PROTECTING PATIENTS WHO WANDER POLICY

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Policy Owner	Director of Nursing		
Author	Mental Health Lead		
First approval or date last reviewed	October 2011		
Staff/Groups Consulted	Dementia Specialist Nurse Director of Nursing Deputy Director of Nursing Heads of Nursing Clinical Governance		
Discussed by Policy Group	Patient Safety Steering Group		
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Equality Impact Assessment Completed		December 2016	

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1. INTRODUCTION

1.1 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.

1.2 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

2.1 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

3.1 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

4.1 This policy sets out the screening, assessment and care planning processes for adult patients who have been identified as at risk of wandering. **(Appendix 2 & 3)**

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

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

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

5. ROLES AND RESPONSIBILITIES

Chief Executive

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

Director of Nursing

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

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. **(Appendix 4) i**ncident 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.

Matrons / Ward Sisters

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 Team.
- Ensuring documentation is completed appropriately and within set timescales.

Nursing Staff

Are responsible for ensuring that:

- All ‘vulnerable’ patients have been assessed for their ‘risk’ of wandering from the ward (Appendix 2 - Dewing Wandering patient Risk Assessment Tool)

- Ensuring that an appropriate action plan has been created when the risk of wandering has been identified within the first 24 hours after admission (Appendix 3 - Outcome of Risk Assessment / Steps to take).
- 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.

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

6.1 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).

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

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

Restraint and Restrictions:

6.4 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

6.5 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 5)**

Use of Assistive Technology

6.6 If the patient has been identified as high risk using the Dewing Wandering Patient Risk Assessment Tool **(Appendix 2)**, to help staff to consider the use of assistive technology, e.g.:

- Pressure and pad alarm sensors
- Electronic Location Devices

6.7 Assistive technology where available for use, should only be used in a therapeutic manner in extra-ordinary circumstances to maintain patient safety and promote safer wandering.

6.8 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).

One to One Supervision

6.9 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 6) and reviewed daily.

7. IMPLEMENTATION, MONITORING AND EVALUATION

7.1 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.

7.2 The use of this policy will be monitored by the Mental Health 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.

7.3 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
- Algase, D et al (2001) Impact of cognitive impairment on wandering behaviour. Western Journal of Nursing Research. 23, 3, 283-295. Alzheimer's Society (2007) , Internet source accessed on 31/01/2008; www.wanderingnetwork.co.uk
- Mental Capacity Act 2005Husebo B S, Ballard C, Sandvik R, Nilsen OB, and Aarsland D. (2011) Efficacy of treating Pain to reduce behavioural disturbances

in residential and nursing homes with dementia: clustered randomised clinical trial: British Medical Journal 343:3913
- Kunik ME, Snow AL, Davila, JA, Steele AB, Balasubramanyam V, Doody RS, (2010) Causes of aggressive behaviour in patients with Dementia Journal of Clinical Psychiatry 71: 1145-1152
- Rosenburg PB, (2011) Treating Agitation in Dementia British Medical Journal 343:3913
- Dewing Wandering Patient Assessment Tool - http://www.wanderingnetwork.co.uk/Dewing%20Wandering%20Risk%20Assessment%20Tool%20version%202%20Sept%2008.pdf

9. EQUALITY IMPACT ASSESSMENT

9.1 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 1: WANDERING PATIENT RISK ASSESSMENT TOOL

Wandering Patient Risk Assessment Tool - Baseline Assessment			
Level of Risk	**Attributes**	**Scorer 1**	**Scorer 2**
0 **Nil - Minimal**	• No recent history or reports of wandering from others. • No current observable evidence of wandering.		
1 **Low Probable Risk**	• Recent history or reports of wandering from others. • Recent observable evidence of wandering of **either**: a) Short duration/infrequent/and the person contains them self to safe limits and does not transgress set boundaries (or is positively responsive to being contained within the same) b) Longer periods and the person accepts containing them self to safe limits and does not transgress set boundaries (or is positively responsive to being contained within the same).		
2 **Moderate Actual Risk**	• Recent history or reports of wandering from others. • Recent observable evidence of wandering that involves a) Wandering is not easily ended or diverted. **and/or** b) The person responding negatively to being contained within boundaries set by others. **and/or** c) Infrequent and unsuccessful attempts to transgress boundaries set by others.		
3 **Significant Actual Risk**	• Recent history and/or reports of wandering and/or observable evidence that wandering has involved • Regular transgressing safe limits and boundaries and that others (eg carers) have set • Carers found coping with the transgressing wandering activity to be difficult or impossible **and/or** • Recent observable evidence of wandering that transgresses safe limits and boundaries **and/or** • The person usually demonstrates way finding problems and easily 'gets lost' and is often unable to retrace their steps or return the same way they went.		
4 **Serious Actual Risk**	• Current observable evidence of wandering that is occurring at a high frequency where the person is a) Not responsive to distraction or diversion from wandering b) Unable to participate in any therapeutic activity/behavioural management plan. c) The person makes repeated attempts to leave a safe place and is regularly close to or achieves this successfully. d) Receiving regular or high dosage medication to contain their wandering activities. e) Not prevented from leaving by the family/carer and/or the carer is unable to easily seek help to locate or return the person f) Is wandering almost constantly and eating and drinking minimally.		
Date:	Assessor 1 Name:	Assessor 2 Name:	Overall Agreed Score:

*Now refer to '**Outcome of Risk Assessment / Steps to Take**'*

APPENDIX 2: OUTCOME OF RISK ASSESSMENT / STEPS TO TAKE

Outcome of Risk Assessment / Steps to take

1 **Low Probable Risk**	• Give families / carers 'This is Me' document to complete, ask for a recent photo • Ensure clear signage available for orientation around bed space and throughout ward • Provide meaningful activities where person is no longer self-initiating these e.g. rummage bag • Reassess when behaviour / environment changes • Modify environment to reduce appeal of favoured exits where possible e.g. use screens • List ways to avoid conflict & confrontation about containment & boundaries
2 **Moderate**	• Give families / carers 'This is Me' document to complete, ask for a recent photo • Look at companion / volunteer & space to enable meaningful wandering • Strategy on how to prevent person from leaving - explanations that person will accept • Consider psychiatric & psychological assessments and interventions • Share information with adjacent wards • Inform site mangers of risk • Can this person go home safely as soon as possible? • Introduce intentional rounding on hourly basis
3 or 4 **1. Significant or Serious**	• Implementation of 1:1 care / supervision / 'specialling' • 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:

- Complete Mental Capacity Assessment

Name:		**Signed:**		**Date:**	

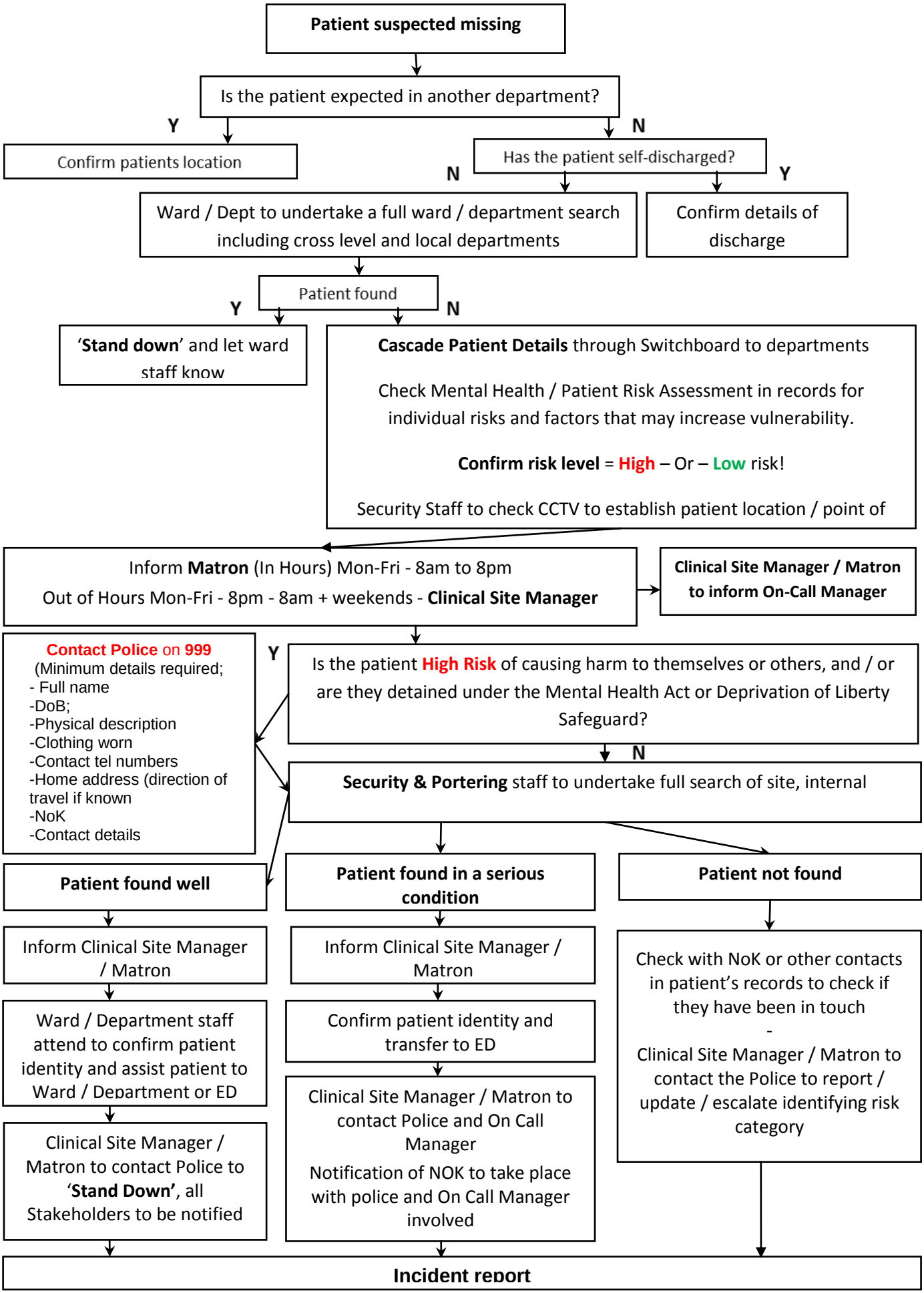
The following factors must be considered as part of a patient's therapeutic care plan to be used with the risk whilst wandering assessment tool:

- 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 3/4 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 'specialling' 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 6.2 of this policy)
- If a patient goes missing from the clinical area please instigate the cascade process for missing patients – see missing patient procedure in the Protecting Patients Who Wander Policy (Appendix 4).
- Consider DOLS application if patient does not have capacity, and is not free to leave hospital whilst receiving treatment. As part of this process, mental capacity should always 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 assessments, for example, 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

APPENDIX 3: MISSING PATIENT PROCEDURE FLOWCHART



APPENDIX 4: YDH DOLS APPLICATION PROCESS CHECKLIST

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.

STAGE 1	**The person considering a DoLS application MUST:**	**Initial**
	Notify the relevant person's family friends and carers when an DoLS application is being considered.	
	Ensure there is a clearly documented assessment of capacity (re care and treatment / discharge planning) carried out by the clinician responsible for the patient's care stating the patient lacks capacity around this decision making.	
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).	
STAGE 3	**Once form is completed ensure all following steps are followed:**	
	Email the completed form to the relevant Supervisory Body (either dols@somerset.gov.uk -for Somerset residents or mcateam@dorsetcc.gov.uk -for Dorset residents).	
	Email copy of application emailed to safeguardingadults@ydh.nhs.uk (and if patient has diagnosis of dementia dementia.team@ydh.nhs.uk) for monitoring / recording purposes.	
	Print and sign copies and give to the following: • A copy should be held in the patients ('relevant person's') medical file	
	• to the patient ('relevant person')	
	• the relevant person's representative (RPR - if appointed- most likely to be next of kin)	
	• to any IMCA that is involved.	
	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).	
	Provide the patient / 'relevant person' with a copy of the YDH DoLS Patient Information leaflet.	

FURTHER INFORMATION:
Further information and guidance can be found in "YDH Guidance on the Use of the Deprivation of Liberties Safeguards (DoLS)" (2015).

APPENDIX 5: ONE TO ONE SUPERVISION RISK ASSESSMENT & DECISION RECORD

Complete and file in patient notes

SECTION 1: IMMEDIATE ACTIONS REDUCE RISKS **2.** Please tick- **YES** or **NO** in response to actions below			
Immediate actions:	**Yes**	**No**	**Subsequent actions**
Is the patient at risk to themselves or others?			**If Yes – refer to Section 2**
Recent medical / medication review?			If No- Request review
Behavioural chart completed?			If No - chart behaviour and record triggers
Life history / carers questionnaire i.e. "this is me" commenced?			If No – Provide questionnaire and involve patient and family in completion (If not applicable record N/A)
• Have appropriate referrals been made to the multi-disciplinary team? • Is there a clear multi-disciplinary management plan			If No – Make referrals and use behavioural chart / triggers to develop a management plan
Is there a current substance misuse problem?			If yes- refer to Substance Misuse Nurse
Have environmental concerns been considered?			If No – reduce environmental stimuli / Move to a more observable position
Has the Fall risk assessment been completed?			If No- complete assessment (consider ultra-low bed / mats etc)
Is a mental health assessment required?			If Yes – Refer to appropriate Psychiatric team (Holly court / Magnolia House)
Has intentional rounding / intermittent observation been introduced?			If No – introduce. Document interventions and outcomes.
Can the patients care be safely maintained within usual staffing levels?			**If No - Proceed to section 2.**
DoLs Safeguard Completed			

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.

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

PRINT NAME: **DESIGNATION:**

3. **SIGN:** **DATE:**
   TIME:

APPENDIX 6: 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	**Yes / No / N/A**	**Comments**
1. Does the policy/guidance affect one group less or more favourably than another on the basis of:	No	
• Race	No	
• Ethnic origins (including gypsies and travellers)	No	
• Nationality	No	
• Gender	No	
• Culture	No	
• Religion or Belief	No	
• Sexual orientation including lesbian, gay and bisexual people	No	
• Age	No	
• Disability	No	
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 December 2016