



# **Department of Veterans Affairs Office of Inspector General**

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## **Healthcare Inspection**

### **Follow-Up Evaluation of Veterans Health Administration Missing Patient Policies and Procedures**

**To Report Suspected Wrongdoing in VA Programs and Operations:**

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## Executive Summary

This review follows up on an Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), report entitled *Evaluation of Veterans Health Administration Missing Patient Policies and Procedures*, report number 00-00282-12, dated November 30, 2000. In that report, we made multiple recommendations to improve the safety of patients at risk for wandering or elopement. In response, Veterans Health Administration (VHA) implemented new policies and enhanced procedures.

We randomly sampled 30 medical facilities from all 21 Veterans Integrated Service Networks related to their missing patient events that occurred in FY 2009. We conducted individual medical record reviews to validate the self-reported data. Selected self-reported data and the results of our full medical record validation of same were used to determine compliance with VHA Directive 2008-057, *Management of Wandering and Missing Patients*.

We focused on the following areas and requirements:

- Pursuing the outcome of every patient who was reported missing.
- Conducting and documenting risk assessments.
- Implementing and documenting safety measures.
- Reporting incidents as required.

A representative sample of 200 missing patient events occurring in FY 2009 reflected that VHA facilities were following up on missing patients and documenting the outcomes of those efforts, and that staff were reporting missing patient events in accordance with guidelines. VHA has also shown substantial improvement in the areas of elopement/wandering risk assessment and implementation of safety measures; however, additional actions were needed. Specifically, staff were not consistently applying the assessment criteria or completing the assessments before the missing patient events occurred, documenting proactive and concurrent safety measures, or placing Patient Record Flags as required. We also found that VHA Directive 2008-057 provides confusing guidance related to the timing of risk assessments, and that local policies didn't always comply with other requirements as outlined in the Directive.

The Under Secretary for Health agreed with the findings and conclusions and provided acceptable improvement plans.

## Part I. Introduction

### Purpose

This review follows up on an Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), report entitled *Evaluation of Veterans Health Administration Missing Patient Policies and Procedures*, report number 00-00282-12, dated November 30, 2000. In that report, we made multiple recommendations to improve the safety of patients at risk for wandering or elopement. In response, Veterans Health Administration (VHA) implemented new policies and enhanced procedures focusing on patient assessment, safety measures, and incident reporting, among other issues. The purpose of this review was to determine VHA facilities' compliance with those updated policies and procedures.

### Background

After several sentinel events involving missing patients in the late 1990s, the OIG conducted a review to assess VHA's overall guidance related to missing patients. That review evaluated missing patient events, as reported by individual VHA medical facilities, during fiscal years (FYs) 1998-1999. It also included site visits to 11 VHA medical centers, 428 employee surveys, 198 medical record reviews, and 67 physical plant tours.

### *Summary of Findings from OIG Report 00-00282-12*

Our November 2000 report reflected that during the 2-year period in question, 4,088 patients were reported missing, and that 233 were not found as a result of the search process. While 146 of the 233 subsequently presented back to a VHA medical facility or were located through other means, we asked the Under Secretary for Health to follow up on the remaining 86<sup>1</sup> patients. Ultimately, 82 of those patients were accounted for; however, 4 patients remained missing at the time of report publication.

We recommended that managers assure that employees aggressively pursue the outcome of every patient reported as missing in a timely manner. We also made recommendations related to policy enhancement, staff training, risk assessment completion, supplemental safety measure implementation and documentation, incident reporting, construction site safety, and electronic monitoring system functionality. Further, we noted dramatic variation in the numbers of missing patients reported by Veterans Integrated Service Networks (VISNs), from a low of 28 to a high of 642. We suggested that VHA revisit its missing patient reporting policies and procedures to ensure consistent application throughout the nation.

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<sup>1</sup> The list contained 86 names rather than 87 names as one patient was listed as missing twice.

In response, VHA issued Directive 2002-103, *Management of Wandering and Missing Patient Events*, dated March 4, 2002, and updated the National Center for Patient Safety (NCPS) Handbook. Both documents provided detailed instructions for the assessment and management of patients at risk for wandering and elopement and provided guidance relative to safety measures, search procedures, and incident reporting. The Directive also called for the development of a Missing Patient Register, which would aid in flagging the medical records of patients who might present to other VHA medical facilities and would allow for analysis of national patterns.

On September 23, 2008, VHA updated the relevant guidance and issued VHA Directive 2008-057, *Management of Wandering and Missing Patients*. The most significant changes from 2002-103 and its successor, 2008-057, included a change in terminology from “high-risk” patient to “incapacitated” patient (although the definition remained virtually the same), elimination of the Missing Patient Registry, and implementation of electronic patient record flags (PRFs) and alerts.

Directive 2008-057 outlines systematic definitions to clearly differentiate between those high-risk patients for whom VHA has a fiduciary responsibility and low risk (or absent) patients who would not require the same level of safety precautions or follow-up. The Directive provided the following definitions:

- (1) **Incapacitated patient** is considered incapacitated if, at a minimum, they are legally committed; or have a court-appointed guardian; or are considered a danger to self or others; or lack cognitive ability to make decisions; or have mental or physical impairments that increase their risk of harm to self or others.
- (2) **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** is a high-risk patient who disappears from an inpatient or outpatient treatment area or while under the control of VHA, such as during transport.
- (4) **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.

According to policy, an otherwise absent patient is to be classified as missing when one or a combination of additional environmental and/or clinical factors may increase the patient’s vulnerability and risk such as weather conditions, recent trauma, or homelessness.

## Scope and Methodology

We randomly sampled 30 medical facilities from all 21 VISNs. Twenty-seven facilities provided data on their missing patient events that occurred in FY 2009; the remaining 3 facilities reported no missing patient events during the specified date range. The facilities provided data on their missing patient events that included, among other elements, basic patient demographic information, diagnosis, and condition when found. We also conducted individual medical record reviews to validate the self-reported data. In those cases where we disagreed with the medical center's response, a second (or in some cases, third) level review was conducted by another OIG inspector. We summarized selected self-reported data and provided the results of our full medical record validation of same. This data was used to determine compliance with Directive 2008-057.

For this review, we focused on the following areas and requirements:

- Pursuing the outcome of every patient who was reported missing.
- Conducting and documenting risk assessments.
- Implementing and documenting safety measures.
- Reporting incidents as required.

The inspection was conducted in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

## Report Findings

Twenty-seven of the 30 facilities reported a total of 200 missing patient events in FY 2009. The 14 VISNs reported as few as 2 to as many as 46 missing patient events. The average age of patients when they were reported as missing was 58 years. About 33 percent of patients were reported missing from inpatient medicine/surgery units, 23 percent from long-term care units, 17 percent from inpatient mental health settings, and 11 percent from emergency departments. The remaining patients were reported missing from outpatient clinics, community placements, or other VHA programs. About 99 percent of the missing patients were reportedly found as a result of the search or were located later; only 2 patients were listed as "not found" (although they were later accounted for). Further, 95 percent of the missing patients reportedly had no injuries when found, 4 percent had minor injuries, and 1 percent had major injuries. There were no missing patient event-related deaths reported.

### Issue 1. Missing Patient Follow-up

Overall, VHA medical facilities have shown improvement in pursuing the outcome of patients who eloped or wandered from their treatment settings.

All 200 patients who eloped or wandered from their treatment settings in FY 2009 were found as a result of the search or were subsequently located. During our medical record review, though, we found one case where medical center staff erroneously reported that a patient had been found the day following his elopement in November 2008 and that his pension checks continued to be sent to his direct deposit account at a local bank. However, we found no evidence in the medical record of any actual contact with the patient since the day of his elopement. We expanded our electronic medical record search to all VHA facilities without success. We confirmed that the patient's pension checks were still being sent to a local bank; however, this does not establish with certainty that the patient is no longer missing. In fact, a private-sector website devoted to missing persons still lists this patient as missing. The case was referred back to the Medical Center Director for investigation and disposition.

Irrespective of this case, we concluded that VHA facilities were appropriately following up on missing patients and documenting the outcomes of those efforts.

## **Issue 2. Risk Assessments**

VHA clinical staff did not consistently complete elopement and wandering risk assessments in a manner which could prevent missing patient events. VHA Directive 2002-013 included the requirement to “systematically assess all patients to determine the risk potential for those who may wander or become missing from a treatment setting” and goes on to define high-risk patients as those that are incapacitated if, at a minimum, they meet at least one of five criteria, as follows:

1. Are legally committed, or
2. Have a court-appointed guardian, or
3. Are considered dangerous to self or others, or
4. Lack cognitive ability (either permanently or temporarily) to make relevant decisions, or
5. Have physical or mental impairments that increase their risk of harm to self or others.

Then, in its *TIPS* newsletter (Volume 5, Issue 6) dated November/December 2005 the NCPS reported that assessment was a contributing factor in 28 percent of missing patient events (based on 277 root cause analyses involving missing patients as of December 2004). *TIPS* specifically noted, “Use of assessments or lack of staff education on using assessments, documentation and/or communication of assessments was inadequate, assessments were not applied consistently and/or the application of assessment criteria was inconsistent, and a lack of implementation of preventive measures from assessments led to patients not being assessed or treated as high risk for elopement/wandering.”



In September 2008, VHA issued Directive 2008-057 with precisely the same guidance for elopement/wandering and cognitive assessments. This review found that while elopement/wandering risk assessment compliance has improved somewhat, the condition still exists. Specifically, we found that:

- Clinicians were not consistently applying the elopement/wandering risk criteria.
- Clinicians were not consistently completing elopement/wandering risk assessments before a missing patient event.
- Instructions on when to complete an elopement/wandering risk assessment as outlined in VHA Directive 2008-057 are vague and, therefore, confusing.

### ***Application of Elopement/Wandering Risk Assessment Criteria***

The data included 200 missing patient events and reflected 76 (38 percent) high-risk patients, 108 (54 percent) low-risk (or absent) patients, and 16 (8 percent) patients who were not assessed. We noted, however, that 4 of the 16 patients left the treatment setting before they could be assessed. While the self-reported data suggests that VHA clinicians generally complied with elopement/wandering risk assessment requirements, we found that clinicians needed to more consistently apply established criteria when determining risk and to complete elopement/wandering risk assessments in a more systematic and proactive manner.

We conducted individual medical record reviews on the 76 self-reported high-risk patients and applied the elopement/wandering risk criteria as detailed in VHA Directive 2008-057. We agreed with the high-risk assessment ratings in 72 of those cases; however, we believe the remaining cases, based on medical record documentation, did not meet the criteria defining “incapacitation” and were, therefore, not technically high-risk. Alternatively, we identified 13 cases that were reported as low-risk, but based on the medical record documentation, more appropriately fit the criteria for incapacitation at the time the patient was reported missing and should, therefore, have been categorized as high risk.

One example of VHA-OIG disagreement involved a 74-year-old patient with a history of vascular dementia who was admitted to a medical ward after he left his Adult Board & Care home and was found wandering in the street. A similar event had occurred approximately 3 years prior. The patient was admitted for the purpose of nursing home placement. On March 7, documentation reflected that conservatorship was pending and that an electronic monitoring system should be “sufficient” if the patient was placed in the Community Living Center (CLC). On March 9, a CLC clinician completed an admission assessment that categorized the patient as low-risk, noting that he had not wandered from his medical ward treatment setting “recently.” No safety measures were implemented. On March 10, the patient eloped. As the patient was cognitively impaired enough to necessitate a conservator and also had a history of wandering, we believe he

should have been categorized as high-risk. The fact that he had not wandered away from the supervised unit in the previous 10 days does not mean that he wouldn't do so in the future, given the opportunity.

We acknowledge that cognitive status, mood, and intentions can fluctuate from day to day, or from hour to hour, possibly leading staff to perceive that patients are not at risk at certain times. However, due to the often unpredictable nature of wandering and elopement, assessment using established criteria is critical to patient safety.

### ***Timing of Elopement/Wandering Risk Assessments***

The self-reported data showed that 184 cases had elopement risk assessments, yet we validated that 62 (34 percent) had not been completed prior to the missing patient event. Ultimately, 26<sup>2</sup> (42 percent) of the 62 patients were later designated to be high-risk.

Missing Patient Events FY 2009 (30 sample sites)	200			
Evidence of Risk Assessment	184	RA completed BEFORE event	122	<ul style="list-style-type: none"> <li>• 50 High-Risk</li> <li>• 72 Low-risk</li> </ul>
		Risk level designated AFTER event	62	<ul style="list-style-type: none"> <li>• 26 High-risk</li> <li>• 36 Low-Risk</li> </ul>
NO Risk Assessment Completed	16			

While VHA Directive 2008-057 does not specifically outline when or how often an elopement risk assessment should be completed, it clearly identifies the need to “prevent and effectively manage missing patient events that place patients at harm” and to be “as proactive as possible in minimizing risks for aging patients.” It further states that if the patient is incapacitated, the responsible clinician should “make an assessment and determine safety measures appropriate for the patient that need to be part of the treatment plan.” We interpreted these statements to mean that elopement/wandering risk assessments are intended to be part of a risk reduction and prevention strategy and should, therefore, be completed prior to missing patient events. Without proactive risk assessments, clinicians could not implement appropriate safety measures to prevent elopement and wandering.

### ***Instructions as Outlined in VHA Directive 2008-057***

Elopement/wandering risk assessments. We found guidance regarding elopement/wandering risk assessments to be vague and confusing. As noted earlier, there are no specific requirements for when and how often these risk assessments should be

<sup>2</sup> Fourteen of those patients were reported missing from inpatient settings, seven from an ED, and seven from outpatient settings.

completed; however, other language in the document implies that they are the basis for preventive safety measures. Another section of the Directive requires designation of persons who can perform a clinical review of patients when they have disappeared to determine if they are missing (high-risk/incapacitated requiring a search) or absent (low-risk, requiring no formal search). Thus, it appears that the assessment of risk category is supposed to be completed at least twice — once before the patient elopes or wanders so as to permit safety measures and increased monitoring, and once after the patient is reported missing to determine whether an official search is needed. However, the Directive does not explicitly define this distinction.

Cognitive assessments. We also found the wording and instructions regarding the completion of cognitive assessments to be somewhat misleading. The below excerpt can be found on page 7 of the Directive and describes the responsibility of each Director, or designee, for:

*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 incapacitated patient's status regarding legal commitment, guardianship, dangerousness to self or others, and cognitive ability and the associated safety risks. The frequency for assessing the cognitive ability of patients must be determined with regard to their safety and for developing safety measures, as appropriate for the patient's condition by:*

*(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 the patient has disappeared from a clinical setting.*

The first italicized paragraph again elucidates the criteria for determining elopement/wandering risk. However, the paragraph goes on to focus on the cognitive assessment and when it should be completed, to the exclusion of the other criteria. We believe that the way the paragraph reads, and how it is immediately followed by the expectations for when cognitive assessments should be completed, could be inadvertently misleading. Specifically, some clinicians could interpret this section to mean that completion of the cognitive assessment at the specified intervals meets the intent of the elopement/wandering risk assessment.

We found high compliance with the requirement to assess cognitive ability at specified times as required by the Directive. In 193 (97 percent) of the 200 missing patient cases, we confirmed that some minimal level of cognitive assessment was completed prior to the event. We credited VHA for completing a cognitive assessment if the documentation

reflected, at a minimum, the patient's level of alertness and orientation, even though that may not be a complete measure of decision making capacity. While cognitive ability is central to the determination of incapacitation, this evaluation is but one component of an elopement/wandering risk assessment. The other components that could establish "incapacitation" must also be considered.

Local policies. We reviewed eight facility policies governing missing patient events that were issued after VHA Directive 2008-057 became effective on September 23, 2008, to determine whether these policies expanded on the VHA Directive and provided clear guidance on when elopement/wandering risk assessments should be completed. In general, we found that the policies followed the VHA Directive and did not specifically identify the timing of those assessments. We also found that several local policies tended to focus on assessing the patient's risk level and managing the event after the patient was reported missing. These policies generally outlined, often in great detail, search procedures and reporting requirements after a patient was reported missing. We further noted that one policy did not include specific requirements to complete a cognitive assessment per VHA guidelines. We also noted other discrepancies involving patient record flags (PRFs - see page 9 for details) and the Missing Patient Registry. We noted that three policies required entry of patients into the missing patient registry if they were not found as a result of the search. However, Directive 2008-057 replaced the missing patient registry with VISN Issue Briefs in September 2008.

We concluded that while VHA has shown substantial improvement in the area of elopement/wandering risk assessment, staff were not consistently applying the assessment criteria or completing the assessments before the missing patient events occurred. In addition, VHA Directive 2008-057 provides vague and confusing guidance related to these issues, and local policies don't always comply with other requirements as outlined in the Directive.

### **Issue 3. Proactive Safety Measures**

VHA clinicians and other responsible staff did not consistently implement and document safety measures once patients were assessed to be high risk for elopement or wandering. VHA Directive 2008-057 requires that "assessment and related safety measures must be discussed by each patient's treatment team and documented as being discussed." In this section, we evaluated the use and documentation of interventions such as 1:1 observation, 15-minute head counts, escorts, colored vests/pajamas; electronic monitoring systems; and PRFs.

Safety Interventions. In an effort to fairly and accurately evaluate facilities' compliance with safety measure requirements, we based this section of the review on the 50 patients that the facilities assessed to be high-risk before the missing patient event. In those cases, facilities should have clearly implemented safety measures to prevent elopement or

wandering. We did note multiple cases where patients were admitted to locked units, placed on 1:1 observation, or issued blue pajamas because of suicide risk, and in these cases, those safety measures would have served to prevent or limit the opportunity to elope or wander. We credited VHA for these measures even though they were not specifically addressing elopement/wandering risk. Of the 50 patients, our record review found that 11 (22 percent) did not have documented proactive safety measures in place.

Electronic Monitoring Systems and Concurrent Safety Measures. VHA clinical staff did not consistently assure that patients with electronic monitoring devices also had concurrent safety measures in place. Electronic wristband and anklet tracking devices are used in many hospitals and long-term care facilities that treat patients who are impaired or otherwise at high risk for wandering or elopement. When a monitored patient attempts to leave a unit through a monitored exit, an alarm is triggered, notifying employees of the breach.

The data reflected that 11 facilities used electronic monitoring systems. While the facilities stated that 24 patients had wristbands or anklets placed before the missing patient event, we could only confirm this in 16 of those cases. A majority of electronic monitoring systems were applied to patients in the CLC. Of note, several facilities reported that patients were able to remove the wristbands, and in one case, “chew through” the wristband. Because these systems can apparently be defeated by determined patients, the use of concurrent safety measures becomes critical to the safety plan. Our review found that concurrent safety measures were not documented for 11 (69 percent) of the 16 patients.

Patient Record Flags. Facility-wide PRFs (also known as Category II PRFs or clinical reminders) were not consistently placed in the electronic medical record when patients were assessed to be high risk for elopement. Directive 2008-057 notes that “Staff needs to be alerted to patients’ special risk through a Patient Record Flag or clinical reminders.” This requirement refers to a medical record alert that notifies other staff within the facility that a patient is at-risk and requires special attention or safety measures. Of the 50 cases that medical center clinicians assessed before the event to be high-risk, only 7 (14 percent) medical records were flagged. All seven were flagged before the elopement or wandering event. To be an effective risk reduction strategy, facility-wide PRFs should be placed before patients elope or wander from their treatment settings.

The Directive also requires that a Category I PRF be placed when a search fails to locate a missing patient and that it should be removed as soon as the patient is located. Category I PRFs display at all VHA facilities where the patient is known, registered, or appears for treatment. As a result, patients with a Category I PRF who present an immediate safety risk to themselves or others by virtue of their behavior, their health status, or other characteristics may be safely treated wherever in VHA they may seek care. We can’t say with certainty whether Category I PRFs were routinely initiated when searches failed to

locate patients, and were subsequently removed after patients were found. However, seven of the eight policies we reviewed did not contain any statement about the requirement for a Category I PRF. In addition, we know that the one patient we identified as still missing did not have a Category I PRF.

## **Issue 4. Reporting Missing Patient Incidents**

VHA facilities generally complied with missing patient reporting requirements. When VHA issued its 2002 Directive and updated its Patient Safety Handbook, requirements for the evaluation and reporting of missing patient events were clearly outlined. Since that time, guidance has mandated that individual or aggregate root cause analyses (RCAs) be conducted on missing patient events and that appropriate data be entered into NCPS' incident reporting database (referred to as SPOT).

The data suggests substantial improvement with reporting requirements. Of the 200 missing patient events, 183 were reportedly entered into NCPS' incident reporting database and 170 were included in aggregate RCAs. Consistent reporting of missing patient events permits NCPS to conduct meaningful analyses and make suggestions to improve systems and processes.

## **Conclusions**

Following our November 2000 report, VHA implemented and updated guidance to improve the safety of patients at risk for wandering and elopement. A representative sample of 200 missing patient events occurring in FY 2009 reflects that VHA facilities were following up on missing patients and documenting the outcomes of those efforts, and that staff were reporting missing patient events in accordance with guidelines. And while VHA has shown substantial improvement in the area of elopement/wandering risk assessment and implementation of safety measures, additional actions are needed to promote patient safety. Specifically, staff were not consistently applying the assessment criteria or completing the assessments before the missing patient events occurred, documenting proactive and concurrent safety measures, or placing PRFs as required.

We also found that VHA Directive 2008-057 provides confusing guidance related to the timing of risk assessments, and that local policies don't always comply with other requirements as outlined in the Directive.

## Recommendations

**Recommendation 1.** The Under Secretary for Health should ensure that clinicians consistently assess patients' elopement and wandering risk using established criteria.

**Recommendation 2.** The Under Secretary for Health should revise VHA guidance to specifically define when and how often full elopement/wandering risk assessments should be completed, with an emphasis on prevention of missing patient events.

**Recommendation 3.** The Under Secretary for Health should require medical facilities' Missing Patient policies to conform to revised VHA guidance.

**Recommendation 4.** The Under Secretary for Health should ensure that clinicians consistently implement and document proactive safety measures for patients assessed to be incapacitated.

**Recommendation 5.** The Under Secretary for Health should ensure that clinicians consistently implement and document concurrent safety measures for patients on electronic monitoring systems.

**Recommendation 6.** The Under Secretary for Health should ensure that medical facilities utilize PRFs in accordance with VHA guidance.

## Comments

The Under Secretary for Health agreed with the findings and conclusions and provided acceptable improvement plans. See Appendix A for the complete text of the Under Secretary's comments. We will continue to follow up until all actions are complete.

*(original signed by:)*

JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
Healthcare Inspections

## Under Secretary for Health Comments

**Department of  
Veterans Affairs**

### Memorandum

**Date:** June 25, 2010

**From:** Under Secretary for Health (10)

**Subject:** OIG Draft Report, Follow-Up Evaluation of Veterans Health Administration Missing Patient Policies and Procedures (WebCIMS 401081)

**To:** Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the recommendations. Attached is the Veterans Health Administration's (VHA) corrective action plan for the report's recommendations.

2. VHA concurs with the report's recommendations. The Office of Patient Care Services is currently revising VHA's Directive on Management of Wandering and Missing Patients. In addition, the Office of the Deputy Under Secretary for Health for Operations and Management will resend the Management of Wandering and Missing Patients Directive to the field, and instruct the Medical Center Directors to develop, publish, and implement policies for both on-facility grounds and off-facility grounds that require early intervention to minimize risks to wandering.

3. Thank you for the opportunity to review the draft report. A complete action plan to address the report's recommendation is attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

*(original signed by:)*  
Robert A. Petzel, M.D.

Attachment



## VETERANS HEALTH ADMINISTRATION (VHA) Action Plan

Office of Inspector General (OIG) Draft Report, Follow-Up Evaluation of Veterans Health Administration Missing Patient Policies and Procedures, (WebCIMS 401081)

**Date of Draft Report: May 2010**

Recommendations/ Actions	Status	Completion Date
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**Recommendation 1. The Under Secretary for Health should ensure that clinicians consistently assess patients' elopement and wandering risk using established criteria.**

### VHA Comments

Concur

The Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) will:

- Resend the Management of Wandering and Missing Patients Directive to the field requesting certification from the Veterans Integrated Service Network (VISN) Director that processes are in place to ensure compliance.
- Add an announcement to the National Hot-Line call agenda to ensure expectations of compliance are clear and offer the opportunity for questions and further clarification.
- Instruct the Medical Center Directors to develop, publish, and implement policies for both on-facility grounds and off-facility grounds that require:
  - a. Timely assessments of patients and documentation of such assessments.
  - b. Early intervention to minimize risks to wandering patients.
  - c. Clear designation of responsibility for security of construction and other environmental hazards to minimize risks of inappropriate or unauthorized access to unsafe areas.
  - d. Timely and thorough searches, staff competency, and referral of these events for Root Cause Analysis (RCA) or Administrative Review (AR).

In process

December 30, 2010

**Recommendation 2. The Under Secretary for Health should revise VHA guidance to specifically define when and how often full elopement/wandering risk assessments should be completed, with an emphasis on prevention of missing patient events.**

VHA Comments

Concur

The Office of Patient Care Services is currently revising the VHA Directive on Management of Wandering and Missing Patients. Attention to timing of risk assessments and prevention of missing patient events are part of the revision. Attention will be paid to other OIG recommendations to determine any additional changes to the draft directive.

In process

November 30, 2010

**Recommendation 3. The Under Secretary for Health should require medical facilities' Missing Patient policies to conform to revised VHA guidance.**

VHA Comments

Concur

The DUSHOM will:

- Resend the Management of Wandering and Missing Patients Directive to the field requesting certification from the VISN Director that processes are in place to ensure compliance.
- Add an announcement to the National Hot-Line call agenda to ensure expectations of compliance are clear and offer the opportunity for questions and further clarification.
- Instruct the Medical Center Directors to develop, publish, and implement policies, for both on-facility grounds and off-facility grounds that require:
  - a. Timely assessments of patients and documentation of such assessments.
  - b. Early intervention to minimize risks to wandering patients.
  - c. Clear designation of responsibility for security of construction and other environmental hazards to minimize risks of inappropriate or unauthorized access to unsafe areas.
  - d. Timely and thorough searches, staff competency, and referral of these events for RCA or AR.

In process

December 30, 2010

**Recommendation 4. The Under Secretary for Health should ensure that clinicians consistently implement and document proactive safety measures for patients assessed to be incapacitated.**

VHA Comments

Concur

The DUSHOM will:

- Resend the Management of Wandering and Missing Patients Directive to the field requesting certification from the VISN Director that processes are in place to ensure compliance.
- Add an announcement to the National Hot-Line call agenda to ensure expectations of compliance are clear and offer the opportunity for questions and further clarification.
- Instruct the Medical Center Directors to develop, publish, and implement policies for both on-facility grounds and off-facility grounds that require:
  - a. Timely assessments of patients and documentation of such assessments.
  - b. Early intervention to minimize risks to wandering patients.
  - c. Clear designation of responsibility for security of construction and other environmental hazards to minimize risks of inappropriate or unauthorized access to unsafe areas.
  - d. Timely and thorough searches, staff competency, and referral of these events for RCA or AR.

In process

December 30, 2010

**Recommendation 5. The Under Secretary for Health should ensure that clinicians consistently implement and document concurrent safety measures for patients on electronic monitoring systems.**

VHA Comments

Concur

The DUSHOM will:

- Resend the Management of Wandering and Missing Patients Directive to the field requesting certification from the VISN Director that processes are in place to ensure compliance.
- Add an announcement to the National Hot-Line call agenda to ensure expectations of compliance are clear and offer the opportunity for questions and further clarification.

- Instruct the Medical Center Directors to develop, publish, and implement policies for both on-facility grounds and off-facility grounds that require:
  - a. Timely assessments of patients and documentation of such assessments.
  - b. Early intervention to minimize risks to wandering patients.
  - c. Clear designation of responsibility for security of construction and other environmental hazards to minimize risks of inappropriate or unauthorized access to unsafe areas.
  - d. Timely and thorough searches, staff competency, and referral of these events for RCA or AR.

In process

December 30, 2010

**Recommendation 6. The Under Secretary for Health should ensure that medical facilities utilize PRFs in accordance with VHA guidance.**

VHA Comments

Concur

The DUSHOM will:

- Resend the Management of Wandering and Missing Patients Directive to the field requesting certification from the VISN Director that processes are in place to ensure compliance.
- Add an announcement to the National Hot-Line call agenda to ensure expectations of compliance are clear and offer the opportunity for questions and further clarification.
- Instruct the Medical Center Directors to develop, publish, and implement policies for both on-facility grounds and off-facility grounds that require:
  - a. Timely assessments of patients and documentation of such assessments.
  - b. Early intervention to minimize risks to wandering patients.
  - c. Clear designation of responsibility for security of construction and other environmental hazards to minimize risks of inappropriate or unauthorized access to unsafe areas.
  - d. Timely and thorough searches, staff competency, and referral of these events for RCA or AR.

In process

December 30, 2010

Veterans Health Administration  
June 2010

## OIG Contact and Staff Acknowledgments

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