Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Replaces VHA Directive 96-029

VHA DIRECTIVE 2002-013

March 4, 2002

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.

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 VA has responsibility for all patients under its care, physically or mentally impaired patients require a distinctly higher degree of monitoring and protection.

b. To prevent accidental deaths and injuries, 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.

c. **Definitions**

(1) **High-risk Patient.** A high-risk patient is one who is incapacitated because of frailty, or physical or mental impairment. Patients are considered incapacitated if, at a minimum, they:

(a) Are legally committed;

(b) Have a court appointed legal guardian;

(c) Are considered dangerous to self or others;

(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 a high-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.

(3) **Missing Patient**. A missing patient is a high-risk patient who disappears from an inpatient or outpatient treatment area or while under control of VA, such as during transport. Examples of situations when patients who meet the above criteria should be considered missing include, but are not limited to, the following:

(a) Inpatient or day treatment high-risk patient not present to receive a scheduled medication, treatment, meal or appointment, and whose whereabouts are unknown.

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

(c) High-risk outpatients from a community facility who do not return to their community facility following the appointment, whose whereabouts are unknown.

(d) A high-risk patient who is using VA-sponsored transportation (Disabled American Veterans (DAV) vans, VA drivers, VA shuttles) who does not report to that transportation for the return trip.

(e) High-risk patients who do not return from pass as scheduled and whose whereabouts are unknown.

(4) **Absent Patient**

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

(b) An otherwise absent patient should be classified as a missing patient 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 not be limited to, the following:

1. Weather conditions, i.e., the patient has inappropriate dress, the patient's safety is compromised;

2. Construction sites or other dangerous conditions exist nearby;

3. Recent trauma, unexpected bad news, or abrupt change in clinical status;

4. Local geographic conditions increase risk; or

5. Homelessness, in combination with other factors that create risk.

(5) **Assessment.** An assessment is a clinical evaluation of patients with regard to their capacity to make decisions relative to their immediate physical safety or well being. Past history may be a guide, as well as information obtained by friends, relatives, or caregivers. Patients

whose mental status may change rapidly, such as those suffering from post-surgical delirium or drug-induced psychosis, may require repeated assessments during the day. An assessment is a clinical event and should be recorded in the medical record, whether paper-based or electronic. Staff may be alerted to patients at special risk through electronic "flags" or reminders.

d. **Preliminary Search.** As soon as it is determined that a high-risk patient is missing, a preliminary search must be initiated to include nearby ward or clinic areas, offices and adjacent areas such as lobbies, stairwells, elevators, etc., and will be coordinated by locally designated staff in each clinical area.

e. **Full Search.** If a missing patient is not located during the preliminary search and the clinical assessment indicates the patient is at high-risk, a full search is authorized by the medical center Director, or designee.

(1) VA Police, Security Service, and appropriate medical center 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:

(a) All grounds areas, parking lots, ball fields, tennis courts, outdoor seating and picnic areas, woods, and areas off, but contiguous to, the property (e.g., local neighborhood attractions, with 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), as appropriate; and

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

(2) When appropriate during or following the full search, VA Police and Security Service 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. This policy should not preclude those Police and Security Services units from entering this data themselves provided they have the capability to do so.

3. POLICY: It is VHA policy for all facilities to maintain:

a. A system of identifying high-risk patients needing a higher degree of monitoring and protection.

b. A detailed plan for assessment, identification, and prevention of wandering.

c. A detailed plan for searching and locating of missing patients. ***NOTE:*** *This policy is applicable to all sites and levels of care such as: hospital, domiciliary, and nursing care facilities; residential bed care facilities (psychiatric residential rehabilitation and treatment programs); VA-owned or leased, off-ground health care facilities; day centers, day hospitals,*

and day treatment centers; and Community Based Outpatient Clinics (CBOCs) or independent clinics.

4. ACTION

a. **Responsibilities**

(1) **Network Directors.** Network Directors are responsible for ensuring that each medical center within their respective Veterans Integrated Service Network (VISN) has local policy that meets the guidelines established in this directive.

(2) **Medical Center Directors.** Medical center Directors are responsible for:

(a) Developing local policies that require:

1. Timely assessments of patients and documentation of such assessments;

2. Early intervention to minimize wandering risks;

3. Clear designation of responsibility for security of construction and other environmental hazards to minimize risks of inappropriate or unauthorized access to unsafe areas;

4. Timely and thorough search procedures;

5. Staff competency with ongoing education and training in the care of wandering or missing patients;

6. Missing patient events to be referred for Root Cause Analysis (RCA) or Aggregated Review consistent with VA's National Center for Patient Safety (NCPS) procedures described in the Patient Safety Improvement Handbook; and

7. Continuous learning through the integration of lessons learned from drills, close calls, or actual missing patient events.

(b) Each medical center must establish and publish a local plan (policy) that reflects the full scope of services to be provided and designates all sites of care to be involved, in order for the effective prevention and management of wandering patients and of missing patient events to be achieved. This plan must define preparation for and responses to missing patient events; it needs to include, but is not limited to:

1. Designation of persons who can perform a clinical review of patients when they have "disappeared" to determine if they are either "missing" or "absent," and 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.*

2. Designation of who may declare a patient "missing" and under what circumstances as well as who will determine the level of search required for each category of patient.

3. Command responsibilities and procedures both during administrative hours and non-administrative hours, including designation of a Search Command Post and Search Coordinator.

4. 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 an incapacitated missing patient is considered to be unsuccessful.

5. Designation of persons who will communicate with relatives, guardians, other responsible persons, and nearby treatment facilities, as appropriate, until a missing patient is found.

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

7. 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 will 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.*

8. Designation of responsibility to maintain the Missing Patient Register, i.e., entering the names of missing patients as soon as the full local search has failed to locate them, and removing their name from the Register as soon as they are located. ***NOTE:*** *This process will aid in flagging patients who may present to other VA facilities and will allow analysis of national patterns.*

(c) Ensuring that the prevention or management of wandering patients and the management and reporting of actual missing patient events is integrated into initial orientation, annual, and/or other ongoing education and training of staff, especially within those special units and/or sites designated for the care of high-risk patients.

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

(3) **Employees.** All employees, including both clinical and non-clinical staff, are responsible for assessing, reviewing, and/or developing processes to enhance patient safety associated with wandering or missing patient events within the scope of their job, as well as intervening when appropriate.

(4) **NCPS.** NCPS is responsible for reviewing RCAs and Aggregate Reviews involving missing patients that are submitted to NCPS. NCPS is responsible for disseminating and making relevant information from the RCAs and Aggregate Reviews available to VHA facilities to foster the reduction and elimination of risks. This information may be communicated in numerous ways, including advisories, alerts, newsletters, and national calls.

(5) **Employee Education Service (EES).** EES will support the establishment of a national training program on wandering and missing patients to be made available at all VA facilities to assure minimum uniform training standards by October 1, 2002. This program should be directed toward relevant staff at all levels and disciplines as well as family members of high-risk patients. The program should include information from the NCPS on the requirements and basic procedures for addressing missing patients as described in the VHA Handbook 1050.1, Patient Safety Improvement Handbook.

b. **Prevention and Management.** The prevention and effective management of wandering and missing patient events is based on clinical assessment of cognitive ability for each patient and the associated safety risks. Each facility must determine the frequency for assessing the cognitive ability of patients with regard to their safety and developing safety measures, as appropriate for the patient's condition.

(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 they have disappeared from a clinical setting.

NOTE: *If the patient is at high-risk, then assessment and the safety measures appropriate for the patient need to be part of the treatment plan which must be discussed among the patient's health care providers. In addition, that assessment and the safety measures need to be included in the alert that comes to the attention of all applicable health care providers when the patient's record is accessed. The assessment must occur. The assessment and related safety measures must be discussed by the each patient's treatment team and documented as being discussed.*

(2) **Minimizing Risks.** Because of the documented risks inherent in the aging veteran population, VHA aims to be as proactive as possible in minimizing risks for patients under its care. 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 1050.1, and integrate the resulting information into education and training of staff and/or improving existing processes to enhance patient safety.

(c) Initial and annual training of all relevant staff regarding policy and search policies and procedures for identifying, assessing, and finding missing patients.

(d) Missing Patient Drills that integrate findings from environmental rounds or other patient safety processes (such as aggregated RCAs), must be conducted that at each medical center or site of jurisdiction, including CBOCs. Once staff have received initial training, additional drills must be conducted at least annually (or more frequently, if judged prudent due to local circumstances) to effectively evaluate known areas of vulnerability throughout and surrounding the facility. Once staff 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. It is recommended that the sites for missing patient drills be prioritized based on known areas of vulnerability and lessons learned from RCAs 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. It is essential to plan appropriate security measures, including method for promptly discovering breaches and response to such a discovery, for areas of the medical center 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.* 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.

c. **High-risk Patients**

(1) **Electronic Technology.** The use of electronic technology for those patients considered to be high-risk 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 encouraged at a minimum of every 24 hours to assure 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. 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 1050.1, sub par. 5d).

(b) Electronic devices and/or 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 high-risk. Supervision of patients must be consistent with review findings.

(3) **Identification.** Each facility must establish processes to assure the availability of pictures and physical descriptions for all high-risk patients in the event that they are suspected to be missing as a means to enhance the effectiveness of search procedures. Patient Identification System photographs may be used where available.

(4) **Transport.** Each facility must take special precautions during the transport of known high-risk patients and/or those reported to have a change in mental status, in the absence of clinical assessment.

5. REFERENCES

a. M-1, Part I, Chapter 13.

b. M-2, Part I, Chapter 35.

c. DM&S Supplement MP-I, Part I, Change 42.

d. Vet. Affairs Opinion Gen. Counsel Prec 37-91 (1991).

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e. National Center for Patient Safety (NCPS) guidelines.

f. VHA Handbook 1050.1, Patient Safety Improvement Handbook.

6. FOLLOW-UP RESPONSIBILITY: Mental Health Strategic Health Care Group (116) is responsible for the content of this Directive. Questions may be referred to 202-273-8435.

7. RESCISSIONS: VHA Directive 96-029 is rescinded. This VHA directive expires March 31, 2007.

S/ Tom Sanders for
Frances M. Murphy, M.D., M.P.H.
Acting Under Secretary for Health

Attachment

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ATTACHMENT A

PATIENT SEARCHES USING GRID SECTORS

1. Work with facility engineering staff to obtain a site plot of the facility and surrounding areas. Super-impose a grid map to delineate the grid sectors.

2. One individual is to be responsible to gather all pertinent information concerning the grid search. This needs to include:

   a. Search grid sector assignments;

   b. Times and by whom grid sectors are searched;

   c. Times and by whom each building is searched;

   d. Times and to whom notifications and requests are made; and

   e. Result of search.

3. The indoor search needs to include all buildings within the assigned search area to include any unsecured: stairwells, closets, attics, crawl spaces, equipment rooms, all smoking shelters, indoor construction areas, bathrooms, vending areas, and all other areas large enough for the subject to hide.

4. The outdoor search 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 subject could have wandered.

5. The outdoor search is to be a methodical and complete visual inspection of open terrain for a lost or injured person, or for indications and marks of a person'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.

6. 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.

7. 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.

8. If the subject is found, the search team will render first aid if needed and notify command post of the location and, if needed request that medical personnel be sent. If the subject is unharmed, the search team will transport the subject back to the appropriate treatment area.

9. If subject is found deceased, the subject and area surrounding the subject will be cordoned off and preserved as a possible crime scene until instructions and the proper authorization have been received.