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Risk Resources for Health Care

Resident Elopement
EDUCATION GUIDE

- FACTS
- PREVENTION
- RESPONDING
- TOOLS AND REFERENCES
- ADDITIONAL RESOURCES

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Resident Elopement – Facts

Elopement Examples:

Pennsylvania – $650,000 settlement: An 80-year-old Alzheimer's patient wandered away from the defendant's facility and was found four days later, drowned in a nearby creek.

Washington – $700,000 settlement: A 67-year-old female resident died after being locked out overnight. She was an alcoholic, a smoker and severely underweight. She had previously recovered from throat cancer.

Missouri – The state cited a facility after the decomposed body of a patient known for wandering off was found, surrounded by beer cans and liquor bottles, in a ditch. The facility never notified authorities the patient was missing.

Alabama – A 64-year-old assisted living resident with dementia was found drowned. The resident was outside the facility without permission, despite state rules that forbid the home from having residents with such afflictions.

Alabama – A 92-year-old assisted living resident broke a window, crawled out of his room and wandered across a parking lot into a field where he collapsed and died in freezing temperatures. The dementia-afflicted man was looking for his wife, who had been taken temporarily to a hospital.

RESIDENT ELOPEMENT is defined as a dependent resident in a licensed facility who leaves without staff observation or knowledge of their departure.

Here are some alarming statistics:

- Upwards of ten percent of all lawsuits involving nursing homes deal with elopements.
- 79 percent of these lawsuits involve the death of a resident.
- The primary causes of elopement-related deaths include:
  - being struck by a vehicle or train;
  - exposure to heat or cold (e.g. frostbite injuries, heat stroke, etc.);
  - drowning;
  - abuse (physical and sexual);
  - fractures or head injuries;
  - falling off roofs or out of windows; and
  - falling into ravine or road ditch.
- In 80 percent of cases, the resident was known to be a chronic wanderer with prior elopements.
- In 45 percent of cases, the elopement occurred within the first 48 hours following admission.
- Incidents of elopement occur in every state and in all levels of care.
- Unsafe wandering and elopement are associated with falls and related injuries.
- The average out-of-court settlement (2009) was $393,650. In Delaware, a jury awarded $18 million dollars against a LTC facility for a single elopement.

Resident Elopements

Elopement-related deaths create mental anguish for both families and nursing home staff. The courts have shown to be harsh in ruling facilities were negligent in their duty to provide a safe environment.

The discovery of an elopement by a resident that was a known risk almost always results in a G or J deficiency tag if surveyors find the facility at fault (F323).

The CMS guideline for determining immediate jeopardy is failure to prevent neglect [due to] lack of supervision of cognitively impaired individuals with known elopement risk (Appendix Q – State Operations Manual).

Most states require mandatory reporting of elopements, especially if the outcome involves harm to the resident.

Why Should I Be Concerned?

Resident elopements happen so infrequently that it is uncommon for a facility to have a written elopement plan and program. This is a mistake that can lead to litigation and disciplinary action. Pull your team together and develop a plan now! Review the plan at least once per year and after every elopement incident.

Many elopements occur in the late afternoon and evening hours (often due to Sundowning Syndrome) when a greater number of staff members are not available.

Many Administrators and DONs have a false sense of security thinking an elopement will never occur in their facility because exit doors have alarms. The problem is many elopements occur because the resident was able to punch the numbers in the key pads, staff turned the alarms off or the resident just simply walked out through the doors behind staff or visitors.

No facility is elopement-proof, which is why planning is essential.

More Elopement Examples:

Alabama – An 83-year-old female resident walked out of an unlocked door at a personal care facility around midnight. She fell into a watery pit at a construction area on the care facility's grounds and drowned in the mud.

Colorado – In the middle of winter, a resident with Alzheimer's Disease wandered away from the assisted living facility where he lived. His disappearance went unnoted for three hours. He was finally found alive, face down in a field, according to a state report. Three months later, another resident wandered away from the same facility and was later found crossing a four-lane road.

Florida – A resident walked away from a nursing home, fell in a drainage ditch and drowned. The verdict resulted in $1.8 million compensatory and $4.5 million punitive damages.

Preventing an Elopement

Examples of Effective Interventions:

A facility had a confused resident that liked to turn door handles and go into other resident rooms and through the alarmed exit doors. Although the staff was always quick to redirect him when the alarms sounded, their actions did not prevent him from repeating his actions several times a day. The facility's Safety Committee met to discuss the problem and someone suggested that if they change the texture of the door handle, it might be enough to prevent him from wanting to turn it. The committee agreed that it was worth investigating so they ordered a felt door knob holder found in a catalog. To their satisfaction, they found the change in texture was just enough to detract the resident from wanting to grab the handle, so his attempts to exit the building ceased. This simple, inexpensive intervention worked well for this resident and didn't detract anyone else from using the door when they needed to.

A resident in a small nursing facility began to wander aimlessly more often and the staff became concerned that she would exit from the facility and not know where she was. They did not want to lock the doors because none of the other residents were elopement risks. The staff met with the resident and her family to discuss the problem and everyone agreed to purchase a safety bracelet that would lock the doors when she came near them. The staff wanted to make sure to have a back-up plan in case another resident held the door open for her, not knowing that she wasn't supposed to go out. They finally found a bracelet that would not only lock the door when she came near it, but would also sound a door alarm if she were able to exit.

Develop policies and procedures to include these elements:

1 **Risk Assessments –** Every facility should develop a method to identify residents who are at risk for elopement, such as known wanderers. A risk assessment should be completed upon resident admission, 72 hours after admission and quarterly thereafter, or more if condition changes. Reassess each month for residents identified as high risk to wander. Some diagnoses pertinent to the risk of elopement include:

- Delusions, Hallucinations;
- Alzheimer's Disease, other dementia;
- Anxiety Disorder, Manic Depression, Schizophrenia; and
- History of wandering.

2 **Interventions –** Once a resident has been identified as being high-risk, appropriate interventions should be implemented. These should include:

- Behavior logs to document wandering tendencies. Once these behaviors have been exhibited, the potential for elopement increases.
- Supervision and periodic checks as much as possible. A secured Alzheimer's/ Memory Care Unit is best for those individuals at high risk for wandering/ elopement.
- Ongoing activity programs to minimize aimless wandering tendencies.
- Identification bracelets and/or alarms worn by residents, as indicated. Consider using an electronic ankle/wrist band system with a resident who displays wandering tendencies, per facility protocol. Both the physician and responsible party should be involved in this process.
- Exit doors secured with alarms or keypads that are tested daily/weekly according to manufacturer recommendations and documented. The interior stairwell doors should be equipped with alarms reporting to the Nurses Station that also will detect undesired entry to stairwells. All alarm systems should be connected to a central alarm system and include the ability to monitor elevator access. If alarms are disengaged (i.e., for repair or delivery), cordon off the area or institute a safeguard until the alarm is reactivated.
- Fenced yard controls with either an electronic alarm or staff supervision.
- Install window limiters as approved by state codes.
- Monitor closely following a room change or change in roommate.
- Increased vigilance is needed when resident verbalizes that he/she is going home. Also when exit-seeking behavior is observed.

3 **Communication –** Once a resident has been identified as being at risk for elopement and preventative interventions have been implemented, everything needs to be documented in the resident's chart and communicated to everyone involved with the resident's care, beginning with:

- The resident's care plan, which should list all interventions that are used to prevent an elopement from happening. The interdisciplinary team and power of attorney for health care decisions/resident representative need to be involved with this process.
- Assignment sheets – All direct-care staff need to know which residents are at risk for elopement and the interventions needed to prevent an occurrence.
- Discretely post current pictures of known wanderers to alert staff to the potential for elopement. Postings should be at the nurse's station and possibly at the front entry areas.
- Check In/Check Out Logs – Utilize these anytime a resident leaves the facility alone, with family or facility-planned outings.
- The QA Committee should review and discuss all elopement concerns. Records should be kept of all incidents so that trends and risks can be identified and reduced.

Responding to an Elopement

Despite your best efforts, elopements may occur. Be proactive – develop policies and procedures to address elopements before they occur.

Procedure for responding to an elopement:

1 Any staff member observing a confused or previously identified wandering resident attempting to leave the premises shall attempt to prevent such departure. Should the attempt fail, the staff member shall obtain the assistance of other staff in the immediate vicinity. If none are available, the staff member shall immediately notify Administration or the nursing staff that the resident has left the premises, and then return quickly to the resident, continuing an attempt to redirect the resident safely back into the building. Staff members are not to leave the resident for any reason if the resident's safety is in immediate jeopardy.

2 Upon notification that a resident is missing, the supervisor shall be responsible for initiating a thorough search of the facility and the premises.

- Call all staff to a central location.
- Give specific instructions for the search:
  - Two staff per hall, one on each side.
  - Check all rooms, bathroom, closets, etc.
  - Check the elevator, activity room, dining room, chapel, etc.
  - Two staff members will go outside around the building, each going in the opposite direction. After meeting behind the building, the individuals should return to the central location to report results to the supervisor.

3 Should the search prove unsuccessful, the person in charge shall carry out the following steps:

- Notify the Administrator and Director of Nursing;
- Notify the Police Department, i.e., 911;
- Notify the resident's responsible party;
- Notify the resident's physician; and
- Notify any other regulatory agencies required by law.

4 Once the preceding steps have been taken, the authorities will assume command of the search. Provide the following pertinent information:

- Full name and nickname;
- Gender;
- Age;
- Recent photograph;
- Time discovered missing;
- Physical description: height, weight, race, color of hair and eyes;
- Where the resident was last seen;
- Mental/emotional status;
- Language spoken;
- Color and type of clothing being worn, if known;
- Home address; and
- Address of known friends and relatives.

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Examples of Effective Responses:

A confused resident began exhibiting "exit-seeking behaviors" and was transferred to a secured Alzheimer's Unit with an alarmed keypad next to all of the exit doors. One night, during bed checks, the resident was noted to be missing. After a thorough search of the building and surrounding premises, the resident was found unharmed, in the facility's parking lot. The investigation revealed that the resident exited from the facility through his bedroom window. The Safety Committee met and decided to install window limiters on all of the double hung and swing-out windows on the unit. Before the equipment was purchased, the staff called the state Department of Health to ensure that no life-safety codes would be violated. The facility has not had another incident of resident elopement since.

A confused resident eloped from a nursing home one evening and was later found with minor scrapes and bruising. The subsequent investigation revealed that the resident exited through a door on which the battery in the alarm was dead, so the alarm did not go off. The alarm was checked and, once the battery was replaced, worked well. The Safety Committee purchased a battery acceptable indicator with a light and audio alarm, so as to reduce the likelihood of another resident elopement due to failure of the alarm system. In addition to the battery indicator, the staff implemented daily alarm checks and kept a log to document.

5 Upon return of the resident to the facility, the following steps will be carried out:

- All previously contacted persons and organizations shall be notified of the resident's return to the facility.
- The resident will have a complete assessment done to determine if any injuries occurred.
- The licensed nurse responsible for the resident's care shall record all pertinent details of the elopement into the resident's medical record including notifications of the resident's elopement and results of the assessment upon the resident's return to the facility.
- The resident's care plan must be reviewed and revised to reflect the elopement and a prevention plan developed.

6 An Incident Report is not a part of the resident's legal/ medical record. It will need to be completed in a timely manner per facility protocol. The report should include the following:

- Describe physical, mental and emotional status prior to events;
- Note times and details – last seen, staff actions, status of how, when and where found, condition;
- Describe assessment, note any injuries and what treatment was given;
- Note clothing, temperature outside, areas of skin exposed, etc.;
- Provide facts of how it occurred; and
- List new/revised interventions.

7 A complete and thorough investigation of the elopement needs to be done ASAP in order to prevent another occurrence as well as to protect other residents.

Questions that need to be asked may include:

- Were the alarm systems working properly?
- Were all internal and external doors visually checked?
- Were there any deficient practices or system failures?

Plan of correction should include:

- Areas to be addressed;
- Person(s) responsible; and
- Completion date.

8 All of the information obtained from the elopement investigation should be summarized and discussed at the next Quality Assurance and Performance Improvement (QAPI) meeting. Records should be kept of all incidents, so trends and risks can be identified and reduced. Other QA functions should include:

- Randomly test door and personal alarm systems; and
- Stage quarterly mock drills to test compliance of the plan.

Now that these plans are in place, staff training is critical. In-service training should be provided to all staff during orientation and at least annually thereafter. A written copy of these plans should be kept near the nurse's station for easy access, as the nurse supervisor will most likely be in charge of the initial search.

Tools and References to Help You

Documentation

Item #	Description
3680P	Behavior Management Plan
3667HH/HF	Behavior Monitoring Form
1909P	Behavior Symptoms Care Area Assessment (CAA) Form
3713HH/HF	Elopement QA & A Audit Form
3712HH/HF	Elopement Risk Tracking Log
CFS6-18/2P	Incident/Accident Report Form
3090	Incident Report QA CQI Log
3092	Investigation Follow-up Form
3699	Missing Resident Identification Form
3687	Short Portable Mental Status Questionnaire
3711HH/HF	Wander Data Collection Tool

Education & Training

Item #	Description
1862	MDS 3.0 User's Manual, Updateable
1766	Survey Guide

Signage/Chart Labels

Item #	Description
6507DS	Magnetic Wander Prone Attention Sign–2"x9"
6508DS	Magnetic Wander Prone Attention Sign–3"x5"
L-9931	STOP Sign Label
L-2041	Wander Risk Chart Label

Medical Supplies

Item #	Description
11-7082	Dynarex Personal Alarm
99-8210	Posey Door Guards
190	SoftGuard Tubular ID Bands

Additional Resources

Wandering and Elopement Resources – National Council of Certified Dementia Practitioners (NCCDP)
www.nccdp.org/wandering.htm

Elopement Resources – National Institute for Elopement Prevention and Resolution
www.elopement.org

Wandering and Elopement Resources – Alzheimer's Association
www.alz.org/national/documents/card_wanderingwhoisatrisk.pdf
www.alz.org/care/alzheimers-dementia-wandering.asp
www.alz.org/national/documents/brochure_stayingsafe.pdf
www.alz.org/care/alzheimers-dementia-sleep-issues-sundowning.asp
www.alz.org/national/documents/topicsheet_wandering.pdf
www.alz.org/national/documents/brochure_DCPRphases1n2.pdf

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