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A Toolkit: Patients At Risk for Wandering

By Paula Allstetter, B.B.A., M.B.A, M.Div., NCPS program analyst, and Rodney Williams, M.P.A., J.D., L.L.M., NCPS program manager

This article is designed to provide an overview of patients "at risk" for wandering, as well as a variety of interventions to prevent patients from wandering or missing from VA facilities and grounds. Think of it as toolkit; a quick reference you can use to support your efforts.

The suggested interventions range from the most desirable to the most restrictive. It's important to consider that each patient is an individual with particular characteristics. A specific measure may work for a particular patient, while it may not work for another. Some measures may need to be used at specific times of the day or under certain circumstances.

The best approach is to be flexible and creative. You may want to consider a combination of the suggested interventions. Try to involve the patient and family as much as possible. Also remember that a patient may have a variety of disorders to take into consideration. Ensure that underlying conditions are assessed through a complete history and physical. And always assess the patient first!

Definitions[1]

Wandering patient: An at-risk 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.

Missing patient: An at-risk patient who disappears from the patient care areas (on VA property), or while under control of the VHA, such as during transport.

Absent patient: A patient who leaves a treatment area without the staff's knowledge or permission (after checking in), but who *does not meet* the at-risk criteria outlined for a missing patient and is *not* considered at risk. According to recent data, this appears to happen most often during patient transport, staff and/or patient communication, or some ambiguity in the process.

At-Risk Patients

Patients are considered "at risk" if, at a minimum, they:

- Are legally committed
- Have a court-appointed legal guardian
- Are considered dangerous to self or others
- Have a history of wandering or being missing
- Lack cognitive ability (either permanently or temporarily) to make relevant decisions
- Have physical limitations that increase their risk

At-risk patient assessments for cognitive impairment must be carried out and recorded in the health record in all of the following circumstances:

- At the time of inpatient admission, discharge or transfer between units or settings
- As a component of each initial and annual outpatient evaluation
- When there is a reported change in mental status for any reason

At-risk patients can sometimes exhibit the following behavior:

- Anxiety/stress
- Confusion
- Depression
- Hallucinations/delusions
- Pacing
- Wandering
- Verbalizing intent to leave
- Restlessness

Preparations

A preliminary missing patient procedure, at a minimum, should include:

- Designating persons who can perform a clinical review of a patient's chart when they have disappeared.
- Designating who may declare a patient "missing or "absent" and what level of search is required.
- Designating a "Search Command Post" and publishing the duties of "Search Coordinator."

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Stop the Line for Patient Safety

By Joe Murphy, APR, NCPS public affairs officer

An interdisciplinary team effort at the Robley Rex VA Medical Center,[1] Louisville, Ky., has led to an inclusive approach to the "Stop the Line for Patient Safety" initiative, launched by the VA in April 2013.

"The roll-out of our program was a team effort between patient safety, quality management and education, with strong support from our leadership," said Jennifer N. Pendleton, B.S.N., R.N., C.C.R.N., facility patient safety manager.

The original idea for the initiative came from the automotive industry. The Toyota Production System gave assembly-line workers the responsibility and authority to stop the assembly line whenever one of them noticed a defect or problem with production. When reframed to a health care setting, the object is similar: Empower individuals to speak up when a problem is seen, regardless of that person's position or title.

The facility's effort was based upon an education plan that included a time line for implementation. Two training modules were developed: one tailored for leadership; the other for staff at all levels. Other products were created in support of the effort, including course evaluations that could be used to monitor the value of the program and make changes as required.

Whether it be a the leadership or staff module, both included a key element of the program, known as the "3Ws" communication tool,[2] which is based on three simple principles:

- Say what you see
- Say what you are concerned about
- Say what you want to happen

Creating a Culture of Safety

The Stop the Line initiative is an important aspect of VA's approach to patient safety. Prior to the 1999 publication of the Institute of Medicine's landmark report, *To Err is Human*, when adverse medical events occurred, the focus was typically was on individuals and their mistakes, rather than on system-level vulnerabilities and events that had combined in an unfortunate sequence to cause an incident to occur.

Based on a "name and blame" culture, the emphasis was not on prevention, but on individual correction or discipline. By shifting the goal from eliminating errors to reducing or eliminating harm to patients – through investigating system-level vulnerabilities, rather than focusing on individuals – much has been accomplished at the VA.

Over the years, VA patient safety efforts have grown, not just in the number of programs offered, but in depth. The systems-based approach to problem solving has led to an emphasis on the creation of what is termed a "Just Culture." In such a culture, caregivers at all levels are encouraged to speak up – take action – if one witnesses another making a mistake. This is exactly what Stop the Line is meant to promote.

"Having someone stop someone else from making a potential mistake is in everyone's best interest," said Pendleton, "and most importantly, it puts Veterans' interests first. It also allows us to judge whether or not the specific medical care system involved is flawed."

Empowering people to speak also reduces the rigidity of an organization's hierarchy, another aspect of how the Stop the Line initiative promotes a Just Culture.

An excellent summation concerning the nature of a Just Culture was presented in a position statement originated by the Congress on Nursing Practice and Economics:[3]

"Traditionally, health care's culture has held individuals accountable for all errors or mishaps that befall patients under their care. By contrast, a *Just Culture* recognizes that individual practitioners should not be held accountable for system failings over which they have no control. A *Just Culture* also recognizes many individual or 'active' errors represent predictable interactions between human operators and the systems in which they work. However, in contrast to a culture that touts 'no blame' as its governing principle, a *Just Culture* does not tolerate conscious disregard of clear risks to patients or gross misconduct (e.g., falsifying a record, performing professional duties while intoxicated)."

Silence is "Deadly"

A 2005 study, *Silence kills*, co-sponsored by the American Association of Critical-Care Nurses, shed new light on the importance of speaking up.[4]

Of the 1,700 nurses and other clinical-care providers interviewed, the study indicates:

- 62 percent saw rule breaking
- 53 percent were concerned about incompetence in peers; 12 percent shared their concerns
- 75 percent concerned about poor team work; 16 percent shared their concerns
- 77 percent encountered disrespect, but only 7 percent shared their concerns

On the positive side, the study also indicates:

"Health care workers who are confident in their ability to raise … crucial concerns observe better patient outcomes, work harder, are more satisfied, and are more committed to staying. About 10 percent of the health care workers surveyed fall into this category. While additional confirming research is needed, the implication is that if more health care workers could learn to do what this influential 10 percent seem to be able to do systematically, the result would be significantly fewer errors, higher productivity, and lower turnover."

It's clear from a study of this nature that programs, such as Stop the Line, which empower clinicians and other staff to speak up directly benefit not only Veterans, but have the added potential of engendering a more productive and stable workforce.

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A "Great Catch" for Patient Safety

By Joe Murphy, APR, NCPS public affairs officer

The Veteran's Health Care System of the Ozarks[1] began a program in January 2013 to promote the reporting of close calls.

"We began the program after we decided to take a fresh look at our 2011 patient safety survey, which we had used in the past to improve our program," said Kathleen Wilcox, R.N., M.S.N., facility patient safety manager. "Based on the reevaluation, we saw a number of additional opportunities to improve our care systems. One of these was to encourage people to report close calls."

A close call is an event or situation that could have resulted in an accident, injury or illness, but did not, either by chance or through timely intervention. These events can occur from 3-300 times more often than actual adverse events and are given the same level of scrutiny at the VA as adverse events that result in harm to a patient.[2]

"Close calls are opportunities for learning," she said. "They can give us a chance to develop preventive strategies and actions, which is why we encourage people to report them."

In particular, reporting can help identify areas where patients' quality of care and safety might be improved. "That's one of the reasons we made reporting them a 'Great Catch' that comes with rewards," Wilcox said.

These include:

- Great Catch award certificate
- A lapel pin or commemorative coin
- Special recognition on the facility's patient safety website

"It comes with our sincere thanks also, "said Medical Center Director Mark Enderle, M.D. "It's very important to recognize these individual efforts. Sometimes, it's only due to the vigilance of a staff member that a patient avoids suffering an adverse event. We can also learn how to prevent future problems and improve our care systems by examining each close call reported."

Each Great Catch is reviewed to determine if additional safety measures should be implemented.

The long-term goal of the program is to change any negative perceptions facility staff members may have about reporting errors.

"We also make it easy for people to report," Wilcox said. "We have a form that is available on our Intranet site and can be easily accessed by staff members. It also includes photos of the director posing with past recipients as he presents them their award certificates."[3]

"We have given out 25 awards since the program began," she continued. "And not just to a wide range of clinical staff members, but also to members of other services within the facility, such as our police and chaplain service. It's has been very encouraging to see the patient safety program expanding."

Examples

"Housekeeping was working in an area and noticed a wet spot on the floor. Further investigation was done, and it was recognized that we had a major leak that could affect biomedical services and dietetics." Wilcox said. "It's a great example of staff members at all levels willing to take action."

This was categorized, along other close calls, in terms of the Joint Commission's National Patient Safety Goals[4]: "We considered it to be in support of National Patient Safety Goal 7, to reduce the risk of health care-associated infections."

"In another example, while editing medications within a medication profile, a pharmacy staff member recalled a recent medication change that had not been noted during a patient's transfer," she said. "The staff member questioned why specific orders were not continued upon this specific patient transfer. This prevented the Veteran from missing future medication doses."

Reporting this event directly supported National Patient Safety Goal 03.06.01: Maintain and communicate accurate patient medication information. "The information was also incorporated into the medication reconciliation process," Wilcox said, "contributing to the development of a Level of Care Medication Reconciliation Transfer Note."

Housekeeping was also given an award for reporting a serious problem in the mental health unit. "They were making the beds, when one of the housekeepers noticed an irregularity with one of the special pillows we use in that unit," she said.

It soon became apparent that a number of patients had opened a vent in the pillow, designed to prevent suffocation, to hide contraband within them and potentially be very dangerous. "Thanks to housekeeping, we added a new entry into our system of safety checks," Wilcox said. "This mitigated the problem and the action supports National Patient Safety Goal 15.01.01: Identify patients at risk for suicide."

Leadership

Wilcox sites the consistent support of leadership for the system's patient safety efforts: "Our leadership is fully engaged and fully supportive in a wide range of efforts aimed at advancing the facility's culture of safety. The Great Catch initiative is just one example."

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3. VA employees can view the site: *http://vaww.fayettevillear.va.gov/patient-safety/documents/great-catch.html*
4. Learn more about the National Patient Safety Goals: *http://www.patientsafety.va.gov/docs/TIPS/TIPS_JanFeb14.pdf#page=1*

A Toolkit: Patients At Risk for Wandering

(Continued from page 1)

- Ensuring command responsibilities and procedures are covered on a 24/7 basis.
- Ensuring time frames and level of each search based on local circumstances are published.
- Designating persons who will notify relatives or guardians and are responsible for communicating with them until a patient is found.
- Establishing criteria to determine when a missing patient search is unsuccessful.
- Assigning specific staff to given areas to ensure that all areas are searched, and to avoid random or uncoordinated searches.
- Developing "A Patient Search Grid" that contains all pertinent information and times, directions for searching indoors, directions for searching outdoors, and search team grid assignments.[1]

Interventions

Before providing a number of interventions, here are a few suggestions for communicating with at-risk patients:

- Speak clearly
- Use a calm voice
- Make visual cues to re-enforce your words
- Make eye contact
- Get their attention by motion or touch
- Look for facial signs of understanding
- Ask yes or no questions and use short simple phrases

Interventions can be divided into four degrees. First-degree interventions include diversional activities, such as:

- Aromatherapy
- Change of staff
- Familiar objects
- Family, volunteer, group
- Hobbies
- Pet therapy
- Reading/music/movies
- Rocking
- Social interaction
- Walks/regular exercise
- Orientation/reorientation to unit
- Purposeful focused activities
- Therapeutic touch

First-degree interventions can also include monitoring activities:

- One-on-one monitoring
- Medication review
- Escorts, sitters
- Location checks

Second-degree interventions focus on environmental enhancements, such as:

- Therapeutic decor (i.e., aquariums, aviaries, plants)
- Soft door barriers/door knobs

Third-degree interventions include environmental designs:

- Color schemes to identify unit
- Location maps
- Circular unit design
- Clearly marked signs that can be easily read
- Clearly marked patient's room
- Lighting change
- Offer a quiet room
- Reality orientation board
- Camouflaged doors (exit signs must remain)

Finally, fourth-degree interventions emphasize a different set of environmental designs:

- Locked unit
- Door alarms
- Tracking system
- Seclusion room

Conclusion

As previously stated, this article may be used as a starting point to support and develop your missing patient program. The safety of our Veterans during their care is of paramount importance. Wandering patients may endanger themselves, and so we owe it to them, as well as to their families, to minimize harm in every way possible.

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1. VHA Directive 2010-052, Management of Wandering and Missing Patients: *http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2340*

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