**INSTRUCTIONS FOR COMPLETING THE WANDERING AND ELOPEMENT**

**RISK ASSESSMENT**

**Reason for Assessment**: Mark “Yes” beside appropriate category.

**Ambulation Status**: Assess resident and mark “Yes” if the resident ambulates independently or with any assistive devices. If the answer is “No” in each of these categories, then the resident is not at risk for wandering or elopement.

**Wandering History**: Gather the information from the resident, the responsible party and the medical record. It is important to have accurate information in order to determine if the resident is at high risk for wandering (pacing, intrusion, searching) or is at high risk for elopement. If the resident has had episodes of elopement, has cognitive impairment, and ambulates independently or with assistive devices, the resident should be placed on q 15’ monitoring.

**Cognitive Status**: Assess the resident and gather information from the responsible party and the medical record. A diagnosis of dementia/cognitive impairment or absence of safety awareness/judgment skills does not by itself make the resident at risk for wandering or elopement, but in conjunction with being ambulatory and with a history of wandering and/or elopement places the resident at high risk for one or both.

**Psychiatric History**: This information can be obtained from the responsible party and the medical record. A history of any of these illnesses may increase the risk of wandering and elopement if the resident is ambulatory and has a wandering or elopement history.

**Associated Symptoms**: Gather this information from the responsible party and the medical record. Knowing any associated symptoms will help you to determine an appropriate treatment plan for the resident.

**History of Negative Outcomes**: Information can be obtained from the resident, responsible party and the medical record. This information will help you to develop an appropriate plan of care. For example, if the resident has recently started pacing and has had a concurrent weight loss, then mealtimes and having fluids and snacks available will be extremely important. If the resident wanders into other’s rooms (intrusion), with ensuing verbal or physical altercations, then room placement becomes very important.

**Medications**: Obtain this information from the medical record. A “Yes” in any of these categories may increase the resident’s risk of becoming confused or having a change in cognitive status. These medications may also increase the risk of falls and therefore, you may need to place the resident on the fall prevention program.

**Functional Status**: Assess the resident and gather information from the responsible party and the medical record to complete this section. Assessment of these functional areas will assist you in developing an appropriate plan of care. For example, if the resident has any incontinent episodes and is unable to read and understand signs, it will be more difficult to provide direction to the restrooms.

**Any “Yes” under “Wandering History”, complete this section**: It is very important to determine what type of wandering behavior the resident is exhibiting in order to provide the appropriate care. By exploring the precipitating factors, you may be able to determine that the resident begins to pace when he/she needs to toilet or is hungry. Ask the responsible party as many questions as necessary to determine if the resident has had episodes of elopement.

**No identifiable Risk for wandering/elopement**: Mark this if you cannot identify any risk areas from the assessment.

**INSTRUCTIONS FOR COMPLETING THE WANDERING AND ELOPEMENT**

**RISK ASSESSMENT**

**(Continued)**

**High risk for wandering**: Mark this is the resident ambulates independently or with assistive devices, cognitively impaired, with a history of pacing, intrusion, or searching.

**High risk for elopement**: Mark this if the resident is a new admission, with a diagnosis of dementia or cognitive impairment and ambulates independently or with assistive devices. Also, mark this section if the resident is a re-admission with a history of elopement or resident is experiencing a change in status that has resulted in episodes of elopement. Remember to place the resident on q 15’ monitoring.

**Care Plan Interventions**: It is very important to perform and accurate and thorough assessment and then to develop an appropriate plan of care that addresses the resident’s specific wandering behavior. Involve the interdisciplinary team and include the direct care staff when developing a care plan for the wandering resident. REFER TO THE “WANDERING AND ELOPEMENT DEVELOPMENT OF THE CARE PLAN” FORM FOR POSSIBLE INTERVENTIONS TO ADDRESS EACH TYPE OF WANDERING BEHAVIOR. The interdisciplinary team should continually assess the resident’s wandering behavior and the effectiveness of interventions, and then decide when and if to discontinue and/or change interventions. For example, the IDT should decide on how long to continue q 15’ monitoring by evaluating the resident’s wandering behavior. It is very important in the area of wandering and elopement as it is in all areas of assessment and care planning to DOCUMENT, DOCUMENT, and DOCUMENT.

**Quarterly Reviews**: The IDT should review the assessment quarterly. IF there has not been a change in the resident’s wandering behavior, write a summary to this effect. If there has been a change in the resident’s wandering behavior or if the resident has a change in status that increases his/her risk for wandering/elopement, the IDT should complete another Wandering and Elopement Risk Assessment.