Protecting Patients Who Wander Policy

<table>
<thead>
<tr>
<th>Version Number</th>
<th>2</th>
<th>Version Date</th>
<th>10th August 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Owner</td>
<td>Director of Nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Dementia Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First approval or date last reviewed</td>
<td>October 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff/Groups Consulted</td>
<td>Dementia Specialist Nurse</td>
<td>Director of Nursing</td>
<td>Deputy Director of Nursing</td>
</tr>
<tr>
<td>Discussed by policy group</td>
<td>Patient Safety Steering Group</td>
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<tr>
<td>Approved by HMT</td>
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<td>Next Review Due</td>
<td>September 2017</td>
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<td>Policy Audited</td>
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<tr>
<td>Equality Impact Assessment Completed</td>
<td>August 2015</td>
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</table>
# PROTECTING PATIENTS WHO WANDER POLICY

## Table of Contents

1. Introduction.......................................................................................................................... 3
2. Rationale.................................................................................................................................. 3
3. Definitions.................................................................................................................................. 3
4. Policy Aim................................................................................................................................ 4
5. Roles and Responsibilities......................................................................................................... 4
   5.1 Chief Executive.................................................................................................................... 4
   5.2 Director of Nursing.............................................................................................................. 4
   5.3 Associate Directors of Nursing.............................................................................................. 4
   5.4 Matron / Ward Sister........................................................................................................... 4
   5.5 Nursing Staff........................................................................................................................ 5
   5.6 Other hospital staff.............................................................................................................. 5
6. Assessment and screening of patients........................................................................................ 5
   6.1 Restraints and restrictions .................................................................................................. 5
   6.2 Use of assistive technology................................................................................................ 6
   6.3 One to one supervision........................................................................................................ 6
7. Implementation, monitoring and evaluation............................................................................... 6
8. References................................................................................................................................. 7
9. Equality Impact Assessment................................................................................................... 7

Appendix 1 – To protect Patients Who Wander........................................................................ 8
Appendix 2 – Wandering patient assessment tool...................................................................... 10
Appendix 3 – YDH DOLS Application Process Checklist........................................................... 11
Appendix 4 – One to one supervision .......................................................................................... 12
Appendix 5 – Equality impact assessment tool......................................................................... 14
PROTECTING PATIENTS WHO WANDER POLICY

1. INTRODUCTION

Wandering cannot or should not always be prevented or reduced. A balance needs to be found between prevention of actual risk and enabling the person to have freedom of movement. People wander for a variety of reasons, seeking a safe place, wanting to take some exercise and to familiarise themselves with their surroundings. However, people who are confused and who wander are not only at risk in the ward environment, but that level of risk increases once they leave the ward.

Apart from patients held under the Mental Health Act, Deprivation of Liberty Safeguards, or prisoners in criminal custody, patients may make their own choices whether they wish to remain in hospital and be treated if they have the capacity to do so.

2. RATIONALE

The Trust has a duty of care to patients, a part of which is preventative care to ensure that patients do not fall or go missing, particularly those who are vulnerable and confused. These patients may lack the mental capacity to make an informed choice regarding leaving the hospital. Therefore, staff must ensure the patients’ safety whilst not infringing their human rights to liberty (Human Rights Act 1998). If it is that the patient does not have capacity then a formal mental capacity assessment should be carried out and a Deprivation of Liberty Order should be applied for in order to keep the patient safe.

3. DEFINITIONS

There is no agreed definition of wandering; Algase et al (2001) propose that wandering is a locomotion that is non-direct or more simply it is travelling about without any clear destination. It can take the form of pacing, lapping or a random pattern. For the purposes of this policy wandering is defined as:

- Repetitive walking: This includes pacing: walking in a set pattern covering the same ground repeatedly, also following staff, other patients, family, friends or visitors
- Pottering: walking without a specific purpose from one place to another looking at things, touching things, speaking to people, exploring etc in a patient who has some form of dementia or cognitive impairment, or
- Purposeful walking: walking with a specific purpose (e.g. going home, looking for Someone or something, going to the toilet, etc) when there is a risk that this walking could lead to harm (if the patient does not have capacity to understand the risks that come with these actions).
4. POLICY AIM

This policy sets out the screening, assessment and care planning processes for adult patients who have been identified as at risk of wandering.

The policy will also detail good practice standards for promoting ‘safer’ wandering as part of the fundamental care needs of the person.

This policy does not cover patients that have absconded. For this please refer to the Missing Patients Policy Procedure.

The policy applies to all healthcare staff working within YDH including bank and agency staff and those on honorary contracts.

5. ROLES AND RESPONSIBILITIES

5.1 Chief Executive

The Chief Executive, on behalf of the Board of Directors, has ultimate responsibility for all aspects of the management of wandering patients.

5.2 Director of Nursing

The Director of Nursing is responsible for the implementation of this policy and its monitoring and effectiveness.

5.3 Associate Directors of Nursing

Are responsible for ensuring that:

- Patients at risk from wandering are identified and assessed during admission.
- Appropriate information, training and supervision is provided to all staff on risks and controls identified in relation to patients who wander.
- Ensure that following an inpatient going missing that the cascade procedure is followed.
- Incident forms are completed effectively with all relevant information included and learning outcomes from the incident result in changes in practice.
- Appropriate/effective remedial action is taken to reduce risk of patient going missing again.
- Monitoring and reviewing missing patients within their area to identify trends and efficiency of remedial action taken, communicating any relevant issues to the Clinical Governance office.

5.4 Matron/ Ward Sister

They are responsible for ensuring that:

- They and their staff are aware of any vulnerable or ‘high risk’ patients in their care and how these patients should be safely ‘managed’.
• Referring any concerns regarding vulnerable adults and suspicions of abuse or inability to care for themselves at home to the Safeguarding Vulnerable Adults Clinical Lead.
• Ensuring documentation is completed appropriately and within set timescales.

5.5 Nursing Staff

Are responsible for ensuring that:
• All ‘vulnerable’ patients have been assessed for their ‘risk’ of wandering from the ward.
• Ensuring that an appropriate action plan has been created when the risk of wandering has been identified within the first 24 hours after admission.
• Adhering to and updating, where necessary, the care plan of a patient identified as ‘at risk of wandering’.
• Attending to and escorting any ‘found’ patient back to the ward;
• Completing an incident report form, should a patient be identified as ‘missing’.
• Instigate the cascade system, available on each ward.

5.6 Other Hospital Staff

If any hospital staff member finds a patient who appears to be ‘lost’ and confused and unable to find their way back to their ward unaided then the staff member should check name band to find out the ward and ask the staff to come and collect the patient.

6. ASSESSMENT AND SCREENING OF PATIENTS

Patients may be unable to communicate their sensation of pain because of impaired memory or lack of expressive language. Under-diagnosed and undertreated pain has been associated with agitation in dementia (Kunik et al 2010). Thus, better pain management may decrease agitation in dementia (Rosenberg 2011). Effective management of pain can play an important part in the treatment of agitation and could reduce the number of unnecessary prescriptions for psychotropic drugs in this population (Husebo et al 2011).

Staff should complete the initial multidisciplinary assessment record, nursing and identify how likely the patient is to wander.

For guidance on Care Planning refer to Appendix 1 which should be used alongside the ‘Wandering Patient Risk Assessment Tool (Appendix 2). If the patient is deemed a high risk of wandering then restrictive Intervention may be required.

6.1 Restraint and restrictions

The Mental Capacity Act allows restrictions and restraint to be used in a person’s support, but only if they are in the best interests of a person who lacks capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the care giver is seeking to prevent and can include:

• using locks or sensors pads which stop a person leaving the ward
• the use of some medication, for example, to calm a person
• one to one supervision
• physically stopping a person from doing something which could cause them or others harm.
• removing items from a person which could cause them harm
• holding a person so that they can be given care, support or treatment
• bedrails, wheelchair straps, restraints in a vehicle, and splints

Such restrictions or restraint can take away a person’s freedom and so deprive them of their liberty. If the patient lacks capacity to consent to their care and treatment, is not free to leave and is under continuous supervision and control and will continue to be in this state for a ‘non-negligible period of time’ then a DoLS application should be completed and submitted to the local authority. For Guidance please see YDH DoLS Application Process Checklist (Appendix 3)

6.2 Use of Assistive Technology

If the patient has been identified as high risk using the Wandering Patient Risk Assessment Tool, staff can consider the use of assistive technology.

• Pressure and pad alarm sensors
• Electronic Location Devices

Assistive technology where available for use, should only be used in a therapeutic manner in extraordinary circumstances on order to maintain patient safety and promote safer wandering.

Where possible the patient’s consent should be sought for the use of these devices. If a person lacks capacity to make a decision the practitioner must take into account the views of anyone named by the person as someone to be consulted and/or engaged in caring for the person. The practitioner should also consider the use of an Independent Mental Capacity Advocate (IMCA) for there is no one acting in the patient’s best interest (Please refer to the MCA Policy).

Alongside the use of any assistive technology the Restrictive Intervention Risk Assessment (Appendix 4) must be completed and reviewed daily with the care plan.

6.3 One to One Supervision

In extreme cases it may be appropriate for a patient to have additional staffing to keep them safe. In order for this decision to be made a One to One Supervision Risk Assessment and Decision Record should be completed (Appendix 4) and reviewed daily.

7. IMPLEMENTATION, MONITORING AND EVALUATION

Awareness raising for using the risk assessment tool will be cascaded down from the Safeguarding Vulnerable Adults Lead through the Dementia Lead for the Trust. Awareness of this policy will be disseminated at Staff meetings and all mandatory training.

The use of this policy will be monitored by the Safeguarding Adults Lead and the Dementia Lead. Investigations will be carried out into any complaints or incidents related to the application or content of this policy by the Governance Lead.
Action plans will be created to address any identified concerns and these action plans will be monitored by the Governance Group in conjunction with the Dementia Steering Group and the policy will be updated as necessary. This will include staff compliance with the policy and its overall effectiveness.

8. REFERENCES

- www.alzheimers.org.uk/site/scripts/press_article.php
- www.wanderingnetwork.co.uk
- Rosenberg PB, (2011) Treating Agitation in Dementia *British Medical Journal* 343:3913

9. EQUALITY IMPACT ASSESSMENT

This policy has been assessed and implemented in line with the policy on procedural documents and an equality impact has been carried out to ensure the policy is fair and does not discriminate any staff groups. A completed Equality Impact Assessment can be found at Appendix 5.
APPENDIX 1– TO PROTECT PATIENTS WHO WANDER POLICY

Care Planning guidance notes to support the wandering assessment tool

The following factors must be considered as part of a patient’s therapeutic care plan to be used with the risk whilst wandering assessment tool:

- Wandering should only be prevented where there are high level safety risks and the person does not respond to diversion or distraction and regularly or constantly seeks to leave the designated clinical area. (Risk outcome level 3 / 4).
- Check for causes of physical discomfort such as hunger, thirst, pain and desire to go to the toilet.
- Patients at risk of wandering should be nursed in a high observation area within the ward area where possible & ensure they are placed away from main thoroughfares and exits and that ward door security alarms or locks are used where fitted
- Ensure that patients with dementia are not moved between wards unless it is essential to patient care.
- Ensure Ward doors are always closed; such a physical barrier can simply prevent wandering out of a clinical area.
- Provide appropriate signs and cues (words and/or pictures) for orientation purposes including personal photos & clocks to identify personal bed space and the toilets.
- If the patient is sensitive to over stimulation from noise and light levels, then consider a quieter area.
- Ensure the person is wearing a correct identity band and appropriately dressed to ensure dignity.
- Consider if delirium is the cause for confusion.
  - Encourage carers to support patients and staff with family or volunteers to provide support during busy periods for staff or at the times when the wandering usually occurs.
  - Ensure the person has an escort for all tests outside of the main care setting and where possible re-orientate the person on their return
- Check the person is present on the ward on a regular basis using intentional rounding documentation where available. The nurse in charge must assess the level of supervision required but the patient should be checked at least every 30 minutes as a minimum level of supervision. However, following completion of the risk assessment with an outcome at level 4 there may be times when the patient requires continuous supervision. The nurse in charge is responsible for delegating team member/s to be responsible for this duty during a shift. Consideration may need to be given as to whether the patient requires ‘specialing’ and this should be discussed with the Matron for the ward. This may also be the time when the use of assistive technologies should be considered / implemented. (See Section 7 of this policy)
  - If a patient goes missing from the clinical area please instigate the cascade process for missing patients – see missing patient procedure.
• Consider DOLS application if patient has capacity, as patient is not free to leave hospital whilst receiving treatment. As part of this process, mental capacity should be assessed.

Simple patient centred care plans can help prevent behavioural and psychological symptoms in patients with dementia whilst in hospital

**Consider**:

• High quality ward and nursing environment
• Availability of appropriate activities for patients with dementia in hospital
• Physical assessment e.g. are they in pain? Do they have an infection?
• Mental state assessment to consider alternative causes and treatments e.g. for depression or sleep disturbances
### Outcome of Risk Assessment / Steps to take

<table>
<thead>
<tr>
<th>Level</th>
<th>Action</th>
</tr>
</thead>
</table>
| **Low** | Ensure completion of 'This is Me' document including photo  
Modify environment to reduce appeal of favoured exits where possible eg use screens  
Offer meaningful activities / therapeutic interventions sensitively  
Ensure falls assessment completed  
Share information with adjacent wards  
Consider if this person can go home safely as soon as possible to reduce anxiety/stress  
Introduce intentional rounding on hourly basis |
| **High** | Implementation of 1:1 care / supervision / 'specia  
Does this person lack mental capacity?  
Deprivation of Liberty Safeguards (DOLS) must be considered and application commenced by ward team.  
Care planning to include family & significant others  
Alert matron of ward to risks & consequences to date – staff to complete incident forms |

**Action Taken**

**Name:**

**Signed:**

**Date:**
APPENDIX 3

**YDH DOLS Application Process Checklist**

**Reasons you will be considering a DoLS application:**
- Patient has a pre-existing DoLS in-situ from their normal place of residence and therefore may require ongoing application whilst in YDH.

If the patient lacks capacity to consent to their care and treatment, is not free to leave and is under continuous supervision and control and will continue to be in this state for a ‘non-negligible period of time’ then a DoLS application should be completed.

<table>
<thead>
<tr>
<th>STAGE 1</th>
<th>The person considering a DoLS application MUST:</th>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Notify the relevant person’s family friends and carers when an DoLS application is being considered.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure there is a clearly documented assessment of capacity (re care and treatment / discharge planning) carried out by the clinician responsible for the patients care stating the patient lacks capacity around this decision making.</td>
<td></td>
</tr>
</tbody>
</table>

| STAGE 2 | Complete DoLS Form 1 Standard application and urgent notification form for Somerset or Dorset Residents (found on YCloud/Teams/Safeguarding Adults/ MCA & DoLS- guidance on completing the form also available on this site). |        |

<table>
<thead>
<tr>
<th>STAGE 3</th>
<th>Once form is completed ensure all following steps are followed:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Email the completed form to the relevant Supervisory Body (either <a href="mailto:dols@somerset.gov.uk">dols@somerset.gov.uk</a> -for Somerset residents or <a href="mailto:mcateam@dorsetcc.gov.uk">mcateam@dorsetcc.gov.uk</a> -for Dorset residents).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Email copy of application emailed to <a href="mailto:safeguardingadults@ydh.nhs.uk">safeguardingadults@ydh.nhs.uk</a> (and if patient has diagnosis of dementia <a href="mailto:dementia.team@ydh.nhs.uk">dementia.team@ydh.nhs.uk</a>) for monitoring / recording purposes.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Print and sign copies and give to the following:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- A copy should be held in the patients (‘relevant person’s’) medical file</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- to the patient (‘relevant person’)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- the relevant person’s representative (RPR - if appointed-most likely to be next of kin)</td>
<td></td>
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<tr>
<td></td>
<td>- to any IMCA that is involved.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Explain to the patient / ‘relevant person’ (the person being deprived of their liberty) the effect of the authorisation and their right to challenge the authorisation via the Court of Protection (included in the detailed DoLS patient information leaflet).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide the patient / ‘relevant person’ with a copy of the YDH DoLS Patient Information leaflet.</td>
<td></td>
</tr>
</tbody>
</table>
FURTHER INFORMATION:
Further information and guidance can be found in “YDH Guidance on the Use of the Deprivation of Liberties Safeguards (DoLS)” (2015).

APPENDIX 4
One to one supervision
Risk assessment and decision record
Complete and file in patient notes

<table>
<thead>
<tr>
<th>Immediate actions:</th>
<th>Yes</th>
<th>No</th>
<th>Subsequent actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent medical / medication review?</td>
<td></td>
<td></td>
<td>If No- Request review</td>
</tr>
<tr>
<td>Behavioural chart completed?</td>
<td></td>
<td></td>
<td>If No - chart behaviour and record triggers</td>
</tr>
<tr>
<td>Life history / carers questionnaire i.e. “this is me” commenced?</td>
<td></td>
<td></td>
<td>If No – Provide questionnaire and involve patient and family in completion (If not applicable record N/A)</td>
</tr>
<tr>
<td>• Have appropriate referrals been made to the multi-disciplinary team?</td>
<td></td>
<td></td>
<td>If No – Make referrals and use behavioural chart / triggers to develop a management plan</td>
</tr>
<tr>
<td>• Is there a clear multi disciplinary management plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a current substance misuse problem?</td>
<td></td>
<td></td>
<td>If yes- refer to Substance Misuse Nurse</td>
</tr>
<tr>
<td>Have environmental concerns been considered?</td>
<td></td>
<td></td>
<td>If No – reduce environmental stimuli / Move to a more observable position</td>
</tr>
<tr>
<td>Has the Fall risk assessment been completed?</td>
<td></td>
<td></td>
<td>If No- complete assessment (consider ultra low bed / mats etc)</td>
</tr>
<tr>
<td>Is a mental health assessment required?</td>
<td></td>
<td></td>
<td>If Yes – Refer to appropriate Psychiatric team (Holly court / Magnolia House)</td>
</tr>
<tr>
<td>Has intentional rounding / intermittent observation been introduced?</td>
<td></td>
<td></td>
<td>If No – introduce. Document interventions and outcomes.</td>
</tr>
<tr>
<td>Can the patients care be safely maintained within usual staffing levels?</td>
<td></td>
<td></td>
<td>If No - Proceed to section 2.</td>
</tr>
</tbody>
</table>

Continued on next page
SECTION 2: RISK REASON + SPECIALLING RECOMMENDATION  

Please tick the appropriate risk

Patient must consent to specialling. If patient lacks capacity to consent to specialling the Mental Capacity Act and Restrictive Interventions policies **must** be followed.

<table>
<thead>
<tr>
<th>No.</th>
<th>Risk / Reason</th>
<th>Tick</th>
<th>Recommended level of specialling: professional judgement must be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acutely ill / complex care requiring constant observation + intervention by Staff Nurse.</td>
<td></td>
<td>1:1 Staff Nurse</td>
</tr>
<tr>
<td>2</td>
<td>Preventable fall requiring 1:1 observation (as per Falls Risk Assessment)</td>
<td></td>
<td>1:1 Health Care Assistant</td>
</tr>
<tr>
<td>3</td>
<td>Confused and wandering presenting risks to self and others (patients and staff)</td>
<td></td>
<td>1:1 Health Care Assistant</td>
</tr>
<tr>
<td>4</td>
<td>Pulling lines / tubes that may result in significant harm</td>
<td></td>
<td>1:1 Health Care Assistant</td>
</tr>
<tr>
<td>5</td>
<td>Expressing intent or recently attempted self harm / suicide ideation</td>
<td></td>
<td>1:1 Staff Nurse or Mental Health Nurse (to assess, plan, deliver + evaluate mental health care) dependant on patient need, HCA may be suitable</td>
</tr>
<tr>
<td>6</td>
<td>Extreme challenging behaviour (violence and aggression)</td>
<td></td>
<td>1:1 Security staff</td>
</tr>
</tbody>
</table>

**PRINT NAME:**

**DESIGNATION:**

**SIGN:**

**DATE:**

**TIME:**
### APPENDIX 5

**Equality impact assessment tool**

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Name of Document: **Protecting Patients who Wander Policy**

<table>
<thead>
<tr>
<th>1. Does the policy/guidance affect one group less or more favourably than another on the basis of:</th>
<th>Yes/No/NA</th>
<th>Comments</th>
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<tbody>
<tr>
<td>- Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Ethnic origins (including gypsies and travellers)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Nationality</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Gender</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Culture</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Sexual orientation including lesbian, gay and bisexual people</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>- Disability</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

2. Is there any evidence that some groups are affected differently?  
None

3. If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?  
None Known

4. Is the impact of the policy/guidance likely to be negative?  
No

5. If so can the impact be avoided?  
N/A

6. What alternatives are there to achieving the policy/guidance without the impact?  
None

7. Can we reduce the impact by taking different action?  
N/A

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Trust’s lead for Equality & Diversity, together with any suggestions as to the action required to avoid / reduce this impact.

For advice in respect of answering the above questions, please contact the Trust’s lead for Equality & Diversity.  
Signed – Name: Gaynor Appleby  
Date: August 2015