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## MANAGEMENT OF WANDERING AND MISSING PATIENTS

**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. **NOTE:** *This policy is applicable to all sites and levels of care including: hospital and VA Community Living Centers; domiciliary and residential bed care facilities (mental health residential rehabilitation and treatment programs); VA-owned or leased off-ground health care facilities; day centers; day hospitals; day treatment centers; Psychosocial Rehabilitation and Recovery Programs (PRRC); community-based outpatient clinics (CBOC); Independent Outpatient Clinics; and Outreach Clinics.*

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

b. Although the Missing Patients Register no longer exists, missing patients continue to be tracked as Issue Briefs, which facility Directors submit to the Office of the Deputy Under Secretary for Health for Operations and Management (10N).

c. To prevent accidental deaths and injuries to wandering and missing patients, 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.

d. The National Center for Patient Safety (NCPS) reviews Root Cause Analysis (RCA) investigations and Aggregate Reviews (AR) involving missing patients that are submitted to NCPS, and disseminates relevant information to VHA facilities to foster the reduction and elimination of risks. **NOTE:** *This information is communicated in numerous ways, including advisories, alerts, newsletters, and national calls. Examples: [Topics in Patient Safety](http://vaww.ncps.med.va.gov/Publications/TIPS/Docs/TIPS_NovDec05.pdf#page=1) newsletter [http://vaww.ncps.med.va.gov/Publications/TIPS/Docs/TIPS\\_NovDec05.pdf#page=1](http://vaww.ncps.med.va.gov/Publications/TIPS/Docs/TIPS_NovDec05.pdf#page=1) and NCPS Report [http://vaww.ncps.med.va.gov/Initiatives/RCATopics/docs/Secure\\_Unit\\_Elopement.pdf](http://vaww.ncps.med.va.gov/Initiatives/RCATopics/docs/Secure_Unit_Elopement.pdf). These are internal websites and are not available to the public.*

**THIS VHA DIRECTIVE EXPIRES DECEMBER 31, 2015**

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### e. Definitions

(1) **The At-Risk Patient.** The essential question in determining if a patient is at-risk when they have wandered or gone missing is whether they are at-risk for harm to themselves or others if not found and returned to a safe treatment environment. A patient's cognitive ability, the ability to make rational decisions, is a major feature of the assessment of risk in such situations.

*NOTE: A more detailed discussion of the "at-risk" assessment is found in Attachment A.*

Patients are considered at-risk 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) Are gravely disabled due to a mental disorder;
- (e) Lack cognitive ability (either permanently or temporarily) to make relevant decisions; or
- (f) Have physical limitations that increase their risk.

(2) **Wandering Patient.** A wandering patient is 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.

(3) **Missing Patient.** A missing patient is an at-risk patient who disappears from the patient care areas (on VA property), or while under control of VHA, such as during transport. Examples of situations when patients who meet the preceding criteria, and need to be considered missing include, but are not limited to the following:

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

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

(c) An at-risk outpatient from a community facility (e.g., personal care residence, community nursing home) who does not return to the community facility following the appointment, and whose whereabouts are unknown.

(d) An at-risk patient who is using VHA-sponsored transportation (e.g., Disabled American Veterans vans, VHA drivers, VHA shuttles) who does not report to that transportation for the return trip, and whose whereabouts are unknown.

(e) An at-risk patient who does not return from pass as scheduled, and whose whereabouts are unknown.

(4) **Absent Patient.** An absent patient is a patient who leaves a treatment area without the staff's knowledge or permission, but who does not meet the at-risk criteria outlined for a missing patient and is not considered at-risk.

(a) An otherwise absent patient is to be classified as missing when one or a combination of additional environmental or clinical factors may, in the judgment of the responsible clinician, increase the patient's vulnerability and potential for harm or injury.

(b) Conditions that might lead to this decision may include, but are not limited to:

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

2. Construction sites or other dangerous conditions, which exist nearby;

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

4. Local geographic conditions which increase risk; or

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

(5) **Search for the At-Risk Patient.** As soon as it is determined that an at-risk patient is missing, a search, coordinated by locally-designated staff in each clinical area must be initiated. *NOTE: See Attachment B for a discussion of Preliminary and Full Searches and Attachment C for Patient Searches Using Grid Sectors.*

(6) **Category II Missing Patient Record Flag (MPRF).** A Category II MPRF is a local computer-based advisory that alerts clinicians to at-risk patients who are missing. When activated, it automatically appears on the computer screen when a staff member enters the name of a patient to access the electronic medical record of that patient.

(a) Category II MPRFs are locally created, and display only at the VHA facility where the patient is being treated. As a result, patients with a Category II MPRF who present an immediate safety risk to themselves or others by virtue of their behavior, their health status, or other characteristics may be identified and safely treated at the local facility or an affiliated clinic where the Category II MPRF was initiated. The information is not displayed across facilities. An example of use of the Category II Patient Record is described in VHA Directive 2008-036, "Use of Patient Record Flags to Identify Patients at High Risk for Suicide."

**3. POLICY:** It is VHA policy that each VHA facility maintain written policy and procedures for the assessment, identification, and awareness training for the prevention and management of wandering patients and for searching and locating missing patients.

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#### 4. ACTION

a. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for providing oversight to the Veterans Integrated Service Networks (VISN) to ensure policies for prevention and management of missing patients are appropriately implemented by the VISNs.

b. **VISN Director.** The VISN Director, or designee is responsible for oversight and implementation of the Directive at the VISN level. *NOTE: Management of wandering patients during recent emergencies and disasters has been problematic. Special attention needs to be paid to dealing with potential wandering patients during emergencies (e.g., hurricanes, tornados, fires) and other events that disrupt electrical service, cause a reduction in staffing levels, or result in evacuation.*

c. **Facility Director.** Each medical facility Director, or designee, is responsible for:

(1) Developing, publishing, and implementing local policies for both on- and off-grounds facilities that:

(a) Require:

1. Timely assessments of patients and documentation of assessments;
2. Early intervention to minimize risks to wandering patients;
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, including designating one individual, defined in facility policy, to establish grid sector procedures (see Att. A);
5. Staff competency with ongoing awareness training in the care of wandering or missing patients;
6. Referring missing patient events for RCA or AR consistent with VA's NCPS procedures described in VHA Handbook 1050.01; and
7. Continuous learning through the integration of lessons learned from annual drills, close calls, or actual missing patient events.

(b) Reflect the full scope of services to be provided.

(c) Designate all sites of care to be involved, both on- and off-grounds, in order for the effective prevention and management of wandering and missing patient events to be achieved.

(d) Define preparation for, and responses to, missing patient events; it must include, but is not limited to:

1. Designating persons who can perform a clinical review of patients when they have “disappeared” to determine if they are either “missing” or “absent.”

2. Designating who may declare a patient “missing” or “absent” and under what circumstances, as well as who will determine the level of search required for each category of missing person.

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

4. Ensuring time frames, based on local circumstances are published for:

a. Initiating preliminary and full searches;

b. Notifying relatives, guardians, and other responsible persons; and

c. Determining when the full search for a missing patient is considered to be unsuccessful.

5. Designating persons who are responsible for communicating with relatives, guardians, other responsible persons, and nearby treatment facilities, as appropriate, until a missing patient is found.

6. Designating persons who are to follow-up with the patient, relatives, guardians, and other responsible persons regarding those patients considered “absent” and to assure them of the patient's 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.*

7. Assigning specific staff to given areas to ensure that all areas are searched, and to avoid random or uncoordinated searches. **NOTE:** *Use of a grid search is recommended (see Att. C).*

8. Immediately notify VA Police, the Federal Bureau of Investigation (FBI), state and local police, the Office of the Medical Examiner, and local management officials in the event a missing patient is found deceased on VA property. **NOTE:** *Local law enforcement agencies and officials need to be oriented, and become involved with the search activities of the VA medical center by being invited to policy and operational planning sessions.* The VA Police must 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.

9. Designating the responsibility to create, delete, and monitor MPRF(s). During normal business hours, it is suggested that the Chief, Medical Administrative Service (MAS), or

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comparable position, enter and remove the MPRF(s). During off-tour hours it is suggested that the Administrative Officer of the Day (AOD) enter and remove the MPRF(s). This responsibility includes:

a. Entering a Category II MPRF in the electronic medical record of a missing patient, including a Text Integration Utility (TIU) progress note describing the risk and circumstances, as soon as the full local search has failed to locate the patient. **NOTE:** *See Attachment D for Sample Patient Record Progress Note.*

b. Removing the MPRF as soon as the patient is located.

(2) Ensuring that:

(a) Awareness training regarding prevention and management of wandering patients is integrated into initial orientation and other ongoing training of all staff. **NOTE:** *See Attachment E.*

(b) Specific awareness training for prevention, management, and reporting of actual missing patient events is provided to all relevant staff, especially within those special units and sites designated for the care of at-risk patients at a frequency determined by the medical center.

(3) Incorporating the comprehensive review and assessment of the facility's processes and any aggregated data on actual missing patient events, or close calls into the appropriate committee activity at the facility to continuously and systemically enhance environmental safety.

(4) Alerting employees to the status of a patient who has been designated as "missing" by the Computerized Patient Record System (CPRS) Patient Record Flag (PRF) (Category II-Local) system." **NOTE:** *All employees, including both clinical and non-clinical staff, need to enhance patient safety associated with wandering or missing patient events within the scope of their job, by assessing, reviewing, and developing processes, as well as intervening when appropriate.*

(5) Ensuring the prevention and effective management of wandering and missing patients. The prevention and effective management of wandering and missing patient events is based on awareness by clinicians of each at-risk patient's status regarding legal commitment, guardianship, dangerousness to self or others, cognitive ability, and the associated safety risks.

(6) Designating a single individual, defined in local policy, as being responsible for gathering all pertinent information concerning the grid search (see Att. A).

## 5. REFERENCES

a. M-1, Part I, Chapter 13.06.

b. M-1, Part I, Chapter 10.

c. Veterans Affairs Opinion General. Counsel Prec 37-91 (1991).

d. VHA Directive 2008-036, "Use of Patient Record Flags to Identify Patients at High Risk for Suicide."

e. VHA Handbook 1050.01.

**6. FOLLOW-UP RESPONSIBILITY:** Office of Mental Health Services (116) is responsible for the content of this Directive. Questions may be referred to (202) 461-7349.

**7. RESCISSIONS:** VHA Directive 2008-057 is rescinded. This VHA Directive expires December 31, 2015.

Robert A. Petzel, M.D.  
Under Secretary for Health

Attachments

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 12/8/2010

**ATTACHMENT A**

**ASSESSMENT FOR AT-RISK STATUS**

1. All primary care physicians, geriatricians, and mental health providers must assess and document the cognitive impairment status of any patient that has a physical or mental condition that in the judgment of the clinician, makes that individual vulnerable to harm if outside of the Department of Veterans Affairs (VA) control (e.g., would this patient be safe from harm if allowed to leave the VA facility on their own?). At a minimum, all patients meeting the definition of “at risk” in this policy are considered to be vulnerable to harm if outside of VA control.
2. Assessment for cognitive impairment of these patients must be carried out, and recorded in the health record in all of the following circumstances:
  - a. At the time of inpatient admission, discharge, or transfer between units or settings;
  - b. As a component of each initial and annual outpatient evaluation; and
  - c. When there is a reported change in mental status for any reason.
3. In those circumstances when a patient has disappeared from a clinical setting the clinician, with direct responsibility for the patient’s treatment plan and problem list, is responsible for retrospectively documenting cognitive impairment in those progress note in the electronic medical record.



## ATTACHMENT B

### PRELIMINARY AND FULL SEARCH FOR THE MISSING AT RISK PATIENT

**1. Preliminary Search.** As soon as it is determined that an at-risk patient is missing, a preliminary search, coordinated by locally-designated staff in each clinical area, must be initiated to include: nearby ward, unit, clinic areas, or offices and adjacent areas, such as: lobbies, stairwells, elevators, the Veterans Canteen, or smoking areas.

**2. Full Search.** If a missing patient is not located during the preliminary search, a full search is authorized by the medical facility Director or designee.

a. Those participating in the search must have 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.

b. The Department of Veterans Affairs (VA) Police and appropriate on-duty medical facility staff must participate in the search to include all areas of the facility, in addition to those covered by the preliminary search, such as:

(1) All grounds areas, parking lots, ball fields, tennis courts, outdoor seating and picnic areas, woods, and areas off, but contiguous to the property, as appropriate (e.g., local neighborhood attractions). *NOTE: There may be times when it is appropriate to notify the local police (outside law enforcement agency) to enlist their assistance for at-risk patients known or believed to have left VA grounds. This could occur when a suicidal patient refuses to accept inpatient treatment. The patient can leave the area, go to a car and drive away. If this is known, it would be appropriate for VA Police to immediately contact the local police for assistance.*

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

c. When appropriate during or following the full search, VA Police 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. *NOTE: This policy does not preclude those VA Police units from entering this data into NCIC themselves, provided they have the capability to do so.*

## ATTACHMENT C

### PATIENT SEARCHES USING GRID SECTORS

1. **Designated Individual.** The single individual defined in local policy (see subpar. 4c(1)(a)4) is responsible for:

a. Working with facility engineering staff to obtain a site plot of the facility and surrounding areas.

b. Super-imposing a grid map to delineate the grid sectors. Larger areas are to be divided into smaller manageable grids. Each grid is to be approximately 500 by 500 feet and is designated with coordinates illustrated on the search grid maps.

c. Gathering all pertinent information concerning the grid search. This needs to include:

- (1) Search grid sector assignments;
- (2) Times and by whom grid sectors are searched;
- (3) Times and by whom each building is searched;
- (4) Times and to whom notifications and requests are made; and
- (5) Result of searches.

2. **The Indoor Search.** The indoor search needs to include all buildings within the assigned search area and:

- a. Any unsecured stairwells, closets, attics, crawl spaces, and equipment rooms;
- b. All smoking shelters, indoor construction areas, bathrooms, vending areas; and
- c. All other areas large enough for the patient to hide.

3. **The Outdoor Search.** The outdoor search:

a. 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 patient could have wandered.

b. Is to be a methodical and complete visual inspection of open terrain for a lost or injured patient, or for indications and marks of a patient's movement.

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### **4. Search Team**

a. 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. Search team members are to be spaced abreast and sweep by lines. Several sweeps may be necessary to completely cover assigned grids. A designated team leader directs the search team.

b. The team leader is responsible for the safety of all team members, and for ensuring the search is completed. Failure to check one small area may result in a failed search.

c. If the patient is found, the search team renders first aid if needed, and notifies the command post of the location, and if needed, requests medical personnel be sent. If the patient is unharmed, the search team transports the patient back to the appropriate treatment area.

**5. Patient Is Found Deceased.** If the patient is found deceased, the patient and surrounding area must be cordoned off and preserved as a possible crime scene until instructions and the proper authorization has been received.

**ATTACHMENT D**

**SAMPLE PATIENT RECORD PROGRESS NOTE**

1. The entry of either a Category I or a Category II Patient Record Flag (PRF) requires an accompanying Text Integration Utility (TIU) Progress Note. The flag narrative itself needs to reference the date of this accompanying progress note. In keeping with PRF conventions as prescribed in current Veterans Health Administration (VHA) policy, there are three separate Computerized Patient Record System (CPRS) entries associated with every PRF:

a. The PRF Flag Narrative (the advisory that an end-user such as a receptionist or triage nurse would first see when opening the patient's record);

b. A progress note title for locating a progress note with detailed information relevant to the patient; and

c. The CPRS progress note.

**2. Sample Missing Patient Record Flag (MPRF) Narrative**

a. **Problem.** This patient is Missing and is also Medically At High-Risk. At a minimum, this patient's medical incapacitation means that the patient is:

(1) Legally committed;

(2) Has a court-appointed legal guardian;

(3) Is considered dangerous to self or others or gravely disabled due to a mental disorder;

(4) Lacks cognitive ability (either permanently or temporarily) to make relevant decisions;

or

(5) Has physical or mental impairments that increase the risk of harm to self or others.

**b. Recommendations**

(1) If this patient appears:

(a) Department of Veterans Affairs (VA) Police are notified that the patient has been located;

(b) VA Police or others are asked to supervise the patient, until the patient's safety can be ensured; and

(c) Refer to CPRS Progress Note dated \_\_\_\_\_ for additional information about this patient, required contacts, or other required procedures.

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- (2) Flag Name: Missing Patient
- (3) Flag Type: CLINICAL
- (4) Flag Category: II (LOCAL)
- (5) Assignment Status: ACTIVE
- (6) Initial Assignment: 08/11/08 @ 08:30:41
- (7) Last Review Date: N/A
- (8) Next Review Date:
- (9) Owner Site: PORTLAND (OR) VA Medical Center
- (10) Originating Site: PORTLAND (OR) VA Medical Center
- (11) MPRF Progress Note Title:

**3. MPRF Category II – Missing and Medically at-Risk**

**Sample MPRF TIU Progress Note.** The body of the progress note must include the unique information pertinent to the specific missing patient. Current VHA policy states the body of the TIU Progress Note should describe “the risk and circumstances, as soon as the full local search has failed to locate the patient.”

a. “This patient has been determined by the patient's Primary Care Provider or other clinicians to be medically at-risk and to be missing as of \_\_\_\_ (date) \_\_\_\_\_. Under current VHA policy, to be missing also means the patient is medically at-risk.

b. This patient is at-risk or medically at-high-risk because \_\_\_\_\_  
\_\_\_\_\_ (details of patient’s condition, time and place last seen, who to call, etc.)  
Once the patient is located, the PRF is de-activated.

c. Questions about this patient or the flag are to be directed to \_\_\_\_ (person’s name) \_\_\_\_ at  
\_\_\_\_\_ (telephone number) \_\_\_\_\_.

## ATTACHMENT E

### PREVENTION OF MISSING PATIENT EVENTS

Because of the documented risks inherent in the aging patient population, the Veterans Health Administration's (VHA) aim is to be as proactive as possible in minimizing risks for aging patients under VHA's care, and at the same time, balance those risks against the autonomy due individuals. 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:

1. Policies on patient privileging, requirements for patient supervision and surveillance, and search procedures with regard to early identification of missing patients.
2. Consideration of actual or close call missing patient events in accordance with National Center for Patient Safety (NCPS) guidelines and VHA Handbook 1050.01, and integration of the resulting information into awareness training of staff and improving existing processes to enhance patient safety.
3. Initial orientation of all new staff will include awareness training regarding policy, including search policies and procedures, for identifying, assessing, and finding missing patients.
4. Missing Patient Drills that integrate findings from environmental rounds or other patient safety processes (such as aggregated Root Cause Analysis (RCA)), must be conducted at least once a year for all shifts at the facility or site of jurisdiction, including community-based outpatient clinics (CBOC).
  - a. Once relevant staff have received initial awareness 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 the surrounding facility.
  - b. Once the staff members are fully trained and the search plan is fully implemented, an actual search will be conducted and critiqued; this will substitute as a drill for the shift involved in the search. *NOTE: It is recommended that the sites for missing patient drills be prioritized based on known areas of vulnerability and lessons learned from RCA's and other risk management or performance improvement processes.*
5. The systematic and comprehensive monitoring and assessment of hazardous areas and construction sites must be an integral part of this process.
  - a. It is essential to plan appropriate security measures, including methods for promptly discovering breaches and devising responses to such discoveries, for areas of the medical facility 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 when entered by an untrained individual could reasonably be considered to hold potential danger must be integrated into local processes.*

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b. 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.

6. Ensuring the location of at-risk patients by use of:

a. **Electronic Technology.** The use of electronic technology (e.g., patient tracking bracelets, for those patients considered to be at-risk) may only be used as one tool to enhance and augment other processes for minimizing the risk of patients wandering away from a designated area or care site. This use must not be considered as a substitute for professional vigilance and systematic verification of patients' location (e.g., shift changes, and other in patient supervised settings). When electronic technology is in use:

(1) 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 required every 24 hours at a minimum to ensure proper functioning and minimize risk. Maintenance of the system must be consistent with manufacturer's guidelines; however, a complete systems check must be performed at least annually. *NOTE: A proactive assessment of potential vulnerabilities of the system and its use (e.g., failure Modes Effects Analysis) needs to be performed to guide the appropriate use of the system (see VHA Handbook 1050.01).*

(2) Electronic devices and systems must be re-evaluated at the time of each wandering or missing patient event to assess possible contributing factors.

b. **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 at-risk. Supervision of patients must be consistent with review findings.

c. **Identification.** Facility processes must be established to ensure the availability of pictures and physical descriptions for all at-risk patients suspected to be missing; this is a means to enhance the effectiveness of search procedures. Patient Identification System photographs may be used where available. In addition, once a patient is identified as both at-risk and missing, the facility that "owns" the patient needs to immediately issue a local intranet announcement to all employees.

d. **Transport.** Special precautions must be taken during the transport of known at-risk patients and for those with a reported change in mental status.