## Wandering Resources

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Sample Policies/Directives/Templates

Management of Wandering and Missing Patient Events Directive
This is a VA Directive that addresses how to prevent, detect, and respond to wandering behavior of VA patients. It is accompanied by an Employee Education Service electronic training program made available and required by all staff at all levels and disciplines as well as family members of high risk patients.

Department of Veterans Affairs
Veterans Health Administration
Washington, DC  20420

VHA DIRECTIVE 2002-013
March 4, 2002

MANAGEMENT OF WANDERING AND MISSING PATIENT EVENTS

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy to ensure that each Department of Veterans Affairs (VA) medical facility has an effective and reliable plan to prevent and effectively manage wandering and missing patient events that place patients at risk for harm.

2. BACKGROUND

a. In VHA facilities, patients straying beyond the normal view or control of employees may be at risk for injury or death. Although VA has responsibility for all patients under its care, physically or mentally impaired patients require a distinctly higher degree of monitoring and protection.

b. To prevent accidental deaths and injuries, VHA must:

   (1) Recognize, specify, and maintain appropriate staff responsibility for the whereabouts of patients;

   (2) Systematically assess all patients to determine the risk potential for those who may wander or become missing from a treatment setting;

   (3) Detect missing patients early; and

   (4) Initiate prompt search procedures.

c. **Definitions**

   (1) **High-risk Patient.** A high-risk patient is one who is incapacitated because of frailty, or physical or mental impairment. Patients are considered incapacitated if, at a minimum, they:

      (a) Are legally committed;

      (b) Have a court appointed legal guardian;
(c) Are considered dangerous to self or others;

(d) Lack cognitive ability (either permanently or temporarily) to make relevant decisions; or

(e) Have physical or mental impairments that increase their risk of harm to self or others.

(2) **Wandering Patient.** A wandering patient is a high-risk patient who has shown a propensity to stray beyond the view or control of employees, thereby requiring a high degree of monitoring and protection to ensure the patient’s safety.

**THIS VHA DIRECTIVE EXPIRES MARCH 31, 2007**

(3) **Missing Patient.** A missing patient is a high-risk patient who disappears from an inpatient or outpatient treatment area or while under control of VA, such as during transport. Examples of situations when patients who meet the above criteria should be considered missing include, but are not limited to, the following:

(a) Inpatient or day treatment high-risk patient not present to receive a scheduled medication, treatment, meal or appointment, and whose whereabouts are unknown.

(b) A high-risk patient checked in for an outpatient clinic appointment who is not present for the appointment when called, and whose whereabouts are unknown.

(c) High-risk outpatients from a community facility who do not return to their community facility following the appointment, whose whereabouts are unknown.

(d) A high-risk patient who is using VA-sponsored transportation (Disabled American Veterans (DAV) vans, VA drivers, VA shuttles) who does not report to that transportation for the return trip.

(e) High-risk patients who do not return from pass as scheduled and whose whereabouts are unknown.

(4) **Absent Patient**

(a) An absent patient is one who leaves a treatment area without knowledge or permission of staff, but who does not meet the high-risk criteria outlined for a Missing Patient and is not considered incapacitated.

(b) An otherwise absent patient should be classified as a missing patient when one or a combination of additional environmental and/or clinical factors may, in the judgment of the responsible clinician, increase the patient’s vulnerability and risk. Conditions that might lead to this decision may include, but not be limited to, the following:

1. Weather conditions, i.e., the patient has inappropriate dress, the patient’s safety is compromised;
2. Construction sites or other dangerous conditions exist nearby;

3. Recent trauma, unexpected bad news, or abrupt change in clinical status;

4. Local geographic conditions increase risk; or

5. Homelessness, in combination with other factors that create risk.

(5) Assessment. An assessment is a clinical evaluation of patients with regard to their capacity to make decisions relative to their immediate physical safety or well being. Past history may be a guide, as well as information obtained by friends, relatives, or caregivers. Patients whose mental status may change rapidly, such as those suffering from post-surgical delirium or drug-induced psychosis, may require repeated assessments during the day. An assessment is a clinical event and should be recorded in the medical record, whether paper-based or electronic. Staff may be alerted to patients at special risk through electronic “flags” or reminders.

d. Preliminary Search. As soon as it is determined that a high-risk patient is missing, a preliminary search must be initiated to include nearby ward or clinic areas, offices and adjacent areas such as lobbies, stairwells, elevators, etc., and will be coordinated by locally designated staff in each clinical area.

e. Full Search. If a missing patient is not located during the preliminary search and the clinical assessment indicates the patient is at high-risk, a full search is authorized by the medical center Director, or designee.

(1) VA Police, Security Service, and appropriate medical center staff on duty participate in the search to include all areas of the facility in addition to those covered by the preliminary search, such as:

(a) All grounds areas, parking lots, ball fields, tennis courts, outdoor seating and picnic areas, woods, and areas off, but contiguous to, the property (e.g., local neighborhood attractions, with specific instructions as to what action(s) to initiate if the patient is found since there is no legal authority, lacking an extreme exigency, for patients to be physically detained against their will off facility property), as appropriate; and

(b) All other buildings, elevators, designated smoking areas, accessible areas for outpatient clinics, construction sites, and other structures.

(2) When appropriate during or following the full search, VA Police and Security Service must contact the appropriate outside law enforcement agencies to file a missing persons report providing all the needed data so as to ensure that the patient is entered into the National Crime Information Computer (NCIC) system. These agencies must also be informed in a timely manner to cancel this alert when a missing patient is recovered. This policy should not preclude those Police and Security Services units from entering this data themselves provided they have the capability to do so.

3. POLICY: It is VHA policy for all facilities to maintain:
a. A system of identifying high-risk patients needing a higher degree of monitoring and protection.

b. A detailed plan for assessment, identification, and prevention of wandering.

c. A detailed plan for searching and locating of missing patients. **NOTE:** This policy is applicable to all sites and levels of care such as: hospital, domiciliary, and nursing care facilities; residential bed care facilities (psychiatric residential rehabilitation and treatment programs); VA-owned or leased, off-ground health care facilities; day centers, day hospitals, and day treatment centers; and Community Based Outpatient Clinics (CBOCs) or independent clinics.

4. **ACTION**

a. **Responsibilities**

(1) **Network Directors.** Network Directors are responsible for ensuring that each medical center within their respective Veterans Integrated Service Network (VISN) has local policy that meets the guidelines established in this directive.

(2) **Medical Center Directors.** Medical center Directors are responsible for:

(a) Developing local policies that require:

1. Timely assessments of patients and documentation of such assessments;

2. Early intervention to minimize wandering risks;

3. Clear designation of responsibility for security of construction and other environmental hazards to minimize risks of inappropriate or unauthorized access to unsafe areas;

4. Timely and thorough search procedures;

5. Staff competency with ongoing education and training in the care of wandering or missing patients;

6. Missing patient events to be referred for Root Cause Analysis (RCA) or Aggregated Review consistent with VA’s National Center for Patient Safety (NCPS) procedures described in the Patient Safety Improvement Handbook; and

7. Continuous learning through the integration of lessons learned from drills, close calls, or actual missing patient events.

(b) Each medical center must establish and publish a local plan (policy) that reflects the full scope of services to be provided and designates all sites of care to be involved, in order for the effective prevention and management of wandering patients and of missing patient events to be achieved. This plan must define preparation for and responses to missing patient events; it needs to include, but is not limited to:
Wandering Resources

1. Designation of persons who can perform a clinical review of patients when they have “disappeared” to determine if they are either “missing” or “absent,” and designation of persons who will follow up with the patient, family, or extended family regarding those patients considered “absent” to assure their safety. **NOTE:** If there are concerns regarding an absent patient, it is recommended that a telephone call be placed to the next of kin or other designated individual, to ascertain the patient’s whereabouts in lieu of a search, i.e., to validate the patient’s safety.

2. Designation of who may declare a patient “missing” and under what circumstances as well as who will determine the level of search required for each category of patient.

3. Command responsibilities and procedures both during administrative hours and non-administrative hours, including designation of a Search Command Post and Search Coordinator.

4. Time frames, based on local circumstances, for initiating preliminary and full searches, for notifying relatives (next of kin), and for determining when the full search for an incapacitated missing patient is considered to be unsuccessful.

5. Designation of persons who will communicate with relatives, guardians, other responsible persons, and nearby treatment facilities, as appropriate, until a missing patient is found.

6. Specific staff assigned to given areas to ensure that all areas are searched and to avoid random or uncoordinated searches. Use of a grid search is recommended (see Att. A).

7. Immediate notification of VA Police in the event that a missing patient is found to be deceased on VA property. The Federal Bureau of Investigation (FBI), State and local police, the Office of the Medical Examiner, and local management officials are to be notified. The police will establish and maintain the area as a possible crime scene, ensuring that the body and premises are not disturbed until instructions and the proper authorization have been received. After positive identification is confirmed, notification of next of kin is accomplished in accordance with local policy. **NOTE:** Local law enforcement agencies and officials should be oriented and become involved with the search activities of the VA medical center by being invited to policy and operational planning sessions.

8. Designation of responsibility to maintain the Missing Patient Register, i.e., entering the names of missing patients as soon as the full local search has failed to locate them, and removing their name from the Register as soon as they are located. **NOTE:** This process will aid in flagging patients who may present to other VA facilities and will allow analysis of national patterns.

   (c) Ensuring that the prevention or management of wandering patients and the management and reporting of actual missing patient events is integrated into initial orientation, annual, and/or other ongoing education and training of staff, especially within those special units and/or sites designated for the care of high-risk patients.

   (d) Ensuring that the comprehensive review and assessment of each facility’s processes and any aggregated data on actual missing patient events or close calls are incorporated into the appropriate committee activity at each facility to continuously and systemically enhance environmental safety.
(3) **Employees.** All employees, including both clinical and non-clinical staff, are responsible for assessing, reviewing, and/or developing processes to enhance patient safety associated with wandering or missing patient events within the scope of their job, as well as intervening when appropriate.

(4) **NCPS.** NCPS is responsible for reviewing RCAs and Aggregate Reviews involving missing patients that are submitted to NCPS. NCPS is responsible for disseminating and making relevant information from the RCAs and Aggregate Reviews available to VHA facilities to foster the reduction and elimination of risks. This information may be communicated in numerous ways, including advisories, alerts, newsletters, and national calls.

(5) **Employee Education Service (EES).** EES will support the establishment of a national training program on wandering and missing patients to be made available at all VA facilities to assure minimum uniform training standards by October 1, 2002. This program should be directed toward relevant staff at all levels and disciplines as well as family members of high-risk patients. The program should include information from the NCPS on the requirements and basic procedures for addressing missing patients as described in the VHA Handbook 1050.1, Patient Safety Improvement Handbook.

b. **Prevention and Management.** The prevention and effective management of wandering and missing patient events is based on clinical assessment of cognitive ability for each patient and the associated safety risks. Each facility must determine the frequency for assessing the cognitive ability of patients with regard to their safety and developing safety measures, as appropriate for the patient’s condition.

(1) **Assessment of Cognitive Impairment.** At a minimum, the clinical assessment of cognitive impairment must be recorded in the patient’s record:

(a) At the time of inpatient admission, discharge, or transfer between units or care setting;

(b) As a component of each initial and annual outpatient evaluation;

(c) When there is a reported change in mental status for any reason; and/or

(d) In absentia, i.e., when they have disappeared from a clinical setting.

**NOTE:** If the patient is at high-risk, then assessment and the safety measures appropriate for the patient need to be part of the treatment plan which must be discussed among the patient’s health care providers. In addition, that assessment and the safety measures need to be included in the alert that comes to the attention of all applicable health care providers when the patient’s record is accessed. The assessment must occur. The assessment and related safety measures must be discussed by the each patient’s treatment team and documented as being discussed.

(2) **Minimizing Risks.** Because of the documented risks inherent in the aging veteran population, VHA aims to be as proactive as possible in minimizing risks for patients under its care. As a result, the following processes must be integrated into each facility’s policy for the prevention or effective management of wandering and missing patient events:
(a) Policies on patient privileging, requirements for patient supervision and surveillance, and search procedures with regard to early identification of missing patients.

(b) Each facility must consider actual or close call missing patient events in accordance with NCPS guidelines and VHA Handbook 1050.1, and integrate the resulting information into education and training of staff and/or improving existing processes to enhance patient safety.

(c) Initial and annual training of all relevant staff regarding policy and search policies and procedures for identifying, assessing, and finding missing patients.

(d) Missing Patient Drills that integrate findings from environmental rounds or other patient safety processes (such as aggregated RCAs), must be conducted that at each medical center or site of jurisdiction, including CBOCs. Once staff have received initial training, additional drills must be conducted at least annually (or more frequently, if judged prudent due to local circumstances) to effectively evaluate known areas of vulnerability throughout and surrounding the facility. Once staff are fully trained, an actual search during which the search plan is fully implemented and a critique is completed may take the place of the drill for the shift involved in the actual search. It is recommended that the sites for missing patient drills be prioritized based on known areas of vulnerability and lessons learned from RCAs and other risk management or performance improvement processes.

(e) The systematic and comprehensive monitoring and assessment of hazardous areas and construction sites must be an integral part of this process. It is essential to plan appropriate security measures, including method for promptly discovering breaches and response to such a discovery, for areas of the medical center that contain hazards such as: construction sites, staging areas, areas involved in maintenance procedures, mechanical spaces, utility areas, crawl spaces, electrical vaults and closets, shops, utility plants, storage areas, water towers, lakes, ponds, rivers, streams, laboratories, research space and morgues. **NOTE:** Essentially any area that when entered by an untrained individual could reasonably be considered to hold potential danger must be integrated into local processes. Any portion of the security plan where failure is not immediately obvious (such as fire or motion alarms) must be periodically checked for proper function.

c. **High-risk Patients**

   (1) **Electronic Technology.** The use of electronic technology for those patients considered to be high-risk may be used only as one tool to enhance and augment other processes for minimizing the risk of patients wandering away from a designated area or site of care. This use must not be considered as a substitute for professional vigilance and systematic verification of patient location such as during change of shift rounds for inpatient and other supervised settings. When electronic technology is in use:

   (a) There must be systematic and frequent checks of all critical components of the system with clear designation of responsibility for monitoring and maintaining that system. A basic check of the system in high-risk areas is encouraged at a minimum of every 24 hours to assure proper functioning as intended to minimize risk. Maintenance of the system must be consistent with manufacturer’s guidelines; however, a complete systems check must be performed at least annually. A proactive assessment of potential vulnerabilities of the system and its use (e.g.,
failure Modes Effects Analysis) should be performed to guide the appropriate use of the system (see VHA Handbook 1050.1, sub par. 5d).

(b) Electronic devices and/or systems must be re-evaluated at the time of each wandering or missing patient event to assess possible contributing factors.

(2) **Activities.** A comprehensive review and assessment of locations for activities away from the facility must be conducted and integrated in the planning of recreational activities to facilitate safety, especially for those patients known to be high-risk. Supervision of patients must be consistent with review findings.

(3) **Identification.** Each facility must establish processes to assure the availability of pictures and physical descriptions for all high-risk patients in the event that they are suspected to be missing as a means to enhance the effectiveness of search procedures. Patient Identification System photographs may be used where available.

(4) **Transport.** Each facility must take special precautions during the transport of known high-risk patients and/or those reported to have a change in mental status, in the absence of clinical assessment.

5. **REFERENCES**

   
   b. M-2, Part I, Chapter 35.
   
   c. DM&S Supplement MP-I, Part I, Change 42.
   
   
   e. National Center for Patient Safety (NCPS) guidelines.
   

6. **FOLLOW-UP RESPONSIBILITY:** Mental Health Strategic Health Care Group (116) is responsible for the content of this Directive. Questions may be referred to 202-273-8435.

7. **RESCISSIONS:** VHA Directive 96-029 is rescinded. This VHA directive expires March 31, 2007.

S/ Tom Sanders for
Frances M. Murphy, M.D., M.P.H.
Acting Under Secretary for Health

Attachment

ATTACHMENT A

PATIENT SEARCHES USING GRID SECTORS

1. Work with facility engineering staff to obtain a site plot of the facility and surrounding areas. Super-impose a grid map to delineate the grid sectors.

2. One individual is to be responsible to gather all pertinent information concerning the grid search. This needs to include:
   a. Search grid sector assignments;
   b. Times and by whom grid sectors are searched;
   c. Times and by whom each building is searched;
   d. Times and to whom notifications and requests are made; and
   e. Result of search.

3. The indoor search needs to include all buildings within the assigned search area to include any unsecured: stairwells, closets, attics, crawl spaces, equipment rooms, all smoking shelters, indoor construction areas, bathrooms, vending areas, and all other areas large enough for the subject to hide.

4. The outdoor search needs to include: brush and open areas, all parking areas, all government and non-government vehicles, all courtyard areas, all shrubbery around buildings, all construction areas, all outlying structures on grounds not assigned to interior search personnel, and any other area where a subject could have wandered.

5. The outdoor search is to be a methodical and complete visual inspection of open terrain for a lost or injured person, or for indications and marks of a person’s movement. Larger areas are to be divided into smaller, more manageable grids. Each grid is approximately 500 by 500 feet and is designated with coordinates as illustrated on the search grid maps.

6. Each search team is assigned to a grid or number of grids. Each grid is to be searched from south to north by a search team in sweeps by lines of team members spaced abreast. Several sweeps may be necessary to completely cover assigned grids. A leader directs the search team.

7. The leader is responsible for the safety of team members and to make sure the search of assigned grids is complete. Failure to check one small area may result in search failure.

8. If the subject is found, the search team will render first aid if needed and notify command post of the location and, if needed request that medical personnel be sent. If the subject is unharmed, the search team will transport the subject back to the appropriate treatment area.

9. If subject is found deceased, the subject and area surrounding the subject will be cordoned off and preserved as a possible crime scene until instructions and the proper authorization have been received.
Management of Cognitively Impaired, Wander Risk Veterans in Medical Center Outpatient Clinics (sample)
(Provided by Vivian E. Bugaoan, LCSW, Northport VA Medical Center, Northport, NY)

Department of Veterans Affairs
Northport, New York 11768

Center Memorandum 122-13
Northport, New York 11768

SUBJ: MANAGEMENT OF COGNITIVELY IMPAIRED, WANDER RISK VETERANS IN MEDICAL CENTER OUTPATIENT CLINICS

1. PURPOSE AND SCOPE: To establish policy and procedures for the identification, assessment and management of cognitively impaired, wander risk veterans who attend medical center outpatient clinics and are at risk to wander.

2. POLICY: Outpatient veterans identified as a wander risk will be escorted during clinic appointments by a competent family member/significant other or VA escort. It is the policy of the Medical Center to:

   A. Assess the wander risk potential of outpatient veterans who have a DSM IV dementia diagnosis.

   B. Develop an individualized plan to provide for the escort/accompaniment of wander risk veterans.

   C. Instruct wander risk outpatient veterans and their families/caregivers regarding safety precautions to be taken in the community and outpatient clinic.

   D. Evaluate the biopsychosocial environment of cognitively impaired wander risk veterans to determine the need for community psychosocial support services to enhance/sustain community living.

   E. Take appropriate action to locate a wander risk veteran and ensure their safety should they become missing during an outpatient clinic visit.

3. DEFINITIONS:

   A. Wander Risk: A veteran with a dementia diagnosis whose degree of cognitive impairment is such that clinical staff assess that veteran is unable to reliably get from one place to another in a clinic setting without being accompanied/escorted is considered to present a wander risk.
B. Outpatient Clinic[s]: This includes the clinical pavilion in Building 200, other areas of Building 200 where ambulatory services are provided to outpatient veterans, and [ ] [Mental Health Clinic / Bldg. 64].

C. Missing: A cognitively impaired outpatient veteran who has been assessed as a wander risk will be considered missing if:

1.) Veteran is transported to the Medical Center, but does not appear for scheduled clinic appointment.
2.) Veteran presents for outpatient clinic appointment, but leaves prior to completion of treatment.
3.) Veteran does not appear at designated area for transportation home by DAV.

4. PROCEDURES:

A. The identification of wander risk in a cognitively impaired veteran attending an outpatient clinic will occur during scheduled clinic appointments.

B. An outpatient veteran with a dementia diagnosis will be [ ] [assessed by their primary care provider for wander risk and document the assessment in the medical record.]

C. [ ] A veteran with a dementia diagnosis who is not assessed as a wander risk will be reassessed by their primary care provider when the provider identifies a significant change in the veteran's mental status during a subsequent clinic visit.

D. The **primary care provider** who determines that veteran is a wander risk will:

1.) [Immediately] advise the veteran/family/caregiver, as appropriate, of the provider's assessment of wander risk and the need for the veteran to be escorted/accompanied during all clinic visits. [The primary provider will document this discussion in the veteran’s medical record.]

2.) Provide veteran/family with initial education to outline precautions that family members and caregivers can take in the home and community setting when caring for a veteran at risk for wandering. [ ]

3.) [ ] [The clinician will ensure that the veteran has been issued a color photo Veteran Identification Card (VIC) as this VIC photo is available under the VISTA Image Display in CPRS. If ID card was issued from another facility, the admissions Supervisor should be contact to gain access. If veteran does not have a new color photo VIC card, the veteran should be escorted to Central Intake to have a picture taken.

4.) Immediately refer the veteran and family/significant other to the outpatient clinic social worker.
5.) Document these actions in a progress note.

E. The **clinic Social Worker** will:
   1.) Meet with the veteran/family/significant other, as appropriate, to provide further education regarding the assessment of wander risk and the precautions that family members and caregivers can take in the clinic and community to ensure the veteran's safety. [ ] [The social worker will give the veteran/family/significant other the Medical Center Brochure: “Protecting a Person Who Wanders”].

   2.) Provide a biopsychosocial assessment to include:

   a.) Evaluation of veteran's safety in his home environment and ability of caregiver to meet veteran's needs.

   b.) Evaluation of community support services which would enhance/sustain veteran's ability to remain in a community setting.

   c.) Evaluation of [veteran’s] need for alternate level of care.

   d.) Plan of psychosocial intervention to assure veteran safety in the community, address veteran psychosocial needs, and provide caregiver support.

3.) Develop with the veteran/family/significant other an individualized plan to provide for the escort/accompaniment of the veteran in clinic settings.

F. **Specific measures to escort/accompany veterans to clinic appointments** will be initiated by the interdisciplinary team as follows and will [ ] [involve] the veteran's community residence and the psychosocial support services available to the veteran.

   1.) **For veterans residing independently in the community or with a family member:**

   a.) Veteran's family member/significant other will be instructed by the primary care provider to accompany veteran to all clinic appointments. If veteran utilizes DAV transportation, the [ ] [clinic social worker] will provide a letter for DAV, stating that the veteran requires accompaniment by the family member/significant other.

   b.) For those veterans whose family members are unable to accompany them and who utilize DAV transportation, the family member will contact the ER [Nurse Manager] (extension 2380) when scheduling DAV transportation and arrange for veteran to be met at the DAV drop off location by an assigned VA escort. The escort will accompany the veteran to his clinic, [ ] return veteran to the DAV pick-up point and wait with the veteran until the DAV van arrives.
and veteran is placed on the van. The family member will advise DAV when scheduling transportation that veteran will be met by VA escort.

2.) **For veterans residing in Contract Nursing Homes:**

a.) The VA Contract Nursing Home (CNH) Coordinator or VA Public Health Nursing (PHN) Coordinator will notify the Contract Nursing Home Director of Nursing that the veteran is a wander risk and develop a plan with the CNH to ensure that veteran is accompanied to all clinic appointments by VA Escort Services.

b.) The CNH Coordinator or PHN Coordinator will notify the following VA staff of veteran's status as a wander risk:

   (1) CNH Coordinator  
   (2) Public Health Nurse Coordinators  
   (3) ER Nurse Manager

c.) **Escort Procedure for Scheduled Clinic Appointments:**

   (1) The Contract Nursing Home will notify the PHN Coordinator of the date and time of clinic appointments

   (2) Transport of CNH veterans to the medical center is scheduled by the VA travel coordinator. The VA travel coordinator will e-mail the CNH Coordinator and PHN Coordinator at least 24 hours in advance of scheduled appointment that travel has been arranged.

   (3) The PHN Coordinator will coordinate with VA Escort and VA travel to ensure that veteran is dropped off and picked up at the VA Escort office by VA travel and a VA escort is assigned to accompany the veteran during the visit to the Medical Center.

d.) **Escort Procedures for Unscheduled Clinic Appointments:**

   (1) The CNH will inform the ER Nurse Manager that the veteran is a wander risk and needs VA Escort.

   (2) The ER Nurse Manager will assign VA Escort or ER staff during off tours to remain with and supervise the veteran.

e.) **Other Escort Procedures**

   (1) A small number of CNH’s routinely provide escort for veterans on contract. Since this service is not included in the contracted per diem rate, this option can only be utilized with the CNH’s agreement.
3.) **For veterans residing in Community Residential Care Program [Adult] Homes:**

   a.) The CRC Social worker will advise the CRC home that veteran is considered a wander risk and develop a plan with the home [ ] [to ensure veteran’s accompanied to VA appointments.]

   b.) Options include:

   (1) The CRC home assigns a member of their staff [or another responsible resident] to [ ] [accompany] the veteran to clinic and provide escort to clinic appointments. Since such escort services are not part of the monthly rate paid by the veteran to the home, an additional special rate may be negotiated by CRC for this service.

   (2) If veteran travels to clinic by DAV, the CRC home will contact the ER Nurse Manager (extension 2380) after scheduling DAV transportation and arrange for veteran to be met at the DAV drop off location by an assigned VA escort person. The VA escort will accompany veteran to his clinic, return the veteran to the DAV pick up point and wait with the veteran until the DAV van arrives and veteran is placed on the van. The home will advise DAV when scheduling the transportation that the veteran will be met by a VA escort.

G. **Search Procedures:** In the event that a wander risk veteran is found to be missing, the following actions will be initiated:

   1.) The veteran will be overhead paged in the clinical pavilion and in Building 200.

   2.) The clinic staff will conduct a preliminary search of the clinic area, nearby offices and adjacent areas such as bathrooms, the smoking shelter, the DAV van pick up and HART bus pick up.

   3.) A clinical practitioner will contact veteran’s residence to ensure that veteran has not returned home on his own.

   4.) The VA Police should be contacted if the above efforts do not result in finding the missing veteran. Police should be provided with a description of the veteran, to include clothing and other identifying features. [ ] The VA Police will conduct a preliminary search of the medical center grounds.

   5.) If these efforts to find the veteran fail, and if the treating physician assesses that the veteran is a danger to himself/herself or others, the treating physician will contact the Medical Center Director, Associate Director or Chief of Staff requesting
authorization for a full search (Code Green). If a full search is authorized, procedures outlined in CM 07B-05 shall be followed.

5. REFERENCES: Center Memorandum 07B-05, “Search for Missing Patients Plan,” dated [April 15, 2005]

6. RESCISSION: Center Memorandum 122-13, dated [April 11, 2003]

7. ATTACHMENTS:
   A. Brochure: Protecting a Person Who Wanders

[ROBERT S. SCHUSTER, MHCA]
[Director]
Dist. A
Sample Respite Admission Questionnaire
(Provided by Fern Pietruszka, Greater Los Angeles VA)

Respite Care Screening
The following questionnaire is used as part of the screening process for respite admissions to the Nursing Home Care Unit (NHCU). Each veteran and a caregiver/spouse is interviewed in person to determine if the NHCU can provide a safe respite admission for the veteran. This set of questions is for the caregiver. In conjunction with this subjective set of questions, we look at the veteran’s cognition, transfer and ambulation ability as well as the veteran’s ability to sit through the full respite screening interview process. This helps to identify those veterans who may need one-to-one supervision and those who may also need additional evaluation of their cognitive status or medication needs prior to admission for respite.

WANDER RISK ASSESSMENT

1. Does the veteran walk around his usual environment aimlessly?  Yes  No
2. Does the veteran get easily agitated with doing simple tasks like dressing?  Yes  No
3. Does the veteran frequently ask where he is?  Yes  No
4. Does the veteran ask the same question(s) often throughout the day?  Yes  No
5. Does the veteran get confused with any change in his routine?  Yes  No
6. Does the veteran get confused with any change in his location?  Yes  No
7. Has the veteran ever gotten lost?  Yes  No
8. Has the veteran needed to be frequently re-directed in a task?  Yes  No
9. Does the veteran have a conservator or DPA for Health Care?  Yes  No
10. Can the veteran walk more than 200 yards?  Yes  No
11. Can the veteran walk up stairs?  Yes  No
12. Have you ever been told that the veteran has dementia or mental health illness?  Yes  No
Resources

The National Center for Patient Safety (www.patientsafety.gov)
- TIPS Newsletter Nov/Dev 2005: Analyzing Missing Patient Events at the VA by Joseph M. DeRosier, PE, CSP, NCPS program manager and Lesley Taylor, BS, NCPS program analyst
  http://www.patientsafety.gov/TIPS/tips.html

The Missing Patient Directive Web Course

For VA Employees only: http://vaww.sites.lrn.va.gov/mp/mpbegin.html

The Missing Patient Directive web site was developed by The Employee Education System for the VHA Central Office.

The Management of Wandering and Missing Patient Events is a national initiative, created by a large multi-disciplinary group chaired by William Van Stone of the Mental Health Strategic Health Care Group in VA Central Office.

Missing Patient Directive Committee Biographical Information (alphabetical)
Ron Alford
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For non-VA Employees, following is the text of the Missing Patient Directive Presentation and Test that you can adapt for your own facility’s use.
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td><strong>Absent Patient</strong></td>
<td>A VA patient who leaves a treatment area without knowledge or permission of staff, but who does not meet the high-risk criteria outlined for a missing patient and is not considered incapacitated.</td>
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<tr>
<td><strong>Assessment</strong></td>
<td>A clinical evaluation by a mental health professional of the mental ability of a patient to care for him or herself.</td>
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<td><strong>CBOC</strong></td>
<td>Community Based Outpatient Clinics. VA clinics located some distance from a VA medical center.</td>
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<td><strong>Clinical Status</strong></td>
<td>The assessment of a combination of illnesses or physical disabilities that may put a patient at risk.</td>
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<tr>
<td><strong>Cognitive Ability</strong></td>
<td>The ability of a person to remember, think, reason, and use judgment.</td>
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<td><strong>Contiguous</strong></td>
<td>Contiguous to the property. Nearby to VA property.</td>
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<tr>
<td><strong>Drills, Missing Patient</strong></td>
<td>Regularly scheduled drills that imitate preliminary and full searches as they might occur at your own facility.</td>
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<tr>
<td><strong>Electronic Technology</strong></td>
<td>Electronic devices physically attached to a high-risk patient that ring an alarm at the nursing station when a high-risk patient nears an exit.</td>
</tr>
<tr>
<td><strong>Extreme Exigency</strong></td>
<td>An emergency situation involving patients.</td>
</tr>
<tr>
<td><strong>Full Search</strong></td>
<td>A full search includes all areas of the facility in addition to those covered by the Preliminary search.</td>
</tr>
<tr>
<td><strong>High-Risk Patient</strong></td>
<td>A high-risk patient is one who is incapacitated because of frailty or physical or mental impairment.</td>
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<tr>
<td><strong>Incapacitated Patient</strong></td>
<td>A patient who is injured or debilitating physically or mentally to the extent that he or she is unable to function adequately.</td>
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<tr>
<td><strong>Legally Committed</strong></td>
<td>A legal process that varies state by state whereby a judge decides that a person must receive psychiatric treatment because of severe mental illness. While usually treatment must occur in a hospital, a number of states also have outpatient commitment.</td>
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<tr>
<td><strong>Mental Status</strong></td>
<td>A part of a psychiatric or mental examination that describes how well a patients mind is functioning.</td>
</tr>
<tr>
<td><strong>Missing Patient</strong></td>
<td>A missing patient is a high-risk patient who leaves a treatment area without knowledge or permission of staff.</td>
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<tr>
<td><strong>Missing Patient Register</strong></td>
<td>The Missing Patient Register is a national computer system that has recently been replaced by a new Web-Based Missing Patient Register (WBMPR).</td>
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<tr>
<td><strong>NCIC</strong></td>
<td>NCIC (National Crime Information Computer). A national system used by police that includes a list of missing patients.</td>
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Chapter 1: New Definitions

What is a high-risk patient?
A high-risk patient is one who is incapacitated because of frailty or physical or mental impairment. Patients are considered incapacitated if, at a minimum, they:

- Are legally committed;
- Have a court appointed legal guardian;
- Are considered dangerous to self or others;
- Lack cognitive ability (either permanently or temporarily) to make relevant decisions;
- Have physical or mental impairments that increase their risk of harm to self or others.

In addition, patients whose mental status may change rapidly, such as those suffering from post-surgical delirium or drug-induced psychosis become at risk. When there is a reported change in mental status for any reason, patients may require repeated assessments during the day to determine if they are at high risk.

What is meant by an assessment?
An assessment is a clinical evaluation of patients with regard to their capacity to make decisions relative to their immediate physical safety or well-being. Past history may be a guide, as well as information obtained by friends, relatives, or care-givers. Each facility must determine the frequency for assessing the cognitive ability of patients with regard to their safety and developing safety measures, as appropriate for the patient's condition.

Timing of Assessments
- Patients whose mental status may change rapidly, such as those suffering from post-surgical delirium or drug-induced psychosis, may require repeated assessments during the day. An assessment is a clinical event and should be recorded in the medical record, whether paper-based or electronic. An assessment may be recorded as part of the routine mental status during a physical or mental health examination or listed separately in the progress note. At a minimum, the clinical assessment of cognitive impairment must be recorded in the patient's record:
  - at the time of inpatient admission, discharge, or transfer between units or care setting;
  - as a component of each initial and annual outpatient evaluation
  - when there is a reported change in mental status for any reason; and/or · in absentia, i.e., when they have disappeared from a clinical setting.

## Preliminary Search
A preliminary search includes nearby ward or clinic areas, offices and adjacent areas such as lobbies, stairwells, elevators.

## Root Cause Analysis
Root Cause Analysis. A system for looking at problems and incidents that involve the safety of patients.

## Wandering Patient
A high-risk patient who tends to stray beyond the view or control of clinical staff.

## WBMPR
The Web-Based Missing Patient Registry is a national electronic program available at all VA facilities that lists the names of high risk patients who are missing along with the date and name of the facility where they were last seen.
Staff may be alerted to patients at special risk through electronic "flags" or reminders.

**Wandering Patient**
What is a wandering patient? A wandering patient is a high-risk patient who has shown a propensity to stray beyond the view or control of employees, thereby requiring a high degree of monitoring and protection to ensure the patient's safety.

**Missing Patient**
A missing patient is a high-risk patient who disappears from an inpatient or outpatient treatment area or while under control of VA, such as during transport. Situations when patients meet the high-risk patient criteria and should be considered missing include, but are not limited to, the following:

- An inpatient or day treatment high-risk patient who is not present to receive a scheduled medication, treatment, meal or appointment, and whose whereabouts are unknown.
- A high-risk patient who does not return from pass as scheduled and whose whereabouts are unknown. Of course, staff must determine the circumstances under which a high-risk patient may be given a pass and the safeguards established at the time.
- A high-risk patient who checked in for an outpatient clinic appointment but is not present for the appointment when called, and whose whereabouts are unknown. If someone accompanied the patient, that person should be located immediately if possible.
- A high-risk outpatient from a community facility who does not return to his or her community facility following the appointment and whose whereabouts are unknown.
- A high-risk patient who is using VA-sponsored transportation (Disabled American Veterans (DAV) vans, VA drivers, VA shuttles) who does not report to that transportation for the return trip.

**Missing Patient vs. Absent Patient**
How can you tell the difference between a missing patient and one who is just absent? An "absent patient" is one who leaves a treatment area without knowledge or permission of staff, but who does not meet the high-risk criteria outlined for a "missing patient" and is not considered incapacitated. The great majority of the patients we see are not at high-risk. Under some circumstances a patient whose whereabouts are unknown, and who usually would not be considered incapacitated or at high risk, may be in potential danger and should be considered missing. Those circumstances should be noted in the clinical record by a responsible clinician.

An otherwise "absent patient" should be classified as a "missing patient" when one or a combination of additional environmental and/or clinical factors may, in the judgment of the responsible clinician, increase the patient's vulnerability and risk. Conditions that might lead to this decision may include, but are not be limited to, the following:

- Weather conditions, i.e., the patient has inappropriate dress and the patient's safety is compromised;
- Construction sites or other dangerous conditions exist nearby;
- There has been recent trauma, unexpected bad news, or an abrupt change in clinical status;
- There are local geographic conditions that increase risk; or
- Homelessness, in combination with other factors that create risk.

**Chapter 2: The Search for Missing Patients**

**Preliminary vs. Full Search**
Preliminary search definition: A preliminary search must be initiated as soon as it is determined that a high-risk patient is missing. A preliminary search includes nearby ward or clinic areas, offices and adjacent areas such as lobbies, stairwells, elevators, etc. A preliminary search will be initiated and coordinated by locally designated staff in each clinical area as defined in your local facility's Missing Patient Plan.
Full search definition: A full search is authorized by the medical center Director, or designee, if the missing patient is not located during the preliminary search and a review of the clinical assessment confirms that the patient is at high-risk. VA Police and Security Service and appropriate medical center staff on duty participate in the search.

What Areas Must be Searched under a Full Search?

A full search includes all areas of the facility in addition to those covered by the preliminary search, such as:

- All buildings, elevators, designated smoking areas, accessible areas for outpatient clinics, construction sites, and other structures.
- All grounds areas, parking lots, ball fields, tennis courts, outdoor seating and picnic areas, woods, and areas off, but contiguous to the property (e.g., local neighborhood attractions. See "Grid Search" below for details of planning, organizing and performing a systematic search of VA property. NOTE: The facility Missing Patient Plan must include specific instructions as to what action(s) to initiate if the patient is found off the grounds since there is no legal authority, lacking an extreme exigency, for patients to be physically detained against their will off facility property.

Grid Search (Patient Searches Using Grid Sectors)

1. Work with facility engineering staff to obtain a site plot of the facility and surrounding areas. Superimpose a grid map to delineate the grid sectors.
2. One individual is to be responsible to gather all pertinent information concerning the grid search. This needs to include:
   a. Search grid sector assignments;
   b. Times and by whom grid sectors are searched;
   c. Times and by whom each building is searched;
   d. Times and to whom notifications and requests are made; and
   e. Result of search.
3. The indoor search needs to include all buildings within the assigned search area to include any unsecured: stairwells, closets, attics, crawl spaces, equipment rooms, all smoking shelters, indoor construction areas, bathrooms, vending areas, and all other areas large enough for the subject to hide.
4. The outdoor search needs to include: brush and open areas, all parking areas, all government and non-government vehicles, all courtyard areas, all shrubbery around buildings, all construction areas, all outlying structures on grounds not assigned to interior search personnel, and any other area where a subject could have wandered.
5. The outdoor search is to be a methodical and complete visual inspection of open terrain for a lost or injured person, or for indications and marks of a person's movement. Larger areas are to be divided into smaller, more manageable grids. Each grid is approximately 500 by 500 feet and is designated with coordinates as illustrated on the search grid maps.
6. Each search team is assigned to a grid or number of grids. Each grid is to be searched from south to north by a search team in sweeps by lines of team members spaced abreast. Several sweeps may be necessary to completely cover assigned grids. A leader directs the search team.
7. The leader is responsible for the safety of team members and to make sure the search of assigned grids is complete. Failure to check one small area may result in search failure.
8. If the subject is found, the search team will render first aid if needed and notify command post of the location and, if needed request that medical personnel be sent. If the subject is unharmed, the search team will transport the subject back to the appropriate treatment area.
9. If subject is found deceased, the subject and area surrounding the subject will be cordoned off and preserved as a possible crime scene until instructions and the proper authorization have been received.

In What Ways are VA Police Involved in a Search?

- VA Police and Security Service participate with appropriate medical center staff on duty in every full search.
When appropriate during or following the full search, VA Police and Security Service must contact the appropriate outside law enforcement agencies to file a missing persons report providing all the needed data so as to ensure that the patient is entered into the National Crime Information Computer (NCIC) system.

VA Police are to be notified immediately in the event that a missing patient is found to be deceased on VA property. The Federal Bureau of Investigation (FBI), State and local police, the Office of the Medical Examiner, and local management officials are to be notified as designated by your facility’s Missing Patient Plan.

What are Missing Patient Drills?
Every VA medical center and clinic, including CBOCs must conduct Missing Patient Drills that replicate preliminary and full searches as they might occur at your own facility. Once staff have received initial training, additional drills must be conducted at least annually (or more frequently if judged prudent due to local circumstances) to effectively evaluate known areas of vulnerability throughout and surrounding the facility. Clinical settings that provide 24-hour care must train staff on all shifts initially and subsequently at least on an annual basis for each shift.

Missing Patient Drills that integrate findings from environmental rounds or other patient safety processes (such as aggregated RCAs), must be conducted that at each medical center or site of jurisdiction, including CBOCs. Once staff have received initial training, additional drills must be conducted at least annually (or more frequently, if judged prudent due to local circumstances) to effectively evaluate known areas of vulnerability throughout and surrounding the facility. Once staff are fully trained, an actual search during which the search plan is fully implemented and a critique is completed may take the place of the drill for the shift involved in the actual search. It is recommended that the sites for missing patient drills be prioritized based on known areas of vulnerability and lessons learned from RCAs and other risk management or performance improvement processes.

How Can You Tell if a Missing Patient Might be at Another VA Facility?
The new Web-Based Missing Patient Registry (WBMPR) is a software application available at all VA facilities that contains information on high-risk patients who are missing. It replaces a previous non-web version. Each facility’s Missing Patients Plan needs to designate at least one person who can access the WBMPR. The WBMPR user(s) will be given a user ID and password. Anyone with a user ID and password can access the WBMPR.

When a full search has failed to locate a missing patient, a WBMPR user should enter the name of that patient in the WBMPR. When the facility reports a patient as missing, the WBMPR will send an e-mail to selected officials at the reporting facility to inform them of the missing patient event, so each facility will need to maintain, in the WBMPR, a list containing the officials who should be notified by the WBMPR. A special feature of the WBMPR is that it will also automatically contact the officials on that e-mail list when their missing patient presents for care at another VA facility. In addition, the MPWBR will send an e-mail with pertinent information about the formerly-missing patient to the officials on the MBMPR e-mail list that is maintained at the facility where that patient has presented for care.

Chapter 3: Prevention: Everyone’s Responsibility

What do I have to do with Missing Patient Events?
All employees, including both clinical and non-clinical staff, are responsible for assessing, reviewing, and/or developing processes to enhance patient safety associated with wandering or missing patient events within the scope of their job, as well as intervening when appropriate. The prevention and effective management of wandering and missing patient events is based on clinical assessment of cognitive ability for each patient and the associated safety risks. (See “Assessment” below).

Assessment
An assessment is a clinical evaluation of patients with regard to their capacity to make decisions relative to their immediate physical safety or well being. Past history may be a guide, as well as information obtained by friends, relatives, or caregivers. Patients whose mental status may change rapidly, such as those suffering from post-surgical delirium or drug-induced psychosis, may require repeated assessments during the day. An assessment is a clinical event and should be recorded in the medical record, whether paper-based or electronic. Staff may be alerted to patients at special risk through electronic “flags” or reminders.

To prevent accidental deaths and injuries, VHA must: (1) Recognize, specify, and maintain appropriate staff responsibility for the whereabouts of patients; (2) Systematically assess all patients to determine the risk potential for those who may wander or become missing from a treatment setting; (3) Detect missing patients early; and (4) Initiate prompt search procedures.

NOTE: If the patient is at high-risk, then assessment and the safety measures appropriate for the patient need to be part of the treatment plan which must be discussed among the patient's health care providers. In addition, that assessment and the safety measures need to be included in the alert that comes to the attention of all applicable health care providers when the patient's record is accessed. The assessment must occur. The assessment and related safety measures must be discussed by each patient's treatment team and documented as being discussed.

What Do I Look to See Where My Group Can Minimize Risks?
Because of the documented risks inherent in the aging veteran population, VHA aims to be as proactive as possible in minimizing risks for patients under its care. As a result, the following processes must be integrated into each facility's Missing Patients Plan and become part of the daily operation of the facility:

- Policies on patient privileging, requirements for patient supervision and surveillance, and search procedures with regard to early identification of missing patients.
- Initial and annual training of all relevant staff regarding policy and search policies and procedures for identifying, assessing, and finding missing patients.
- The systematic and comprehensive monitoring and assessment of hazardous areas and construction sites must be an integral part of this process. Click on Hazardous Areas for details.
- A comprehensive review and assessment of locations for activities away from the facility must be conducted and integrated in the planning of recreational activities to facilitate safety, especially for those patients known to be high-risk.
- Each facility must take special precautions during the transport of known high-risk patients and/or those reported to have a change in mental status, in the absence of clinical assessment.
- Each facility must establish processes to assure the availability of pictures and physical descriptions for all high-risk patients in the event that they are suspected to be missing as a means to enhance the effectiveness of search procedures. Patient Identification System photographs may be used where available.
- Missing Patient Drills that integrate findings from environmental rounds or other patient safety processes (such as aggregated Root Cause Analysis), must be conducted that at each medical center or site of jurisdiction, including CBOCs. Click on Missing Patient Drills for details. Aggregated Review should be done in response to one or more adverse events or close calls involving missing patients. It is recommended that the sites for missing patient drills be prioritized based on known areas of vulnerability and lessons learned from RCAs and other risk management or performance improvement processes.
- Each facility must consider actual or close call missing patient events in accordance with NCPS guidelines and VHA Handbook 1050.1, and integrate the resulting information into education and training of staff and/or improving existing processes to enhance patient safety.

How Does Root Cause Analysis Help Prevent Missing Patient Events?
VA considers reducing and preventing missing patient events an important part of improving patient safety. The VA National Center for Patient Safety (NCPS) has developed a system for looking at
problems and incidents that involve the safety of patients called Root Cause Analysis (RCA). The RCA process is used to study selected incidents, including both actual events where a patient was harmed and close calls where an event almost occurred but was averted. VA NCPS emphasizes that we can learn as much from close calls as from actual events and that learning from close calls can help us to prevent adverse events, including missing patient events, before they happen. Your Patient Safety Manager is the person that you should contact after a missing patient event or close call has occurred. Using tools developed by NCPS your Patient Safety Manager will determine if an RCA should be performed.

**Does technology help us to prevent high-risk patients from leaving without permission?**

Electronic devices physically attached to a high-risk patient that ring an alarm at the nursing station when a high-risk patient nears an exit have been in use for some time. The use of electronic technology for those patients considered to be high-risk may be used only as one tool to enhance and augment other processes for minimizing the risk of patients wandering away from a designated area or site of care. This use must not be considered as a substitute for professional vigilance and systematic verification of patient location such as during change of shift rounds for inpatient and other supervised settings. Electronic devices and/or systems must be re-evaluated at the time of each wandering or missing patient event to assess possible contributing factors. (See “Electronic Devices” below for detail on system checks and maintenance).

**Electronic Devices**

The use of electronic technology for those patients considered to be high-risk may be used only as one tool to enhance and augment other processes for minimizing the risk of patients wandering away from a designated area or site of care. This use must not be considered as a substitute for professional vigilance and systematic verification of patient location such as during change of shift rounds for inpatient and other supervised settings. When electronic technology is in use: (a) There must be systematic and frequent checks of all critical components of the system with clear designation of responsibility for monitoring and maintaining that system. A basic check of the system in high-risk areas is encouraged at a minimum of every 24 hours to assure proper functioning as intended to minimize risk. Maintenance of the system must be consistent with manufacturer's guidelines; however, a complete systems check must be performed at least annually. A proactive assessment of potential vulnerabilities of the system and its use (e.g., failure Modes Effects Analysis) should be performed to guide the appropriate use of the system (see VHA Handbook 1050.1, sub par. 5d). (b) Electronic devices and/or systems must be re-evaluated at the time of each wandering or missing patient event to assess possible contributing factors.
Training Courses (from slide presentations)

Bay Pines VAMC Geriatric Psychiatry Unit “Don’t Get Lost” Inpatient and Day Treatment Programs Wandering Prevention Training Course
Gail Vaillancourt RN, Kelly Fethelkheir RN

The following information is from a slide presentation used during this training course…

Overview of Programs—Inpatient Program
- Treatment of acute mental and behavioral conditions
- Geared for diagnoses of dementia and depression and other psychiatric diagnoses
- 10 bed locked unit
- Specially trained staff
- Interdisciplinary Team consisting of Geriatric psychiatrist, Nurse Practitioner, Social Worker, Pharmacist, Dietician, Nursing, PT, OT and KT.
- Daily case review

Overview of Programs—Outpatient Day Treatment Program
- Locked Unit
- Geared for dementia, depression and other psychiatric diagnoses
- 25 patients attend daily from 9am to 2pm
- Daily structure, support, and socialization
- Recreation, crafts, field trips, music, reminiscing, health education
- Lunch provided daily along with nutritious snacks
- Nursing intervention for psychiatric and medical problems
- Respite for caregivers

Philosophy
- Structure and routine
- Limit Goals
- Look at patients in a holistic way
- Patient and Caregiver are main focus
- “No-Fail Environment” for dementia patients*

Goals of the Unit
- Provide comprehensive biopsychosocial care to veterans with age related psychological and behavior problems
- Maximize their functional capacity and maintain the highest level of independence in the least restrictive environment
- Prevent relapse

No-Fail Environment
- Based on validation therapy
- Customer is always right
- Can prevent catastrophic reactions that can trigger a wandering event
The most useful intervention that prevents agitation and behavioral problems
- Anosognosia – fail to recognize one’s own deficits
- Support and educate staff and family
- Provide reassurance

**Definition of Wandering**
"aimless or purposeful motor activity that causes a social problem such as getting lost, leaving a safe environment or intruding in inappropriate places."
(www.alz.org)

**Types of Wandering**
- **Random Wandering**
  - No apparent goal
  - Aimless
  - Random occurrence
  - Passive in nature

- **Goal Directed**
  - Searching for something
  - Purposeful
  - Exit seekers

**Wandering Statistics**
- Time of year – Warmer season
- Time of day – 6am to 12 midnight
- Usually found within one mile of point last seen
- Wander in straight lines until they encounter resistance
- Two-thirds of all dementia patients wander
- 7 of every ten people diagnosed with dementia will wander and become lost
- It is the MOST frequent and challenging problem for caregivers

**Critical Wanderers**
- Definition: any person with dementia that wanders away from supervised care, a controlled environment or cannot be located
- Each year over 125,000 people become critical wanderers
- Survivability - Only 50% of critical wanderers that require greater than 24 hours to locate will survive

**Wandering Triggers**
- Unfamiliar Environment
- Argumentative Situation
- Change in Schedule / Routine
- Medications
- Left alone in car
- Day care
- Unfamiliar sights or sounds
- Restlessness due to lack of physical activity
- Searching for food, drink, bathroom or companion
- Trying to complete former tasks (work etc..)

**Geropsychiatry Inpatient Unit Wandering Prevention**
- Identification of patients at risk for wandering
- Low patient to staff ratio
Wandering Resources

- Locked Unit
- ESO (Enhanced Safety Observation) for patients at risk for wandering. Staff visualizes patients on ESO at all times.
- Staff escorts ESO patients to ALL appointments
- Education of non-clinical personnel and volunteers

Geropsychiatry Day Treatment Wandering Prevention
- Locked Unit
- Identification of patients and use of Special ID badge for patients at risk for wandering
- Numerous roll calls by seasoned staff
- Escorted to and from unit and to all appointments by staff/trained volunteers
- Low patient to staff ratio
- Use of cell phones and walkie-talkies
- Educate staff, volunteers and non-clinical staff about at risk patients and those patients permitted to leave unit
- Medic-Alert Bracelets provided
- Continuous patient reassessments

Missing Patient Protocol—High Risk Patient (* VA Center Memorandum 516-00-00-24)
- Preliminary and immediate search of area by staff
- Notify VA police and provide description
- Notify Nursing Supervisor, Admitting Officer of the Day (AOD), and Physician
- Complete Report of Unauthorized Absence
- Notify family
- Critique of record of recovery goes to Quality Systems and a Root Cause Analysis is completed

Remember…
The above image is a stop sign image created by the Bay Pines, FL VA Hospital’s Geriatric Psychiatry Unit using the acronym “DON’T GET LOST” to show the steps involved in assessment and coping with wandering behavior.

DON’T GET LOST
D   Determine at risk patients
O   Observe for wandering triggers
N   “No-Fail” Environment
T   Teach staff/non-clinical support
G   Get patient involved in activities
E   Exit Control
T   Talk to patient and provide reassurance
L   Low patient to staff ratio
O   Offer food, drink and toileting
S   Structure and routine
T   TEAMWORK!!
**Missing Patient Process Improvement Presentation**

VA Sierra Nevada Health Care System (654), Reno, NV

Judith O’Neal, RN, Patient Safety Officer

Why?

- Prevent a catastrophic event due to patient elopement from facility
- Decrease risk of patient abuse / exploitation by preventing unauthorized persons from having access to the patients

**Reno Presents Unique Problems**

- 24 hour town
  - Transient
  - Gambling
  - Drinking
- Recent elopements have been patients leaving on unauthorized passes for “recreation”
- Due to clinician concerns, patient is bumped up to “missing” rather than “absent”

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<thead>
<tr>
<th>Year</th>
<th>2C Med/Surg</th>
<th>5C Psych</th>
<th>ICU</th>
<th>TCU Transitional Care</th>
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**Environmental**

- Reduced the number of available TCU exits from 6 to 1
Locked four north doors and one east door of the TCU
 Allows patient free access to courtyard and entire unit
 Doors automatically unlock in the advent of fire
 Requires 1:1 monitoring of high risk patients during fire

This left only one exit resulting in faster staff response to code-alert alarm at main entrance.

**Staff Education**

- Clinician education “missing” vs. “absent”
- Missing Patient Directive revised with user friendly checklist
- Missing patient and code alert included in mandatories
- Missing patient education completed when new problems are identified by root cause analysis
  - Additional abuse/exploitation education for TCU staff (also in mandatories for all nursing personnel)
  - VA Police standby while secure door unlocked until relocked

**Identify Wanderers**

- Wander risk assessment alert developed
- Chart is flagged
- Place code-alert on “high-risk” patient
- Place orange armband on “high-risk” patient
- TCU orange nameplates indicate “high risk” for wandering

**Supportive Processes**

- TCU pass procedure
  - sign out log
  - tracking tool
  - improved pass order
  - templates
- Compressed guardianship process for high risk patients
- Wander risk alert displays at check-in, PSAs assure 1:1 and document in record
- 1:1 suicidal patient in Triage
- Direct admits from Mental Health to inpatient Psych
- Involved local bus drivers - report patient’s in PJs and orange armbands trying to board
- National Crime Information Computer (NCIC) installed, VA Police trained, enter missing patients

**Code “66”**

- Overhead announcement “Code 66” summons the personnel pool similar to facility disaster plan
- All available staff respond
- VA police use facility map to make assignments
- Staff report back after search and are asked for recommendations for improvement next time
  - Send staff with radios to the outside areas
  - Purchase more radios
  - Critique is submitted with missing patient police report to Patient Safety Officer who forwards recommendations to responsible parties
Wandering Resources

◆ Frequent drills - initially

Staffing

◆ We wanted to place a staff person at the main entrance of the TCU with
  – Pictures of the high-risk patients
  – List of approved visitors
  – Monitor patient passes
◆ We did not have the resources to staff this low level position (we were already having difficulty filling patient transport positions).
Family/Caregiver Educational Materials

Family/Caregiver Brochure
(Provided by Vivian E. Bugaoan, LCSW, Northport VA Medical Center, Northport, NY)
10. Involve Your Neighbors
Inform your neighbors of the person's condition and keep a list of their names and telephone numbers handy. Ask your neighbors to call you or the police, if you cannot be reached, if they see the person walking alone in the neighborhood.

11. Be Aware of Hazards.
Places that appear safe to you can be dangerous for the person who wanders. Check around your home for possible hazards such as swimming pools, dense bushes, bus stops, tunnels and busy roadways.

12. Use Signs.
A confused person may start to wander looking for the bathroom at home. A sign on the bathroom door may help.

13. Consult Your Doctor.
Certain medications may make the confused person less restless. Other drugs can cause restlessness. All medications, whether prescribed by the doctor or purchased over the counter, must be closely supervised by a doctor.

14. Enroll the Person in “Safe Return.”
The Alzheimer Association's Safe Return Program provides I.D. products, registration in a National Information/Photo Database, a 24-hour toll-free crisis line and a nationwide fax alert system.

For further assistance in managing the needs of a person who wanders, please contact the clinic social worker or call Social Work Service, 516-261-4400, extension 7030

Protecting A Person Who Wanders:

Helpful Hints and Safety Precautions

VA Medical Center
79 Middleville Rd.
Northport, NY 11768
PROTECTING A PERSON WHO WANDERS

Caring for a person who wanders can be very stressful on families and caregivers. You may feel overwhelmed at times and uncertain what to do. It’s helpful to know that you are not alone.

The VA and community agencies can assist you in dealing with wandering. There are some commonly used techniques which have proven helpful in managing wandering. They include:

1. Be Prepared.
   There’s no way to predict who will wander or when and how it might happen. Some people never get lost and others get lost often. The best advice is to be prepared. Keep a recent photograph of the person available.

2. Try to Understand.
   Don’t take the person’s wandering away personally. The individual is probably trying to make sense of a world that no longer seems familiar.

3. Use Written Reminders.
   A pocket reminder card can help a person who is mildly confused, but still able to read and follow directions. The pocket card should include simple instructions that the person can refer to if he becomes lost. You might write on the card “call home” and put your name and telephone number. When taking the person to the VA, you might write on the card “ask a VA staff member to take you to the (specify color) clinic area and ask the clinic staff to page me. I will come for you.”

4. Obtain and Use I.D. Products.
   You can purchase an I.D. bracelet or necklace in your local pharmacy. These products contain a telephone number that can be called for more information about the person.
   I.D. bracelets or necklaces are also available for caregivers to wear to alert others to look after the person if the caregiver becomes suddenly unable to do so.
   A forgetful person should carry a card on their person which includes their name, address and phone number.

5. Talk with the Person.
   A person who becomes easily confused in an unfamiliar setting needs frequent reminders about where he is and reassurance that you will stay with him and will make sure that he returns home with you.

6. Avoid Changes in Routines.
   Even simple changes can increase wandering. Develop daily routines with the person and stick to them. Resist that urge to re-arrange furniture or re-order the kitchen cabinets.

7. Encourage Movement and Exercise.
   Exercise helps to reduce the restlessness that may lead to wandering. When the person’s general health permits, try taking him/her for a brisk walk each day.
   If you think someone is wandering because he is restless, try giving him some active task like dusting or sweeping.

8. Secure Your Living Area.
   Use a double bolt door lock, keeping the key handy for emergencies.
   There is a plastic device available in hardware stores called a childproof door knob. It slips over the door knob. You can still open the door, but the confused person cannot figure out how to open it.
   Place locks on outside gates.
   Consider putting an electronic buzzer or chimes on your outside doors.
   Place an alarm mat in front of the door.
   Place a two foot square of black cloth in front of the door knob.
   Put gates at the top and bottom of stairs.

9. Learn How to Re-Direct the Person.
   If the confused person tries to wander away from home, you will need to go after him and re-direct him. Experts advise that you try to distract the person rather than directly confronting him. Tell him you will walk with him. Then lead him around in a large circle back to home. Talking calmly and in a reassuring voice can prevent the person from struggling and resisting your efforts to re-direct him.
TEXT VERSION OF BROCHURE:

Department of Veterans Affairs
VA Medical Center
79 Middleville Road
Northport, NY 11768

“Protecting a Person who Wanders: Helpful Hints and Safety Precautions”

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