PCH Mutual Insurance Company, Inc. RRG

Elopement/Wandering

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SAFE WANDERING & ELOPEMENT PREVENTION

Wandering by a resident with dementia can result in elopement from your facility. If the resident is not found quickly, injury or possibly death can occur.

This document will help you with the management of wandering & the prevention of elopement.

Potential Cost & Impact

The short and long term effects of wandering and elopement on residents are obvious and can be devastating. The short and long term effects on your organization are equally obvious and devastating.

Short Term Costs:

1. Investigation Costs
2. Building modifications
3. Staff training
4. Legal representation expense
5. Punitive financial penalties
6. Individual prosecution of supervising and executive management

Long Term Costs & Impact on the Organization:

1) Impaired reputation
2) Negative moral impact on the staff
3) Inability to obtain related insurance
4) Loss of existing and future residents
5) Negative publicity in the community
6) Loss of Licensure

Management Techniques

As with any general safety issue the problem needs to be clearly identified. In this case, it is wandering and elopement. Executive management must first acknowledge the exposure for it to have credence with lower management, direct care workers, volunteers, independently contracted providers of service, the residents and their families. It is best accomplished through a written statement, employee handbook, standard operating procedures, job descriptions and contractual agreements. Any recognition and prevention efforts must first be embraced at the top, for them to be observed through the operation.

Next, the statement, prevention activities and control techniques must be implemented. Implementation must involve written procedures and tangible activities.
Communication, documentation and monitoring are the other key elements of successful implementation.

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Prevention Statement

It is the expressed policy of this organization that residents that display wandering tendencies will do so safely within the building. Risk of elopement will be minimized and if the resident cannot live safely within the building he/she should be transferred to a secure facility.

Definitions

1) Wandering - The movement from area to area by an individual without any defined purpose. It may help the individual to reduce anxiety, provide exercise and keep them busy safely.
2) Critical Wandering – Wandering with the specific purpose of leaving the facility. It can be life threatening and must be prevented.
3) Elopement – Leaving the facility without the knowledge of staff or family. Individual may or may not be aware of the dangers associated with leaving the facility. If individual is not found within 48 hours he/she may be found deceased.

RULES

The following rules are prevention techniques

1) Staff should be aware that the first week upon admission of any resident is critical for observing the resident's adjustment and propensity for elopement.
2) If a resident is known to wander and has a history of elopement, staff must daily write what the resident is wearing (ex: blue plaid shirt, navy pants, red suspenders, white tennis shoes).
3) Take a picture of every resident on admission. One should be a close up of the face and one full body picture showing height, stance and distinguishing characteristics (ex: widow's hump, bow legs, any durable medical equipment used such as walker or cane etc.).
4) If a facility admits residents who wander, the building must have alarmed doors or secured locked doors.
5) Notify local police and neighbors when a resident who wanders is admitted to the facility so they can be alerted if the resident does elope from the facility. If a resident leaves/wanders from the facility and will not come back with the police, obtain a copy of the police report and any forms the resident signed for the police.
6) If it is the policy for your facility to have a resident use "time out" after an altercation, and this resident may wander, the resident must have "time out" in the residence or if does go outside must be observed by a staff member until safely back inside the facility.

PREVENTION DESIGN CONCEPTS

1) Remove or keep trigger items out of sight of residents who wander (ex: hats, coats, purses, keys etc.). Have staff's personal belongings in an area that residents cannot see and have visitors hang coats in lobby area rather than taking their coats to resident areas.
2) Put large signs on bathroom doors and keep night lights on in bedrooms.
3) Reduce inside noises by keeping televisions and music low and on stations that are appropriate for the residents.
4) Try to keep consistent staff each shift caring for residents who wander as they need the security of familiar staff.
5) Regularly check doors/gates/alarms to ensure they are in proper working order.
6) If able, install fencing or hedging around the property.
7) Install special door handles – if it does not look like a handle they will not know how to use it. Use child safety devices, if allowed by your regulations.
8) Conceal doors – paint or wallpaper the same as surrounding walls, put a Velcro stop sign on or over the door and avoid windows in doors.
9) If designing the facility, put doors in the middle of the hallways rather than the end. Have doors be flush with the walls, not recessed.
10) Put alarms on the doors.
11) Use video surveillance on exits if able.
12) When placing residents in time-out, outside the building, keep them under observation.

TRAINING

Staff should be trained on wandering and elopement, behavioral measurers and environmental controls to ensure safe wandering.

Staff needs to be trained on behavioral profile of a resident with Alzheimer's or Dementia when they have eloped from the facility.

Staff needs to know how to respond when a resident elopes from the facility. They must know how to search inside and outside for the resident to ensure resident safety and survivability.

Train staff with enclosed In-Service On Wandering And Elopement.

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PROTOCOL FOR SEARCH ING A FACILITY

1) Start on top floor, furthest corner.
2) Thoroughly search room to room
    a. Look under beds
    b. Look in closets – moving clothes and anything on the floor
    c. Look behind chairs, sofas, anything not flush with the wall
    d. Look behind curtains (if they are ceiling to floor length)
    e. Look in bathrooms, in tubs and behind shower curtains
    f. * If a resident is lying in the bed, check to be sure it is not the resident that you are looking for and make sure that only I person is in the bed (your wanderer may have crawled in a bed with someone else).
3) After the room is checked, close the door so you know it has been searched.
4) Check linen closets, supply rooms, clean & dirty utility rooms, hallway bathrooms, med rooms etc. **DO NOT** assume because a door is normally locked that the wanderer is not in the room.
5) When a floor has been searched, move to the next checking the stairwells (elevator if you have one) and again repeating steps 2 – 4.
6) Search general rooms such as activity room, dining room, office area, laundry etc.
7) Search the basement, again looking in every nook & cranny, locked and unlocked rooms.
8) If the resident is not found, start a search party outside and have someone again search the building room to room.
9) Contact the Police and file a missing person report, obtain a copy of the report and keep in resident file.
10) Should a resident decline to return, have the resident sign that they have elected not to return to the facility and notify the Family using the Notice to Family Regarding Resident and Call and Communication Log.

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IN-SERVICE
ON
WANDERING & ELOPEMENT

Wandering can be normal behavior – we have all seen a confused resident going room to room or chair to chair. Wandering in itself is not harmful. Wandering in fact can be very helpful to the resident as follows:

a) Can reduce anxiety
b) Provides needed exercise
c) Can keep the individual busy and feeling that they have a purpose

The wandering referred to above is wandering that does not have the purpose of leaving the building.

CRITICAL WANDERING is wandering with the purpose of leaving the building. CRITICAL WANDERING IS LIFE THREATENING AND MUST BE PREVENTED.

STEPS FOR SAFE WANDERING

If you admit a resident who wanders it is critical to follow these steps:

1. Talk with the family/responsible party honestly about who we are as Assisted Living Facilities – just like at home, a person cannot guarantee the individual will stay in the home, the assisted living facility cannot either (unless you have a locked unit).
2. Write into your contract, "The Assisted Living Facility will take measures to ensure a resident cannot leave, but because an Assisted Living Facility cannot lock a resident in the facility by law, they may wander outside or of the facility premises. If the Resident leaves the facility, the facility is not responsible." Have the resident /responsible party sign-off on this statement.
3. Notify the policy that you have a resident prone to wander at your facility and provide them a picture and description of the resident for their file.
4. Place the neighbors of the facility and nearby businesses on notice that you have a resident that may come to "visit" and ask them to call if they do. This will help to provide a prompt response if the resident does leave the facility.

Critical wandering can be broken down into three main categories. Before identifying these three categories, it is extremely important for you to do everything you can inside the building to prevent the resident from leaving.

Three Categories of Critical Wandering are as follow:

1. Behavioral – The identification of the factors that lead to wandering
2. Environmental – Modifying the environment to enable the individual to move about safely within the Assisted Living Facility.

3. Exit Control – Reducing unsupervised access to external areas of the Assisted Living Facility as appropriate.

Behavioral Measures to Control Critical Wandering:

a) Determine what triggers the wandering.
   1. Have they been placed in a new environment (they are new to your Assisted Living Facility)?
   2. Can they easily see staff/visitors gathering their coats and purses and leaving for the day, so they decide it is time for them to leave also?
   3. Have they had a change in their routine?
   4. Have they had a recent change in their medication?
   5. Are they ill? UTI's cause confusion and because they have to utilize the bathroom frequently, they may leave the facility by mistake looking for the bathroom.
   6. Did they overhear a disagreement or argument, (staff and family) and feel responsible, so they look to leave?
   7. Are they stressed, does time confuse them, are they disoriented to the facility and staff, are they restless?
   8. If you are not able to identify what is causing the resident to wander, begin a log of the day's pattern and how they are affected by something going on. Staff must be specific about time, events before wandering, visitors, activities, etc when completing the log. In reviewing the log you will probably locate the source.

b) Now that you have identified the Trigger, develop a plan to stop the wandering using the following steps:
   1. Check with the doctor about the side effects before a resident is put on a new medication. Also inquire with the doctor if you see new or bizarre behavior after a new medication si started.
   2. Make sure the resident is kept hydrated and fed, taken to the bathroom frequently and dressed appropriately. If the resident is uncomfortable for any reason (hungry, thirsty, having to void, hot/cold, etc) they will move about to find relief for that discomfort. Put signs on the bathroom doors so they can recognize what are behind the door, keep snacks available and offer liquids frequently.
   3. Encourage activity – exercise reduces anxiety which results in reducing wandering.
   4. Redirect the wandering by offering foods, liquids, activities, etc. DO NOT ARGUE WITH THE RESIDENT AS IT ONLY REENFORCES THEIR NEED TO LEAVE.
   5. Place interesting items near the exits – baby dolls, rocking chairs, pictures of the past, games, etc. The intention is to divert them from leaving, therefore, find what interests them and place it near the exit.

6. Orient them to the time, date and day. Have the staff wear nametags the resident can see and read. Often time when they can recognize people and names, the wandering decreases.
7. Make sure the residents glasses, hearing aides and dentures fit properly. When they can see, hear and eat comfortably, the wandering tends to decease.
8. When the need to divert the resident arises, always approach from the front. Approaching from behind may result in startling the resident and they may react aggressively. Talk in a clam, low voice. Reassure the individual and touch them gently.
9. Provide rocking chairs as the movement makes them feel as if they are going somewhere and provides them exercise.
10. Provide as much one on one time as you are able to the resident.

c) Inside Environment Modifications:

1. Keep clocks and calendars on each floor. Clocks should be digital to reduce confusion.
2. Remove trigger items – hats, coats, purses, keys, etc. Have a designated room for the staff to keep their personal items and to enter and leave the facility at shift change. It is preferable that visitors items also be kept out of site of the residents also.
3. Place large signs on bathroom doors and keep night lights on in bath rooms.
4. Place a picture of the resident when they were younger or a collage of family photos next the residents door to their room.
5. Reduce inside noises – keep the television turned down and music low.
6. Keep the bedroom and furniture at the same places to avoid confusion.
7. Assign the same staff person each shift to care for the wandering resident.
8. Regularly check the doors, gates and alarms to assure they are working as intended
9. Place a large STOP sign on the exit doors.
10. Ask another resident to help in watching over a confused resident. We all know that the residents know everything that is going on and they can be your best insurance of a resident being safe.

d) Exit Control

1. Install fencing or hedges around the property
2. Install special door handles – if the handle does not look like a handle, they will often not use it and pas it by. Child safety devices over the handles of the doors make it difficult to open and may deter the resident.
3. Conceal the door – paint it the same color as the walls or place curtains over the door.
4. Avoid having windows on the door if possible.

5. Put alarms on doorways – Wanderguard has a device with a bracelet the resident wears, or if the resident does not know to key in a code, the door will alarm.
6. Use video surveillance on exits.

BAHAVIORAL PROFILE OF AN ALZEIMER OR RELATED DISEASE REESIDENT THAT LEAVES THE FACILITY

1. Will keep moving until they get stuck.
2. They do not know how to turn around anymore.
3. Oriented to the past.
4. Usually found in a creek or drainage area and arecaught in briars or bushes or they have fallen and are unable to get up.
5. Their mobility is limited to other medical problems.
6. Usually found within 1 mile of were they had last been seen, half are found within ½ mile and are usually found 33 yards off the road.
7. May attempt to go to where they last remember living or a relative lives.
8. They do not leave many clues.
9. They DO NOT CRY OUT FOR HELP or ANSWER CALLS OF THEIR NAME.
10. Should they die, it is usually a response to the environment (hypothermia, drowning or dehydration).
11. Other Common Findings include:
    a) Most will leave between the hours of 7 a.m. and 12 midnight, however, it can occur at any time.
    b) Most leave during the warm months or after a warm day during the cooler months.
    c) There seems to be a tendency to follow the sun. This has been called the "Florida Factor". Alzheimer residents tend to like light, however, this is not an absolute.
12. Survivability:
    a) There is a direct relation between the time a person leaves the assisted living facility and the time they are found and if they live or die.
    b) Weather also has s significant impact on life or death.
    c) Virginia Study:
        1. Residents located within 12 hours all survived.
        2. From 12-24 hours 20% died.
        3. From 24-48 hours 32% died.
        4. From 48-72 hours 40% died.
        5. At 72 hours 80% died.
        6. If Search & Rescue (SAR) was notified within the first 12 hours, everyone survived, however, if SAR was not notified till 50 hours after 90% died.

RESPONSE PLANNING TO CRITICAL WANDERING

1. Have a written plan that you instruct staff on when they are hired and review annually there after. The administrator should review a minimum of two times annually for changes and accuracy for the residents.
2. Take a photograph of residents and maintain it with a profile of the resident in their file. The profile should include all info on the transfer sheet including their height, weight, color of eyes and hair, birthmarks, hearing aides, glasses, dentures, type of shoes normally worn, where they previously lived, address of closest relative, any serious contributing health factors (i.e. diabetes, heart condition, dialysis, etc.), when and how much they last ate, when they last had medication and the type of medication, what they had been last seen wearing. If a resident is classified as high risk of wandering on the Level of Care Assessment or the Wandering Risk Assessment forms, have the staff document every day exactly what the resident is wearing.
3. Enroll the resident in the Alzheimer's Safe Return Program. They provide a bracelet, iron on clothing labels; stickers, etc. go to http://www.alz.org/Services/SafeReturn.asp or call 800-272-3900.

YOU HAVE DONE EVERYTHING YOU CAN TO KEEP YOUR RESIDENTS SAFE, BUT
ONE WANDERS AWAY.

WHAT DO YOU DO?

1. DO NOT PANIC. Your staff needs you to be calm and give direction. Do a highly systematic search of the Assisted Living Facility. Search every closet, bed, behind and under chairs and couches, shower stalls and bathtubs, other residents rooms, common areas, etc. Do a floor-by-floor search. DO NOT exclude looking anywhere – they may be where you least expect to find them.
2. Thoroughly search the immediate outside of the building, keeping in mind that they will go until they get stuck or fall down.
3. IF YOU HAVE NOT FOUND THEM AFTER SEARCH THE FACILITY THOROUGHLY, CALL THE POLICE AND FAMILY.
4. Patrol along roadways, search where there are natural breaks in trees, bushes, brush or shrubs, as they will enter these areas.
5. Send staff to where they had been last found if they had wandered before.
6. Check at the neighbors and immediate businesses.
7. Go to their previous home.
8. Go to the home of the nearest relative to the facility.
9. Have all the residents information in a profile ready for the police and volunteers to assist them in finding the resident (keep on file a list of volunteers to call for help in the search).
10. Search every area in the Assisted Living Facility again.
11. Be honest with the police and family about when the resident was last seen.

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ELOPEMENT CHECKLIST

- ☐ Develop and Implement Elopement Policies and Procedures.
- ☐ Establish a "Missing Resident Protocol".
- ☐ Develop a "Family Notification Procedure".
- ☐ Develop an "Emergency Personnel Notification Procedure".
- ☐ Train staff on "missing resident Protocol".
- ☐ Develop and complete a "Wandering Risk Assessment" on all new Residents.
- ☐ Implement interventions to reduce high-risk elopement residents from wandering. Including wrist alarms, signs at exits (STOP), regular checks by staff and activities.
- ☐ Document in residents care plan.
- ☐ Keep current photos and descriptions of residents as well as a list of some of their favorite places or likes if at risk of wandering.
- ☐ Alarm all exit doors and test alarms regularly.
- ☐ Meet regularly with staff to discuss changes in resident's conditions.
- ☐ Have a sign-in and sign-out sheet for residents.