental Welfare Commission guidance Rights, Risks and Limits to Freedom is a good guide to support decision making.
- Induction for staff must always include the importance of knowing the whereabouts of people during their shift, checking technology and responding to alarms. Staff should also be familiar with the location and purpose of the Herbert Protocols.
- All homes must have a procedure for handover of information between the different shifts, and all staff, before commencing shift, must receive a handover.
- All internal alarm systems, including all doors regardless of how infrequently they are used, are maintained, and checks are carried out regularly and recorded. A good time for this is along with weekly fire safety checks. All exit doors should have a functioning alarm attached. All alarms should be heard in different parts of the home. All staff on all shifts should be able to hear exit door alarms, not be isolated to separate units. Systems should be in place to ensure exit door checks are part of routine maintenance checks.
- Staff must be able to hear alarms on doors and be aware of the need to respond to these immediately to ensure people are safe.

- Where door alarms have been disabled for any reason, effective communication across the staff team is imperative so all on shift are aware of the alarm deactivation. An appropriate system must be in place and implemented to ensure doors are reactivated within appropriate timescales and additional physical checks are carried out.

Notifications

If someone has left the premises undetected and unmonitored the correct notification must be made in line with your statutory requirements as a registered service. Information is set out in our Adult care services: Guidance on records you must keep and notifications you must make. The information should set out the actions you have taken in relation to identified risks and protection concerns as an adult or older person has exited the premises unsupervised or without staff knowledge.

Acknowledgement

Learning from a Short Life Working Group with partners from North and South Lanarkshire Health and Social Care Partnerships and Police Scotland has informed this through consultation.

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