

**Policy for Assessment and Care  
Management of Patients who are at risk of  
Wandering in the Acute Care Setting**

**Approved by: Policy and Guidelines Committee**

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## **1. Introduction**

- 1.1** Any person of any age who has a confusional state that may be acute or chronic may be at risk of wandering. This could be related to a dementia type illness, but not exclusively. (UK Wandering Network, 2005) However the literature that supports this policy is limited to patients with dementia who wander, nonetheless the principles of assessment and care management can be applied to any patient who may wander.
- 1.2** People wander for a variety of reasons, seeking a safe place, wanting to take some exercise and to familiarise themselves with where they are. They may also wander when they are in a strange or unfamiliar place such as a hospital.
- 1.3** Wandering cannot always be prevented or even reduced. A balance needs to be found between prevention of actual risk and enabling the person to have freedom of movement.

## **2. Definitions**

- 2.1** 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.

## **3. Policy Intention**

- 3.1** This policy sets out the screening, assessment and care planning processes for adult patients, who after initial assessment have been identified as at risk of wandering.
- 3.2** This policy will also detail good practice standards for promoting 'safer' wandering as part of the fundamental care needs of the person.
- 3.3** This policy does not cover patients that have absconded, please refer to the Missing Patients Policy (Document number 19918)
- 3.4** The policy applies to all healthcare staff working within UHL including Bank & Agency staff and those on honorary contracts.

## **4. Roles & Responsibilities**

- 4.1 The senior team including, General Managers, Heads of Nursing, Clinical directors & Heads of Departments are responsible for ensuring that all clinical staff are made aware of this policy, screening tool and factors to be considered as part of the patient's treatment and care.
- 4.2 Individual Clinical Directorates are responsible for agreeing the criteria and risk factors that trigger the use of the Dewing Tool for Wandering.

## **5. Screening**

- 5.1 The Healthcare Professional who identifies concern at initial patient assessment that wandering may be possible must then complete the Dewing Tool for Wandering Screening ideally in partnership with the patient and their carers and take appropriate action.  
(© Dewing, J. 2005 - Appendix 1)
- 5.2 The Dewing tool for wandering screening will help practitioners to identify patients who are at risk of wandering and particularly those who are likely to try to leave a safe setting, in this instance the Ward or department.
- 5.3 It enables staff to care plan measures for responding to safer or unsafe wandering.
- 5.4 It also prompts practitioners to recognise the need to talk with families and have proactive discussions about risk, supervision and helpful interventions to respond to wandering activity and document helpful information.

## **6. Assessment**

- 6.1 If a patient has been screened and identified as 'at risk of wandering' then the Wandering Assessment and therapeutic plan (Appendix 2) should be completed. This tool can be used to help identify triggers to wandering and should be used to plan interventions and care accordingly.
- 6.2 The Wandering Assessment & therapeutic plan (Appendix 2) can also be used in conjunction with the dementia patient profile (Document number 46099).

## 7.0 Care planning

The following factors must be considered as part of a patient's therapeutic care plan;

- 7.1 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.
- 7.2 Wandering should only be contained where the environment is an actual risk for the person or if the person is becoming distressed, exhausted or their health is adversely effected
- 7.3 Any delirium should be ruled out and/ or reversed – a delirium can be diagnosed using the 'Confusional Assessment Method' (CAM) (Appendix 3)
- 7.4 Ensure a baseline cognitive assessment has been recorded, in most instances this will be the 'Abbreviated Mental Test Score (AMTS)'. A detailed 'Mini-Mental State Examination (MMSE); is recommended – (Appendix 4)
- 7.5 A patient 'Falls Assessment Tool' (Document number 39224) should be completed on admission, repeated and regularly reviewed to identify the patient's risk of falling.
- 7.6 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.
- 7.7 If the patient is sensitive to over stimulation from noise and light levels, then consider a quieter area but ensure 7.8 is actioned.
- 7.8 Ensure Ward doors are always closed, such a physical barrier can simply prevent wandering out of a clinical area.
- 7.9 Check the person is there on a regular basis, the nurse in charge must assess the level of supervision, the patient must be checked at least every 30 minutes as a minimum level of supervision, however following risk assessment there maybe 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.
- 7.10 Ensure the person is wearing a correct identity band and appropriately dressed to ensure dignity.
- 7.11 Provide appropriate signs and cues (words and/or pictures) for orientation purposes including personal photos & clocks to identify personal bed space and the toilets.
- 7.12 Check for causes of physical discomfort such as hunger, thirst, pain and desire to go to the toilet.
- 7.13 Negotiate with family or volunteers to provide 'sitter' companionship services during busy periods for staff or at the times when the wandering usually occurs.

- 7.14 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.
- 7.15 Where possible accompany the person whilst they wander/walk, this will reassure the person making them feel more at home in our environment and less likely to leave. If you can accompany the person for a longer walk so they can leave the ward or department for a short time this can be beneficial.
- 7.16 If a patient goes missing from the clinical area please refer to the UHL Missing patient policy for guidelines and actions (Document number 19918).

## **8. Use of Assistive technology**

- 8.1 If the patient has been identified through the Screening tool to have the potential to undertake a more risky type of wandering and or has made an attempt to leave/wander from the ward, then staff can consider the use of assistive technology such as pressure pad alarm sensors or electronic location devices. Assistive technology where available for use, should only be used in a therapeutic manner, in extra-ordinary circumstances in order to maintain patient safety and promote safer wandering.
- 8.2 Where possible the patient's consent should be sought for the use of these devices. If a person lacks capacity to make this decision the practitioner must take into account the views of anyone named by the person as someone to be consulted and/or anyone engaged in caring for the person interested in their welfare. The practitioner should also consider the use of an Independent Mental Capacity Advocate (IMCA) please refer the MCA Policy (INsite Document no 38513)
- 8.3 Prior to using any equipment the following check list (Appendix 5) must be completed and filed in the patients notes and reviewed daily

## **9. Education and Training**

- 9.1 Training to use the screening tool and therapeutic interventions will be cascaded through the Education & Practice Development Teams in conjunction with the Directorate of Services for Older People.

## 10. Legal Liability

The Trust will generally assume vicarious liability for the acts of its staff, including those on honorary contract. However, it is incumbent on staff to ensure that they:

- Have undergone any suitable training identified as necessary under the terms of this policy or otherwise.
- Have been fully authorised by their line manager and their Directorate to undertake the activity.
- Fully comply with the terms of any relevant Trust policies and/or procedures at all times.
- Only depart from any relevant Trust guidelines providing always that such departure is confined to the specific needs of individual circumstances. In healthcare delivery such departure shall only be undertaken where, in the judgement of the responsible clinician it is fully appropriate and justifiable- such a decision to be fully recorded in patient's notes.

Staff are commended to have Professional Indemnity Insurance cover in place for their own protection in respect of those circumstances where the Trust does not automatically assume vicarious liability and where Trust support is not generally available. Such circumstances will include Samaritan acts and criminal investigations against the staff member concerned.

Suitable Professional Indemnity Insurance cover is generally available from the various Royal Colleges and Professional Institutions and Bodies.

For advice please contact: Steve Murray, Head of Legal Services on Ext 8960.

## 11. Audit & Review

11.1 This policy has been created to allow a simple audit process to be reviewed through Datix and Clinical Governance Teams. When auditing the following outcomes should be measured;

- Reduction in the number of incidents of patients attempting to leave an area of safety
- Reduction in the number of incidents of patients with dementia, who are wandering, that abscond from the Ward/Department.
- Reduction in the number of falls related incidents
- Use of assistive technology as a therapeutic intervention

- The number of patients with a baseline cognitive assessment – Abbreviated Mental Test (AMT) completed
- The number of patients with a delirium diagnosis using the Confusion Assessment Method (CAM)

11.2 It is encouraged that if any audit is undertaken using this policy, the author and or the Directorate of Services for Older People should be informed to advise and implement audit results into subsequent policy and practice reviews.

## 12. References

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© Jan Dewing 2005 Methods for preventing/responding to wandering in acute care settings Internet source accessed 31/1/2008 [www.wanderingnetwork.co.uk](http://www.wanderingnetwork.co.uk)

© Jan Dewing 2005 The Dewing Tool for Wandering Screening – permission to use tool given by the author.



## **Acknowledgements**

Claire Agnew

Jan Dewing

Nicolette Morgan

Lara Wealthall

Patient Name
Date
Ward

**Appendix 1**

**The Dewing Tool for Wandering Screening**  
(Dewing 2005)

**Part A (pre-dementia)**

*Please circle as appropriate:*

Does the patient have a history of being a regular walker, whether as a hobby or as part of their daily life?	YES	NO
Has the patient regularly used walking as a means of thinking things through, coping, dealing with stress or cooling off?	YES	NO
Does the person have a history of being extremely sociable or known to have an outgoing personality?	YES	NO

**Part B (currently)**

*Please circle as appropriate:*

**In the last year, has the person:**

Moved home (or been moved between or within a care setting)?	YES	NO
Shadowed or closely followed a relative/carer around for prolonged periods?	YES	NO
Moved around more frequently and had difficulty in sitting still for more than a few minutes?	YES	NO
Entered into others personal areas to investigate their belongings to rummage?	YES	NO
Made attempts to leave a safe place? (Note: the place must be well known to the person)	YES	NO
Left a safe place and got lost? (Note: the place does not have to be known to the person)	YES	NO

If the answer to any question in Part A is YES and there is a diagnosis of dementia (especially Alzheimer's) then the person is **at risk** of wandering/has the potential to wander if they become excessively under or over cognitively stimulated.

If the answer to any question in Part B is YES, the person is highly likely to be engaging in one type of wandering and **may be at risk**/have the potential to undertake a more risky type of wandering.

Spencer 02.09.2008. 28756 JW

Patient Name
Date
Ward

**Wandering Assessment and Therapeutic Plan**

*Should be used in conjunction with the personal profile*

Please ensure family members, carers, next-of-kin are involved in assessment where possible

*Please circle as appropriate:*

- Does the patient usually wander at home? YES NO
- Has the patient tried to leave their home or an area of safety? YES NO
- Does the wandering usually occur at : Night Day Both
- Does the wandering have a pattern/type? Pacing Trailing Pottering Rummaging Strolling

*Please tick as appropriate:*

- Do any of the following conditions trigger and cause the patient to wander? *Comments*
- Darkness  If YES, ensure adequate lighting \_\_\_\_\_
  - Noise  If YES, consider side-room \_\_\_\_\_
  - Crowding  If YES, consider side-room \_\_\_\_\_
  - High level activity  If YES, consider side-room \_\_\_\_\_
  - Desire to go to the toilet  If YES, offer regular toileting. Ensure pictorial signs are in place. \_\_\_\_\_
  - Hunger  If YES, offer regular snacks \_\_\_\_\_
  - Thirst  If YES, ensure drinks are available \_\_\_\_\_
  - Tiredness  If YES, encourage rest periods \_\_\_\_\_
  - Pain  If YES, observe for verbal and non-verbal clues \_\_\_\_\_
  - Boredom  If YES, consider planned activities or rummage bags \_\_\_\_\_
  - Over-stimulation  If YES, encourage rest periods \_\_\_\_\_
  - Loneliness  If YES, consider planned activities, outside visitors, volunteers \_\_\_\_\_
  - Anxiety  If YES, encourage the use of familiar objects, photos, clocks etc \_\_\_\_\_
  - Being upset  If YES, reassure and establish normal comfort mechanisms \_\_\_\_\_
  - Anger  If YES, reassure and establish if in pain or normal comfort mechanisms \_\_\_\_\_
  - Extreme temperatures  If YES, use of fans, blankets \_\_\_\_\_

Completed by:  
Name \_\_\_\_\_ Signature \_\_\_\_\_

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### Appendix 3

#### The Confusion Assessment Method (CAM)

#### The Confusion Assessment Method (CAM) Diagnostic Algorithm

##### Feature 1 *Acute Onset or Fluctuating Course*

This feature is usually obtained from a family member or nurse and is shown by positive responses to the following questions:

Is there evidence of an acute change in mental status from the patient's baseline? Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go, or increase and decrease in severity?

##### Feature 2 *Inattention*

This feature is shown by a positive response to the following question:

Did the patient have difficulty focusing attention, for example, being easily distractible, or having difficulty keeping track of what was being said?

##### Feature 3 *Disorganised Thinking*

This feature is shown by a positive response to the following question:

Was the patient's thinking disorganised or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

##### Feature 4 *Altered Levels of Consciousness*

This feature is shown by any answer other than "alert" to the following question:

Overall, how would you rate this patient's level of consciousness?:  
alert [normal], vigilant [hyperalert], lethargic [drowsy, easily aroused], stupor [difficult to arouse], coma [unarousable]

*The diagnosis of delirium by CAM requires the presence of features 1 and 2 and either 3 or 4*

Patient Name
Date
Ward

**Appendix 4**

**Mini Mental State Examination**

**Orientation** (1 point for each correct answer)

What is the: year  season  day  date  month  =

Where are we: country  county  town  hospital  floor  =

**Registration** (1 point for each correct answer)

Ask patient to name three unrelated objects.    =

*Allow one second to say each.*

Then ask the patient to repeat all three after you have said them.  
Repeat them until he or she learns all three. Count trials and record  
Number of trials:

**Attention and Calculation** (1 point for each correct answer)

Ask patient to count backwards from one hundred by sevens.  
(93; 86; 79; 72; 65; 58; 51; 44; 37; 30; 23; 16; 9; 2) Stop after five answers.      =

*(Alternatively, spell world backwards) (5 points)*

**Recall** (1 point for each correct answer)

Ask patient to recall the three objects previously stated    =

**Language**

Show patient a wrist watch; ask patient what it is   =

Repeat for a pencil. (1 point for each correct answer)

Ask patient to repeat the following: "No ifs, ands, or buts" (1 point)

Ask patient to follow a three-stage command:  
"Take a piece of paper in your right hand, fold it in half, and place it on the floor" (3 points)

Ask patient to read and obey the following sentence, which you have written  
on a piece of paper: "Close your eyes" (1 point)

Ask patient to write a sentence (1 point)

Ask patient to copy a design (1 point)

**TOTAL SCORE:**

**Assess level of consciousness along a continuum**

Alert  Drowsy  Stupor  Coma

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Patient Name
Date
Ward

**Appendix 5**

**Checklist for the Use of Assistive Technology**

1. Using the screening tool, has the patient been identified as very high risk for leaving an area of safety? YES  NO
2. Has the patient tried to leave the current area of safety? YES  NO

If the answer to both questions is **no**, then please refer back to therapeutic plan; if the answer to either question 1 or 2 is **yes** then continue

3. Is the patient able to consent to the use of assistive technology? YES  NO

If **yes** record in notes; if **no** continue

4. Has consent been sought and recorded from the person(s) interested in the patient's welfare?
5. Has the decision been supported by the Consultant & Nurse in Charge? YES  NO

**Consultant**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Designation: \_\_\_\_\_

**Nurse in Charge**

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Designation: \_\_\_\_\_