

# Hospital security and patient elopement: protecting patients and your healthcare facility

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*Regulatory and financial consequences of adverse events associated with patient elopements are bringing new challenges to healthcare security to develop policies and procedures to prevent and respond to such incidents. This article provides an overview of the problem of elopement in healthcare and what it means to the security function; gives a working knowledge of healthcare related standards and guidelines aimed at reducing patient elopement; and reviews the elements of an elopement prevention and response plan for your organization.*

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The problem of patient elopement in healthcare and its impact on the security function has recently commanded increased regulatory attention to go with the risks of costly civil actions and lack of public confidence that can result when a missing patient cannot be found, is injured, exposed to the elements for a prolonged period, or dies. To the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC), and state health departments, an adverse event associated with an elopement now ranks in importance with patient restraint and use of force, criminal incidents involving patients, infant and pediatric abduction, and other major incidents posing risk to patients, such as active shooters. Such attention can result in substantial fines and jeopardize Medicare and Medicaid reimbursement.

The regulatory agencies have previously been concerned with the elopement problem. But just as the shooting in September 2010 of a doctor at Johns Hopkins by the son of a patient stirred them to new action in that area, so did the death by freezing of an 88-year-old patient who was found on the roof of a hospital about 15 hours later in December 2008 provoke new regulator concern and attention about elopement. For example, in 1998, the TJC Sentinel Alert approved elopement as one of eight voluntarily reportable events. In May 2009, the issue of *Inside the Joint Commission Online* contained several articles dealing with wandering, elopements and missing patients.

### **TWO COSTLY EXAMPLES**

In one example of the possible cost of a typical incident, ten mental health patients were taken outside by one mental health technician. One of the patients scaled a 12 foot fence and jumped to his death. The patient's family was awarded \$12 million for wrongful death. The facility had no emergency response plan.

In the death of the missing patient on the roof of the hospital

mentioned previously, a plan was in place to keep her from wandering, but it was not consistently applied. The State Department of Health cited the hospital in a 22-page document and required the hospital to take corrective action, which it did, creating a new procedure to quickly locate missing persons modeled after other rapid response teams used in hospital emergencies. The hospital was sued, however, by the son of the patient for wrongful death and the case was settled for \$900,000. (A review by a legal journal of the lawsuit and the lessons to be learned from it is presented at the end of this article.)

### **NEEDED: POLICIES AND PROCEDURES TO MEET REGULATORY REQUIREMENTS**

This increased regulatory attention comes at a time when some hospitals may not have response plans in place to deal with a patient elopement problem, or others have plans which do not measure up to the required policies and procedures for:

- doing an assessment for risk of wandering or elopement
- implementing risk reduction

strategies for those patients at risk --performing a prompt and thorough search when a patient is missing.

To facilitate the changes that may be required, this article will provide overview of the problem of elopement in healthcare and what it means to the security function; provide a working knowledge of healthcare related standards and guidelines aimed at reducing patient elopement; and review the elements of an elopement prevention and response plan for your organization.

### **FREQUENCY OF PATIENT ELOPEMENTS IN HOSPITALS**

According to the most recent IAHS membership survey, the number of patient elopements that occurred in 2009 ranged from one to 50 in over 70% of the facilities reporting. Only 11% reported no elopements. Some 10%, however, reported from 50 to over 300 elopements! The largest proportion of patients was in the custody of the nursing staff when elopement occurred, according to the survey. This suggests that nursing staff may need additional assistance and resources from security

staff to prevent elopement, in addition to the security staff having the responsibility to find and return patients. More important, the high number of reported elopements may include patients who should not be classified as representing "a risk to themselves or others." This overstatement of the total can have negative consequences should a Joint Commission survey or CMS investigation occur.

### **THE IMPORTANCE OF ACCURATELY DEFINING 'ELOPEMENT'**

To prevent overstating the problem, security managers must have a process in place for making sure incidents are properly categorized. It is important to be careful as to designating an elopement versus an AMA (against medical advice) or a patient wandering. It is also important to properly identify those elopement attempts and to properly categorize those attempts. To me, an attempted elopement incident is an example showing that your processes for preventing elopement are working. Hopefully the incidents will identify those measures that lead to the system working and the

elopement was successfully prevented. Those who say they have 300 elopements a year may be wrongly categorizing that total. I like the definition that the Agency for Healthcare Research and Quality (AHRQ) website uses for defining elopement, patient wandering and missing patient. (<http://www.webmm.ahrq.gov/case.aspx?caseID=164>), citing the VA National Center for Patient Safety (NCPS).

**Elopement patient**--A patient who "is aware that he/she is not permitted to leave, but does so with intent."

**Wandering patient**--A patient who "strays beyond the view or control of staff without the intent of leaving (cognitive impairment)."

**Missing patient**--"A patient missing from a care area without staff knowledge or permission."

Legally, according to the VA definition, elopement defines a patient who is incapable of adequately protecting himself/herself, and who departs the health care facility unsupervised and undetected. Wandering is defined as occurring when patients aimlessly move about within the building or grounds without ap-

preciation of their personal safety. Some wandering patients may be significant safety risks when the patient has decreased capacity.

Leaving against medical advice (AMA), however, is different from elopement or wandering and is determined by the patient's decision to leave the facility having been informed of and appreciating the risks of leaving without completing treatment. Fully competent patients are legally able to discharge themselves without completing treatment.

*When surveyors come in looking for anything, whether on a regular survey or a complaint, they often come first to the hospital's police or security department and ask for the incident log for the last 30,60, or 90 days. Then, if they see "elopement," and if you have titled it "elopement" when it should really be titled "AMA" or "wandering," you're drawing more attention to it than you need to. It causes you to explain a lot more than if it had been properly titled.*

## UNDERSTANDING THE ROLES OF TJC AND CMS

**The Joint Commission.** Approximately 88 percent of hospi-

tals in the United States are accredited by The Joint Commission (TJC), an independent, non-profit organization, which includes among its requirements these areas that can involve the participation of healthcare security--environment of care, emergency management, and life safety. A TJC sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response. Sentinel events with regulatory implications for security programs include:

- Patient Restraint and Use of force
- Criminal Incidents Criminal Incidents Involving Patients
- Infant and Pediatric Abduction
- Other major incidents posing risk to patients
- Patient Elopement
- Accreditation and certification

by TJC qualifies a healthcare facility (HCF) to receive Medicare and Medicaid funds.

**Centers for Medicare and Medicaid Services.** Disbursement of these funds is the role and prerogative of CMS, the federal government agency which requires that HCFs accepting payment for Medicare and Medicaid patients meet certain federal standards called "Conditions of Participation" (CoPs). These requirements are promulgated by the CMS to improve quality and protect health and safety. CoPs are regulatory standards hospitals agree to follow as a condition to receive federal dollars. State healthcare licensure agencies conduct surveys of hospitals and enforce compliance with CoPs.

To meet demand for compliance surveys and address concerns about healthcare quality, CMS enlarged its compliance survey staff in 2010. Your likelihood of experiencing a survey is greater than ever before.

- HCFs are subject to random onsite reviews and surveys.
- Unannounced surveys can result from patient or public complaints or inquiries.
- Incidents reported in the media

also attract CMS attention.

Elopement is a serious concern for HCFs and regulators alike. Breaches to patient safety determined to be elopement can result in CMS finding of immediate jeopardy, along with significant civil monetary penalties or other CMS-imposed remedies. CMS expectations are 100% compliance 100% of the time.

### **CMS/TJC IMPLICATIONS OF ELOPEMENT INCIDENTS**

Both TJC and CMS use similar processes for investigating complaints or when publicized major incidents draw attention.

--A review of incident reports (hospital, and police reports)

--Interviews with patients, staff, police and any witnesses

--A policy review

--A training record review

Staff must be able to articulate and demonstrate policy requirements and that training records must be produced.

A note or warning: When developing or reviewing policies and procedures security professionals should review what is reportable with your compliance staff. There may be differences in what may

be required depending upon your local jurisdiction and philosophy of your organization.

### **DEVELOPING A PATIENT ELOPEMENT POLICY**

A patient elopement policy for HCFs providing inpatient services is a multidisciplinary procedure for preventing and responding to patient elopements. Fortunately there is no need to reinvent the wheel as there is a wealth of materials available for formulating prevention procedures and response plans. These include:

- 2007 Agency for Healthcare Research and Quality (AHRQ) Web Site Materials Dedicated to Reducing Patient Elopement
- 2008 International Association for Healthcare Security & Safety Operational Guideline 09 Areas of Higher Risk . 04 Patient Elopement
- 2009 VA National Center for Patient Safety Web site established covering Escape and Elopement Management.

### **Prevention**

Elopement Prevention procedures, are generally a clinical responsibility, and should include,

according to the IAHSSE Guideline:

- Assessing each patient's elopement risk.

- Steps to consider for patients at a high risk of elopement: i.e. room location

- Wearing distinctive color gown

- High tech options (RFID or other tag)

- A means of identifying patients who are authorized to leave the unit.

What makes a patient an elopement risk? According to the United States Department of Veteran Affairs, if any of the following questions are answered "yes" then consider the patient to be a risk for escape or elopement:

- Does this patient have a court appointed legal guardian?

- Is this patient considered to be a danger to self or others?

- Has this patient been legally committed?

- Does this patient lack the cognitive ability to make relevant decisions?

- Does this patient have a history of escape or elopement?

- Does this patient have physical or mental impairments that increase their risk of harm to self or others?

An excellent source of information of patients at risk of elopement are nursing homes who have considerable experience with patients with Alzheimer's disease and dementia. Elizabeth Gould, MSW, Director of State Programs at the Alzheimer's Association, Chicago, interviewed in the IAHSSE Directions newsletter, reported that people who wander persistently are the source of 80 percent of elopement cases. Additionally, she notes that 45 percent of these incidents occur within the first 48 hours of admission to the residence.

### Design

There is excellent design information available from several resources including: "Design Guide for the Built Environment of Mental Health Facilities" published by the National Association of Mental Health Facilities ([http://www.naphs.org/Teleconference/documents/Design-Guide4.FINAL.5.24.10\\_002.pdf](http://www.naphs.org/Teleconference/documents/Design-Guide4.FINAL.5.24.10_002.pdf)) and "Environmental Design Principles – Adult medium secure units" prepared by the Department of Health Secure Services Policy Team (United Kingdom). <http://www.dh.gov.uk/publications>

Design Guidelines for HCFs are also forthcoming from IAHS.

### **Response**

Response plans, according to the IAHS Elopement Guidelines, should include:

- Search of floor by clinical staff and notification of security if patient not found.

- Search facility buildings and grounds.

- Consider mass notification alert similar to "Code Pink". Some HCFs use "Code Walker".

- Clear distinction for Security Officer role in returning patient. Do they chase and use force? How far?

- Notification of Law Enforcement within reasonable time.

- Notification of patient's family

- Documentation is critical

At our facility, we developed "Code Walker." When someone has eloped, staff must call security Hospital Police immediately. The response is very similar to a "Code Pink," for infant kidnapping abduction. The staff goes immediately to pre-assigned locations at exits. We have a missing persons procedure if they actually get out and get away. You don't want to wait to notify local law enforcement that somebody has

escaped to get them looking. Sometimes there is a hesitation to contact local authorities. That is a big mistake. The longer you wait, the longer something adverse is going to happen. The key is: is somebody at risk for harming themselves or others? If yes, reach out to local law enforcement authorities notifying them in a pre-arranged plan. If they're not, it's pretty much an AMA.

### **A Corrective Action Plan**

When an elopement takes place which impacts on security, it is essential that a multi-disciplinary Corrective Action Plan be formulated. This plan, which identifies the contributing factors, specifies the corrective action to be taken, assigns responsibility, fixes completion dates, and most importantly, plans for monitoring the actions taken. An actual plan is illustrated. In the incident, a patient escaped from a psychiatric unit with the help of a visitor who forcefully blocked open an entry exit door.

### **Wording Policies**

Remember, there is no such thing as an elopement proof facility. Policies should avoid wording such as "ensure, assure, shall,



### Sample Corrective Action Plan

Contributing Factor	Plan for Corrective Action	Responsible Person	Completion Date	Plan for Monitoring
Visitor forcefully blocked door open when exiting locked unit allowing patient to escape from unit	Complete installation of all interim phase elopement buffers on all locked unit doors	George Mason		Expectation of zero elopements from psychiatric units. Any elopement that occurs will undergo a Root Cause Analysis
Lack of clarity in visitation policy that addresses after hour visitation in Psychiatry	<ul style="list-style-type: none"> <li>Revise visitation policy</li> <li>Educate all nursing staff in Psychiatry</li> <li>Implement process for identifying adult visitors to Psychiatry with picture ID</li> <li>Revise Visitor Sign In Log</li> </ul>	Suzanne Jones and Harold Paul		<ul style="list-style-type: none"> <li>Nurse Managers to monitor visitor log for 3 months to assess compliance with visitor ID verification.</li> <li>Expectation that all adult visitors will provide picture ID plus staff to document on visitor log.</li> </ul>
Patient at risk for elopement allowed to loiter near entry/exit door	<ul style="list-style-type: none"> <li>Designate safety zone around locked doors in which patients are not allowed to loiter</li> <li>Educate staff about safety zone</li> <li>Initially, define area by taping off zone</li> <li>Area to be tiled in different color to delineate zone</li> </ul>	Mary Wall, George Mason		Expectation of zero elopements from psychiatric units. Any elopement that occurs will undergo an RCA
Psychiatry staff triggered panic button immediately but did not provide specific patient identifiers for "Code Walker"	<ul style="list-style-type: none"> <li>Reeducate staff on Code Walker Policy</li> <li>Reeducate Security Dispatch that all psychiatric elopements are Code Walker</li> </ul>	Mary Wall, George Mason, Harold Paul	10/20/10 10/21/10	Conduct mock Code Walker on all locked units.

must.” Policy should be worded “to reduce the potential for” or “to attempt to prevent elopement,” or “to take reasonable measures to prevent ...”

### **Policy, Procedures and Training**

The biggest mistake we make is assuming that, after a policy is written and the staff are informed, compliance with the policy is consistent and complete. Without constant attention, employees will forget to follow all the steps. Processes will drift if the managers lose their focus. The old three legged stool concept: if one of these is missing the stool falls.

### **IN SUMMARY: EIGHT STEPS TO AN EFFECTIVE, WORKABLE POLICY**

1. Know security related CoPs and implement reasonable and appropriate protective measures
2. Make sure your staff know the policies and your training is documented
3. Ensure quality of incident documentation
4. Respond to investigations quickly
5. Provide only what is requested

6. Don't overpromise (identify realistic, attainable goals that can be adopted by frontline staff)

7. Do not debate “security” with surveyors

8. Follow-up and retrain

### **References**

"VHA NCPS Escape and Elopement Management." United States Department of Veteran Affairs, 10112009. Web. 30 Oct 2011. <<http://www.patientsafety.gov/CogAids/EscapeElope/index.html>>

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Healthcare Security Basic Industry Guidelines, IAHSW Web sources

"United States Department of Health & Human Services." Elopement Spotlight Case. Agency for Healthcare Research and Quality, 12012007. Web. 30 Oct 2011. <<http://www.webmm.ahrq.gov/case.aspx?caseID=164>>.

"Sentinel Event Data Root Causes by Event Type 2004-Third Quarter 2011." The Joint Commission. The Joint Commission, 18 10 2011. Web. 1 Nov 2011. <[http://www.joint-commission.org/assets/1/18/Root\\_Causes\\_Event\\_Type\\_2004-3Q2011.pdf](http://www.joint-commission.org/assets/1/18/Root_Causes_Event_Type_2004-3Q2011.pdf)>.

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**Alleged Failure to Recognize and Restrain Patient That Presented Elopement Risk Leads to \$900,000 Settlement**

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**NEWS**

An 88-year-old woman was taken to a local hospital after being found sitting outside her son's home, apparently confused. She was then transferred to a nursing facility, where she was diagnosed with altered levels of consciousness and inability to perform activities of daily living. The woman was again admitted to the hospital and fitted with a vest-restraint system. Based on an interdisciplinary plan of care with regard to the restraints, the woman's vest and wrist restraints were discontinued three days after her admission. The next day, the woman was visited by her son. Soon after her son left, the woman went missing and was found on the hospital roof approximately 14-16 hours after disappearing, dead of hypothermia. The parties settled for \$900,000 prior to trial.

**BACKGROUND**

A woman was found sitting outside of her son's home apparently confused and was taken to a local hospital. After remaining in the hospital for approximately one week, the woman was transferred to a nursing facility, where she remained for two months and was diagnosed with altered levels of consciousness and an inability to perform the activities of daily living. During her stay at the nursing facility, the woman began experiencing an unsteady gait and a continued altered level of consciousness. She was admitted to another local hospital with diagnoses of prior stroke, dementia, and normal pressure hydrocephalus, all causally linked to altered levels of consciousness. A note was entered into the woman's chart that read, "pt. becoming agitated, not wanting to stay in bed." Another notation stated that the patient was an "imminent risk to self" and that she had been found trying to remove the Hep-Lock and attempting to climb out of her bed. In light of these observations, the woman was fitted with a vest-restraint system and moved to a patient room.

A couple of days later, an interdisciplinary plan of care with regard to the restraints was prepared. With respect to the vest restraint and wrist restraints, the

plan noted that the woman was "attempting to discontinue therapeutic interventions," as the woman had been found trying to remove the restraints. The defendant alleged that despite the plan of care, the restraints were ultimately removed. The next day, a physical therapist made a notation on the woman's chart that read, "[patient] sitting in recliner at nursing station due to increased tendency to wander and not tolerating Posey vest." At 10:30 a.m. that same day, an occupational therapist noted that the woman was in her room. Later that day, the woman's son came to visit her for four hours and alleged that the woman recognized him and was able to effectively converse with him. Some time after the visit ended, the woman went missing in the hospital. She was later found dead from hypothermia on the hospital's roof.

The woman's son sued the hospital claiming wrongful death on behalf of his mother's estate. The plaintiff alleged that while his mother was in the hospital, he observed numerous staffers at the facility observing the woman wandering and that none of them took steps to address the elopement/disappearance risk. Furthermore, the plaintiff brought forth evidence that the woman traveled through a fire door without an alarm, through stairs above her room, through a door in the boiler room that should have been locked and through yet another door that should have been locked before reaching the roof, where she ultimately died. Documentation was introduced that confirmed that a mechanical room that the woman traveled through to reach the roof should have been locked, but that the lock had been broken for at least a few months prior to the woman's admission to the facility. Plaintiff's counsel also alleged that the facility had received numerous continuing violations of care-planning regulations, and that an unreasonable number of patient elopements had occurred at the facility in the two years preceding the woman's death. Despite having knowledge of these issues, argued the plaintiff, the facility took no steps to update its policies or provide training or emergency drills.

The defendants denied any wrongdoing, and a settlement was reached between the parties prior to trial in the amount of \$900,000.

#### **REFERENCE**

Court of Common Pleas of Pennsylvania, Fifth Judicial Circuit, Allegheny County, No. GD-08~026648

#### **WHAT THIS MEANS TO YOU**

This case perfectly illustrates several key principles of safety science that help to explain how errors like this occur. In his work on complex systems failure, James Reason posits that every accident is the result of multiple and sometimes seemingly small and unrelated system failures. By themselves, none of these small or latent failures are sufficient to produce a major accident. It is only when the failures ag-

gregate - when the holes in Reason's "Swiss Cheese" model line up - that serious events with disastrous consequences occur. Such was the case here. This patient's death occurred because of multiple latent failures in two seemingly unrelated systems - clinical judgment and routine maintenance. None of these failures by themselves would have resulted in the death of the patient. It was the confluence of these latent defects - the failure of the staff to employ adequate clinical judgment in preventing elopement, combined with lapses in routine maintenance that left several doors unalarmed and unlocked - that produced the disastrous outcome.

An examination of the clinical judgments made in this case reveals several shortcomings. The decision to apply the vest restraint at the hospital was made after multiple observations by the staff of the patient's altered mental status. Specifically, staff noted that the patient was agitated, was attempting to climb out of bed, was an imminent danger to herself, and had been trying to pull out her Hep-Lock. While this initial decision might have been well-reasoned, it was poorly documented. An interdisciplinary plan of care addressing the use of the vest restraint was not prepared for "a couple of days," and when the plan was finally developed, the staff employed circular reasoning to justify the need for the vest restraint - the patient needed the vest restraint because she kept trying to remove the vest restraint. This raises the question of whether the staff had a clear understanding of the patient's risk factors and indications for restraint use, and may have led to the subsequent erroneous decision to discontinue use of the vest restraint without employing alternative methods to ensure the patient's safety.

The day after the vest restraint was discontinued, a physical therapist clearly documented the patient's tendency to wander and also her inability to "tolerate" the vest restraint. This created the duty on the part of the staff to address the potential safety risk of elopement, especially after prior observations that the patient was an imminent danger to herself. The staff initially and appropriately addressed this risk by positioning the patient in a chair near the nurses' station. However, this protective measure was not maintained, and the patient wandered off the unit and to her death later that day. The staff apparently did not consider other alternatives to the vest restraint, which might have included assigning a sitter to the patient.

Also, it appears that the staff did not recognize that the patient's mental state fluctuated during the course of the day. On the day the patient wandered from the unit, a physical therapist noted that the patient had a tendency to wander and that she was positioned in a recliner near the nurses' station. Later that day~ the patient's son reported that his mother had recognized him and had conversed with him. While this report from the patient's son may have been reassuring, it did not mean that the patient was no longer an elopement risk. This is particularly true in light of the fact that providers had related the patient's altered mental status to underlying clinical diagnoses of dementia, prior stroke, and normal pressure hydrocephalus.

Thus, the staff may have been erroneously reassured by the son's report of the patient's behavior, and as such failed to maintain the proper level of vigilance necessary to prevent her from eloping and harming herself.

An important strategy in guarding against complex systems failure is the implementation of critical redundancies--layers of safety strategies that guard against each other's failure. Interestingly, the hospital had a system of critical redundancy in place - two locked doors and one door with an alarm - but failure to properly maintain the doors defeated this important safety measure. The many failures of the maintenance system illustrate yet another important safety principle --normalization of deviance. This is a phenomenon whereby system failures that go unaddressed over a period of time are no longer seen as deviations and become the organizational norm. Information developed by the plaintiff in this case showed that the lock on one of the doors had been broken for several months. It is clear that lapses in maintenance had become normalized at this organization - it is the way the organization routinely operated. In addition to highlighting key safety principles, this case illustrates several important safety lessons for healthcare risk managers:

- Protective measures for confused, disoriented, or wandering patients must be implemented based on clear evidence of safety risks and may be discontinued only if the safety risks are no longer present or if the measure is being replaced with another, equally effective measure.

- Patients who are a danger to themselves because of altered mental status or due to any other cause must be assessed regularly to determine safety measures needed to prevent harm. Transient improvements in mental status must not be interpreted as resolution of the underlying causes of previously observed mental status changes.

- Routine maintenance plays a critical role in maintaining a safe environment for patients. Environment-of-care rounds are a critical component of the organization's safety program and should serve as the "canary in the coal mine" when routine maintenance and upkeep is being neglected.

#### REFERENCE

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