NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

June 1, 2016

DAL: NH DAL 16-03

RE: Unsafe Wandering

Dear Nursing Home Administrator:

Please remind your staff to be especially diligent in preventing unsafe wandering behavior.

It is recommended that a review be conducted of your facility's wandering behavior management program. The program should promote time for outside activities that can be therapeutic and helpful to the resident's health status and quality of life, while also including mechanisms that reduce the risk of unsafe behaviors and adverse outcomes that can result.

In order to better familiarize yourself and staff with your facility's wandering/elopement policies and procedures, please re-examine your security systems to ensure that adequate safeguards are in place.

Special attention should be given to the following:

- The desire of residents to spend time outside.
- Changes in resident health or mental status. Ensure residents are reassessed for risk of unsafe wandering behavior when any significant change in status occurs and modify the resident's care plan accordingly.
- Assignment of staff (as a result of increased staff vacations) who are not familiar with all residents and their special needs.
- Increased number of visitors who are unfamiliar with facility procedures/operations and residents. Staff who monitor building egress locations should be especially vigilant during times of the day when visitor traffic is high.
- Weather related conditions that might impact alarms or other environmental features of the facility.
- Functionality of door and wander alarm alerts (including all bracelets). Please ensure that all alarms are functioning and that they are tested frequently.

It is important that your facility remain attentive to prevent negative resident outcomes associated with unsafe wandering. **ALL** staff should be aware of the facility's systems, policies and procedures for identifying, managing, preventing, and responding to unsafe behaviors.

Additionally, to ensure ongoing resident safety, leadership should communicate with staff when back-up systems are implemented due to non-functioning primary alarm systems.

Please note per 42 CFR 483.13 and 10 NYCRR 415.4 reports of elopement should be submitted to the Department within **24 hours** after discovery of the incident.

Please consider posting this letter at all nursing stations, staff rooms and security areas.

Thank you in advance for your efforts to provide our residents with a safe environment that allows them to enjoy a meaningful and satisfying quality of life. If you have any questions, please call the Bureau of Quality Assurance and Surveillance for Nursing Homes at (518) 408-1267.

Sincerely,

Shelly Glock, Director
Division of Nursing Homes and ICF/IID Surveillance
Center for Health Care Provider Services and Oversight