### POLICY

1. Clients (refer to Definitions) who are admitted to Capital Health facilities, are to be assessed for the risk of wandering by the Interdisciplinary Team.

   **Exception:** *East Coast Forensics* Hospital facilities which will be governed under a separate policy - *CC 65-065 Absent Without Leave (AWOL)* - *East Coast Forensic Hospital*.

2. The following components are to be implemented to enhance client safety:

   2.1. A system of identifying individuals at risk of wandering and needing a higher degree of monitoring and protection
   
   2.2. A detailed plan for the assessment, identification, and prevention of wandering; and
   
   2.3. Employee education on missing, wandering, and absent clients and basic procedures for addressing missing clients and activating and responding to applicable Emergency Voice Codes.

### DEFINITIONS

**Client:** For the purposes of this policy the word client is used to represent patients, veterans and residents.

**High Risk Client:** A client who is at risk of harm because of frailty, or physical or mental impairment. Clients are considered high risk if, at a minimum, they:

   1. Are involuntary clients or voluntary clients who lack capacity;
2. Have an adult protection, public trustee, or court-appointed legal guardian;

3. Have physical or mental impairments or have been determined by the interdisciplinary team to be or likely to be a danger to themselves or others;

4. Lack capacity/cognitive ability (either temporarily or permanently) to make decisions or consent to care and treatment. (Reference Form A, Declaration of capacity to consent to treatment – Section 53 – Hospitals Act)

Wandering Client: 1. A high risk client who has exhibited a tendency to stray beyond the view or control of health care providers, requiring a high degree of monitoring and / or protection to ensure the individual's safety.

2. A client whose degree of cognitive impairment is such that the individual is unable to reliably get from one place to another in the hospital / residence setting without being accompanied is considered to present a risk of wandering or elopement.

Wandering Risk Factors: History of wandering or elopement, dementia, memory/recall deficits/disorientation/poor visual-spatial abilities, language deficits, depression, boredom, emotional behaviour (anxiety, frustration, restlessness, pacing, fidgeting, etc.)

GUIDING PRINCIPLES AND VALUES
1. In keeping with Our Promise, Capital Health is dedicated to maintaining a safe, person-centred environment and experience for clients including for individuals who are at risk of wandering or eloping. The goal is to ensure that clients enjoy the most freedom possible while maintaining their safety. To achieve this goal the following components will exist:

1.1. Every person has the right to freedom/liberty/choice as long as it does not interfere with the safety of self or others. When this occurs, employees are expected to make a reasonable and proportionate response which both maintains safety, privacy and respects the human rights and dignity of all persons.

1.2. Capital Health is committed to a philosophy of least restraint and intrusion and use of alternative interventions consistent with respect for and preservation of the person’s dignity, rights, values and preference.

1.3. Capital Health is committed to providing a safe and healthy environment for all Capital Health clients, visitors, volunteers, employees, physicians and learners.
PROCEDURE

1. Assessment

1.1. Upon admission and upon specific intervals identified by the interdisciplinary team and documented on the admission assessment after admission (e.g.: if there is a change in a person’s cognitive status) the interdisciplinary team conducts a comprehensive assessment of the client’s risk of wandering or eloping to elicit specific information from the client and/or other sources.

1.1.1. The team assesses using the following questions and documents appropriately:

- Is the client independently mobile?
- Is the client cognitively intact – cognitive functioning/mental status?
- Does the client have competent decision making ability?
- Does the client have a history of wandering?
- Does the client have ‘exit seeking’ behaviour?
- Is there a past history of wandering/elope/ment or exiting a home or facility without required supervision?
- Does the client accept their current residency in the facility? / Does the client understand the reason they are in the facility? / Are they willing to stay?
- Does the client verbalize a desire to leave?
- Has the client asked questions about the facility’s rules when leaving the facility?
- Is there a special event / anniversary in the near future that the client would normally go to?
- Is the client exhibiting restlessness or agitation?
- Is the person oriented to place, time, person, season, etc.?

1.2. If the answers to any of these questions or to a combination of these questions indicate the client poses a risk for wandering, utilize the Wandering Risk Assessment Decision Tree (Appendix A).

1.2.1. Immediately advise the client/family/SDM/caregiver, as appropriate, of the assessment of wandering risk and the need for the client to be escorted/accompanied during any clinic visits, excursions or activities that take place off the unit.

1.2.2. Provide the client/family/SDM/caregiver, as appropriate, with initial education on steps that family members/SDM and caregivers can take at home or in the community setting when caring for a person at risk of wandering.

1.2.3. Request Security or staff with department camera to take a color photograph of the client for inclusion on the client’s health record or an appropriate
database, if available. (For further information see CH 30-040 Patient Identification and Same Name Alert.)

1.2.4. Document the assessment information on the client’s health record and care plan.

1.3. Following the assessment, the interdisciplinary team develops a client specific care plan.

2. **Interventions / Mitigations.**

2.1. Allow the person to wander if the environment is safe and secure (i.e.: the area does not contain hazards to the health and safety of the client).

   **Note:** Wandering is a natural behaviour and is an opportunity to exercise and utilize energy.

2.2. Ensure completion of a comprehensive medical examination, including a review of the client's medications.

   2.2.1. If the wandering begins suddenly and is a new responsive behavior for the individual a medical exam is especially important to rule out medical health issues that are treatable such as delirium, infections, pain, etc.

2.3. In order to reduce the risk posed by the client to self and others due to wandering, use procedural and electronic monitoring methods where applicable to prevent, where possible, unsafe wandering behaviour. Examples of such interventions include:

   2.3.1. Posting signs with the client’s name on their room, to assist them with way finding.

   2.3.2. Use of a yellow identification wristband to identify at risk clients in acute care.

   2.3.3. Installing restrictive devices requiring a high degree of hand-eye coordination and memory to bypass (e.g. Plates over elevator buttons), up to and including appropriate electronic monitoring devices.

   2.3.4. Reviewing the plan of care weekly and monitoring interventions on each shift for effectiveness.

   2.3.5. Increase level of observation and monitoring

   2.3.6. Sign out/sign in book or documentation

   2.3.7. Utilize attendants to provide distraction and monitoring

   2.3.8. See Appendix B for possible Care Strategies.

   **Note:** The goal of these measures is to provide the least restrictive form of intervention for the client who, due to confusion/ disorientation, may become lost outside the building structure, and/or would be unable to find his/her way back to his/her unit.

3. **Missing or Absent Client.**

3.1. Refer to CC 05-060 Code Yellow - Missing Patient/Client for search, reporting and documentation procedures.
REFERENCES

Legislation


Other

Alzheimer Disease and Other Dementia Care Course Manual, Revision 2008, 6th Edition
Alzheimers Association, www.alz.org
Australian Psychological Society, www.psychology.org.au

RELATED DOCUMENTS

Policies

CC 05-060 Code Yellow
CC 65-065 Absent Without Leave (AWOL) - East Coast Forensic Hospital
CH 30-040 Patient Identification and Same Name Alert

Forms

Form A, Declaration of Capacity to Consent to Treatment (Section 53 – Hospitals Act), Nova Scotia Department of Health and Wellness
Form C, Declaration of Competency (Section 53, Hospitals Act), Nova Scotia Department of Health and Wellness

Appendices

Appendix A - Wandering Risk Assessment Decision Tree
Appendix B – Care Strategies

Other

Emergency Responders Guide – Code Yellow

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Appendix A
Wandering Risk Assessment
Decision Tree

INTERVIEW
1. Step 1:
   1.1. Is the client ambulatory or self mobile in a wheelchair?
       If YES, continue to Step 2. If NO, STOP.

2. Step 2:
   2.1. New client who has questioned the need to be admitted or
   2.2. Client is cognitively impaired with poor decision making skills and / or other pertinent diagnosis (e.g. dementia, organic brain syndrome, Alzheimer’s Disease, mental illness, stroke, traumatic brain injury, delirium), or
   2.3. Client is legally committed; as per Involuntary Patient Treatment Act (IPTA), the person’s legal status is either Voluntary Incapable, Involuntary Assessment or Involuntary Admission, or for East Coast Forensics Hospital as per Court Ordered Assessment (COA) or
   2.4. Client has a legal guardian/does not have capacity to make decisions or
   2.5. Client is alert but not able or willing to follow facility protocols regarding leaving the unit
       If YES to any of the above, continue to Step 3. If No, STOP.

3. Step 3 -
   3.1. Client has a history of unsafe wandering (in facility of elsewhere) or
   3.2. Opening the doors to outside and / or history of elopement or
   3.3. Is making statements that they are leaving or seeking to find someone or something or
   3.4. Displays behaviours, body language, etc, indicating a plan or attempt to elope may be forthcoming
       If YES to any of the above questions, go to Step 4 (Care Plan). If NO, STOP.

CARE PLAN
4. Step 4 –
   4.1. Develop a plan of care and monitoring level for high risk client behaviour differentiating strategies for cognitively intact vs. cognitively impaired individuals (See Appendix B for Care Strategies).
   4.2. Provide information and education for staff.
   4.3. Consider use of electronic or physical interventions to reduce the risk of unsafe client wandering.
   4.4. Ensure the client’s photograph with consent and description are placed in the client’s file and web-based database if available once identified as a risk.
   4.5. Utilize family members if available and/or attendants to monitor and observe client.
Appendix B

Care Strategies

Least Restrictive Interventions and Strategies

Care assumptions for all individuals:

- Use the person’s name frequently
- Address any visual or auditory deficits that the person has
- If appropriate, place a yellow name bracelet on the person
- Assess for pain, heat/cold, hunger/thirst, need to use bathroom frequently
- Identify yourself and your role to the person
- Orient the person to the unit and environment
- Use visual cues to help the person identify where they can and cannot go (use pictures and written posters)
- Organize volunteers/support persons to visit and provide diversion
- Provide reassurance and support
- Assess medications, assess for side effects, assess medical condition, assess changes in mental status
- Identify time / times of the day the individual may wander and plan activities for those times
- Document types of conversations or statements that trigger the individual to wander or exit seek

Interventions for individuals with cognitive impairment:

- Determine if the person is lost, afraid, is hungry, has delusions, hallucinations or is misinterpreting sights, sounds or smells. Attempt to address these issues.
- Use visual cues for the person’s room and other areas on the unit
- Provide simple commands and prompting – make 1 request at a time
- Visual barriers – e.g. Stop signs, grids on the floor at exits, bands across room doors
- Learn from family and friends what interest the individual has to help establish activities and routines that support the individual
- Try to identify and deal with sources of stress and agitation
- Provide distraction and redirection as required
- Provide regular physical exercise and activity
- Decrease environmental stimuli and noise
- Approach the individual from the front, slightly to the side with an open posture, in a quiet and gentle manner
- Avoid reasoning or arguing or correcting as this may increase agitation and confusion. Do not ask for explanations as the person may not know the answer
- Provide rocking chair to use excess energy
- Walk with the individual and attempt to suggest alternate activities such as sitting and having a cup of tea
• Give meaningful tasks, e.g. folding towels, dusting, etc
• Regular toileting routine
• Provide analgesics and other comfort measures
• Assist with meals and snacks
• Offer fluids frequently
• Bedtime routines
• Make room conducive to sleep – quiet, temperature, light
• Provide regular snacks – high calorie
• Provide a quiet dining experience, presenting 1 food at a time
• Keep items that suggest outdoor activities out of sight
• Establish a routine to help provide structure
• Recreational activities to provide distraction
• Play music that the person enjoys