Wandering Patient Critical Incident Exercise

Timeline

Date/Time	Item	Source
4 months prior to incident	75-year-old female resident admitted to the secured dementia unit of the home. Medical history: Type II diabetes, dementia. Assessed as an elopement risk and an electronic monitoring bracelet was placed on her right wrist.	Health Record Staff Interviews
6 weeks prior to incident	Resident has become increasingly confused and agitated. Assessed by physician who ordered Risperidone (antipsychotic agent) 0.25 mg at bedtime.	Nursing progress notes
4 weeks prior to incident	Resident found outside the home in the early evening. Resident was in the staff parking lot at the back of the building and was found by a staff member coming in for the evening shift. Staff on duty did not recall hearing any alarms sound. The resident's electronic bracelet was tested and found to be working.	Nursing progress notes Staff interviews
2 weeks prior to incident	Resident very confused and attempting to leave unit; redirected numerous times by staff. Physician contacted; order received to increase Risperidone to 0.25 mg twice daily.	Nursing progress notes
Day of incident 1145h	Resident told nurse who gave noon medications that she "was going home". Staff planned for resident to eat lunch in the dining room and then nap in her room per her usual routine. She was last observed eating lunch.	Staff interviews
1305h	Back door alarm sounded; reset by staff without checking as one staff member had just left the desk on lunch break and usual practice was to exit through back door to gain easy access to the parking lot.	Staff interviews
1600h	Care aide went to check on resident to get her ready for supper but did not find her in her room; assumed she was already in the common room watching TV.	Staff interviews
1730h	Dietary staff noticed that resident was not in the dining room. Discussed with care aide who went to check her room.	Staff interviews
1740h	Care aide unable to locate resident. Checked other care units and walked around perimeter of building but could not locate her.	Health record Staff interviews
1755h	Care aide reported to charge nurse that resident is missing. Overhead announcement of Code Yellow. Full search of entire facility initiated.	Health record Staff interviews
1840h	Staff unable to locate resident on the grounds. Resident's family contacted. Evening staff are arriving so three of the day shift staff get in their personal vehicles and begin searching the surrounding area. Call made to local police. Police advised that an elderly woman was found unresponsive, along the highway 2 km from the home at approximately 1800h and that she has been transported to hospital for treatment. Patient was dressed only in light clothing and slippers, temperature 0˚C.	Health record Staff interviews
1845h	Resident's family contacted to advise that resident has been found and is at local emergency department.	Health record Staff interviews
1850h	Charge nurse contacted local emergency department for report on resident condition. Patient severely hypothermic; warming protocol initiated.	Health record Staff interviews
1 day after incident	Patient died.	Health record
1 week after incident	Electronic alert bracelet returned to facility. Found not to be working. It was later determined that the resident had been fitted with a 90-day device, rather than a 12-month device as intended.	Health record

Critical Incident Review Exercise

Summary of findings

Task
- Lack of standard expectations regarding resident status checks decreased the likelihood that the resident elopement would be detected in a timely way.

Equipment
- Two types of electronic monitoring bracelets with similar appearance stocked in the LTC home increased the likelihood that the incorrect device would be selected and applied.
- No standardized internal process to ensure testing of electronic monitoring bracelets with accompanying documentation decreased the likelihood that the bracelet would be identified as non-functioning prior to an elopement incident.

Work environment
- Routine use of an emergency exit to access the staff parking lot decreased the likelihood that the alarm function would be effective as staff became "desensitized" to frequent alarms.

Patient
- The resident's cognitive impairment decreased the likelihood that she would be aware of the risk of leaving the facility.

Care team
- Communication lacking between team members when resident first identified as missing, combined with lack of familiarity with Code Yellow procedures decreased the likelihood that a Code Yellow would be initiated immediately.

Organization
- Lack of a formal process to report and investigate close calls decreased the likelihood that the previous incident in which the resident eloped but was found immediately, would be followed-up to identify process changes to prevent future occurrences.
- Lack of a standardized process for regular "mock" codes to provide ongoing training and assess staff understanding of processes decreased the likelihood that staff would be familiar with Code Yellow procedures.

Other
- No other factors identified.

Source: Incident Analysis Collaborating Parties. Canadian Incident Analysis Framework. Edmonton, AB: Canadian Patient Safety Institute; 2012. (With modifications).