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PREVENTION OF WANDERING FROM LONG-TERM CARE FACILITIES

February 2002

Unfortunately deaths and injuries have occurred as a result of residents wandering away from long-term care facilities. The elderly are particularly vulnerable to hypothermia after exposure to even relatively mild cold, especially during the winter months. Staff in facilities need to take measures to prevent wandering and also assess for the signs and symptoms of hypothermia and take appropriate action in the event that a resident does elope from the facility in cold weather.

Accordingly, the staff of each facility should assess the appropriateness of the policies and procedures that have been developed and assess the capabilities of current staff in preventing this problem or in acting quickly and prudently should an elopement occur in cold weather. It is important to raise the consciousness of staff during cold weather. Special attention should be given to how staff respond to alarms and what they commonly do when "re-setting". An alarm system can be functional, but how staff function is also critical. Implementing preventive measures for the necessary care and supervision of residents who wander will help avert future tragedies. It is very important that the following steps are taken:

Identify all residents with any history, past or present, of wandering or confusion with associated wandering and especially those with a history of elopement. Document all instances of wandering, and review periodically to identify behavior patterns. Have residents who wander wear a colored bracelet or some easily identifiable item of clothing.

Develop and implement care plans for each identified wandering resident (MDS, Section E) with specific approaches and time-measured goals. For example, attempt to determine if there is a pattern and cause for wandering. If a resident is attempting to leave the facility to find family or friends, the care plan might include approaches to encourage participation in group activities, identify other residents with similar interests and encourage communication, and encourage family members to visit with the resident. Approaches should be reviewed regularly, at least quarterly, to review their effectiveness and modified as appropriate. Special attention may also be needed for residents with alterations in cognitive patterns (MDS, Section B) even if they have no overt history of wandering, especially if they are ambulatory, including devices such as a wheelchair.

The whereabouts of each identified resident should be frequently observed by the staff person assigned to care for the resident. The responsibility for these observations may only be transferred as appropriate according to the plan of care, i.e., attendance at scheduled functions, physical therapy, occupational therapy activities. Transfer of responsibility must be formally carried out and not assumed by either party.

All facility staff including staff in dietary, housekeeping, and maintenance should be able to recognize the identified residents and be prepared to intervene as the care plan indicates.

If provided, all existing surveillance/monitoring devices, i.e., door alarms, must be operational 24 hours a day. These devices should be routinely scheduled for maintenance checks.

Prior arrangements with community resources, i.e., local police, sheriff, should be reflected in the policy and procedure formulation with timetables for notification specified. Maintain photographs of residents that can be shared with law enforcement agencies if a search is necessary.