

September 23, 2008

MANAGEMENT OF WANDERING AND MISSING PATIENT EVENTS

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes policy to ensure that each Department of Veterans Affairs (VA) medical facility has an effective and reliable plan to prevent and effectively manage wandering and missing patient events that place patients at risk for harm. *NOTE: This policy is applicable to all sites and levels of care including: hospital and nursing care facilities; domiciliary and residential bed care facilities (mental health residential rehabilitation and treatment programs); VA-owned or leased, off-ground health care facilities; day centers, day hospitals, day treatment centers, Psychosocial Rehabilitation and Recovery Programs (PRRCs); Community-Based Outpatient Clinics (CBOCs), Independent Outpatient Clinics, and Outreach Clinics.*

2. BACKGROUND

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

b. Although the Missing Patients Register no longer exists, missing patients continue to be tracked as Issue Briefs submitted to the Office of the Deputy Under Secretary for Health for Operation and Management (10N).

c. To prevent accidental deaths and injuries to wandering and missing patients, VHA must:

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

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

(3) Detect missing patients early; and

(4) Initiate prompt search procedures.

d. The National Center for Patient Safety (NCPS) reviews Root Cause Analysis (RCAs) and Aggregate Reviews involving missing patients that are submitted to NCPS, and disseminates relevant information to VHA facilities to foster the reduction and elimination of risks.

NOTE: This information is communicated in numerous ways, including advisories, alerts, newsletters, and national calls. Examples: [Topics in Patient Safety](#) newsletter http://vaww.ncps.med.va.gov/Publications/TIPS/Docs/TIPS_NovDec05.pdf#page=1 and NCPS Report http://vaww.ncps.med.va.gov/Initiatives/RCATopics/docs/Secure_Unit_Elopement.pdf.

THIS VHA DIRECTIVE EXPIRES SEPTEMBER 30, 2013

VHA DIRECTIVE 2008-057

September 23, 2008

e. **Definitions**

(1) **Incapacitated Patient.** Patients are considered incapacitated if, at a minimum, they:

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

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

(3) **Missing Patient.** A missing patient is an incapacitated patient who disappears from the patient care areas (on VA property), or while under control of VHA, such as during transport. Examples of situations when patients who meet the preceding criteria and need to be considered missing include, but are not limited to, the following:

(a) An inpatient or day treatment incapacitated patient not present to receive a scheduled medication, treatment, meal, or appointment, and whose whereabouts are unknown.

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

(c) An incapacitated outpatient from a community facility who does not return to the community facility following the appointment, whose whereabouts are unknown.

(d) An incapacitated patient who is using VHA-sponsored transportation (Disabled American Veterans vans, VHA drivers, VHA shuttles) who does not report to that transportation for the return trip and whose whereabouts are unknown.

(e) An incapacitated patients who does not return from pass as scheduled and whose whereabouts are unknown.

(4) **Absent Patient**

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

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

1. Weather conditions, i.e., the patient has inappropriate dress, the patient's safety is compromised;
2. Construction sites or other dangerous conditions which exist nearby;
3. Recent trauma, unexpected bad news, or an abrupt change in clinical status;
4. Local geographic conditions which increase risk; or
5. Homelessness, in combination with other factors that create risk.

(5) **Assessment**

(a) An assessment is a clinical evaluation of patients with regard to the patient's capacity to make decisions relative to immediate physical safety or well being and the patient's propensity to wander, as well as identification of triggers or circumstances that may lead to wandering behavior.

1. Past history may be a guide, as well as information obtained by friends, relatives, or caregivers.

2. A patient whose mental status may change rapidly, such as one suffering from post-surgical delirium or drug-induced psychosis, may require repeated assessments during the 24-hour period.

(b) An assessment is a clinical event and must be recorded in the electronic medical record.

NOTE: Staff needs to be alerted to patients' special risk through a Patient Record Flag or clinical reminders.

(6) **Preliminary Search.** As soon as it is determined that a incapacitated patient is missing, a preliminary search, coordinated by locally-designated staff in each clinical area, must be initiated to include: nearby ward, unit, clinic areas, or offices and adjacent areas such as lobbies, stairwells, elevators, Veterans Canteen or smoking areas.

(7) **Full Search.** If a missing patient is not located during the preliminary search and the clinical assessment indicates the patient is incapacitated, a full search is authorized by the medical facility Director, or designee. Those participating in the search must have specific instructions as to what action(s) to initiate if the patient is found since there is no legal authority, lacking an extreme exigency, for patients to be physically detained against their will off facility property.

VHA DIRECTIVE 2008-057

September 23, 2008

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

1. All grounds areas, parking lots, ball fields, tennis courts, outdoor seating and picnic areas, woods, and areas off, but contiguous to the property, as appropriate (e.g., local neighborhood attractions). *NOTE: There may be times when it is appropriate to notify the local Police (outside law enforcement agency) to enlist their assistance for incapacitated patients known or believed to have left the VA grounds. This could occur when a suicidal patient refuses to accept inpatient treatment. The patient can leave the area, go to a car and drive away. If this is known, it would be appropriate for the VA Police to immediately contact the local Police for assistance.*

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

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

(8) **Category I Missing Patient Record Flag (MPRF).** A Category I MPRF is a computer-based advisory that alerts clinicians to incapacitated patients. When activated, it automatically appears on the computer screen when a staff member enters the name of a patient to access the electronic medical record of that patient. Category I MPRFs display at all VHA facilities where the veteran or patient is known, registered, or appears for treatment. As a result, patients with a Category I MPRF who present an immediate safety risk to themselves or others by virtue of their behavior, their health status, or other characteristics may be safely treated wherever in VHA they may seek care.

3. POLICY: It is VHA policy that each VHA facility maintains written policy and procedures for the assessment, identification, and awareness training for the prevention and management of wandering patients and for searching and locating of missing patients. *NOTE: Management of wandering patients during recent emergencies/disasters has been problematic. Special attention needs to be paid to dealing with potential wandering patients during emergencies, (e.g. hurricanes, tornados, fires), and other events that disrupt electrical service, cause a reduction in staffing levels, or result in evacuation.*

4. ACTION: Each facility Director, or designee, is responsible for:

a. Developing, publishing, and implementing local policies for both on-grounds and off-ground facilities that:

- (1) Require:
 - (a) Timely assessments of patients and documentation of such assessments;
 - (b) Early intervention to minimize risks to wandering patients;
 - (c) Clear designation of responsibility for security of construction and other environmental hazards to minimize risks of inappropriate or unauthorized access to unsafe areas;
 - (d) Timely and thorough search procedures;
 - (e) Staff competency with ongoing awareness training in the care of wandering or missing patients;
 - (f) Referring missing patient events for RCA or Aggregated Review consistent with VA's NCPS procedures described in the Patient Safety Improvement Handbook; and
 - (g) Continuous learning through the integration of lessons learned from annual drills, close calls, or actual missing patient events.
- (2) Reflect the full scope of services to be provided and designates all sites of care to be involved, both on and off-grounds, in order for the effective prevention and management of wandering and missing patient events to be achieved.
- (3) Define preparation for, and responses to, missing patient events; it must include, but is not limited to:
 - (a) Designation of persons who can perform a clinical review of patients when they have "disappeared" to determine if they are either "missing" or "absent."
 - (b) Designation of who may declare a patient "missing" or "absent" and under what circumstances as well as who will determine the level of search required for each category of missing person.
 - (c) Command responsibilities and procedures both during administrative hours and non-administrative hours, including designation of a Search Command Post and Search Coordinator.
 - (d) Time frames, based on local circumstances, for initiating preliminary and full searches, for notifying relatives (next of kin), and for determining when the full search for a missing patient is considered to be unsuccessful.
 - (e) Designation of persons who will communicate with relatives, guardians, other responsible persons, and nearby treatment facilities, as appropriate, until a missing patient is found.

VHA DIRECTIVE 2008-057

September 23, 2008

(f) Designation of persons who will follow up with the patient, family or extended family regarding those patients considered “absent” to assure their safety. **NOTE:** *If there are concerns regarding an absent patient, it is recommended that a telephone call be placed to the next of kin or other designated individual, to ascertain the patient’s whereabouts in lieu of a search, i.e., to validate the patient’s safety.*

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

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

(i) Designation of responsibility to create, delete, and monitor Missing Patient Record Flags (MPRFs). This responsibility includes:

1. Entering a Category I MPRF in the electronic medical record of a missing patient, including a progress note describing the risk and circumstances, as soon as the full local search has failed to locate the patient;

2. Removing the MPRF as soon as the patient is located either at the originating facility or at another VA facility; and

3. If the MPRF appears on the record of a patient missing from another VA facility, notifying that facility that the patients has been found.

b. Ensuring that:

(1) Awareness training regarding prevention and management of wandering patients is integrated into initial orientation and other ongoing training of all staff.

(2) Specific awareness training for prevention, management, and reporting of actual missing patient events is provided to all relevant staff, especially within those special units and sites designated for the care of incapacitated patients at a frequency determined by the medical center.

c. Ensuring that the comprehensive review and assessment of the facility’s processes and any aggregated data on actual missing patient events or close calls are incorporated into the appropriate committee activity at the facility to continuously and systemically enhance environmental safety.

d. Ensuring employees are alerted to the status of a patient who has been designated as “missing” by the Computerized Patient Record System (CPRS) PRF (Category I- National) system.” *NOTE: All employees, including both clinical and non-clinical staff, need to enhance patient safety associated with wandering or missing patient events within the scope of their job, by assessing, reviewing, and developing processes, as well as intervening when appropriate.*

e. Ensuring the prevention and effective management of wandering and missing patients. The prevention and effective management of wandering and missing patient events is based on awareness by clinicians of each incapacitated patient’s status regarding legal commitment, guardianship, dangerousness to self or others, and cognitive ability and the associated safety risks. The frequency for assessing the cognitive ability of patients must be determined with regard to their safety and for developing safety measures, as appropriate for the patient’s condition by:

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

- (a) At the time of inpatient admission, discharge, or transfer between units or care setting;
- (b) As a component of each initial and annual outpatient evaluation;
- (c) When there is a reported change in mental status for any reason; and/or
- (d) In absentia, i.e., when the patient has disappeared from a clinical setting.

NOTE: If the patient is incapacitated, then the principal care provider or other clinician who has direct responsibility for the patient’s treatment plan and problem list should make an assessment and determine the safety measures appropriate for the patient that need to be part of the treatment plan. That assessment and related safety measures must be discussed by each patient’s treatment team and documented as being discussed.

(2) **Minimizing Risks.** Because of the documented risks inherent in the aging patient population, VHA aims to be as proactive as possible in minimizing risks for aging patients under its care and, at the same time, balancing those risks against the autonomy due individuals. As a result, the following processes must be integrated into each facility’s policy for the prevention or effective management of wandering and missing patient events:

(a) Policies on patient privileging, requirements for patient supervision and surveillance, and search procedures with regard to early identification of missing patients.

(b) Each facility must consider actual or close call missing patient events in accordance with NCPS guidelines and VHA Handbook 1050.01, and integrate the resulting information into awareness training of staff and improving existing processes to enhance patient safety.

(c) Initial orientation of all new staff will include awareness training regarding policy, including search policies and procedures, for identifying, assessing, and finding missing patients.

VHA DIRECTIVE 2008-057

September 23, 2008

(d) Missing Patient Drills that integrate findings from environmental rounds or other patient safety processes (such as aggregated RCA's), must be conducted for all shifts at the facility or site of jurisdiction, including CBOCs.

1. Once relevant staff have received initial awareness training, additional drills must be conducted a least annually (or more frequently if judged prudent due to local circumstances) to effectively evaluate known areas of vulnerability throughout and surrounding the facility.

2. Once the staff members are fully trained, an actual search during which the search plan is fully implemented and a critique is completed may take the place of the drill for the shift involved in the actual search. *NOTE: It is recommended that the sites for missing patient drills be prioritized based on known areas of vulnerability and lessons learned from RCA's and other risk management or performance improvement processes.*

(e) The systematic and comprehensive monitoring and assessment of hazardous areas and construction sites must be an integral part of this process.

1. It is essential to plan appropriate security measures, including methods for promptly discovering breaches and devising responses to such discoveries, for areas of the medical facility that contain hazards such as: construction sites, staging areas, areas involved in maintenance procedures, mechanical spaces, utility areas, crawl spaces, electrical vaults and closets, shops, utility plants, storage areas, water towers, lakes, ponds, rivers, streams, laboratories, research space and morgues. *NOTE: Essentially any area that when entered by an untrained individual could reasonably be considered to hold potential danger must be integrated into local processes.*

2. Any portion of the security plan where failure is not immediately obvious (such as fire or motion alarms) must be periodically checked for proper function.

f. Ensuring the location of incapacitated patients.

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

(a) There must be systematic and frequent checks of all critical components of the system with clear designation of responsibility for monitoring and maintaining that system. A basic check of the system in high-risk areas is required at a minimum of every 24 hours to ensure proper functioning as intended to minimize risk. Maintenance of the system must be consistent with manufacturer's guidelines; however, a complete systems check must be performed at least annually. *NOTE: A proactive assessment of potential vulnerabilities of the system and its use (e.g., failure Modes Effects Analysis) should be performed to guide the appropriate use of the system (see VHA Handbook 1050.01).*

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

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

(3) **Identification.** Facility processes must be established to ensure the availability of pictures and physical descriptions for all incapacitated patients in the event that they are suspected to be missing; this is a means to enhance the effectiveness of search procedures. Patient Identification System photographs may be used where available. In addition, once a patient is identified as both incapacitated and missing, the facility that “owns” the patient needs to immediately issue a local intranet announcement to all employees.

(4) **Transport.** Special precautions must be taken during the transport of known incapacitated patients and those reported to have a change in mental status, in the absence of clinical assessment.

g. Designating a single individual, defined in local policy, as responsible for gathering all pertinent information concerning the grid search (see Att. A).

5. REFERENCES

- a. M-2, Part I, Chapter 13.06.
- b. M-2, Part I, Chapter 35.
- c. DM&S Supplement MP-I, Part I, Change 42.
- d. Veterans Affairs Opinion General. Counsel Prec 37-91 (1991).
- e. VHA Handbook 1050.01.

6. FOLLOW-UP RESPONSIBILITY: Office of Mental Health Services (116) is responsible for the content of this Directive. Questions may be referred to (202) 461-7349.

VHA DIRECTIVE 2008-057
September 23, 2008

7. RESCISSIONS: VHA Directive 2002-013 is rescinded. This VHA Directive expires September 30, 2013.

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Under Secretary for Health

Attachment

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PATIENT SEARCHES USING GRID SECTORS

1. One individual, defined in local policy, is to be responsible for:

a. Working with facility engineering staff to obtain a site plot of the facility and surrounding areas.

b. Super-imposing a grid map to delineate the grid sectors.

c. Gathering all pertinent information concerning the grid search. This needs to include:

(1) Search grid sector assignments;

(2) Times and by whom grid sectors are searched;

(3) Times and by whom each building is searched;

(4) Times and to whom notifications and requests are made; and

(5) Result of search.

2. **The Indoor Search.** The indoor search needs to include all buildings within the assigned search area to include:

a. Any unsecured stairwells, closets, attics, crawl spaces, and equipment rooms;

b. All smoking shelters, indoor construction areas, bathrooms, vending areas; and

c. All other areas large enough for the patient to hide.

3. **The Outdoor Search.** The outdoor search:

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

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

4. Search Team

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

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

c. If the patient is found, the search team renders first aid if needed and notifies command post of the location, and, if needed, requests that medical personnel be sent. If the patient is unharmed, the search team transports the patient back to the appropriate treatment area.

5. Patient Is Found Deceased. If the patient is found deceased, the patient and area surrounding the patient will be cordoned off and preserved as a possible crime scene until instructions and the proper authorization have been received.