Continuing Care Risk Management

ECRI Institute
The Discipline of Science. The Integrity of Independence.

► Focus On . . .

Wandering and Elopement

Tools in This Packet

People who wander unsafely or in unsafe environments may become injured, elope or get trapped in unsafe areas, become dehydrated or malnourished, or infringe on the rights of other residents. This packet includes the following tools to help organizations manage wandering and prevent elopement:

► Wandering and Elopement: Statistics, Definitions, Characteristics

► The Physical Environment

► Policies and Procedures

► Individualized Assessment

► Individualized Interventions

► Toolkit for Developing Missing-Resident Procedures

► Resource List

Other *CCRM* Resources

► Risk Analysis: Hazardous Wandering and Elopement

► Risk Analysis: Long-Term Care Security

► Risk Analysis: Resident Identification and Security Systems

► Risk Analysis: Mental Health in Aging Services

► Self-Assessment Questionnaire: Wandering and Elopement

► Self-Assessment Questionnaire: Security

The Continuing Care Risk Management (CCRM) System's *Focus On series contains sample tools and at-a-glance information to help you save time and effort. This Focus On, along with links to each individual item in the packet, is also available in the "Focus On" section of the* CCRM *members' website. The website often links to additional ECRI Institute resources not included in the print packet.*

Wandering and Elopement: Statistics, Definitions, Characteristics

A *CCRM* member asked ECRI Institute for information on characteristics of wandering and elopement. Wandering is estimated to occur in 36% of people with Alzheimer disease living in the community and 65% of nursing home residents with Alzheimer disease. About 80% of elopements occur among older adults who wander "persistently," and about 45% occur within 48 hours of admission to a new residence. (Futrell et al.; Smith and Schultz; Alzheimer's Association) Causes, triggers, patterns, and frequency of wandering and elopement attempts vary from person to person, making an individualized approach—as well as a safe environment—essential.

Wandering has been defined in myriad ways in the decades it has been studied. One group of researchers looked through 183 journal articles to develop a definition of wandering. The researchers suggested the following definition:

> A syndrome of dementia-related locomotion behaviour having a frequent, repetitive, temporally-disordered and/or spatially-disoriented nature that is manifested in lapping, random and/or pacing patterns, some of which are associated with eloping, eloping attempts or getting lost unless accompanied. (Algase et al.)

Wandering is not an "inevitable symptom of dementia," the researchers emphasized, and it is not synonymous with its potential outcomes, such as eloping from a designated location, being unable to return without assistance, or getting lost. Although some of the following may appear along with wandering, they are not, in and of themselves, wandering (Algase et al.):

▶ Agitation or restlessness

▶ Standing behavior (e.g., swaying, shifting weight)

▶ Searches for something or requests to leave

▶ Perseverance

▶ Navigational deficits or spatial disorientation

Elopement is one potential outcome of wandering. It is often described as a type of boundary transgression (Algase et al.)—in other words, the person leaves an area he or she is supposed to stay within. Elopements are not always intentional; an individual may simply see a door and go through it without intending to exit (Alzheimer's Association).

In fact, in a study of U.S. newspaper articles on people with dementia who went missing, 59% went missing while conducting a normal, permitted activity alone in the community or home. The study evaluated a total of 325 incidents over four years. Because the study examined newspaper articles, the incidents were not typical of all missing incidents but allowed comparison of factors less often observed in minor incidents. (Rowe et al.)

Nearly two-thirds of all missing people were men. Nearly three-quarters lived at home, while 6% lived in a nursing home, 6% lived in an assisted-living facility, and 3% lived in a domiciliary care setting.

Among all people who went missing, about one-third were found dead. Those found dead were found closer to the place last seen but took longer to find. Assisted-living residents had the highest mortality rate (45%), while nursing home residents had the lowest (18%).

Missing incidents were unpredictable, unexpected, and unprecedented, according to the authors. Many involved modes of transportation other than walking. Missing people's movements did not seem random; about one-quarter went to natural areas within half a mile of the place last seen and stayed there until found, while others walked or drove long distances.

The authors suggest that missing incidents may be triggered when the person becomes spatially disoriented, makes a wayfinding error, and fails to recover from the error because of other dementia-related factors (e.g., poor judgment, memory, or abstract thinking).

Tools included in this packet are also available on the Continuing Care Risk Management *members' website.*

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Rowe MA, Vandeveer SS, Greenblum CA, et al. Persons with dementia missing in the community: is it wandering or something unique? *BMC Geriatr* 2011 Jun 5;11:28. Also available at http://www.biomedcentral.com/1471-2318/11/28 PubMed: http://www.ncbi.nlm.nih.gov/pubmed/21639942

Smith M, Schultz S. Hartford/Csomay Center of Geriatric Nursing Excellence, University of Iowa. Great escapes: the wandering dilemma [brochure online]. 2009 [cited 2014 Jan 8]. http://www.healthcare.uiowa.edu/igec/publications/info-connect/assets/great_escapes.pdf

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The Physical Environment

The physical environment should support safe walking, wandering, exploration, social interaction, stimulation (but not overstimulation), and rest (Alzheimer's Association).

When planning environmental modifications and strategies, organizations should consider the prevalence of wandering in each area and the potential effects of modifications on residents. In one study, researchers recorded video of 122 older adults who wander living at 22 nursing homes and 6 assisted-living facilities with dementia care units; each resident was video-recorded 10 to 12 times.

When residents were in their own room, a dining room during meals, a dayroom, an activities room, or a staff area, they were more often observed not wandering than wandering. The authors note that the resident's own room may be soothing and that the other four areas afford more opportunity for social interaction or serve a clear purpose. Designing spaces with a clear, single purpose may aid resident wayfinding, the authors suggest. When residents were observed in a bathroom, a dining room outside mealtime, a hallway, an off-unit location, or another resident's room, they were more often observed wandering than not wandering. The authors suggest that when wandering occurs in places with a clear purpose (e.g., bathroom, dining room outside mealtime), it may represent an attempt to satisfy a need. Otherwise, it may represent misidentification of a place (e.g., the wrong resident room). When residents were in the lobby or outside, they were about equally likely to be wandering as not wandering.

Brighter light levels, greater variation in sound levels, a more engaging ambience, and closer proximity to other people were associated with a higher likelihood of wandering. Therefore, organizations might cultivate these qualities in areas where they wish to support safe wandering. A more soothing ambience was associated with a lower likelihood of wandering. Thus, organizations might make areas where they wish to reduce wandering, in accordance with appropriate goals of care, more soothing. (Algase et al.)

A 2010 literature review discussed some general principles for making simple improvements to the physical environment for people with dementia (Edgerton and Richie):

▶ Use disguised or unobtrusive safety measures. To protect residents' safety, dementia care environments should have a secure perimeter. However, safety features should be unobtrusive or disguised, the review states. The use of disguised safety features is associated with less depression and greater feelings of independence and control among people with dementia. For example, disguising main exits (e.g., by placing a mirror on the door) has been found to reduce exit attempts.

▶ Arrange the space to support a variety of activities. Having a variety of spaces to support a range of activities and allowing residents to choose which spaces to go to are strategies associated with better quality of life, fewer negative outcomes such as anxiety and depression, and positive behaviors such as social interaction, the review found.

▶ Ensure optimum levels of stimulation. Overstimulation and understimulation both negatively affect behavior among those with dementia, the review notes. Sensory input should be "understandable and controlled." The review found that environmental factors such as noise and temperature can affect agitated behavior in people with dementia and that quieter environments are associated with better orientation.

A multifaceted approach to environmental modifications is more effective than single modifications. When developing modifications, organizations should consider the number of residents at risk, their cognitive and mobility status, and aspects of the facility and campus. (Futrell et al.; New York State) Strategies include the following (Futrell et al.; Alzheimer's Association; Smith and Schultz; Curran; CNA):

▶ Keep the indoor temperature at a comfortable level, day and night.

▶ Improve the sensory appeal of the environment, such as by installing three-dimensional wall art or tactile boards or creating immersive multisensory environments.

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▶ Create secure, well-supervised areas where people with dementia may wander, such as a lounge, garden, or walking area.

▶ Ensure that outdoor wandering areas are fully visible from inside.

▶ Establish activity zones with safe, nonsharp parts. Examples include task-based stations (e.g., working with tools, baby changing, sewing) and themed multisensory boxes.

▶ Provide comfortable, inviting places to rest (e.g., small, homelike settings; simulated nature scenes).

▶ Post large-print signs and large photographs to aid wayfinding.

▶ Place memory boxes containing personal memorabilia (with panes of acrylic plastic rather than glass) next to residents' doors to help them find their rooms.

▶ Install night-lights or motion-activated lights in bathrooms and pathways.

▶ When constructing or renovating buildings, eliminate or minimize hallways.

▶ Place doors on the walls of hallways rather than at the end, as doors at the ends of hallways are believed to more strongly cue exiting behavior.

▶ Remove clutter and other trip and slip hazards, and clear obstructions from pathways.

▶ Remove distractions in pathways to important locations (e.g., bathroom, dining room).

▶ Ensure that surfaces are even, particularly at transitions (e.g., from concrete to grass).

▶ Institute rules and signage for terraces and porches indicating that residents must not be left alone.

▶ On terraces and porches, implement safeguards to prevent exiting (e.g., tall barriers, affixed furniture, ongoing surveillance).

▶ Use safety locks, more complex door latches, or childproof doorknob covers.

▶ Place locks at the bottom of the door.

▶ Place strips of Velcro across doors.

▶ Paint murals or place full-length mirrors or curtains over doors; for example, library-like wallpaper has been used to deter exit seeking while promoting a calm environment.

▶ Cover doorknobs and panic bars with cloth, or paint them the same color as the door.

▶ Use tape to place gridlines on the floor in front of doors (they appear to deter exit seeking).

▶ Place "stop signs" next to or on doors and "off-limits" signs on fences.

▶ Place bright-orange mesh netting over open doorways.

▶ Inform visitors (e.g., through signs posted near exterior doors) that residents with dementia may try to leave when they exit. Instruct visitors not to allow residents to leave and to notify staff if a resident attempts to leave.

▶ Place alarms on all exits from secure units.

▶ Install keypads for access to elevators and doors that lead to exits or stairwells.

▶ At night, lock all external doors (if permitted by applicable codes), and monitor everyone entering or exiting.

▶ Monitor exits and paths of egress with video cameras, without infringing on residents' privacy.

Before making changes, the organization should investigate applicable building and life safety codes, plus relevant laws and regulations, and consider consulting with controlling authorities. For example, fire codes may bar the use of certain types of locks on exit doors, absent an exception approved by the fire marshal. Organizations must also comply with other applicable laws and regulations, such as the Americans with Disabilities Act.

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References

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Smith M, Schultz S. Hartford/Csomay Center of Geriatric Nursing Excellence, University of Iowa. Great escapes: the wandering dilemma [brochure online]. 2009 [cited 2014 Jan 8]. http://www.healthcare.uiowa.edu/igec/publications/info-connect/assets/great_escapes.pdf

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Policies and Procedures

Organizations must develop policies and procedures for addressing unsafe wandering and elopement. The organizational culture should be committed to protecting individuals' safety while respecting their rights and autonomy. To begin, leaders must commit to preventing hazardous wandering and elopement while supporting safe wandering, communicate their commitment, and implement systems to that end. Leaders should engage all staff—including dietary, housekeeping, and maintenance personnel—as well as people with dementia and family members in identifying solutions. (New York State)

Well-designed policies and procedures can help ensure a consistent, accurate approach to individualized assessment and behavior management. Systems to address such behaviors should be multidimensional, tailored to the population served, and flexible to allow customization of strategies based on individual needs (New York State). Topics to address in policies and procedures include the following (Boltz; New York State; CNA):

▶ Criteria for admission and discharge and the process for discharging or transferring residents whose needs cannot be met

▶ Criteria for determining whether and under what conditions a resident may leave without staff supervision (e.g., only when accompanied by a specific family member) and procedures for such situations

▶ Individualized assessment (including the content and frequency of assessment), identification of needs that may prompt wandering or elopement, and development of interventions

▶ How interventions or care plans will be communicated to staff on all shifts

▶ Steps for evaluating the effectiveness of interventions or care plans and revising them as needed

▶ Methods that may be used to supervise people who wander (e.g., behavior logs, periodic checks)

▶ Methods for supervising at-risk individuals during outings

▶ Safeguards used to prevent elopement and other accidents

▶ Strategies to engage and redirect people who wander unsafely

▶ Methods used to identify at-risk individuals (e.g., lists, photographs, identification bracelets)

▶ Technologies used to prevent or detect hazardous wandering or elopement, including alternatives for those who resist

▶ Maintenance and routine checks of equipment (e.g., elopement alarms)

▶ Restraint alternatives and an individual's right to be free from unnecessary restraints

▶ Procedures for responding to incidents and circumstances that trigger such procedures

▶ Procedures for conducting elopement drills

▶ The process for reviewing incidents and developing a plan to prevent recurrence

▶ Staff patrols or watches to be implemented during disaster and fire drills

▶ Methods of accounting for all residents after activities and events in which residents leave the building

Policies and procedures should be reevaluated on a routine basis (New York State), and risk managers should ensure that they are consistent with all applicable laws.

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Individualized Assessment

Before admission, organizations should ask the individual's family and the transferring facility, if applicable, about the individual's history and patterns of wandering and elopement and strategies they used to manage such behavior. However, the organization should not rely entirely on reports from others; family members may lie to have their loved one placed in a particular setting or unit, and behavior can change, particularly in a new setting. Before admission, the organization should cultivate realistic expectations by educating the individual's loved ones about his or her known risk for unsafe wandering or elopement, general protective measures used at the facility (e.g., alarms, environmental safety measures), and what family members can reasonably expect of the facility.

Policies should define when and how often older adults with dementia should be assessed for risk of unsafe wandering and elopement—such as on admission, on a change in condition, and at least quarterly. An evidence-based guideline on assessing older adults with dementia for risk of unsafe wandering and developing individualized interventions is available from the University of Iowa's Hartford/Csomay Center of Geriatric Nursing Excellence (see "Resource List"). It includes the Mini-Mental State Examination (MMSE), the Revised Algase Wandering Scale (RAWS) for long-term care, the Short Geriatric Depression Scale (SGDS), the long form of the Cohen-Mansfield Agitation Inventory, and the Memory and Behavior Problems Checklist (MBPC), which are discussed below.

According to the guideline, criteria for assessing older adults with dementia are as follows (Futrell et al.):

Cognitive impairment. Cognitive impairment of various kinds, such as impairment in memory, recall, orientation, visuospatial ability, or language, may affect wandering behavior. The MMSE may be used to assess this factor.

Wandering behavior. The RAWS quantifies wandering behavior in several domains and includes three subscales: persistent walking, spatial disorientation, and eloping behavior.

Symptoms of depression. The guideline suggests using the SGDS to identify symptoms of depression.

Agitation. Psychiatric and psychosocial issues may contribute to wandering. The guideline suggests assessing agitation using the long form of the Cohen-Mansfield Agitation Inventory.

Memory and behavior problems. Organizations can use the MBPC to determine how frequently such problems occur and how and to what degree they negatively affect caregivers.

Other factors associated with wandering. Factors to consider include inactivity, socially inappropriate behavior, resistance to care, and impairment in performing activities of daily living.

Environmental strategies currently in use. The organization should evaluate the effectiveness of environmental strategies that it already uses—such as barriers to access, secure areas, technological interventions, and visual cues and disguises—in managing the individual's behavior.

Wandering patterns. Common travel patterns include direct travel from one point to another, random travel with no obvious route or repetition, pacing, and lapping, often in large circles. Types of wandering behavior, such as restless pacing, exit seeking, or shadowing, should be identified. Staff should assess triggering conditions, which may be environmental (e.g., sensory stimulation, temperature) or internal (e.g., hunger, pain, boredom, anxiety). The individual's wandering may peak or change at certain times of day.

Premorbid personality and behavior. People who had certain characteristics before developing their condition are more likely to wander. Extroversion is one risk factor. Others include having had an active interest in music, been physically active in social and leisure activities, experienced many stressful events in life, responded to stress with psychomotor activity, and tended toward more motoric behavior.

To cultivate realistic expectations, staff should meet with the family after each assessment to inform them of the resident's risk for unsafe wandering and elopement. In addition, staff can take advantage of family members' knowledge of the individual and keep them abreast of changes in behavior by involving family members in developing

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interventions and updating service or care plans. For example, information about the individual's life history—such as his or her past occupation, daily routines, and interests—may inform the selection of interventions.

Reference

Futrell M, Melillo KD, Remington R, et al. Evidence-based guideline: wandering. *J Gerontol Nurs* 2010 Feb;36(2):6-16. Also available at http://www.healio.com/nursing/journals/jgn/%7B42913621-1b2b-416d-8a87-ff0bafeb8b16%7D/wandering PubMed: http://www.ncbi.nlm.nih.gov/pubmed/20151627

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Individualized Interventions

Interventions to manage wandering and prevent elopement should be tailored to the individual needs of the person with dementia. The following are examples of interventions; no single intervention is likely to be appropriate for all individuals.

SUPERVISION

▶ Place the resident in a highly supervised area.

▶ Routinely assign the same staff members to the individual.

▶ Assign a staff member to check on the resident at a specified interval or to keep the resident in sight at all times.

▶ Perform nighttime checks at a specified interval.

▶ Watch for indications that the individual plans to leave (e.g., packing belongings).

▶ Determine whether the individual is trying to reach a location within the facility or home, and direct or escort him or her, if appropriate.

ACTIVITIES

▶ Develop a consistent routine that follows the person's usual daily pattern.

▶ Regularly take him or her outside.

▶ Engage the individual in any combination of the following:

— Safe wandering, especially during times of day when his or her behavior peaks

— A structured exercise program (e.g., supervised walks at the same time every day)

— Air mat therapy, which involves exercise and relaxation on an inflatable mat, such as those used in gymnastics

— Activities that address his or her needs or wishes

— Tasks that echo premorbid activities (e.g., simulated chores, tasks that mimic previous job duties)

— Lifestyle activities and hobbies (e.g., dance class, gardening)

— Purposeful tasks (e.g., sorting, building)

— Music therapy

— Aromatherapy, especially with calming, soothing scents

— Activities of daily living (e.g., grooming)

▶ To reduce wandering during activities, play music or foster social interaction with staff or visitors.

▶ Encourage visits from family and friends, and invite them to participate in activities.

▶ Balance activities with quiet time for rest.

SAFETY

▶ Place the individual in a room that suits his or her travel patterns or is farther from exits and stairwells.

▶ To increase comfort and familiarity, decorate the individual's room with favorite personal items.

▶ Keep personal items that may cue exiting behavior (e.g., hat, keys, coat, purse) out of sight.

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CONTINUING CARE RISK MANAGEMENT

▶ Ensure the appropriateness of footwear and clothing for safe wandering.

▶ Give the person a form of identification to wear at all times (e.g., bracelet, label sewn onto clothing) that indicates what to do if he or she is found.

▶ Keep a photo of the resident in a secure area near main entrances or in an electronic database. Ensure confidentiality and compliance with federal and state laws.

▶ Train staff, including those who do not provide direct care, on resident-specific redirection techniques.

UNMET NEEDS

▶ Manage chronic and acute health problems (e.g., constipation, urinary tract infection).

▶ Screen for and address depression, pain, and vision problems.

▶ Use medication to treat symptoms that may contribute to wandering (e.g., delusions, anxiety, depression), but remember that no effective pharmacologic treatment exists for wandering.

▶ Limit the use of medications that increase confusion.

▶ Manage incontinence, or develop a toileting schedule.

▶ Ensure adequate hydration, and provide nutritional support; consider offering extra snacks and fluids.

▶ To keep the person's interest during meals, interact with him or her and have focused conversations about the meal, eating, and social aspects of the mealtime experience.

▶ Identify and address other unmet needs.

Sources: Alzheimer's Association. Dementia care practice recommendations for assisted living residences and nursing homes [online]. 2009 [cited 2014 Jan 8]. http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf; Boltz M. *Wandering and elopement: litigation issues.* New York: Hartford Institute for Geriatric Nursing, College of Nursing, New York University; 2005. Also available at http://www.nccdp.org/wandering.htm; Futrell M, Melillo KD, Remington R, et al. Evidence-based guideline: wandering. *J Gerontol Nurs* 2010 Feb;36(2):6-16. Also available at http://www.healio.com/nursing/journals/jgn/%7B42913621-1b2b-416d-8a87-ff0bafeb8b16%7D/wandering PubMed: http://www.ncbi.nlm.nih.gov/pubmed/20151627; New York State. Creating effective systems to manage wandering behavior: guidance for long term care facilities in New York State [online]. 2005 May [cited 2014 Jan 8]. http://www.nccdp.org/WanderingBehavior5-10-05Final.pdf; Smith M, Schultz S. Hartford/Csomay Center of Geriatric Nursing Excellence, University of Iowa. Great escapes: the wandering dilemma [brochure online]. 2009 [cited 2014 Jan 8]. http://www.healthcare.uiowa.edu/igec/publications/info-connect/assets/great_escapes.pdf

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Toolkit for Developing Missing-Resident Procedures

The first three pages of this sample tool are reprinted here. For a link to the complete tool, see the "Focus On" section of the *CCRM* members' website.

Missing Resident Appendix Development Toolkit

For Health Care Facilities in Colorado

This toolkit is designed to help health care facilities in the State of Colorado develop the Missing Resident procedures to include in an Emergency Operations Plan. It is intended for use in conjunction with the other planning resources available online from the Colorado Department of Public Health and Environment at www.healthfacilities.info under the Emergency Planning Resources link.

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CDPHE-HFEMSD

Tools included in this packet are also available on the Continuing Care Risk Management *members' website.*

INTRODUCTION

This toolkit uses the standards in the INTERIM Comprehensive Planning Guide (*CPG 101*) and the INTERIM Emergency Management Planning Guide for Special Needs Populations (*CPG 301*). More information about the CPG project, including the full text of *CPG 101*, can be found at the FEMA website (http://www.fema.gov/about/divisions/cpg.shtm). The project is not yet complete, so some of the guidelines offered in this toolkit also draw on the Guide for All-Hazards Emergency Operations Planning (*SLG 101)*, which the CPG project is replacing. Text drawn directly from the any of these documents appears in *italics* with parenthetical citations at the end of the selection indicating the source. All other informational text appears as normal print. Where applicable, sample text is also provided. This text appears [bracketed and bolded] and is suitable for use in the facility's Missing Resident Appendix. Other examples are available to download from the Development Toolkits at www.healthfacilities.info under the Emergency Planning Resources link.

DEFINING A HAZARD-SPECIFIC APPENDIX

Hazard-Specific Appendices are one part of an Emergency Operations Plan (EOP). They provide the supplemental information that applies only to a specific hazard. They are supporting documents attached to the Basic Plan or Functional Annexes in the EOP. The information contained in the Appendix should clarify the procedures already developed in the EOP by outlining specific concerns, information requirements, equipment needs, operating procedures, or support requests that a facility would not require in a different scenario. The EOP should include a Hazard-Specific Appendix for the most likely and /or dangerous hazards a facility faces. Use the Hazard Analysis Toolkit available online at www.healthfacilities.info under the Emergency Planning Resources link to identify the hazards most common to the facility.

CONTENT

The information contained in a Hazard-Specific Appendix looks very similar to that of the Basic Plan or a Functional Annex. The order is the same, as are the section subdivisions. However, the Hazard-Specific Appendix is briefer and includes more information under the Tabs (Section 9) than the other two documents. Remember that an Appendix should clarify the procedures already established in the EOP or Functional Annex and should not be considered a stand-alone document.

INSTRUCTIONS

1. Assemble the Comprehensive Planning Team (CPT) and distribute this toolkit to each member for review.
2. Collect the following information:
   - The facility's Hazard Analysis Toolkit or comparative document.
   - The facility's Basic Plan document (see the Basic Plan Toolkit online for more help) and the Functional Annexes (also available online).

CDPHE-HFEMSD

Tools included in this packet are also available on the Continuing Care Risk Management *members' website.*

- A copy of the facility's floor plan, and any maps, diagrams, instructions or expert personnel related to finding the missing person.
- Any other materials deemed relevant by the CPT.

3. Read the entire toolkit and use the information collected here to develop a **Missing Resident Appendix** for the facility's **EOP**.
4. Work each section in the toolkit in order. As with the other toolkits, each section of the plan draws on the section previous for clarification and focus.
5. Complete the **entire** toolkit!
6. Stop to check work often with facility, local, state and federal guidelines. The checkmark in the margins will help identify good stopping points.
7. Remember:
   -Most of the *Italicized text* is drawn directly from *CPG 101, CPG 301*, or *SLG 101*.
   - [Bolded, bracketed text] indicates sample text suitable for use in a facility's Appendix.
   - Be sure to address all of the suggestions under each section before moving on.

DEVELOPING THE APPENDIX

Section One: Purpose, Scope, Situations, and Assumptions

This is the brain of the **Appendix**. The material establishes the intent and usage of the **Appendix** and provides direction, clarity and context for the response procedures outlined. The content here focuses more on providing integration guidelines with the **EOP and Functional Annexes**. Consider this section the implementation instructions. When complete, the section should provide the following information:

- What events or hazards can trigger the Appendix and the search (Remember that a missing resident may be a secondary result of another hazard, such as a fire, tornado, earthquake or flood)
- What personnel in the facility have the authority to order the activation of the Appendix
- How long the Appendix can be in effect
- What other aspects of the **EOP**, if any, should be activated with the Appendix
- List what scenarios or assumptions are included in the Appendix.
- Determine how many staff could be involved in the search, and what departments they are from
- Determine when to contact outside authorities, agencies, or other help
- Have protocols or policies in place that state when authorities will be notified, when families of the missing resident will be notified, and how. Pre-scripted messages can be included in Tabs (Section 9).

1. Purpose
   Much like the thesis statement of a paper or article, this paragraph establishes the overarching theme and intent of the Appendix. All other aspects of the Appendix should flow logically from this statement. An example is listed below:

   [The purpose of this Appendix is to save or protect the life and well being of a missing resident of this facility by finding them as quickly as possible.]

2. Scope
   This paragraph establishes how much the Appendix is intended to do. In other words, this section must clarify at what point before or during a disaster the Appendix goes into effect

CDPHE-HFEMSD

Resource List

Alzheimer's Association
(800) 272-3900
http://www.alz.org

▶ Dementia care practice recommendations for assisted living residences and nursing homes. http://www.alz.org/national/documents/brochure_DCPR-phases1n2.pdf

▶ Preparing for and preventing wandering [handout]. http://www.alz.org/national/documents/topicsheet_wandering.pdf

Alzheimer's Disease Education and Referral Center
U.S. Department of Health and Human Services
(800) 438-4380
http://www.nia.nih.gov/Alzheimers

Centers for Medicare and Medicaid Services
(877) 267-2323
http://www.cms.gov

▶ Guidance to surveyors for long term care facilities. Appendix PP. In: State operations manual. https://www.cms.gov/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Hartford/Csomay Center of Geriatric Nursing Excellence
University of Iowa
(319) 335-7083
http://www.nursing.uiowa.edu/hartford/index.htm

▶ Futrell M, Melillo KD, Remington R. Wandering [evidence-based practice guideline]. http://www.healio.com/nursing/journals/jgn/%7B42913621-1b2b-416d-8a87-ff0bafeb8b16%7D/wandering

▶ Smith M, Schultz S. Great escapes: the wandering dilemma [brochure]. http://www.healthcare.uiowa.edu/igec/publications/info-connect/assets/great_escapes.pdf

National Center for Assisted Living
American Health Care Association
(202) 842-4444
http://www.ncal.org

▶ Assisted living regulations [links to annual state regulatory reviews]. http://www.ahcancal.org/ncal/resources/pages/assistedlivingregulations.aspx

Patient Safety Center of Inquiry
Veterans Integrated Service Network 8
(813) 558-3979
http://www.visn8.va.gov/visn8/patientsafetycenter/default.asp

▶ Wandering and missing incidents in persons with dementia [resources and tools]. http://www.visn8.va.gov/visn8/patientsafetycenter/wandering/default.asp

Tools included in this packet are also available on the Continuing Care Risk Management *members' website.*

ECRI Institute

Aging Services Risk, Quality, & Safety Guidance - Guidance

Wandering and Elopement

Published   5/27/2015

EXECUTIVE SUMMARY

Wandering is a behavior often exhibited by older adults with dementia, a group of symptoms most frequently caused by Alzheimer disease. Wandering is estimated to occur in 36% of people with Alzheimer disease living in the community and 65% of nursing home residents with Alzheimer disease. Elopement is, generally, when individuals leave an area they are meant to remain within. About 80% of elopements occur among older adults who wander "persistently," and about 45% occur within 48 hours of admission to a new residence. (Futrell et al.; Smith and Schultz; Alzheimer's Association)

People who wander unsafely or in unsafe environments may face a higher risk of injury and may elope, get lost, or become trapped in unsafe areas. Wandering may place them at higher risk of dehydration and malnutrition, as well as fatigue and sleep disruption. Wandering can lead to caregiver stress and can increase the likelihood of inappropriate restraint use. Long-term care residents who wander may infringe on the rights of other residents, such as by wandering into others' rooms or personal space or interrupting their activities, potentially leading to fights.

People with dementia who elope are at risk for outcomes such as injuries, dehydration, exposure, medical complications, drowning, or being hit by a car (CMS). The longer a person is missing, the greater the risk.

Further, incidents involving unsafe wandering or elopement can lead to regulatory sanctions, litigation, or both. Regulatory sanctions depend on the type of organization and which agencies regulate it but can be severe. Closed claims based on elopement allegations are associated with high payouts.

However, an individual's wandering may represent "a behavioral expression of a basic human need" (Alzheimer's Association). Potential benefits of wandering include stimulation and social interaction; improvement of mood; maintenance of mobility, conditioning, strength, circulation, and function; and prevention of problems associated with immobility (e.g., pressure ulcers, orthostatic hypertension, urinary tract infection, pneumonia, constipation). Because it is autonomous, wandering may also support the individual's independence and sense of control. Often, it is preferable to support an individual's safe wandering than to try to stop it. (Alzheimer's Association; Smith and Schultz)

This article focuses on managing wandering and preventing elopement in older adults with dementia in long-term care settings and offers considerations for other settings as well. Causes, triggers, patterns, and frequency of wandering and elopement attempts vary from person to person. Thus, organizations must perform individualized assessments, develop person-specific interventions, and evaluate the effectiveness of the interventions in managing the individual's behavior. The physical environment should support the safety of those who wander, and organizations must develop sound policies and procedures and provide thorough education to staff.

Action Recommendations

- Ensure that the physical environment supports both rest and activity, including safe wandering.
- Ensure that policies and procedures address the issues discussed in this article.

- Educate and train all staff on wandering, elopement, and organizational policies and procedures.
- Conduct individualized assessments of risk factors and wandering behavior.
- Select interventions targeted at the individual, and monitor their effectiveness.
- Consider ethical issues when evaluating technology use, and ensure that technology is not used to substitute for supervision.
- Establish plans for responding to missing-person incidents, and conduct routine drills.

WHO SHOULD READ THIS

Director of nursing, Facilities/building management, Home care, MDS coordinator, Resident safety officer, Risk manager, Security, Staff education

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THE ISSUE IN FOCUS

Wandering has been defined in myriad ways in the decades during which it has been studied. One group of researchers searched 183 journal articles to develop a definition of wandering, finding a total of 121 unique pairs of terms and definitions for wandering and related issues.

The researchers suggested the following definition of wandering:

> A syndrome of dementia-related locomotion behaviour having a frequent, repetitive, temporally-disordered and/or spatially-disoriented nature that is manifested in lapping, random and/or pacing patterns, some of which are associated with eloping, eloping attempts or getting lost unless accompanied. (Algase et al. "Mapping")

Wandering is not an "inevitable symptom of dementia," the researchers emphasized, and it is not synonymous with potential outcomes, such as eloping from a designated location, being unable to return without assistance, or getting lost. Although some of the following may appear along with wandering, they are not, in and of themselves, wandering (Algase et al. "Mapping"):

- Agitation or restlessness
- Standing behavior (e.g., swaying, shifting weight)
- Searches for something or requests to leave
- Perseverance
- Navigational deficits or spatial disorientation

Elopement is one potential outcome of wandering. It is often described as a type of boundary transgression (Algase et al. "Mapping")—in other words, the person leaves an area he or she is supposed to stay within. Elopements are not always intentional; an individual may simply see a door and go through it without intending to exit (Alzheimer's Association). A related concern is that people with dementia may go missing, and they often do so when performing a usual, permitted activity alone; for more information, see Going Missing: Incidents and Strategies.

Many other definitions for wandering and elopement exist and are likely to be used in certain contexts. Managers and staff should understand the definitions of wandering and elopement used by the agencies that regulate their organization (Curran and Honnors).

Resident and Patient Safety

People who wander unsafely or in unsafe environments may face a higher risk of injury, such as fall-related injuries, burns, fractures, lacerations, or poisoning. They may elope, get lost, or become trapped in unsafe areas (e.g., a freezer, a maintenance closet, a toolshed). Wandering may place them at higher risk of dehydration and malnutrition—due to difficulty focusing on eating or unintended weight loss, for example—as well as fatigue and sleep disruption. Wandering can lead to caregiver stress and can increase the likelihood of inappropriate restraint use. Long-term care residents who wander may infringe on the rights of other residents, such as by wandering into others' rooms or personal space or interrupting their activities, potentially leading to fights.

People with dementia who elope are at risk for outcomes such as injuries, dehydration, exposure, medical complications, drowning, or being hit by a car (CMS). The longer a person is missing, the greater the risk. The National Quality Forum lists "patient death or serious injury associated with patient elopement (disappearance)" as a serious reportable event (NQF).
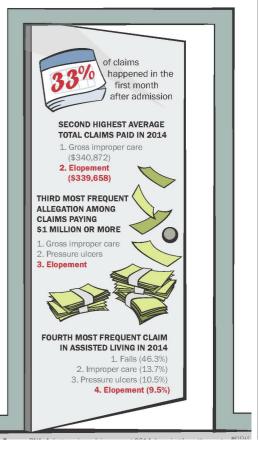
Claims and Lawsuits

Hazardous wandering and elopement present serious liability risks. See Closed Elopement Claims in Aging Services: One Insurer's Experience for highlighted data on elopements from the insurer CNA.

When a person who wanders or has a history of elopement enters a long-term care facility, family members often assume that the resident is now "safe" (Boltz). If they are not informed of the risks that the resident may still face and the organization's plan for promoting the resident's safety, such unrealistic expectations may lead to shock and anger if an incident does occur. CNA previously noted that although failing to prevent an at-risk resident's elopement does not necessarily constitute abuse, the public often views an organization's failure to protect such residents as a failure to protect a vulnerable population. (CNA)

A 2012 case illustrates the high noneconomic damages that juries may award for incidents involving unsafe wandering or elopement. According to published reports, a jury awarded $60 million in compensatory damages and $140 million in punitive damages to the son of a nursing home resident who died after leaving through an exit door and falling down a staircase in her wheelchair. A maintenance worker discovered the 92-year-old resident within an hour after she fell. By then, she had asphyxiated on her own blood. (Hsieh)

Closed Elopement Claims in Aging Services: One Insurer's Experience

33% of claims happened in the first month after admission

SECOND HIGHEST AVERAGE TOTAL CLAIMS PAID IN 2014
1. Gross improper care ($340,872)
2. Elopement ($339,658)

THIRD MOST FREQUENT ALLEGATION AMONG CLAIMS PAYING $1 MILLION OR MORE
1. Gross improper care
2. Pressure ulcers
3. Elopement

FOURTH MOST FREQUENT CLAIM IN ASSISTED LIVING IN 2014
1. Falls (46.3%)
2. Improper care (13.7%)
3. Pressure ulcers (10.5%)
4. Elopement (9.5%)

According to the plaintiff's attorney, the nursing home did not perform elevator maintenance. Because staff were "fed up with having to wait for the elevator," they routinely disabled door alarms so that they could use the stairs. Four former employees testified that because of understaffing, they often disabled residents' personal call buttons to avoid responding to residents' calls.

The high damages in this case may be partly explained by the fact that the nursing home was not defended at trial and by the existence of other allegations (e.g., potential sexual assault, misuse of money, fraud). (Hsieh) Still, elopement claims are generally associated with high severity.

One nursing home's response to an elopement even led to criminal charges. An 88-year-old resident became trapped in a locked outdoor courtyard overnight, according to reports. The resident, who had heart problems, suffered a fatal arrhythmia reportedly triggered by exposure to cold; she was found dead in the morning. According to published reports, staff dragged the resident's body inside, washed it, and placed it in bed, telling the resident's daughter that the resident had died in her sleep.

The administrator and facility were found guilty of criminal charges for neglect of a care-dependent person, involuntary manslaughter, and reckless endangerment. The administrator was also found guilty of conspiring to obscure the circumstances of the resident's death. More than 50 witnesses—including former employees and relatives of former residents, who spoke of injuries, delays in care, medication errors, and inadequate staffing—testified at the trial. The administrator faced federal and state prison sentences and fines; the organization was ordered to pay $490,000 in fines. (Lash)

REGULATIONS AND STANDARDS

State Regulations for Assisted Living

Regulatory oversight of assisted-living facilities falls mainly to individual states. In regard to managing wandering and preventing elopement, state regulations may be specific and detailed, or they may be vague. Examples of issues that states may regulate in regard to wandering and elopement are requirements for dementia care licensure, move-in and move-out, topics for staff training, and reporting of incidents to the state. States may also have regulations specific to dementia care units, which may relate to issues such as admission requirements, physical safety features, access to outdoor areas, egress management, elopement response, and evacuation during emergencies. Assisted-living facilities should be familiar with applicable state requirements and what surveyors will look for. (NCAL; Curran)

CMS Regulations for Skilled Nursing

If a CMS-regulated skilled nursing facility fails to take steps to protect the safety of residents at risk for hazardous wandering or elopement, it risks being cited for noncompliance with federal regulations.

The regulation on accidents (42 CFR § 483.25[h]) requires the facility to ensure that the environment remains "as free from accident hazards as is possible" and that each resident receives "adequate supervision and assistance devices to prevent accidents." In regard to this regulation, the guidance for surveyors (see Resource List) specifically addresses unsafe wandering and elopement, stating that the behaviors are of "particular concern." (CMS)

The guidance includes an investigation protocol that surveyors may use to determine—in regard to a sampled resident who is at risk for unsafe wandering, elopement, falls, or other accidents—whether the organization provided care and services to reduce the resident's risk and provided adequate supervision. The guidance notes that if unsafe wandering or elopement led to actual harm and the organization had no established measures that would have prevented or limited the resident's exposure to hazards or had ineffective measures, the organization should be cited at the immediate-jeopardy level. (CMS) Risk managers with responsibility for skilled nursing should

familiarize themselves with the guidance and revisit it whenever it is updated.

Joint Commission

Across its accreditation programs, the Joint Commission considers any elopement (i.e., unauthorized departure) of a patient or resident from a staffed around-the-clock care setting (including the emergency department) that leads to the individual's death, permanent harm, or severe temporary harm to be a sentinel event. (Joint Commission) For more information on the accrediting agency's policies regarding sentinel events, see Getting the Most out of Root-Cause Analyses.

ACTION PLAN

Optimize the Environment

Action Recommendation: Ensure that the physical environment supports both rest and activity, including safe wandering.

The physical environment should support safe walking and wandering, exploration, social interaction, stimulation (but not overstimulation), and rest (Alzheimer's Association).

When planning environmental modifications and strategies, organizations should consider the prevalence of wandering in each area and the potential effects of modifications on residents. In one study, researchers recorded video of 122 older adults who wander living at 22 nursing homes and 6 assisted-living facilities; each resident was video recorded 10 to 12 times.

When residents were in their own room, a dining room during meals, a dayroom, an activities room, or a staff area, they were more often observed not wandering than wandering. The authors note that the resident's own room may be soothing and that the other four areas afford more opportunity for social interaction or serve a clear purpose. Designing spaces with a clear, single purpose may aid resident wayfinding, the authors suggest.

However, when residents were observed in a bathroom, a dining room outside mealtime, a hallway, an off-unit location, or another resident's room, they were more often observed wandering than not wandering. The authors suggest that when wandering occurs in places with a clear purpose (e.g., bathroom; dining room, outside mealtime), it may represent an attempt to satisfy a need. Otherwise, it may represent misidentification of a place (e.g., the wrong resident room). When residents were in the lobby or outside, they were about equally likely to be wandering as not wandering.

Brighter light levels, greater variation in sound levels, a more engaging ambience, and closer proximity to other people were associated with a higher likelihood of wandering. Therefore, organizations might cultivate these qualities in areas where they wish to support safe wandering. A more soothing ambience was associated with a lower likelihood of wandering. Thus, organizations might make areas where they wish to reduce wandering, in accordance with appropriate goals of care, more soothing. (Algase et al. "Wandering")

A 2010 literature review discussed some general principles for making simple improvements to the physical environment for people with dementia (Edgerton and Richie):

- Use disguised or unobtrusive safety measures. To protect residents' safety, dementia care environments should have a secure perimeter. However, safety features should be unobtrusive or disguised, the review states. The use of disguised safety features is associated with less depression and greater feelings of independence and control among people with dementia. For example, disguising main exits (e.g., by placing a mirror on the door) has been found to reduce exit attempts.
- Arrange the space to support a variety of activities. Having a variety of spaces to support a range of activities and allowing residents to choose which spaces to go to are associated with better quality of life, fewer negative

outcomes such as anxiety and depression, and positive behaviors such as social interaction, the review found.

- Ensure optimum levels of stimulation. Overstimulation and understimulation both negatively affect behavior among those with dementia, the review notes. Sensory input should be "understandable and controlled." The review found that environmental factors such as noise and temperature can affect agitated behavior in people with dementia and that quieter environments are associated with better orientation.

A multifaceted approach to environmental modifications is more effective than single modifications. When developing modifications, organizations should consider the number of residents at risk, their cognitive and mobility status, and aspects of the facility and campus. (Futrell et al.; New York State) Proposed ideas include the following (Futrell et al.; Alzheimer's Association; Smith and Schultz; Curran; CNA):

- Keep the indoor temperature at a comfortable level, day and night.
- Improve the sensory appeal of the environment, such as by installing three-dimensional wall art or tactile boards or creating immersive multisensory environments.
- Create secure, well-supervised areas where people with dementia may wander, such as a lounge, garden, or walking area.
- Ensure that outdoor wandering areas are fully visible from inside.
- Establish activity zones with safe, nonsharp parts. Examples are task-based stations (e.g., working with tools, baby changing, sewing) and themed multisensory boxes.
- Provide comfortable, inviting places to rest (e.g., small, homelike settings; simulated nature scenes).
- Post large-print signs and large photographs to aid wayfinding.
- Place memory boxes containing personal memorabilia (with panes of acrylic plastic rather than glass) next to residents' doors to help them find their rooms.
- Install night-lights or motion-activated lights in bathrooms and pathways.
- When constructing or renovating buildings, eliminate or minimize hallways.
- Place doors on the walls of hallways rather than at the end, as doors at the ends of hallways are believed to more strongly cue exiting behavior.
- Remove clutter and other trip and slip hazards, and clear obstructions from pathways.
- Remove distractions in pathways to important locations (e.g., bathroom, dining room).
- Ensure that surfaces are even, particularly at transitions (e.g., from concrete to grass).
- Institute rules and signage for terraces and porches indicating that residents must not be left alone.
- On terraces and porches, implement safeguards to prevent exiting (e.g., tall barriers, affixed furniture, ongoing surveillance).
- Use safety locks, more complex door latches, or childproof doorknob covers.
- Place locks at the bottom of doors.
- Place strips of Velcro across doors.
- Paint murals or place full-length mirrors or curtains over doors; for example, library-like wallpaper has been used to deter exit seeking while promoting a calm environment.
- Cover doorknobs and panic bars with cloth, or paint them the same color as the door.
- Use tape to place gridlines on the floor in front of doors (they appear to deter exit seeking).
- Place "stop signs" next to or on doors and "off-limits" signs on fences.
- Place bright-orange mesh netting over open doorways.
- Inform visitors (e.g., through signs posted near exterior doors) that residents with dementia may try to leave when they exit. Instruct visitors not to allow residents to leave and to notify staff if a resident attempts to leave.
- Place alarms on all exits from secure units.
- Install keypads for access to elevators and doors that lead to exits or stairwells.

- At night, lock all external doors (if permitted by applicable codes), and monitor everyone entering or exiting.
- Monitor exits and paths of egress with video cameras, without infringing on residents' privacy.

Before making changes, the organization should investigate applicable building and life safety codes, plus relevant laws and regulations, and consider consulting with controlling authorities. For example, fire codes may bar the use of certain types of locks on exit doors, absent an exception approved by the fire marshal. Organizations must also comply with other applicable laws and regulations, such as the Americans with Disabilities Act (see Americans with Disabilities Act: An Overview for more information).

Develop Policies and Procedures

Action Recommendation: Ensure that policies and procedures address the issues discussed in this article.

Systems to address hazardous wandering and elopement should be multidimensional, tailored to the population served, and flexible, to allow customization of strategies based on individual needs. The organization should engage people with dementia, family members, and all staff in identifying solutions. (New York State).

Topics to address in policies and procedures include the following:

- Admission and discharge criteria and/or scope of service
- Staff education and training
- Organizational safeguards
- Individualized assessment and interventions
- Communication regarding individuals who are at risk, including care plans and interventions
- Supervision
- Individual and group outings (with staff)
- Resident leave (without staff)
- Incident response and drills
- Special circumstances (e.g., drills, actual disasters, special events)

Policies and procedures should be reevaluated on a routine basis (New York State), and risk managers should ensure that they are consistent with all applicable laws.

Although this article focuses on hazardous wandering and elopement in long-term care, older adults with dementia may wander in any environment. Managing Wandering in Hospitals outlines issues hospitals might consider when determining how to manage wandering and prevent elopement.

Train Staff

Action Recommendation: Educate and train all staff on wandering, elopement, and organizational policies and procedures.

Staff education is critical to preventing unsafe wandering and elopement. It should include all staff who may interact with people with dementia on all shifts. Education should be provided at orientation and at intervals defined in policies.

Topics to address during staff education and training include the following (Boltz; CNA; Curran and Honnors):

- The organization's policies and procedures
- Effects of dementia on an individual's health, physical function, and emotional state and changes in physical and mental health that may affect dementia
- For professional staff, the clinical presentation of dementia and other conditions or issues that can resemble or attend it

- Wandering as a behavior driven by an attempt to satisfy needs rather than a negative behavior
- Ways to support safe wandering
- Individualized assessment and interventions, including guidelines, specific interventions, and techniques for redirecting people who wander unsafely
- Common methods of exiting
- Use and maintenance of relevant equipment
- Proper response to alarms and the importance of not ignoring alarms
- Incident response
- Individuals' rights
- Restraint alternatives and individuals' right to be free from unnecessary restraints

Records of staff training should be maintained, and further training should be periodically offered. The organization can create and track leading indicators to evaluate the effectiveness of training, see <u>Getting the Most out of Root-Cause Analyses</u> for more information on leading indicators.

Assess the Individual

Action Recommendation: Conduct individualized assessments of risk factors and wandering behavior.

Before admission, organizations should ask the individual's family and the transferring organization, if applicable, about the individual's history and patterns of wandering and elopement and strategies they used to manage such behavior. However, the organization should not rely exclusively on reports from others; family members may lie to have their loved one placed in a particular setting or unit, and behavior can change, particularly in a new setting.

The organization should also cultivate realistic expectations by educating the individual's loved ones about his or her known risk for unsafe wandering or elopement, general protective measures used by the organization, and what family members can reasonably expect of the organization. Long-term care organizations should discuss wandering and elopement with residents who do not wander and their families. For more information, see <u>Discussing Wandering with Families, Visitors, and Other Residents</u>.

Policies should define when and how often older adults with dementia should be assessed for risk of unsafe wandering and elopement—such as on admission, on a change in condition, and at least quarterly. An evidence-based guideline on wandering is available for purchase from the University of Iowa's Hartford Center of Geriatric Nursing Excellence (see <u>Resource List</u>). <u>Table. Domains to Assess</u> lists domains that the guideline suggests assessing, as well as tools that may be used and factors to consider when assessing each domain. The guideline includes some of the assessment tools; also see <u>Tools for Wandering Assessment</u>.

To cultivate realistic expectations, staff should meet with the family after each assessment to inform them of the individual's risk for unsafe wandering and elopement. In addition, staff can take advantage of family members' knowledge of the individual and keep them abreast of changes in behavior by involving family members in developing interventions and updating service or care plans. For example, information about the individual's life history—such as his or her past occupation, daily routines, and interests—may inform the selection of interventions.

Select Interventions

Action Recommendation: Select interventions targeted at the individual, and monitor their effectiveness.

Because wandering behavior and triggers vary from person to person, interventions must be individualized. Potential goals include assessing and addressing causes of wandering, particularly unmet needs; maintaining the individual's mobility and autonomy and supporting his or her safe and independent movement; preventing unsafe wandering and elopement; and minimizing disruption to others. (Alzheimer's Association)

Examples of interventions to manage wandering and prevent elopement appear in <u>Individualized Interventions</u>. Unfortunately, the evidence has yet to pinpoint causes of wandering and clear recommendations regarding interventions, but specific interventions may work for specific individuals (Futrell et al.). Because of the heightened risk of unsafe wandering or elopement just after admission or a move to a different room or unit, additional monitoring strategies or interventions should be implemented during the first few days.

Aging services and healthcare organizations may also wish to use an algorithm for addressing dementia-related behaviors that was developed as part of a toolkit on reducing inappropriate use of antipsychotic medications (see <u>Resource List</u>); the algorithm and toolkit are available from the University of Iowa College of Nursing. Other tools in the toolkit include training videos, a mobile app, pocket guides, materials for patients and family members, and evidence-based reviews.

Organizations must have a process for ensuring that staff are aware of the individual's behavior, needs, and planned interventions and are informed of changes made (e.g., small-group meetings among those who frequently care for a specific individual, morning stand-up meetings, 24-hour reports) (New York State; Curran).

After interventions have been implemented for a particular individual, it is important to continually evaluate their effectiveness. According to the guideline, outcome indicators to monitor include the following (Futrell et al.):

- Wandering behavior
- Safety
- Wayfinding
- Disorientation
- Maintenance of body weight

Staff should document the individual's responses to interventions (Smith and Schultz).

If planned interventions are ineffective, the organization must implement new interventions and update the service or care plan as necessary. Likewise, interventions that are effective will not necessarily remain so—hence the importance of periodic reassessment. For example, the individual's condition may change, or he or she may learn to circumvent certain interventions.

Consider Technology Use

Action Recommendation: Consider ethical issues when evaluating technology use, and ensure that technology is not used to substitute for supervision.

The appropriateness of monitoring technology for people with dementia has spurred ethical debate, as exemplified by a pair of articles. The first author, in favor of electronic monitoring, states that although global positioning system (GPS) tracking does not completely solve the problem, it enables missing individuals to be found quickly. The author suggests GPS tracking for the 5% of people with dementia who get lost repeatedly. In addition, he states, the technology may allow such individuals to continue living in the community. Describing the case of a woman who feared her neighbors' reactions if they were to find out she was putting a tracking device in her husband's coat pocket, the author concluded, "The 'ethical debate' can itself be stigmatizing." (McShane)

The second author writes that a person-centered approach requires that people with dementia be seen as the "lead collaborator" in their care and that early literature indicated that electronic tracking for people with dementia was associated with "objectification, infantilisation, and disempowerment." In addition, tracking may provide a false sense of security, he states. Characterizing electronic tracking as a "quick fix," the author also emphasizes that "the key goal of good dementia care is to interpret and respond to what is driving the wandering." (O'Neill)

In addition, monitoring technologies may frighten or distress people with dementia, who may refuse to wear devices

or try to remove them. If such technologies will be used and will trigger an alarm, organizations should prefer alarms that are less intrusive and distressing, such as verbal alarms. Distressing alarms may exacerbate behavior or prevent any kind of movement. (Futrell et al.; Alzheimer's Association)

Several types of technologies are available, some of which are associated with fewer ethical concerns than others. Examples are the following (Powell-Cope et al.):

- **Door alarms.** An alarm sounds when the door is opened or someone passes through the doorway.
- **Lockout systems.** The system prevents a device an individual may use to elope (e.g., car) from functioning.
- **Optically activated alarms.** A light beam triggers an alarm if someone passes through it.
- **Pressure-activated alarms.** Pads are placed in certain areas, and an alarm sounds if pressure is applied to or removed from the pad.
- **Pull-tab alarms.** A tab is placed on the individual; if he or she moves away from the unit, the tab detaches and an alarm sounds.
- **Tracking systems.** These systems use either radio-frequency technology or GPS locators to find an individual who has left the home or facility.
- **Advanced systems.** Such systems include GPS locators and cellular phones, individualized notification systems, and centralized notification systems.

Use of any technology to monitor or manage wandering or elopement comes with another caveat: As CMS guidance to surveyors explicitly states, "Alarms do not replace necessary supervision" (CMS). Use of a technology should be viewed as only one part of the person's individualized set of interventions. Its effectiveness in managing his or her behavior should be evaluated along with other planned interventions.

Staff must know when and how to check the function of all monitoring devices, and a system should be in place for documenting such checks. For devices that require recharging, a charging schedule may be necessary. The organization should also have a system for alerting staff to the need to replace devices or batteries before they expire, if applicable. A procedure for responding to alarms should be crafted, and responsibilities for responding to and turning off alarms should be clearly assigned. Contingency plans should be developed for times when the system or individual units are out of service (e.g., during repairs or disaster drills).

Create Missing-Person Response Plan

Action Recommendation: Establish plans for responding to missing-person incidents, and conduct routine drills.

Studies on the outcomes of organized search-and-rescue efforts for individuals with Alzheimer disease indicate that mortality rates increase significantly if the person is not found within 24 hours (Koester and Stooksbury). Thus, inadequate response to an elopement or other missing incident could contribute to significant harm.

When developing missing-person response plans, organizations should meet with local law enforcement to identify when and how staff should contact police. The organization should be prepared to e-mail a recent photograph and a description of the individual to police. Periodically assessing buildings, the campus, and surrounding areas for hazards to individuals at risk of unsafe wandering or elopement (e.g., ponds with unrestricted access, construction sites) may inform development of and updates to the response plan.

The response plan should define what constitutes a missing-person incident and requires activation of response procedures. The organization may outline which departments are responsible for searching which areas—for example, it may direct environmental services staff to search stairwells and facilities management staff to search the building and grounds. The organization may wish to develop a readily accessible response toolkit containing items such as maps and checklists tailored to each individual role that has assigned search responsibilities.

Following are steps that the organization might include in a missing-person protocol:

- Thoroughly search the care unit and other immediate areas.
- Use an internal alert system to signal to staff that a person with dementia is missing and that they should begin response procedures.
- Assign search responsibilities to specific staff members, consistent with departmental search roles outlined in the policy.
- Search all spaces, even those that are usually locked or otherwise inaccessible to residents or patients.
- Check off searched areas on a checklist, or shade them in on a floor plan.
- Notify management and the attending physician, and seek their help in implementing procedures.
- Notify family members, and ask them if they know where the individual may try to go.
- Notify law enforcement and the state agency, as required by law.
- Document and give to law enforcement information on where and when the individual was last seen, what he or she was doing, and the individual's history of wandering or elopement. Provide a full description and a recent photograph of the person.
- If the individual is found, obtain a complete medical evaluation to identify injuries and necessary treatment. Notify previously contacted people and agencies of the individual's return.
- During the incident or immediately afterward, document all actions taken.
- Complete an event report.
- Reassess the individual, and adjust his or her interventions and service or care plan as needed.
- Conduct a reactive analysis of the incident.
- Develop and enact a plan to prevent future occurrences.

Organizations may wish to refer to the steps in Toolkit for Developing Missing-Resident Procedures when crafting plans for responding to missing-person incidents.

To ensure that staff know what to do and act swiftly, incident response should be practiced through routine drills. The organization should consider assigning someone dedicated responsibility for assessing staff performance and system vulnerabilities during the drill, and drills should be seen as opportunities to learn and improve, not just practice. The organization must also ensure that drills themselves do not jeopardize resident or patient safety.

In recent years, many states have enacted programs that notify the public when an older adult goes missing (circumstances and individual characteristics that trigger alert activation vary by state). Often called "Silver Alert" programs, they are much like Amber Alert programs for abducted children and typically use the same or similar technology and infrastructure. In most states, local law enforcement or a state agency activates the alert, which may be broadcast on the radio, on television, and on automated highway signs. Bills that would establish a national Silver Alert system have been proposed.

Fee-based emergency response services for older adults with dementia, such as the Alzheimer's Association's Safe Return program, are also available. Organizations may wish to investigate Silver Alert programs in their state and neighboring states and available fee-based services and consider whether and how to incorporate them into missing-person response plans.

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RESOURCE LIST

Alzheimer's Association

(800) 272-3900

http://www.alz.org

- Dementia care practice recommendations for assisted living residences and nursing homes. http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf
- Wandering behavior: preparing for and preventing it [handout]. http://www.alz.org/national/documents/topicsheet_wandering.pdf

Alzheimer's Disease Education and Referral Center

U.S. Department of Health and Human Services

(800) 438-4380

http://www.nia.nih.gov/alzheimers

American Geriatrics Society

(212) 308-1414

http://www.americangeriatrics.org

- Physician's guide to assessing and counseling older drivers. http://geriatricscareonline.org/ProductAbstract/physicians-guide-to-assessing-and-counseling-older-drivers/B013

Centers for Medicare and Medicaid Services

(877) 267-2323

http://www.cms.gov

- Guidance to surveyors for long term care facilities. Appendix PP. In: State operations manual. https://www.cms.gov/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Hartford Institute for Geriatric Nursing

New York University College of Nursing

(212) 992-9416

http://www.hartfordign.org

- Try This resources. http://consultgerirn.org/resources
  - Assessing and managing delirium in older adults with dementia.
    http://consultgerirn.org/uploads/File/trythis/try_this_d8.pdf
  - The Confusion Assessment Method (CAM). http://consultgerirn.org/uploads/File/trythis/try_this_13.pdf
  - Mental status assessment of older adults: the Mini-Cog.
    http://consultgerirn.org/uploads/File/trythis/try_this_3.pdf
  - Recognition of dementia in hospitalized older adults.
    http://consultgerirn.org/uploads/File/trythis/try_this_d5.pdf
  - Therapeutic activity kits. http://consultgerirn.org/uploads/File/trythis/try_this_d4.pdf
  - Wandering in hospitalized older adults. http://consultgerirn.org/uploads/File/trythis/try_this_d6.pdf
  - Working with families of hospitalized older adults with dementia.
    http://consultgerirn.org/uploads/File/trythis/try_this_d10.pdf

Joint Commission

(630) 792-5800

http://www.jointcommission.org

- Sentinel event policy and procedures.
  http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures

National Center for Assisted Living

American Health Care Association

(202) 842-4444

http://www.ncal.org

- Assisted living state regulatory review 2013.
  http://www.ahcancal.org/ncal/resources/Documents/2013_reg_review.pdf

Patient Safety Center of Inquiry

Veterans Integrated Service Network 8

U.S. Department of Veterans Affairs

(813) 558-3979

http://www.visn8.va.gov/visn8/patientsafetycenter/default.asp

- Wandering consortium [resources and tools].
  http://www.visn8.va.gov/visn8/patientsafetycenter/wandering/default.asp

University of Iowa

College of Nursing

(319) 335-7018

http://www.nursing.uiowa.edu

- Futrell M, Melillo KD, Remington R. Wandering [evidence-based practice guideline]. Available for purchase at
  http://www.nursing.uiowa.edu/excellence/evidence-based-practice-guidelines
- Improving antipsychotic appropriateness in dementia patients [toolkit].

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- Algorithm for treating behavioral and psychological symptoms of dementia. Available with registration at https://www.healthcare.uiowa.edu/IGEC/IAAdapt/document/Algorithm_BPSD_products.pdf
- Smith M, Schultz S. Great escapes: the wandering dilemma [brochure].
http://www.healthcare.uiowa.edu/igec/publications/info-connect/assets/great_escapes.pdf

ADDITIONAL MATERIALS

Going Missing: Incidents and Strategies

Serious Incidents

In a study of U.S. newspaper articles on people with dementia who went missing and required law enforcement help to be found, 59% went missing while conducting a normal, permitted activity alone in the community or home. The study evaluated a total of 325 incidents over four years. Because the study examined newspaper articles, the incidents were not typical of all missing incidents but allowed comparison of factors less often observed in minor incidents.

Among all people who went missing, about one-third were found dead. Compared with people who were found alive, people who were found dead were found closer to the place last seen but took longer to find. Assisted-living residents had the highest mortality rate (45%), while nursing home residents had the lowest (18%).

In this study, missing incidents were unpredictable, unexpected, and unprecedented. Many involved modes of transportation other than walking. Missing people's movements did not seem random; about one-quarter went to natural areas (e.g., woods, fields) within half a mile of the place last seen and stayed there until found, while others walked or drove long distances.

The authors suggest that missing incidents may be triggered when the person becomes spatially disoriented, makes a wayfinding error, and fails to recover from the error because of other dementia-related factors (e.g., poor judgment, memory, or abstract thinking). (Rowe et al. "Persons") In addition, there is no established correlation between wandering and going missing (Rowe et al. "Missing Incidents").

Missing-Driver Incidents

Another study found that cases in which people went missing while driving differed from those in which people went missing while walking, as seen in a retrospective review of 156 alerts for missing drivers with dementia from one state's Silver Alert program. Much like those involved in serious incidents, about half of missing drivers (51%) became lost while on a routine, independent trip with the caregiver's permission or knowledge. Among all missing drivers, 89% were found the same day or the next; 5% were found dead, and 11% were found injured.

Only 41% were found in the county where they had gone missing, and when found, only 20% were still driving. In addition, 32% committed known driving or other dangerous errors (e.g., head-on crashes, driving the wrong way, walking on roadways). Most (64%) were found by law enforcement. (Rowe et al. "Missing Drivers")

Prevention and Mitigation Strategies

Strategies to prevent and mitigate missing incidents need to be further developed but may include the following (Rowe et al. "Missing Incidents"; Rowe et al. "Persons"; Rowe et al. "Missing Drivers"):

- Educate people with dementia and their caregivers about going missing versus wandering, the unpredictability of missing incidents, and the need for continual assessment.
  - Stress to caregivers that events often occur when the person with dementia is performing a normal, independent activity.
- Ensure that people with dementia always have identification and contact information with them.

- Ensure that caregivers, both formal and informal, routinely assess for changes in cognitive capacity, such as new difficulties with wayfinding, solving problems, and remembering new information.
- Implement driving assessment and driving retirement strategies for people with dementia. (The American Geriatrics Society offers a guide for physicians on assessing and counseling older drivers; see <u>Resource List</u>.)
- Help informal caregivers find day programs, respite care, or other services if needed to increase supervision.
- Ensure that caregivers have a written response plan, current photo, and important phone numbers readily available.
  - Instruct informal caregivers to contact law enforcement no more than 20 minutes after it is discovered that the person is missing.
  - Consider the need to tailor some aspects of response plans (e.g., search procedures) for situations in which the individual has gone missing while driving.
- Consider use of locating or tracking technologies for high-risk individuals.
  - Alternatively, informal caregivers can use home safety protocols that do not require the person with dementia to wear a device, such as systems with door and window sensors.

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Managing Wandering in Hospitals

In a hospital setting, the acute medical conditions for which an older adult with dementia seeks care can increase the risk of a serious adverse outcome in the event of an incident. Because individuals are more likely to wander when they are in unfamiliar environments, even those who do not wander at home may wander while at a hospital.

Best Practices

The Hartford Institute for Geriatric Nursing offers "Wandering in Hospitalized Older Adults," a Try This article that outlines practices for assessing risk and managing wandering in hospitalized older adults with dementia; see <u>Resource List</u> for information on accessing this and other relevant Try This resources. Best practices are as follows (Silverstein and Flaherty):

- Identify risk. Staff should be aware of the potential for dementia, including unrecognized dementia, and consider assessing older patients for it. Staff can also assess for cognitive impairment and delirium and ask family members about the patient's history of wandering or elopement. Patients with positive results for any assessment are at risk for unsafe wandering or elopement.
- Provide supervision. At-risk patients should be placed in rooms that facilitate high levels of supervision. Consider conducting regular checks of the patient or having volunteer or paid "sitters" stay in the patient's room. At-risk patients may be given hospital gowns of a certain color, and monitoring technologies may be

used. The patient should not be left alone outside his or her room.

- Reduce environmental triggers. At-risk patients should not be placed in rooms that are exposed to high traffic or noise or are within view of architectural exit cues (e.g., stairwells, elevators). Patients should be able to easily see and identify the bathroom. Personal items that may cue exiting behavior (e.g., suitcases, street clothes) should be kept out of sight.
- Implement individualized nursing interventions. Consider implementing patient-specific strategies used by the family or residential facility. For example, staff may walk with the patient or engage him or her in activities, such as sorting objects. To make the environment more calming, reduce noise and glare, play soothing music, and avoid room changes.
- Develop a missing-patient response plan. Providers and security staff should receive education and training on wandering, elopement, and hospital policies and procedures. Drills should be conducted to practice the plan.

The Importance of Knowing about the Patient

The authors of an editorial have described how they developed an "All About Me Board" listing information about the personal lives and activities of hospital patients with dementia to help identify individualized interventions. The editorial presents the case of a 77-year-old man with a diagnosis of dementia who was admitted to the hospital with a gastrointestinal illness and dehydration. Although regular assessments indicated that he was not experiencing delirium, he would often appear restless and try to get out of bed unassisted. By introducing the All About Me Board, the nursing staff learned that one of the patient's favorite activities was a daily three-mile walk around the neighborhood with his wife. As a result, the nurses implemented a schedule allowing him to take progressively longer walks in the hallway with staff and a family member, which decreased his restlessness.

The large, colorful board is placed in a visible place in the patient's room. It contains information including what older adults prefer to be called, their favorite music, what makes them feel calm, their past occupation, hobbies, and the names of family members and pets. The authors note that that All About Me Board is easily designed on the computer, laminated so it can be wiped down with disinfectant and reused, and able to be adapted to any setting and produced for a minimal cost. (Fick et al.)

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Silverstein NM, Flaherty G. Wandering in hospitalized older adults. *Try This* 2012;(D6):1-2. Also available at http://consultgerirn.org/uploads/File/trythis/try_this_d6.pdf

Discussing Wandering with Families, Visitors, and Other Residents

Aging services organizations that are home to people who wander or are at risk for elopement should talk about wandering and elopement with residents who do not wander and their family members.

A primary goal of these discussions is to protect residents at high risk for elopement. To respect residents' privacy and confidentiality, staff should not identify individual residents who wander.

The dangers of "helping" anyone out of a secure door may be discussed during the preadmissions and

admissions processes and reviewed annually at family meetings. The discussion should be respectful, and the theme may be a "call to action" to help keep loved ones safe. The organization may wish to develop a brochure outlining these concepts (see Wandering and Elopement: Brochure for Residents and Family Members). Copies may be shared during the discussion and kept near the main entrance to the unit.

Some organizations also post signs at doors to the unit. However, signs are only one control, and not a very strong one. Addressing such issues during the design of the environment and instituting measures such as stop signs and disguised doors (see the discussion Optimize the Environment) are stronger approaches. Reminders to visitors at sign-in may also aid the effort.

Elopement prevention is an important reason to discuss wandering and elopement, but it is not the only one. Many family members and residents may find wandering behavior in another resident unnerving, especially if they have never seen it before. Another risk is that residents who wander could enter the personal space (or room) of a family member, visitor, or other resident, and that could come as a total shock if the individual has a poor understanding of wandering.

The organization might discuss topics such as the following during the preadmissions or admissions process for any resident moving in to the unit:

- Explaining what wandering and exit-seeking are, what they look like, and why they are such an important issue
- Telling residents and family members that the unit is secure, what that means, and how the unit is monitored
- Explaining that some residents on the unit are at risk for wandering and some are not
- Discussing other strategies the organization uses to manage wandering
- Asking the nonwandering resident and families for their help in protecting the resident's neighbors
- Asking residents and families to share general information about wandering, safety measures, and the unit with others who may visit the resident but to respect wandering residents' privacy by not "naming names"

Another reason it is important to discuss wandering on admission is because residents may begin wandering after moving in. This discussion might invite more conversation about past or current behaviors, including signs that may show up before wandering does, such as the following (Alzheimer's Association):

- Coming back from a regular excursion (e.g., a walk) later than normal
- Wanting or trying to fulfill former obligations (e.g., going to work)
- Wanting or trying to "go home" even when already home
- Acting restless, making repetitive movements, or pacing
- Having difficulty finding familiar places in the home
- Behaving as if performing a task but not accomplishing it
- Acting anxious in crowded places (e.g., shopping mall)

Reference

Alzheimer's Association. Staying safe: steps to take for a person with dementia [guide online]. 2012 [cited 2014 Dec 11]. https://www.alz.org/national/documents/brochure_stayingsafe.pdf

Table. Domains to Assess

Domain	Factors to Assess or Tools to Use
Medical, psychiatric, or psychosocial problems	Factors to assess:

	• General issues that may underlie the behavior
Premorbid personality and behavior	Factors to assess: • Extroversion (recent research has shown conflicting results) • Active interest in music • Physical participation in social and leisure activities • Many stressful life events but less verbal means of coping • Response to stress with psychomotor activity more so than emotional reactions • More motoric behavior
Cognitive impairment	Tools that may be used: • Mini-Mental State Examination • Mini-Cog
Memory and behavior problems	Tools that may be used: • Memory and Behavior Problems Checklist
Attention	Tools that may be used: • Digit span task of the Wechsler Adult Intelligence Scale
Agitation	Tools that may be used: • Cohen-Mansfield Agitation Inventory: Long Form with Expanded Descriptions of Behaviors
Depressive symptoms	Tools that may be used: • Geriatric Depression Scale (Short Form)
Other factors associated with wandering	Factors to assess: • Inactivity • Socially inappropriate behavior • Resistance to care • Impairment in performing activities of daily living
Unmet needs, pain, or other physiologic processes	Tools that may be used: • Pain Assessment in Advanced Dementia Scale

	Factors to assess: • Unmet needs (e.g., boredom, overstimulation, hunger, feeling uncomfortably warm or cold) • Other physiologic processes (e.g., acute illness, exacerbation of a chronic condition, fatigue, effects of medications, constipation)
Wandering behavior	Tools that may be used: • Revised Algase Wandering Scale (long-term care or community version)
Wandering patterns	Factors to assess: • Direct travel from one point to another • Random travel with no obvious route or repetition • Pacing • Lapping
Descriptive typology of wandering	Factors to assess: • Checking or trailing a caregiver or other person • Pottering (i.e., trying, ineffectively, to perform a task) • Aimless walking • Walking with an inappropriate purpose (e.g., seeking a deceased loved one) • Walking with an appropriate purpose but at an inappropriate frequency (e.g., going grocery shopping many times per day) • Excessive activity • Nighttime walking • Need to be brought back • Attempts to leave
Environmental strategies currently in use	Factors to assess: • Frequent evaluation of the effectiveness of strategies (continue use for that individual only if they are effective)

Source: Futrell M, Melillo KD, Remington R, et al. Evidence-based practice guideline: wandering. *J Gerontol Nurs* 2014 Nov;40(11):16-23. Also available at http://www.healio.com/nursing/journals/jgn/2014-11-40-11/%7B5a5affec-1ce2-43d6-aca1-3b52f80b7c56%7D/wandering PubMed:

http://www.ncbi.nlm.nih.gov/pubmed/25310096

Tools for Wandering Assessment

- Mini-Mental State Examination. Available for purchase from http://www4.parinc.com/products/Product.aspx?ProductID=MMSE-2
- Mini-Cog. http://www.alz.org/documents_custom/minicog.pdf
- Revised Memory and Behavior Problems Checklist. https://www.alz.org/national/documents/C_ASSESS-RevisedMemoryandBehCheck.pdf
- Wechsler Adult Intelligence Scale (includes the digit span task). Available for purchase from http://www.pearsonclinical.com/psychology/products/100000392/wechsler-adult-intelligence-scalefourth-edition-wais-iv.html
- Cohen-Mansfield Agitation Inventory: Long Form with Expanded Descriptions of Behaviors. http://www.dementia-assessment.com.au/symptoms/cmai_manual.pdf
- Geriatric Depression Scale (Short Form). https://www.healthcare.uiowa.edu/igec/tools/depression/GDS.pdf
- Pain Assessment in Advanced Dementia Scale. https://www.healthcare.uiowa.edu/igec/tools/pain/PAINAD.pdf
- Revised Algase Wandering Scale. Available for purchase from http://www.springerpub.com/evidence-based-protocols-for-managing-wandering-behaviors.html and in the wandering guideline available at http://www.nursing.uiowa.edu/excellence/evidence-based-practice-guidelines
- Descriptive typology of wandering behavior. In: Hope RA, Fairburn CG. The nature of wandering in dementia: a community-based study. *Int J Geriatr Psychiatry* 1990 Jul-Aug;5(4):239-45. Also available at http://onlinelibrary.wiley.com/doi/10.1002/gps.930050406/abstract

Individualized Interventions

Interventions to manage wandering and prevent elopement should be tailored to the individual needs of the person with dementia. The following are examples of interventions; no single intervention is likely to be appropriate for all individuals.

Supervision

- Place the resident in a highly supervised area.
- Routinely assign the same staff members to the individual.
- Assign a staff member to check on the resident at a specified interval or to keep the resident in sight at all times.
- Perform nighttime checks at a specified interval.
- Watch for indications that the individual plans to leave (e.g., packing belongings).
- Determine whether the individual is trying to reach a location within the facility or home, and direct or escort him or her, if appropriate.

Activities

- Develop a consistent routine that follows the person's usual daily pattern.
- Regularly take him or her outside.
- Engage individual in

- safe wandering, especially during times of day when his or her behavior peaks;
- a structured exercise program (e.g., supervised walks at the same time every day);
- air mat therapy, which involves exercise and relaxation on an inflatable mat, such as those used in gymnastics;
- activities that address his or her needs or wishes;
- tasks that echo premorbid activities (e.g., simulated chores, tasks that mimic previous job duties);
- lifestyle activities and hobbies (e.g., dance class, gardening);
- purposeful tasks (e.g., sorting, building);
- music therapy;
- aromatherapy, especially with calming, soothing scents;
- massage; or
- ADLs (e.g., grooming).

- To reduce wandering during activities, play music or foster social interaction with staff or visitors.
- Encourage visits from family and friends, and invite them to participate in activities.
- Balance activities with quiet time for rest.

Safety

- Place the individual in a room that suits his or her travel patterns or is farther from exits and stairwells.
- To increase comfort and familiarity, decorate the individual's room with favorite personal items.
- Keep personal items that may cue exiting behavior (e.g., hat, keys, coat, purse) out of sight.
- Ensure the appropriateness of footwear and clothing for safe wandering.
- Give the person a form of identification to carry at all times that indicates what to do if he or she is found.
- Keep a photo of the resident in a secure area near main entrances and in an electronic database. Ensure confidentiality and compliance with federal and state laws.
- Train staff, including those who do not provide direct care, on resident-specific redirection techniques.

Unmet Needs

- Manage chronic and acute health problems (e.g., constipation, urinary tract infection).
- Screen for and address depression, pain, and vision problems.
- Use medication to treat symptoms that may contribute to wandering (e.g., delusions, anxiety, depression), but remember that no effective pharmacologic treatment exists for wandering.
- Limit the use of medications that increase confusion.
- Manage incontinence, or develop a toileting schedule.
- Ensure adequate hydration, and provide nutritional support; consider offering extra snacks and fluids.
- To keep the person's interest during meals, interact with him or her and have focused conversations about the meal, eating, and social aspects of the mealtime experience.
- Identify and address other unmet needs.

Sources: Alzheimer's Association. Dementia care practice recommendations for assisted living residences and nursing homes [online]. 2009 [cited 2014 Dec 9]. http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf; Boltz M. Wandering and elopement: litigation issues. New York: Hartford Institute for Geriatric Nursing, College of Nursing, New York University; 2005; Futrell M, Melillo KD, Remington R, et al. Evidence-based practice guideline: wandering. *J Gerontol Nurs* 2014 Nov;40(11):16-23. PubMed: http://www.ncbi.nlm.nih.gov/pubmed/25310096; New York State. Creating

effective systems to manage wandering behavior: guidance for long term care facilities in New York State [online]. 2005 May [cited 2014 Dec 11]. https://www.nccdp.org/WanderingBehavior5-10-05Final.pdf; Smith M, Schultz S. Hartford Center of Geriatric Nursing Excellence, University of Iowa. Great escapes: the wandering dilemma [brochure online]. 2009 [cited 2014 Dec 9]. http://www.healthcare.uiowa.edu/igec/publications/info-connect/assets/great_escapes.pdf

TOPICS AND METADATA

Topics

Culture of Safety
;
Incident Reporting and Management
;
Quality Assurance/Risk Management

Caresetting

Assisted-living Facility
;
Home Care
;
Rehabilitation Facility
;
Short-stay Facility
;
Skilled-nursing Facility

Roles

Healthcare Executive
;
Patient Safety Officer
;
Quality Assurance Manager
;
Risk Manager

Information Type

Guidance

PUBLICATION HISTORY   −

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Continuing Care Risk Management

ECRI Institute
The Discipline of Science. The Integrity of Independence.

► VOLUME 1
May 2015

▶ Wandering and Elopement

Initial assessment
by: _____

Date: _____

In consultation
with: _____

_____

_____

Date of previous
assessment: _____

ECRI Institute's INsight™ Survey

ECRI Institute's assessment tools provide a multidisci-plinary perspective for identifying and managing risks related to this topic and other healthcare services. ECRI Institute's INsight™ survey, a web-based risk assess-ment tool, provides an easy-to-use, unbiased method to survey staff ranging from frontline nurses to the organi-zation's leadership. The survey tool generates reports, benchmarking data, and recommendations to manage risks. More information about INsight is available at http://www.ecri.org/INsight.

People who wander unsafely or in unsafe environments may face a higher risk of injury and may elope, get lost, or become trapped in unsafe areas (e.g., a freezer, a toolshed). People with dementia who elope are at risk for outcomes such as injuries, dehydration, exposure, medical complications, drowning, or being hit by a car (CMS). The longer a person is missing, the greater the risk.

Further, incidents involving unsafe wandering or elopement can lead to regulatory sanctions, litiga-tion, or both. Regulatory sanctions depend on the type of organization and which agencies regulate it but can be severe. Closed claims based on elopement allegations are associated with high payouts.

However, an individual's wandering may represent "a behavioral expression of a basic human need" (Alzheimer's Association). Wandering may have health benefits (e.g., maintenance of mobility) and may support the individual's independence and sense of control. Often, it is preferable to support an individual's safe wandering than to try to stop it.

This self-assessment questionnaire (SAQ) focuses on managing wandering and preventing elope-ment in older adults with dementia in long-term care settings and offers considerations for other settings as well. Because strategies to manage wandering and prevent elopement vary based on organi-zational factors and the individual needs of people with dementia, this SAQ presents key suggestions; it is not exhaustive.

Organizations may wish to complete this SAQ at least annually. Potential participants include the risk manager, the director of nursing, the medical director, nursing supervisors, facilities and building management personnel, the patient or resident safety officer, and security personnel. To assess care provided to people with dementia, users may wish to review records for a sample of individuals at risk for unsafe wandering or elopement. For more information, see the guidance article "Wandering and Elopement."

The following sources were used to develop the questions in this SAQ. This list is not comprehensive.

▶ Alzheimer's Association. Dementia care practice recommendations for assisted living residences and nursing homes [online]. 2009 [cited 2014 Dec 9]. http://www.alz.org/national/documents/brochure_DCPRphases1n2.pdf

▶ Centers for Medicare and Medicaid Services (CMS). Guidance to surveyors for long term care facilities. Appendix PP. In: State operations manual [online]. 2014 Dec 12 [cited 2014 Dec 18]. https://www.cms.gov/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

▶ Futrell M, Melillo KD, Remington R, et al. Evidence-based practice guideline: wandering. *J Gerontol Nurs* 2014 Nov;40(11):16-23. Also available at http://www.healio.com/nursing/journals/jgn/2014-11-40-11/%7B5a5affec-1ce2-43d6-aca1-3b52f80b7c56%7D/wandering PubMed: http://www.ncbi.nlm.nih.gov/pubmed/25310096

▶ New York State. Creating effective systems to manage wandering behavior: guidance for long term care facilities in New York State [online]. 2005 May [cited 2014 Dec 11]. https://www.nccdp.org/WanderingBehavior5-10-05Final.pdf

▶ Smith M, Schultz S. Hartford Center of Geriatric Nursing Excellence, University of Iowa. Great escapes: the wandering dilemma [brochure online]. 2009 [cited 2014 Dec 9]. http://www.healthcare.uiowa.edu/igec/publications/info-connect/assets/great_escapes.pdf

	YES	NO	N/I*	N/A	COMMENTS

CLAIMS AND LAWSUITS

1. When new residents or clients with a history of wandering or elopement begin to receive services from the organization, are they and their family members informed of:

		YES	NO	N/I*	N/A	COMMENTS
a.	The risks that the individual may still face?	☐	☐	☐	☐	_____
b.	The organization's plan for promoting the person's safety?	☐	☐	☐	☐	_____

2. Does the organization track its history of claims related to wandering and elopement?

	YES	NO	N/I*	N/A	COMMENTS
	☐	☐	☐	☐	_____

3. Does the organization evaluate the following incidents related to wandering and elopement to identify system issues and potential strategies:

		YES	NO	N/I*	N/A	COMMENTS
a.	Events?	☐	☐	☐	☐	_____
b.	Near misses?	☐	☐	☐	☐	_____
c.	Individual claims?	☐	☐	☐	☐	_____
d.	The organization's claims history?	☐	☐	☐	☐	_____

* N/I stands for "Needs Improvement."

	YES	NO	N/I	N/A	COMMENTS
4. Does the organization respond to all incidents and near misses promptly and appropriately—for example, by reevaluating the individual's planned interventions?	☐	☐	☐	☐	_____
5. Does the organization conduct reactive analyses of incidents and near misses?	☐	☐	☐	☐	_____
5.1. Does the organization take steps to incorporate lessons learned from reactive analyses?	☐	☐	☐	☐	_____

REGULATIONS AND STANDARDS

	YES	NO	N/I	N/A	COMMENTS
6. Are individuals who are responsible for developing relevant policies familiar with:					
a. The definitions of wandering and elopement used by the agencies that regulate or accredit the organization?	☐	☐	☐	☐	_____
b. Applicable regulatory and accreditation requirements?	☐	☐	☐	☐	_____
c. What surveyors will look for?	☐	☐	☐	☐	_____
7. Does the organization have a process for:					
a. Being alerted to regulatory and accreditation changes and updates to surveyor guidance?	☐	☐	☐	☐	_____
b. Evaluating the need to revise practices in response to changes in regulations or accreditation standards?	☐	☐	☐	☐	_____

OPTIMIZED ENVIRONMENT

	YES	NO	N/I	N/A	COMMENTS
8. Are there areas of the physical environment that support:					
a. Safe and well-supervised walking and wandering?	☐	☐	☐	☐	_____
b. Social interaction?	☐	☐	☐	☐	_____
c. Stimulation (but not overstimulation)?	☐	☐	☐	☐	_____
8.1. Are there also comfortable, inviting spaces where individuals can rest?	☐	☐	☐	☐	_____

(continued)

		YES	NO	N/I	N/A	COMMENTS
9.	Does the organization periodically conduct safety rounds, including assessment of environmental conditions that may pose hazards to people at risk for unsafe wandering or elopement?	☐	☐	☐	☐	_____
9.1.	Does the organization periodically assess surrounding areas for hazards to at-risk individuals (e.g., ponds with unrestricted access, construction sites)?	☐	☐	☐	☐	_____
9.2.	Does the organization take steps to remove or mitigate identified hazards?	☐	☐	☐	☐	_____
9.3.	Does the organization implement additional interventions when temporary hazards (e.g., housekeeping, painting) are present?	☐	☐	☐	☐	_____
9.4.	Are all staff involved in identifying environmental hazards?	☐	☐	☐	☐	_____
10.	When planning environmental modifications, does the organization consider:					
	a. The prevalence of wandering in each area?	☐	☐	☐	☐	_____
	b. The potential effects of the modifications on residents' wayfinding?	☐	☐	☐	☐	_____
	c. The number of residents at risk?	☐	☐	☐	☐	_____
	d. Residents' cognitive and mobility statuses?	☐	☐	☐	☐	_____
11.	Does the organization cultivate an engaging ambience in areas where it wishes to support safe wandering?	☐	☐	☐	☐	_____
12.	Does the organization cultivate a soothing ambience in areas where it wishes to reduce wandering?	☐	☐	☐	☐	_____
13.	Does the organization investigate applicable building and life safety codes, plus relevant laws and regulations, before making environmental modifications?	☐	☐	☐	☐	_____
14.	Are the following unobtrusive or disguised:					
	a. Exits, doorknobs, and panic bars?	☐	☐	☐	☐	_____
	b. Safety features?	☐	☐	☐	☐	_____

	YES	NO	N/I	N/A	COMMENTS
15. Can individuals choose from a variety of activities to participate in?	☐	☐	☐	☐	_____
16. Can individuals choose which spaces to go to?	☐	☐	☐	☐	_____
17. Is the indoor temperature kept at a comfortable level, day and night?	☐	☐	☐	☐	_____
18. Has the organization instituted strategies to aid residents' wayfinding?	☐	☐	☐	☐	_____
19. When constructing or renovating buildings, does the organization eliminate or minimize hallways?	☐	☐	☐	☐	_____
19.1. When constructing or renovating buildings, does the organization place doors on the walls, rather than at the end, of hallways?	☐	☐	☐	☐	_____
20. Are resident areas and pathways free of clutter and other trip and slip hazards?	☐	☐	☐	☐	_____
21. Are pathways to important locations (e.g., bathroom, dining room) free of distractions?	☐	☐	☐	☐	_____
22. Are surfaces even, particularly at transitions (e.g., from concrete to grass)?	☐	☐	☐	☐	_____
23. Do terraces and porches include safeguards to prevent exiting (e.g., tall barriers, affixed furniture, surveillance)?	☐	☐	☐	☐	_____
24. Has the organization implemented visual elements to deter exit-seeking from doors (e.g., gridlines taped on the floor, "stop signs")?	☐	☐	☐	☐	_____
25. Has the organization implemented code-compliant strategies (e.g., use of safety locks) to prevent residents from defeating locks, if used?	☐	☐	☐	☐	_____
26. Are windows prevented from opening all the way (in compliance with codes)?	☐	☐	☐	☐	_____
27. Does the organization inform visitors not to let residents leave when they exit?	☐	☐	☐	☐	_____

(continued)

	YES	NO	N/I	N/A	COMMENTS

27.1. Does the organization instruct visitors on what to do if a resident leaves or attempts to leave? ☐ ☐ ☐ ☐ _____

28. Do elevators and doors that lead to exits or stairwells require keypad access? ☐ ☐ ☐ ☐ _____

POLICIES AND PROCEDURES

29. Are systems to address hazardous wandering and elopement:

   a. Multidimensional? ☐ ☐ ☐ ☐ _____

   b. Tailored to the population served? ☐ ☐ ☐ ☐ _____

   c. Flexible (to allow customization of strategies based on individual needs)? ☐ ☐ ☐ ☐ _____

30. Does the organization engage people with dementia, family members, and all staff in identifying solutions? ☐ ☐ ☐ ☐ _____

31. Do written policies on wandering and elopement address:

   a. Admission and discharge criteria and/or scope of service? ☐ ☐ ☐ ☐ _____

   b. Staff education and training? ☐ ☐ ☐ ☐ _____

   c. Organizational safeguards? ☐ ☐ ☐ ☐ _____

   d. Individualized assessment and interventions? ☐ ☐ ☐ ☐ _____

   e. Communication regarding individuals who are at risk, including care plans and interventions? ☐ ☐ ☐ ☐ _____

   f. Supervision? ☐ ☐ ☐ ☐ _____

   g. Individual and group outings (with staff)? ☐ ☐ ☐ ☐ _____

   h. Resident leave (without staff)? ☐ ☐ ☐ ☐ _____

   i. Incident response and drills? ☐ ☐ ☐ ☐ _____

   j. Special circumstances (e.g., drills, actual disasters, special events)? ☐ ☐ ☐ ☐ _____

32. Are policies and procedures reevaluated on a routine basis? ☐ ☐ ☐ ☐ _____

32.1. Does the organization ensure that policies and procedures are consistent with all applicable laws? ☐ ☐ ☐ ☐ _____

	YES	NO	N/I	N/A	COMMENTS

STAFF TRAINING

33. Do all staff (on all shifts) who may interact with people with dementia—including dietary, housekeeping, and maintenance personnel—receive education on wandering and elopement? ☐ ☐ ☐ ☐ _____

34. Is education provided:

 a. At orientation? ☐ ☐ ☐ ☐ _____

 b. At additional intervals, which are defined in policies? ☐ ☐ ☐ ☐ _____

35. Do topics covered during staff education include:

 a. The organization's policies and procedures? ☐ ☐ ☐ ☐ _____

 b. Effects of dementia on an individual's health, physical function, and emotional state and changes in physical and mental health that may affect dementia? ☐ ☐ ☐ ☐ _____

 c. For professional staff, the clinical presentation of dementia and other issues that can resemble or accompany it? ☐ ☐ ☐ ☐ _____

 d. Wandering as a behavior driven by an attempt to satisfy needs rather than a negative behavior? ☐ ☐ ☐ ☐ _____

 e. Ways to support safe wandering? ☐ ☐ ☐ ☐ _____

 f. Individualized assessment and development of interventions? ☐ ☐ ☐ ☐ _____

 g. Documentation of behaviors, assessments, interventions, and outcomes? ☐ ☐ ☐ ☐ _____

 h. Common methods of exiting? ☐ ☐ ☐ ☐ _____

 i. Use and maintenance of relevant equipment? ☐ ☐ ☐ ☐ _____

 j. Proper response to alarms and the importance of not ignoring alarms? ☐ ☐ ☐ ☐ _____

 k. Incident response? ☐ ☐ ☐ ☐ _____

 l. Individuals' rights? ☐ ☐ ☐ ☐ _____

 m. Restraint alternatives and individuals' right to be free from unnecessary restraints? ☐ ☐ ☐ ☐ _____

(continued)

		YES	NO	N/I	N/A	COMMENTS
36.	Does the organization maintain records of staff education?	☐	☐	☐	☐	_____
37.	Does the organization create and track leading indicators to evaluate the effectiveness of training (see the guidance article "Getting the Most out of Root-Cause Analyses" for more information on leading indicators)?	☐	☐	☐	☐	_____

INDIVIDUALIZED ASSESSMENT

38.	Before admission, do staff ask the individual's family or the transferring organization, if applicable, about:					
	a. The individual's history of wandering and elopement?	☐	☐	☐	☐	_____
	b. Patterns and triggers of such behavior?	☐	☐	☐	☐	_____
	c. Strategies family members or staff have used to manage such behavior?	☐	☐	☐	☐	_____
39.	Before admission, do staff educate the individual's loved ones about:					
	a. The individual's known risk for unsafe wandering or elopement?	☐	☐	☐	☐	_____
	b. General protective measures used by the organization?	☐	☐	☐	☐	_____
	c. What family members can reasonably expect of the organization with regard to the individual's risk of wandering and elopement?	☐	☐	☐	☐	_____
40.	Does the organization discuss wandering and elopement with residents who do not wander and their families?	☐	☐	☐	☐	_____
41.	Does the organization document pre-admission conversations with residents, family members, and transferring organizations?	☐	☐	☐	☐	_____
42.	Do assessments for risk of unsafe wandering and elopement include evaluation of:					
	a. Medical, psychiatric, or psychosocial problems?	☐	☐	☐	☐	_____

		YES	NO	N/I	N/A	COMMENTS
b.	Premorbid personality and behavior?	☐	☐	☐	☐	_____
c.	Cognitive impairment?	☐	☐	☐	☐	_____
d.	Memory and behavior problems?	☐	☐	☐	☐	_____
e.	Attention?	☐	☐	☐	☐	_____
f.	Agitation?	☐	☐	☐	☐	_____
g.	Depressive symptoms?	☐	☐	☐	☐	_____
h.	Other factors associated with wandering (e.g., inactivity, socially inappropriate behavior, resistance to care, impairment in performing activities of daily living)?	☐	☐	☐	☐	_____
i.	Unmet needs, pain, or other physiologic processes?	☐	☐	☐	☐	_____
j.	Wandering behavior?	☐	☐	☐	☐	_____
k.	Wandering patterns?	☐	☐	☐	☐	_____
l.	Wandering typology?	☐	☐	☐	☐	_____
m.	Environmental strategies currently in use?	☐	☐	☐	☐	_____
43.	Are the results of assessments clearly documented?	☐	☐	☐	☐	_____
44.	Do staff meet with the family after each assessment to inform them of the individual's risk for unsafe wandering and elopement?	☐	☐	☐	☐	_____

SELECTION OF INTERVENTIONS

45.	Do staff involve family members in developing interventions and updating service or care plans?	☐	☐	☐	☐	_____
45.1.	Do staff ask family members about the individual's life history (e.g., past occupation, daily routines, interests) to help guide the selection of interventions?	☐	☐	☐	☐	_____
46.	Are interventions individualized?	☐	☐	☐	☐	_____
47.	Does intervention planning focus on serving the individual's needs rather than eliminating "problem" behavior?	☐	☐	☐	☐	_____

(continued)

	YES	NO	N/I	N/A	COMMENTS
48. Are people at risk for unsafe wandering or elopement supervised according to their individual needs?	☐	☐	☐	☐	_____
49. Does the organization facilitate both activities (including safe wandering) and rest?	☐	☐	☐	☐	_____
49.1. Are all staff trained on techniques for redirecting individuals when necessary?	☐	☐	☐	☐	_____
50. Does the organization take steps to proactively meet individuals' needs (e.g., easy access to snacks and hydrating foods and fluids, toileting schedule if needed)?	☐	☐	☐	☐	_____
51. Does the organization effectively manage pain and chronic and acute health problems that may contribute to wandering (e.g., constipation, urinary tract infection)?	☐	☐	☐	☐	_____
52. Does the organization limit the use of medications that increase confusion in at-risk individuals?	☐	☐	☐	☐	_____
53. Do staff take steps to identify and address other unmet needs in at-risk individuals?	☐	☐	☐	☐	_____
54. Are additional interventions or supervision implemented during the first few days after admission or a move to a different room or unit?	☐	☐	☐	☐	_____
55. Does the organization have a process for ensuring that staff are aware of the individual's behavior, needs, and planned interventions and are informed of any changes?	☐	☐	☐	☐	_____
56. After interventions have been implemented, do staff evaluate their effectiveness by monitoring:					
a. Wandering behavior?	☐	☐	☐	☐	_____
b. Safety?	☐	☐	☐	☐	_____
c. Wayfinding?	☐	☐	☐	☐	_____
d. Disorientation?	☐	☐	☐	☐	_____
e. Maintenance of body weight?	☐	☐	☐	☐	_____

		YES	NO	N/I	N/A	COMMENTS
56.1.	Are the individual's responses to interventions documented?	☐	☐	☐	☐	_____
57.	If planned interventions are ineffective, does the organization modify the interventions and update the service or care plan as necessary?	☐	☐	☐	☐	_____
58.	Is the effectiveness of current interventions periodically reassessed?	☐	☐	☐	☐	_____

TECHNOLOGY USE

		YES	NO	N/I	N/A	COMMENTS
59.	Has the organization considered the ethical issues involving the use of technology to monitor individuals with dementia (see the guidance article "Wandering and Elopement" for more information)?	☐	☐	☐	☐	_____
59.1.	Has it sought input from residents or clients and family members regarding the ethical issues?	☐	☐	☐	☐	_____
60.	Do staff understand that such technologies are a complement to—not a substitute for—supervision?	☐	☐	☐	☐	_____
60.1.	Is the effectiveness of technologies in managing an individual's behavior evaluated along with other planned interventions?	☐	☐	☐	☐	_____
61.	Are checks and maintenance of equipment clearly documented?	☐	☐	☐	☐	_____
61.1.	Has a charging schedule been established for all devices that require recharging?	☐	☐	☐	☐	_____
61.2.	Does the organization have a system for alerting staff to the need to replace devices or batteries before they expire, if applicable?	☐	☐	☐	☐	_____
62.	If alarms of any kind are used, are they minimally intrusive and minimally distressing to people with dementia (e.g., silent, verbal)?	☐	☐	☐	☐	_____
63.	Does the procedure for responding to alarms assign clear responsibility to specific individuals for responding to and turning off alarms?	☐	☐	☐	☐	_____

(continued)

	YES	NO	N/I	N/A	COMMENTS
64. Does the organization have contingency plans for times when the system or individual units are out of service (e.g., during disaster drills)?	☐	☐	☐	☐	_____

MISSING-PERSON RESPONSE PLANS

	YES	NO	N/I	N/A	COMMENTS
65. Are buildings, the campus, and surrounding areas periodically assessed for hazards to individuals at risk of unsafe wandering or elopement (e.g., ponds with unrestricted access, construction sites) to inform development of and updates to the response plan?	☐	☐	☐	☐	_____
66. Has the organization met with local law enforcement to identify when and how facility staff should contact police in the event that an individual goes missing?	☐	☐	☐	☐	_____
66.1. Has the organization arranged methods for quickly sending to law enforcement:					
a. A recent photograph of the individual?	☐	☐	☐	☐	_____
b. A full description of the individual?	☐	☐	☐	☐	_____
c. Information on where and when the person was last seen and what he or she was doing?	☐	☐	☐	☐	_____
d. Information on the individual's history of wandering or elopement?	☐	☐	☐	☐	_____
67. Does the response plan define:					
a. What constitutes a missing-person incident?	☐	☐	☐	☐	_____
b. What requires activation of response procedures?	☐	☐	☐	☐	_____
68. Does the response plan assign clear responsibilities for specific tasks?	☐	☐	☐	☐	_____
69. Do steps in the response plan address:					
a. Thorough searches of the care unit and immediate area?	☐	☐	☐	☐	_____
b. Use of an internal system (e.g., a paging system) to prompt staff to begin response procedures?	☐	☐	☐	☐	_____

	YES	NO	N/I	N/A	COMMENTS
c. Searches of all spaces, even those that are usually inaccessible to residents or clients?	☐	☐	☐	☐	_____
d. Method for indicating that an area has been searched (e.g., checklist, shaded sections on a floor plan)?	☐	☐	☐	☐	_____
e. Procedures for notifying management?	☐	☐	☐	☐	_____
f. Procedures for notifying the attending physician?	☐	☐	☐	☐	_____
g. Procedures for notifying family members?	☐	☐	☐	☐	_____
h. Procedures for notifying law enforcement and the state agency, as required by law?	☐	☐	☐	☐	_____
i. If the person is found, how to obtain a complete medical evaluation?	☐	☐	☐	☐	_____
j. If the person is found, procedures for notifying previously contacted parties of his or her return?	☐	☐	☐	☐	_____
k. Documentation of all actions taken?	☐	☐	☐	☐	_____
l. Event reporting?	☐	☐	☐	☐	_____
m. Reactive analysis of the incident?	☐	☐	☐	☐	_____
n. Reassessment of the individual and adjustment of interventions and the service or care plan, if necessary?	☐	☐	☐	☐	_____
70. Does the organization practice incident response through routine drills?	☐	☐	☐	☐	_____
70.1. Does the organization assign someone dedicated responsibility for assessing system vulnerabilities during the drill?	☐	☐	☐	☐	_____
70.2. Does the organization address deficiencies identified during drills?	☐	☐	☐	☐	_____
70.3. Does the organization ensure that drills themselves do not jeopardize the safety of residents or clients?	☐	☐	☐	☐	_____

Action Plan

WANDERING AND ELOPEMENT

Assessment completed by: _____   Date: _____

QUESTION NO.	ACTION REQUIRED	RESPONSIBILITY	TARGET DATE	ACTION COMPLETED	
				DATE	INITIALS

QUESTION NO.	ACTION REQUIRED	RESPONSIBILITY	TARGET DATE	ACTION COMPLETED	
				DATE	INITIALS