Patient Safety Alert

File Number: 16/17-08
February 7, 2017

MONITORING OF RESIDENTS AND PATIENTS AT RISK OF WANDERING

When a patient or resident is at risk of wandering, a monitoring device such as a Wanderguard® bracelet may be used to help ensure safety. Safety then depends upon the ensuring the alarm is activated and staff respond to the alarm when a patient or resident attempts to leave a safe area.

RECOMMENDATIONS

The Ministry of Health recommends that regional health authorities and health care organizations using electronic exit controls (such as a Wanderguard® system) to protect patients and residents at risk of wandering ensure the following:

- **All doors with magnetic locks/key codes and all monitoring stations are checked daily as per manufacturer recommendations to ensure proper latching and alarm activation.**
- **All door/exit alarms are responded to immediately to ensure no patient or resident has left the area.**
- **Door alarms are not placed on bypass and doors are not propped open.**
- **Each signaling device for each patient/resident is tested daily and the results of that test recorded.**
- **Regular patient/resident status checks such as purposeful hourly rounding are in place to ensure if an elopement occurs it can be detected in a timely manner.**
- **Staff are familiar with Code Yellow protocol to ensure a timely organizational response when a patient or resident is discovered to be missing.**
- **A patient or resident's monitoring device from home or another facility is removed upon admission.**
- **The monitoring system remains functional in the event of a power loss or power surge.**

Supporting Documents

None.

Background of the Critical Incident

An 89 year old resident with dementia and a history of wandering was found outside in the locked courtyard of a rural facility on a cool autumn day. The resident was thought to be outside for no longer than 10 minutes because the resident's hands were still warm to touch when the resident was found. The resident had a monitoring bracelet (Wanderguard®) in place however the system did not alarm when the resident went out the door.

There were three similar elopement events reported in the same health region during the same timeframe. On one occasion, a resident of long term care was found in the resident's former home more than 1 km from the facility several hours after having been last seen. In another event, a resident was found frostbitten in a snowbank on a day when the wind chill was -34˚Celsius. The resident was thought to have been outside for up to three hours. In another event, a resident was thought to be wearing a monitoring bracelet but it was from a previous home and not activated for the system in use in the facility. In all events, the door alarm failed to notify staff of the resident's intent to leave the facility.

Multiple causes of the alarm failures included:

- The monitoring station was found to be disarmed/deactivated;
- The door was propped open;
- The monitoring bracelet was not activated for the local system;
- The alarm sounded but was not responded to by staff urgently; and
- A magnetic connection was not engaged, therefore a secure door remained unlocked.

Analysis

Wandering is the non-purposeful movement of a patient or resident from one area to another and can be seen in some people with dementia. Wandering is generally not harmful unless it results in the patient or resident leaving the secured unit or facility. At such time, the risk of wandering heightens and can result in death or injury to the patient or resident. Steps to safely monitor and manage wandering tendencies can minimize risk of elopement.

Upon admission to a unit or facility, all patients and residents should be assessed for risk of elopement and then reassessed at regular intervals throughout the year, or when changes to care needs or behaviours indicate. The purpose of monitoring systems is to provide exit control, such as restricting or reducing access to unsupervised areas through electronic monitoring and controls.

Contributory Factors

1. The resident was known to exhibit wandering behaviour during a previous acute care admission. The resident had a previous elopement attempt four days earlier but was found on the sidewalk in front of the facility and was quickly returned. The attempt to elope was not further investigated and corrective actions not taken.
2. Monitoring systems can be disarmed when there is a power surge or bump.
3. Monitoring systems can convert to battery power following a power loss although this connection is not always automatic.