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ELOPEMENT RESOURCE MANUAL

May 2005

Dear Member:

The Associations have worked directly with the New York State Department of Health (DOH) staff and representatives of Skilled Nursing Facility providers on the Elopement Prevention Work Group from October 2004 to March 2005.

Together we engaged in active dialogue and undertook a review of the literature, a variety of assessment tools, and policies and procedures related to the topic of resident wandering, leave of absence, and elopement. DOH sent out a Dear Administrator Letter (DAL) recently providing the Executive Summary of the Work Group's activities. (See www.nyhealth.gov)

The Associations have compiled the attached resource manual, which is designed to provide helpful samples and to accompany the DAL and the guideline. The resources include a variety of assessment questions, tools, and sample policies and procedures that may assist you in reviewing your current program to define and prevent resident elopement. These have been collected from nursing homes across the State or developed by Work Group members over the past several months.

We are distributing this resource manual free as a member service. We suggest that you bring your key directors and managers together to review your current program for resident elopement prevention and revise your system if needed. If we can be of any additional assistance, feel free to reach out to any of the following Work Group contacts: *Roxanne Tena-Nelson* at the Continuing Care Leadership Coalition (CCLC), (212) 258-5330; *Debora LeBarron* at Healthcare Association of New York State (HANYS) (518) 431-7702; *Nancy Leveille* at New York State Health Facilities Association (NYSHFA) (518) 462-4800 ext. 20; and *Nancy Tucker* at New York Association of Homes & Services for the Aging (NYAHSA) (518) 449-2707 ext. 129.

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INTERNET RESOURCES
FOR
ELOPEMENT AND UNSAFE WANDERING BEHAVIORS

Visit the *Joint Commission on Accreditation of Healthcare Organizations* at http://www.jcaho.org and find the following useful resources:

Forms and Tools:

http://www.jcaho.org/accredited+organizations/sentinel+event/se_forms+and+tools.htm

Failure Mode, Effect, and Criticality Analysis (FMECA) resources:

http://www.jcaho.org/accredited+organizations/patient+safety/fmeca/fmeca.pdf

Example with medication use:

http://www.jcaho.org/accredited+organizations/patient+safety/fmeca/fmeca_chart.pdf

HOW PROVIDERS CAN BENEFIT FROM USING THIS RESOURCE

These resources have been compiled and presented as suggested materials providers and their staff can review and evaluate for their organizations. The Elopement Work Group viewed the contents of these materials as offering examples of different ways to address the key components of a systems approach to resident unsafe wandering and elopement.

These materials are offered for provider consideration with the understanding that each and every example/sample of a document and tool must be carefully evaluated by your organization. Each organization remains responsible for implementing policies and procedures that are in compliance with all existing state and federal laws and regulations governing long term care services in nursing homes.

Suggested ways organizations may evaluate and consider using these materials:

- ***Formatting:***

  Organizations may use these samples as suggested ways to improve the look and format of their own existing documents.

- ***Resources:***

  The sample documents name staff roles and procedures that can represent different approaches and resources to use in care giving activities, different than your organization has considered previously.

- ***Resident Population/ Facility Culture:***

  These samples were collected from facilities in every region of New York State. Each facility represents its own unique culture and serves a diverse resident population. Organizations must evaluate these samples with a sensitivity to those unique qualities and mindful of its own resident population and culture.

- ***Numbering of Documents:***

  For ease of following this manual, we have numbered all pages in the bottom center of each page. Pages that are designed as "sample documents" have an additional numbering system on the top of the respective pages reflecting all pages included in that sample.

RISK ASSESSMENT: ELOPEMENT

All skilled nursing facilities are required to conduct comprehensive resident assessments at specific intervals during the resident's stay. The goal of each assessment is to elicit specific information from that resident to ensure an effective, individualized plan of care can be initiated and evaluated. This is the mechanism to assist the resident in attaining their highest practicable level of physical, mental, and psychosocial well being.

Each facility may have their own process for assessing residents at risk for wandering or elopement. A variety of tools may be used to identify a resident at risk for wandering or elopement; however, the task force recommends that whatever tool is used, the following questions should be asked:

1. Is the resident independently mobile?
2. Is the resident cognitively intact?
3. Does the resident have competent decision making capability?
4. Does the resident wander?
5. Does the resident have exit seeking behavior?
6. Is there a past history of wandering or exiting a home or facility without the needed supervision?
7. Does the resident accept their current residency in the facility?
8. Does the resident verbalize a desire to leave?
9. Has the resident asked questions about the facility's rules about leaving the facility?
10. Is there a special event/anniversary coming due that the resident normally would go to?
11. Is the resident exhibiting restlessness and/or agitation?

Answering yes to any one of these questions or a combination of them can identify the resident at risk for wandering and potential elopement. These questions can be integrated into the overall assessment, as some of them are already asked in the Minimum Data Set.

The task force recommends that these questions are asked of the resident/family/significant others at preadmission, upon admission, quarterly and with any new behavior related to exit seeking activity. The interdisciplinary team should be responsible for identifying when additional assessments are needed.

Note: *T*he first few weeks of admission, a change in diagnosis/condition, or a special event seem to be the higher risk time frames for elopement.

RISK ASSESSMENT ELOPEMENT DECISION TREE

Resident Name:_____ Unit: _____ Date:_____

Resident is ambulatory or self-mobile in wheelchair?

YES | **NO** → **STOP**

- New admission who has made statements questioning the need to be here **or**
- Resident is cognitively impaired, with poor decision-making skills, and/or pertinent diagnosis (e.g., dementia, OBS, Alzheimer's, delusions, hallucinations, anxiety disorder, depression, manic depression, schizophrenia) **or**
- Resident is alert but non-compliant with facility protocols regarding leaving the unit.

YES | **NO** → **STOP**

- Resident has a history of wandering (either in the facility or elsewhere) **or**
- Opening doors to the outside and/or elopement **or**
- Is making statements that they are leaving or seeking to find someone/something **or**
- Displays behaviors, body language, etc. indicating an elopement may be forthcoming

YES | **NO** → **STOP**

- Care plan for high risk for elopement residents differentiating strategies for the cognitively intact vs. cognitively impaired individuals.
- Educate staff and enter notation on CNA care card.
- Utilize wander detection systems per manufacturers instructions as warranted
- Add the name of the resident with the wander detection system on the supervisor's report
- Re-evaluate all interventions at least quarterly and verify the number on the wander detection device
- Notify security – forward resident information and picture

Signature: _____ Date: _____

WANDERING RISK SCALE

Policy#: Patient Care 3B	**Date:** February 13, 2002
Revision: 6 (Last revised September 14, 1999)	

STANDARD

A safe environment is provided for patients/residents who are at risk to wander.

POLICY

1. As part of admission assessment, all newly admitted Patent's/Resident's clinical status will be assessed by a registered nurse to determine their risk for wandering using the Wandering Risk Scale form.

    a. reassessed as follows:
        i. after 72 hours of admission
        ii. every month for Patients/Residents identified as high risk to wander
        iii. whenever there is a change in Patient's/Resident/s clinical status

2. Patients/Residents who are identified at risk to wander and high risk to wander must have an individualized plan of care

PURPOSE

To establish uniform guidelines in identifying and providing safety to all Patients/Residents at risk to wander.

SCOPE

All Patients/Residents

RESPONSIBILITY

Professional Registered Nurses

PROCEDURES

A. Wandering Risk Scale Direction of Use:

1. Enter Patient's/Resident's name and diagnosis in the space provided.

2. For Patients/Residents who are comatose, and/or dependent in ADL (who cannot move without assistance), this form does not need to be completed. However, check the appropriate box found at the left upper corner of the form to justify reason for not completing this form.

3. Enter the dates of assessment and reassessment in the appropriate boxes.

4. Assess Patient/Resident in the following areas:
   - Mental status
   - Mobility
   - Speech patterns
   - History of wandering
   - Diagnosis of dementia

5. Write the score of 0, 1, 2, 3 or 5 for each parameter that best describes the Patient's/Resident's condition.

6. Add the scores and enter the number under the total score which will determine the risk for wandering.

Scores of:	0 – 8	Low Risk
	9 – 10	At Risk to Wander
	11 – above	High Risk to Wander

B. <u>Action Required based on Wandering Risk Scale Score:</u>

1. If the Patient/Resident is identified as **<u>Low Risk to Wander</u>**, no nursing action to prevent wandering is needed.

2. If the Patient/Resident is identified as **<u>At Risk to Wander</u>**. Initiate interdisciplinary care plan accordingly and follow plan of care.

3. If the Patient/Resident is identified as **<u>High Risk to Wander</u>**, the following action must be taken:

   i. Initiate interdisciplinary care plan
   ii. If the physician's order is to keep the patient/resident within the hospital, apply yellow armband and if the order is to keep the patient/resident within the unit, apply the red armband for immediate identification
   iii. Refer to Hospital Police for photograph. Keep one copy of the patient's/resident's photograph in the medical record
   iv. Refer to physician in charge for additional appropriate intervention such as the use of Dynaflow device

   If the Dynaflow device is used, follow the guidelines for use of the Dynaflow System, Administrative Policy Safety #7. If Dynaflow is not used, check the patient's/resident's whereabouts/activities in the unit every hour and more frequently as per assessed needs of the patient/resident.

4. If the Patient/Resident is missing, follow Hospital Policy on Patients Reported Missing – Policy RI 20 and Nursing Policy on Missing Patients/Residents Patient Care 47.

WANDERING RISK SCALE

Not Applicable: ☐ Comatose ☐ Patient dependent in ADL who cannot move without assistance ☐ Stuporous

ADMITTING DIAGNOSIS:_____ Medical Chart Number:_____

Date of Assessment: →							
MENTAL STATUS 1 can follow instructions 3 cannot follow instructions							
MOBILITY 1 can move without assistance while in wheelchair 3 ambulatory							
SPEECH PATTERNS 0 can communicate 3 cannot communicate							
HISTORY OF WANDERING 0 no history of wandering 2 with history of wandering (past hospitalization or history from patient/family)							
Complete this item 72 hours after admission and as per instruction 0 does not wander 1 wanders with intentional destination/knows how to return to unit 2 wanders within the hospital without leaving hospital grounds 5 wanders aimlessly within hospital or off hospital grounds							
Complete this item one month after admission and as per instruction 0 no episode of wandering 1 no episode of wandering for the past 6 months 2 no episode of wandering of the past 3 months 3 with episode for the past month							
0 No diagnosis of dementia 5 Medically diagnosed with dementia							
TOTAL SCORE →							
NURSE'S INITIAL →							

MISSING RESIDENT/ELOPEMENT
POLICY/PROCEDURE STATEMENT

Originating Department: Administration	***Related Department:*** All

POLICY

It is the policy of _____ to provide a safe and secure environment for all residents. In the event of resident elopement it is the policy of _____ to implement its policies/procedures immediately to locate the resident in a timely manner.

PURPOSE

1. To assure the safety and security of all residents
2. To establish policies and procedures in the event of a missing resident
3. To train and maintain staff awareness of the importance of resident safety and security

ELOPEMENT RESPONSE TEAM

The members of the Search Team include the following:

- ***During normal business hours*** Department Heads, Supervisors, Security report to Administrative office.

- ***Off hours*** all nursing personnel and security are to report to the Nursing office except for one CNA from each unit and one nurse from each floor and any other available staff, i.e., Housekeeping, Maintenance, and Dietary.

PROCESS

Responsibility	Action
All Staff	Will notify highest ranking nursing personnel of missing resident
Highest Ranking Nursing Personnel	Will direct unit staff to begin search of unit immediately Will announce from any telephone, Code 100 by dialing 4444 and repeat three (3) times. Notify security by radio.
Response Team	Upon hearing Code 100 announcement, report to designated office
Highest Ranking Onsite Staff Member	Assigns a search sector to each team member and records on the attached Elopement Incident Search Assignment form. Notifies DON/Administrator if needed and provides photo of resident to security, if needed.
Staff Assigned to Sector	When sector search completed report back to command post, i.e., Administrative office during regular business hours or Nursing office during off hours.
Highest Ranking Onsite Staff Member	When resident is found, announce "Code 100 cancelled" and repeat three (3) times over PA system and radio and place call to _____.
Administrator/Designee	Notifies _____ Police Department emergency #337-7777 that a resident is missing.
Nurse in Charge	Completes appropriate documentation including condition of resident when last seen.
Administrator/Director of Nursing/Designee	Notifies D.O.H. as per requirements

ELOPEMENT INCIDENT SEARCH ASSIGNMENT

Highest Ranking on-site staff member coordinating search: _____

Sectors on Premises	Staff Assigned	Post-Search Report & Time
Outdoor areas		
Lower level		
North		
South		
Second Floor		
Third Floor		
Staircases between floors		
Lobby/Auditorium/Main Dining Room/Staff Dining Room		
Elevators		
Roof including staircases leading to roof		
Kitchen		

COMMENTS

MISSING RESIDENT POLICY AUDIT

Staff Responses	YES	NO	N/A
1. Did CNA staff notify NM immediately after resident was discovered missing?			
▪ Within first 15 minutes?			
2. Did NM notify security gate immediately with name, neighborhood and physical description of resident?			
3. Did NM assign staff to conduct room-to-room search on floor, public area and offices?			
▪ Public area on floor			
▪ All offices on floor			
▪ Stairwells			
4. Did NM post message on hotline information – dial __ line at ext. ___? Did NM enter password?			
▪ Name of resident			
▪ Neighborhood of resident			
▪ Resident physical description			
▪ Type and color of clothing			
5. Did NM call switchboard operator to announce Code 100?			
6. Did NM give switchboard operator:			
a. Name of resident			
b. Physical description of resident			
7. Did switchboard operator announce code 100 over public address system?			
8. Did each NM conduct a head-to-head search in their neighborhood to make sure that missing resident is not in their neighborhood?			
9. Did each NM call command post with results of the head-to-head search?			
10. Did Department Heads/NMs call the hotline information line ext. ___ for additional information?			
11. Was a command post set up after code 100 was announced in the nursing office?			

Staff Responses	YES	NO	N/A
12. Did Department Heads/Designee report to command post after announcement of code 100?			
13. Was the most recent photo of resident brought to the command post?			
14. Were search assignment sheets distributed to staff?			
15. Was the family contacted by SW to inform them of situation, gain further information as to family activities that might explain resident's location?			
16. Did the command post notify administrator, nursing administration and director of social services?			
17. Did Administrator consult with command post regarding decision for notification of police department 911/or implementation of pyramid alert?			
18. Did Director of Security notify the police department if authorized by administration?			
19. Did command post move to switchboard after 24 hours?			
20. Did administration decide which staff would return to regular duty?			
21. Did all staff remain on heightened alert?			
22. Was family notified of latest update?			
23. Did security director maintain liaison with police department until resolution of search?			
24. Did NM/SW notify the family?			
25. Did NM/SW ask security supervisor to notify police, if found by other than police?			
26. Did NM/SW disband command post?			
27. Did switchboard operator announce all clear for code 100?			
28. Did command post clear the message from the hotline or update message to say all clear for code 100 "resident found"?			
29. Did NM/charge nurse arrange for resident to be examined by MD?			
30. Did NM/charge nurse update CCP to attempt to prevent further occurrences?			
31. Did NM inform/consult with family regarding modifications in CCP?			
32. Was a post conference held within 72 hours after the resident was reported missing to review incident?			

BEHAVIOR RESIDENT ASSESSMENT PROTOCOL (RAP)

FOR RESIDENTS WHO TRIGGER ON THE MDS DUE TO WANDERING BEHAVIOR, THIS IS AN UNOFFICIAL REVISON OF THE CMS BEHAVIOR RAP.

Do responses to any of these questions indicate risk for elopement?

1. ***Determine if the wandering behavior endangers or distresses the resident.***

    a. Review the intensity, duration, and frequency of wandering behavior over the past 7 to 14 days
    b. Is there a pattern to the wandering behavior (time of day/ nature of the environment/what was the resident doing)

2. ***Identify stability/change in the nature of the wandering behavior***

    a. How did the wandering behavior develop over time/were problems evident prior to admission or earlier in the resident's stay
    b. Has the resident experienced recent changes (new unit/roommate, new caregiver, change in medications etc.)

3. ***How does wandering behavior impinge on other functioning***

    a. Does this endanger the resident and/or others and how?
    b. Are wandering behaviors related to daily variations in functional performances and how?
    c. Does wandering behavior problem lead to resistance to care?
    d. Does wandering behavior lead to difficulties dealing with people and coping in the facility?

4. ***Review of potential causes of wandering behavior***

    a. Cognitive status problems interactions
        i. Rule out delirium
        ii. Consider impact of dementia diagnosis and review Cognitive Loss/Dementia RAP
    b. Presence of Mood and/or Relationship Problem Interactions
        i. Is there unresolved mood state or relationship problems- review Mood State and Psychosocial Well-Being RAPs
        ii. Can a cause and effect relationship be determined?
        iii. Does the presence or absence of other persons precipitate the wandering?
        iv. Did a recent loss of loved one, change in staff etc. lead to the wandering?
        v. Has an activity or anniversary of an event led to the wandering?
    c. Environmental conditions
        i. Is staff sufficiently responsive and do they recognize early warning signs?
        ii. Does staff follow the resident's familiar routines?
        iii. Does noise, crowding or dimly lit areas affect resident wandering, i.e., change of shift?

d. Illness/conditions
    i. Consider physical health factors such as pain
    ii. Is there an acute illness, i.e., UTI affecting cognition)?
    iii. Is a chronic condition worsening (Alzheimer's or other dementias)?
    iv. Is there impaired hearing, vision, ability to communicate or understand others?

5. Current Treatment/Management Procedures: Positive and Negative Consequences

a. Has the resident been evaluated by psych?
b. What treatment if any has been effective?
c. Is the onset of wandering behavior associated with start of a medication?
d. Is the wandering behavior associated with the use of a physical restraint?
e. Has the resident received care in a specially designed therapeutic unit?
f. Are there special staff training programs to focus on managing the wandering behaviors?
g. What disciplines are involved? How frequent/consistent is the training?

PROTOCOL OF CARE
WANDERING RESIDENT MANAGEMENT
ELOPEMENT PREVENTION

1. All residents will be assessed for risk of elopement upon admission, quarterly, with significant change in condition MDS assessments and when behaviors indicate.

2. Appropriate staff will monitor resident whereabouts including the monitoring of responses/reactions to events/activity in surroundings at time of wandering and report unusual behaviors to supervisor immediately.

3. Facility uses multi-faceted approaches to assure resident safety:

    a. Environmental such as but not limited to:
        i. Alarmed doors
        ii. Alarmed bracelets
        iii. Color-coded bracelets
        iv. Camera surveillance
        v. Security guard
        vi. Signage
        vii. Elopement prevention drills
        viii. Missing person drills, etc.

    b. Communication such as but not limited to:
        i. Resident photographs at reception desk/exits
        ii. Written notification to appropriate departments regarding at-risk residents etc.

    c. Staff education regarding responsibility to identify, report, and intervene related to wandering/elopement risk such as but not limited to:
        i. Anticipate resident needs based upon wandering triggers and patterns
        ii. Acknowledge resident's behavior as an attempt to communicate needs
        iii. Encourage verbalization, identify etiology and recognize feelings etc.

4. All residents will have a mechanism for being identified, i.e., name bands and compliance will be monitored.

5. Support and identify need for wandering, and develop individualized activity plan in response, which is detailed in the resident's care plan, i.e., ambulation program, movement, exercise, and dance.

CARE PLAN EXAMPLE #1

Resident Concern/ Issue /Need	Resident's Goal	Staff Approaches	Discipline
Wanderer/Elopement: *Evidenced by*: ▪ Verbalizes intent to leave building/facility ▪ Wanders ▪ Leaves unit ▪ Verbalizes intent of going home ▪ Other *Related to:* ▪ Roommate problems ▪ Unstable medical condition (specify _____) ▪ Pain ▪ Poor interpersonal relationships ▪ Frustration ▪ Memory impairment ▪ Impaired cognition ▪ Poor judgment ▪ Panic state ▪ New admission/change in environment ▪ History of elopement prior to admission ▪ Personal loss/bad news *Resident strengths and preferences* ▪ A need to walk, even at nighttime ▪ One of most favorite things to do was to take long walks in the woods with family ▪ Strong and steady on feet ▪ Strong family involvement	1. Resident will continue to walk in environment 2. Resident will accept walking assistance from staff when he is tired or needs direction 3. Resident will remain safe within the facility	1. Determine resident's walking pattern (day, night, etc.) 2. Identify triggers indicating resident's need for walking assistance 3. Evaluate unit/facility for potential hazards for this resident 4. Walk with resident after lunch daily on the grounds – family will do this on Saturday and Sunday 5. Offer resident participation in walking club 6. Offer resident out of house nature trips, apple picking, leaf looking, etc. 7. Obtain "wandering" history/patterns from family 8. Provide with coffee, pastry, and newspaper each morning in lounge area and wine/cheese and crackers in dining room before supper 9. Show resident "Field and Stream" videos/ magazines or family albums/videos when he appears overly tired from walking 10. Encourage resident to participate in the above activities 11. Wanderguard bracelet on right arm	Nursing/team Nursing, Activities, SS, PT Nursing, PT, Activities, SS Mon. – PT Tues. – OT Wed. – SS Thurs. – Act Fri. – Nsg Activities Activities, SS SS, Nsg Dietary Nursing, SS, Activities Team Nursing

CARE PLAN EXAMPLE #2
RESIDENT CENTERED APPROACH

Resident Concern/ Issue /Need	Resident's Goal	Staff Approaches	Discipline
I am often confused and do not know where I am. I have a need to walk, even at nighttime. I need you to help me, keep me safe, and allow me to do all I can do for myself. One of my most favorite things to do was to take long walks in the woods with my wife and children. I am still strong and steady on my feet. I prefer to take the chance of falling while walking, knowing that I may be injured than to be limited from doing what I enjoy.	I will continue to walk in my environment. I will accept you walking with me when I am tired or need your direction. I will remain safe within the facility.	1. Determine resident's walking pattern (day, night, etc.) 2. Identify triggers indicating resident's need for walking assistance 3. Evaluate unit/facility for potential hazards for this resident 4. Walk with resident after lunch daily on the grounds – family will do this on Saturday and Sunday 5. Offer resident participation in walking club 6. Offer resident out of house nature trips, apple picking, leaf looking, etc. 7. Obtain "wandering" history/patterns from family 8. Provide with coffee, pastry, and newspaper each morning in lounge area and wine/cheese and crackers in dining room before supper 9. Show resident "Field and Stream" videos/ magazines or family albums/videos when he appears overly tired from walking 10. Encourage resident to participate in the above activities 11. Wanderguard bracelet on right arm	Nursing/team Nursing, Activities, SS, PT Nursing, PT, Activities, SS Mon. – PT Tues. – OT Wed. – SS Thurs. – Act Fri. – Nsg Activities Activities, SS SS, Nsg Dietary Nursing, SS, Activities Team Nursing

EXAMPLES OF CARE PLAN INTERVENTIONS

This is a recommended list of interventions to prevent elopement, but is by no means all inclusive:

- Avoiding events that lead to wandering behavior, i.e., crowded events, loud noises
- Reviewing medications that may cause anxiety, impaired visions, or poor balance such as sedative drugs, with ongoing assessment of their effectiveness
- Decorating their room with favorite pictures, books, etc. to provide a sense of comfort and familiarity
- Permitting the residents to look outside a window to keep track of the seasons of the year
- Having residents who wander wear a designated item of clothing for ease of identification
- Camouflaging doors with wallpaper or curtains so they are not recognized as doors***
- Monitor response/reaction to events/activity in surroundings at time of wandering
- Anticipate needs based upon wandering triggers and patterns
- Acknowledge resident's behaviors as an attempt to communicate needs
- Encourage verbalization, identify etiology and recognize feelings
- Support and identify need for wandering, and develop individualized activity plan in response, i.e., ambulation program, movement program, exercise and dance
- Determine resident's walking pattern (day, night, etc.)
- Identify triggers indicating resident's need for walking assistance.
- Evaluate unit/facility for potential hazards for this resident
- Walk with resident after lunch daily on the grounds- family will do this on Saturday and Sunday
- Offer resident participation in walking club
- Offer resident out of house nature trips, apple picking, leaf looking, etc.
- Obtain "wandering" history/patterns from family
- Provide with coffee, pastry, and newspaper each morning in lounge area and wine/cheese and crackers in dining room before supper
- Show resident "Field and Stream" videos/magazines or family albums/videos when he appears overly tired from walking
- Encourage resident to participate in the above activities
- Apply wander guard bracelet on resident's wrist or ankle
- Provide activity at change of shift to keep resident busy at time of high noise and exiting of staff
- Utilize alarmed doors at time of meals to prevent wandering off units
- Identify activities for the residents based on their past work life/habits/hobbies
- Communicate resident's potential for wandering to staff at the unit and exit areas
- Assess resident's psychological or psychiatric status
- Utilize volunteers to visit with residents

*** Check the CMS guidelines to ensure proper coverings allowed by code.

QUALITY IMPROVEMENT GUIDELINES/SUGGESTIONS

A goal of resident safety and risk management should be inherent in each Skilled Nursing Facility's Quality Improvement (QI) program. The following ideas are recommended to be reviewed/ incorporated into the safety/risk management aspect of a skilled nursing facility's QI process:

1. Establish a proactive/preventive method of Quality Improvement

2. Establishment of specific, practical and effective policies and procedures will assist in developing the monitoring aspect of this program

3. Monitor the effectiveness of the elopement/wandering program by:

    - Sampling assessments, care plans and outcomes concurrently to identify if the facility policy and procedures are being followed and establish compliance.

    - Conduct drills periodically to evaluate the effectiveness of the Missing Residents' Procedure and staff knowledge level of procedures.

    - Monitor compliance to providing education as described in facility policy.

    - Evaluate the learning objectives of the orientation program and any other education of staff related to this topic. This can be done by monitoring a few key questions related to the materials after each class and at intervals ongoing in practice settings.

    - Monitor the effectiveness of the environmental methods used to prevent elopement on a periodic basis.

    - Review each incident of elopement or near miss elopements individually but also collectively to identify any resident/facility trends.

4. Utilize the facility's policies, procedures and standards to assist in evaluating the effectiveness of these facility standards and to keep the process simplified.

JCAHO FRAMEWORK FOR CONDUCTING A ROOT CAUSE ANALYSIS

Level of Analysis		Questions	Findings	Root Cause	Ask "Why"	Take Action
What happened?	Sentinel Event	What are the details of the event? (Brief description)				
		When did the event occur? (date, day of week, time)				
		What area/service was impacted?				
Why did it happen?	The process or activity in which the event occurred	What are the steps in the process, as designed? (a flow diagram may be helpful here).				
		What steps were involved in (contributed to) the event?				
	Human factors	What human factors were relevant to the outcome?				
	Equipment factors	How did the equipment performance affect the outcome?				
	Controllable environmental factors	What factors directly affected the outcome?				
	Uncontrollable external factors	Are they truly beyond the organization's control?				
	Other	Are there any other factors that have directly influenced this outcome?				
		What other areas or services are impacted?				

JCAHO FRAMEWORK FOR CONDUCTING A ROOT CAUSE ANALYSIS

Level of Analysis		Questions	Findings	Root Cause	Ask "Why"	Take Action
Why did that happen? What systems and processes underlie those proximate factors? *(Common cause variation here may lead to special cause variation in dependent processes)*	Human Resources Issues	To what degree is staff properly qualified and currently competent for their responsibilities?				
		How did actual staffing compare with ideal levels?				
		What are the plans for dealing with contingencies that would tend to reduce effective staffing levels?				
		To what degree is staff performance in the operant process(es) addressed?				
		How can orientation and in-service training be improved?				
	Information Management Issues	To what degree is all necessary information communicated				
		To what degree is communication among participants adequate?				
	Environmental Management Issues	To what degree was the physical environment appropriate for the processes being carried out?				
		What systems are in place to identify environmental risks?				
		What emergency and failure-mode responses have been planned & tested?				

JCAHO FRAMEWORK FOR CONDUCTING A ROOT CAUSE ANALYSIS

Level of Analysis		Questions	Findings	Root Cause	Ask "Why"	Take Action
Why did that happen? What systems and processes underlie those proximate factors? *(Common cause variation here may lead to special cause variation in dependent processes)*	Leadership Issues	To what degree is the culture conductive to risk identification and reduction?				
	Encouragement of communication	What are the barriers to communication of potential risk factors?				
	Clear communication of priorities	To what degree is the prevention of adverse outcomes communicated as a high priority? How?				
	Uncontrollable factor	What can be done to protect against the effects of these uncontrollable factors?				

JCAHO FRAMEWORK FOR CONDUCTING A ROOT CAUSE ANALYSIS

Findings	Risk Reduction Strategies	Measurers of Effectiveness
For each of the findings identified in the analysis as needing action, indicate the planned action, expected implementation, date, and associated measure of effectiveness, or… If after consideration of such a finding, a decision is made not to implement an associated risk reduction strategy, indicate the rationale for not taking action at this time. Check to be sure that the selected measure will provide data that will permit assessment of the effectiveness of the action. Consider whether a pilot test of the planned improvement should be conducted. Improvements to reduce risk should ultimately be implemented in all areas where applicable, not just where the event occurred. Identify where the improvements will be implemented.	Action Item #1	Measure
	Action Item #2	Measure
	Action Item #3	Measure
	Action Item #4	Measure
	Action Item #5	Measure
	Action Item #6	Measure
	Action Item #7	Measure
	Action Item #8	Measure

Cite any books or journal articles that were considered in developing this analysis and action plan:

GENERAL PRINCIPLES FOR WANDERING/ELOPEMENT POLICIES AND PROCEDURES

The Task Force recognizes that there are a number of factors/principles that can be applied to any and all elopement-related facility policies. While not required by regulations, the following principles will nonetheless likely assist nursing facilities in developing and reviewing their policies and procedures.

1. Policies should reflect an interdisciplinary approach, with the team being involved in the initial and ongoing risk assessments, care planning, and resident/family/staff education.

2. For taking photographs of residents at risk for wandering, it is advisable for it to be clearly spelled out who takes the pictures and when, and the process by which photographs are updated and maintained.

3. For elopement risk assessment tools/forms, it is appropriate and useful for the relevant MDS items to be referenced.

4. Policies should address how all staff will know if a resident is appropriate to be off a unit or outdoors unsupervised, and what actions to take if he/she is in a potentially unsafe situation.

5. It is helpful if there are criteria specified in the resident's plan of care for when interventions are to be implemented.

6. It is also helpful if there are criteria for how often, where, and when missing resident drills are conducted, as well as a defined system for determining frequency and type/location of drills. These factors may be based on criteria the facility establishes, which can include elements such as time of year, the resident population/residents at risk, the outcomes of drills, etc. The facility Quality Assurance committee is an appropriate body to drive these determinations.

7. If alarms are ever disengaged (such as for repair), facilities should consider what backup systems exist to safeguard residents in the interim. For example, if an exit alarm is disengaged for a delivery, the area should be cordoned off during that period of time.

8. Facilities should consider what the process is for determining which residents have a personal alarm in place, who will do the daily maintenance checks, and where are those checks documented, etc.

9 Facilities should consider when a resident is determined "missing." This is very important and needs to be spelled out in facility policies. Time is not necessarily the determining factor.

10. Facilities should consider conducting an immediate root cause analysis when an elopement occurs.

11. Policies should indicate when an elopement is reported to the Department of Health and other authorities.

FREQUENTLY ASKED QUESTIONS RELATED TO RESIDENT ELOPEMENT

Question 1: ***When is a resident considered to have eloped? When he/she leaves the unit…or exits out the main entrance? How is elopement defined?***

Answer: Elopement is defined as the ability of a resident to successfully leave the nursing facility unsupervised and unnoticed and enter into harm's way. Every instance of elopement is considered on a case-by-case basis as to whether a resident was placed at actual or potential risk for harm related to an elopement episode. Because each event will involve a multitude of factors/variables, arbitrary criteria cannot be applied in defining what is a citable situation.

One factor to consider is whether system issues have contributed to the elopement. For example, were there appropriate systems/safeguards in place? Did staff follow the established protocols and systems?

Question 2: ***If a cognitively impaired resident leaves the building, but is seen leaving and immediately returned, does this situation need to be reported to DOH as an elopement?***

Answer: It is difficult to definitively answer the question with a "yes" or "no" response, as the circumstances surrounding the elopement must be thoroughly examined to make such a determination. In such cases, the facility needs to conduct an internal review to determine if facility practices, or failure/lack of them contributed to the resident leaving the building, and what potential or actual harm occurred. If, for example, the resident was not assessed for wandering/elopement risk and the facility did not have a process to determine residents at risk for elopement, this could be a citable situation.

Question 3: ***A short-term resident leaves on a day pass to visit with his brother, but doesn't return by the end of the day. The facility locates the resident in the evening, and he returns safely with his brother. Does this event need to be called into the Health Department?***

Answer: Resident rights will dictate in this situation. If the resident makes the decision to stay away longer than what was originally told to the facility he/she has that right and, consequently, the DOH does not need to be notified, as long as the facility knows the whereabouts of the resident.

Question 4: ***A short-term resident decides she wants to return home rather than complete her course of in-house therapy. The facility explains any risks to the resident, and offers alternatives, but the resident insists on returning home. Does this have to be called into the DOH?***

Answer: No. The resident is leaving the facility Against Medical Advice (AMA) or self-discharging. The facility will want to inform the local Adult Protective Service of the discharge but this would not be considered an elopement situation.

Question 5: ***A resident is missing for three hours and the local police have been notified. When should the facility contact the DOH?***

Answer: Immediately. The resident's whereabouts are unknown. Whether the resident is alert and oriented or confused, facility staff should let the DOH know that the resident is missing.

Question 6: ***Does an elopement/wandering risk assessment have to be conducted for all residents?***

Answer: Yes. Standard procedure in the facility should be to evaluate all residents for the risk of elopement or wandering.

Question 7: ***Does the facility need to conduct a root cause analysis every time a resident attempts to elope from the facility?***

Answer: The facility would need to conduct a system-based analysis, which some identify as a root cause analysis, on any elopements where the resident was able to exit the facility without staff knowledge.

Question 8: ***How often do missing resident drills need to be conducted?***

Answer: It is recommended that the drills be conducted no less than annually.

Question 9: ***What departments other than nursing have a role/responsibility with respect to elopement prevention?***

Answer: All departments should have a role in preventing resident elopement. Whether that role is assessment or general observations of behavior, each department needs to be aware of the potential for residents to exit the facility and place themselves in danger.

TAB ALARMS, BED ALARMS, WANDERGUARD SYSTEM

POLICY

Tab alarms or bed alarms may be used on a resident who is deemed unsafe through the nursing assessment and documented on the resident's care plan that the resident is at risk for falls. The Wanderguard would be used for residents at risk for elopement.

PURPOSE

For each resident to reach his/her highest practicable well being in an environment that prohibits the use of restraints for discipline or convenience.

PROCEDURE

1. Nursing Assessment of each resident must be done on admission and change in status to evaluate if he/she is at risk for falls or elopement.

2. A plan of care must be formulated with the Interdisciplinary Team (Nursing, Physical Therapy, Occupational Therapy, Dietary, Activities, Social Worker, and Resident/Family), to determine the need for tab or bed alarms or Wanderguard bracelet and documented in the Care Plan.

3. The tab alarm will be utilized on the resident when they are out of bed in a wheelchair or chair.

4. The bed alarm will be utilized on the resident while they are in bed.

5. The Wanderguard bracelet will be applied to the resident's wrist or ankle and not removed until replacement is needed.

6. After applying the tab alarm or bed alarms in place, a safety check to make sure they are in proper working condition must be done before leaving the resident.

    a) Documentation of the tab and bed alarm checks will be made in the treatment books on each unit each shift daily.
    b) Before application of tab or bed alarms, they are dated on the date of application and documented in the alarm logbook located in the ADON Office.
    c) The first Monday of each month, a LPN will be assigned to replace all bed and tab alarms on all the units and document in the log book.

7. The Wanderguard bracelets are checked daily on the night shifts by the Supervisor and are documented in the treatment book on the units and the Wanderguard Folder in Peach Treatment Room.

UNPLANNED DISCHARGE
POLICY/PROCEDURE STATEMENT

Department: Administration/Social Work/ Residential Services/Nursing	**No:**	Page 1 of 1
	Subject: Unplanned Discharge (AMA/ACA/AWOL)	

POLICY

_____ will advise residents of the risks of early, unplanned discharge, and provide appropriate referrals & discharge instructions whenever possible.

PURPOSE

To provide the safest discharge possible for residents leaving the facility against advice.

PROCEDURE

1. Discharge Against Medical Advice (AMA)

   The MD, NP, or Nurse will:
   - Advise resident of the risks to their health & well-being if they choose to leave with an unstable medical condition
   - Obtain and witness resident's signature on AMA form
   - Provide referrals for medical, psychiatric or other services as needed

   The Nurse will:
   - Notify the Medical Provider on-call of any resident wishing to leave AMA/ACA
   - Provide residents with discharge instructions & review medications

2. Discharge Against Clinical Advice (ACA)

   The Social Worker or Substance Abuse Counselor will:
   - Advise the resident of the risk of relapse if the resident chooses to leave before completing the Substance Abuse Treatment Program
   - Obtain & Witness resident's signature on AMA/ACA form
   - Provide referrals to community services as needed
   - Notify the Nurse-In-Charge of residents wishing to sign out AMA/ACA

3. Discharge AWOL (Absent Without Official Leave)

   - Residents not returning from pass or outside appointments as scheduled will be considered AWOL
   - Residents who leave the facility without permission & without signing AMA/ACA will be considered AWOL

   The Social Worker will:
   - Notify the Administrator of resident being AWOL
   - Notify resident's legal mandate, if applicable
   - Notify resident's family, if applicable
   - Arrange a meeting with all appropriate parties to discuss discharge

DRILL TO LOCATE MISSING RESIDENT
"PROBE ALERT CODE ORANGE"
POLICY/PROCEDURES STATEMENT

Issued by: Administration		**Policy #:** A – 121
Effective Date:	**Last Review Date:**	**Supersedes:** NONE
Approved by:		
	Department Head Date	Administrator Date

POLICY

In order to comply with regulatory agencies, conduct announced or unannounced drill to locate missing resident. The drill will also suffice the regulation for emergency preparedness (483.75 m).

GOAL

The primary goal is to maintain resident safety for all residents at high risk of elopement from the facility.

PROCEDURE

Drills will be conducted either announced or unannounced to test the effectiveness of the Policies and Procedures affecting residents at high risk for elopement and to test the effectiveness in locating missing residents.

The Policy and Procedure or collection of policies and procedures are not limited to the following:

- Nursing Department P & P #1.37 .(Wandering Residents)
- Administrative P & P #2 – 043 (Missing Residents)
- Administrative P & P #A – 116 (Wandering Residents
- Administrative P & P #A – 119 (Emergency Communication Matrix)
- Administrative P & P #A – 115 (Building Search Protocol for Residents Care Planned as Wanderers)
- Memorandum Dated July 14, 2000 – Additional Procedures to Protocols for Missing, Controlling and Monitoring of Resident Care Planned as Wanderer

DRILL TO LOCATE MISSING RESIDENT
"PROBE ALERT CODE ORANGE"

In addition to the above Policies and Procedures the Security Officer on duty upon receiving an instruction to activate Missing Resident Code will overhead page "**PROBE ALERT CODE ORANGE," followed by resident name three (3) times.**

Individual / Discipline	Responsibility
Clinical Staff/CNA/CN/ Ancillary Staff	• Make a determination if resident is missing • Report to the Charge Nurse that the resident is unaccounted for
Charge Nurse	• Call Lobby Security Officer on duty by dialing ext. 3919 and report "Active Code Orange," in the unit where the resident resides and resident name
Security Officer	• Overhead page **"Probe Alert Code Orange and Resident Name"** three (3) times • Pull out and have the resident's picture ready for reference • Radio call to all officers on duty "Probe Alert Code Orange," the unit and the resident name three (3) times • Call Central Security office to report the event
Administrator/Designee/ AOD/Administrative Nursing Supervisor	• Convene the committee for the planned drill • Present plan to the committee for approval • Establish a command center preferably in the unit where "missing resident" resides • Take the leadership in the delineation of work or assignments • Record progress of search and rescue procedures conducted
Charge Nurse – Other Units	• Establish a "mini" Command Center in their units • Take the leadership in the delineation of work or assignment in that particular unit in carrying out procedures to locate the "missing resident" • Record progress of search and rescue procedure conducted
Security Officer(s)	• Take the leadership in the delineation of work or assignment in the search and rescue procedure of the "missing resident" in the following areas: basement; stairwells; rooftop; 1st floor lobby • Record progress of search and rescue procedures conducted
Commander Officer (Administrator/Designee/AOD/ Administrative Nursing Supervisor	• Take the leadership to make the drill as realistic as possible • Make known to all participants that all actions and decisions shall be known to the Command Officer, especially actions outside of Policies and Procedures or collection of Policies and Procedures to locate a missing resident • Make a determination to continue as to the duration of the drill • Call all participants to convene in an area to critique the drill • Record criticisms of the drill • Present criticism to QA Committee for Performance Improvement

MISSING RESIDENT/ELOPEMENT
POLICY/PROCEDURE STATEMENT

Originating Department: Administration	***Related Department:*** All

POLICY

It is the policy of _____ to provide a safe and secure environment for all residents. In the event of resident elopement it is the policy of _____ to implement its policies/procedures immediately to locate the resident in a timely manner.

PURPOSE

1. To assure the safety and security of all residents
2. To establish policies and procedures in the event of a missing resident
3. To train and maintain staff awareness of the importance of resident safety and security

ELOPEMENT RESPONSE TEAM

The members of the Search Team include the following:

- ***During normal business hours*** Department Heads, Supervisors, Security report to Administrative office.

- ***Off hours*** all nursing personnel and security are to report to the Nursing office except for one CNA from each unit and one nurse from each floor and any other available staff, i.e., Housekeeping, Maintenance, and Dietary.

PROCESS

Responsibility	Action
All Staff	Will notify highest ranking nursing personnel of missing resident
Highest Ranking Nursing Personnel	Will direct unit staff to begin search of unit immediately Will announce from any telephone, Code 100 by dialing 4444 and repeat three (3) times. Notify security by radio.
Response Team	Upon hearing Code 100 announcement, report to designated office
Highest Ranking Onsite Staff Member	Assigns a search sector to each team member and records on the attached Elopement Incident Search Assignment from. Notifies DON/Administrator if needed and provides photo of resident to security, if needed.
Staff Assigned to Sector	When sector search completed report back to command post, i.e., Administrative office during regular business hours or Nursing office during off hours.
Highest Ranking Onsite Staff Member	When resident is found, announce "Code 100 cancelled" and repeat three (3) times over PA system and radio and place call to _____.
Administrator/Designee	Notifies _____ Police Department emergency #337-7777 that a resident is missing.
Nurse in Charge	Completes appropriate documentation including condition of resident when last seen.
Administrator/Director of Nursing/Designee	Notifies D.O.H. as per requirements

ELOPEMENT INCIDENT SEARCH ASSIGNMENT

Highest Ranking on-site staff member coordinating search: _____

Sectors on Premises	Staff Assigned	Post-Search Report & Time
Outdoor areas		
Lower level		
North		
South		
Second Floor		
Third Floor		
Staircases between floors		
Lobby/Auditorium/Main Dining Room/Staff Dining Room		
Elevators		
Roof including staircases leading to roof		
Kitchen		

COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____

MISSING RESIDENT POLICY AUDIT

Staff Responses	YES	NO	N/A
1. Did CNA staff notify NM immediately after resident was discovered missing?			
▪ Within first 15 minutes?			
2. Did NM notify security gate immediately with name, neighborhood and physical description of resident?			
3. Did NM assign staff to conduct room-to-room search on floor, public area and offices?			
▪ Public area on floor			
▪ All offices on floor			
▪ Stairwells			
4. Did NM post message on hotline information – dial __ line at ext. ___? Did NM enter password?			
▪ Name of resident			
▪ Neighborhood of resident			
▪ Resident physical description			
▪ Type and color of clothing			
5. Did NM call switchboard operator to announce Code 100?			
6. Did NM give switchboard operator:			
a. Name of resident			
b. Physical description of resident			
7. Did switchboard operator announce code 100 over public address system?			
8. Did each NM conduct a head-to-head search in their neighborhood to make sure that missing resident is not in their neighborhood?			
9. Did each NM call command post with results of the head-to-head search?			
10. Did Department Heads/NMs call the hotline information line ext. ___ for additional information?			
11. Was a command post set up after code 100 was announced in the nursing office?			

Staff Responses	YES	NO	N/A
12. Did Department Heads/Designee report to command post after announcement of code 100?			
13. Was the most recent photo of resident brought to the command post?			
14. Were search assignment sheets distributed to staff?			
15. Was the family contacted by SW to inform them of situation, gain further information as to family activities that might explain resident's location?			
16. Did the command post notify administrator, nursing administration and director of social services?			
17. Did Administrator consult with command post regarding decision for notification of police department 911/or implementation of pyramid alert?			
18. Did Director of Security notify the police department if authorized by administration?			
19. Did command post move to switchboard after 24 hours?			
20. Did administration decide which staff would return to regular duty?			
21. Did all staff remain on heightened alert?			
22. Was family notified of latest update?			
23. Did security director maintain liaison with police department until resolution of search?			
24. Did NM/SW notify the family?			
25. Did NM/SW ask security supervisor to notify police, if found by other than police?			
26. Did NM/SW disband command post?			
27. Did switchboard operator announce all clear for code 100?			
28. Did command post clear the message from the hotline or update message to say all clear for code 100 "resident found"?			
29. Did NM/charge nurse arrange for resident to be examined by MD?			
30. Did NM/charge nurse update CCP to attempt to prevent further occurrences?			
31. Did NM inform/consult with family regarding modifications in CCP?			
32. Was a post conference held within 72 hours after the resident was reported missing to review incident?			

PATIENT/RESIDENT LEAVE OF ABSENCE AND PASS POLICY

Policy #:	Date:
Revisions:	

POLICY

The facility recognizes the rights of residents, for whom _____ is their home, to leave the campus for limited periods for therapeutic reasons. The facility also recognizes the need of rehabilitation patients for therapeutic leave in preparation for discharge. It is not in the best interest of hospital patients to leave the campus, but they are encouraged to enjoy the hospital grounds between times of the provision of medical care. Because the purpose of admission is to provide a continuum of care and treatment, leaves of absence and passes may be granted in accordance with specific guidelines.

PURPOSE

- To clarify circumstances under which authorization for leaving the facility is needed.
- To establish guidelines regarding the right to return to the residential environment upon termination of an authorized leave of absence or pass.

SCOPE

This policy applies to the hospital and nursing facility.

DEFINITIONS

This policy applies to situations in which the resident desires to leave the facility or the campus for one or more days for reasons other than to attend facility initiated or facility authorized activities, i.e., recreational or other trips accompanied by facility employees, approved continuing education, etc. It also applies to rehabilitation patients who seek leave in preparation for imminent discharge and advises hospital patients of their entitlement to campus passes only and of their lack of eligibility for authorized absences or day passes.

1. **Therapeutic Leave of Absence - Nursing Facility** - (**for nursing facility residents only)** Overnight absence for therapeutic purposes. Not applicable for temporary absence due to admission to other health care facilities.
2. **Therapeutic Leave of Absence - Rehabilitation** - **(For rehabilitation patients only)** Therapeutic leave beyond the normal census-taking hour, which does not exceed two days.
3. **Day Pass - (For nursing facility residents only) -** Authorization to leave the campus until 9:00 p.m. of the day the pass is issued for therapeutic reasons.
4. **Campus Pass** - **(For hospital and rehabilitation patients) -** Authorization to leave the building for periods of time while no medical care is being provided but to remain within the perimeter of the campus, unless traveling to the other campus by facility transport. (For purposes of this policy, the campus is defined as the geographical area, which encompasses the front of the facility buildings and the grounds on which they are situated.)

5. **Days of Absence** - Accounting of days chargeable against a calendar year balance; computation will include day of departure, but not day of return.

RESPONSIBILITY

It is the responsibility of the physicians, nurses and the hospital police department to ensure adherence to this policy. It is the responsibility of the finance department to track the overnight leave time utilized.

It is the responsibility of the resident/family/responsible party to participate in leaves of absences and facility passes in a manner that does not jeopardize or threaten the resident's/patient's goals of treatment and care.

PROCEDURE

1. LEAVE OF ABSENSES

A. Criteria

Patients or residents who leave the facility outside of the parameters of this policy are subject to loss of insurance coverage for the period of their absences and personal responsibility for costs incurred in readmission or holding their bed.

Consistent with New York State regulations (NYCRR 415.3(h) and DOH Interim Policy for Transfer/Discharge of Nursing Home Residents, effective 5/1/04) and facility policy, leaves of absence for patients/residents are authorized under the following conditions:

Nursing Facility:

1. The resident has resided in the nursing facility for a period of 30 consecutive days or more, prior to this leave. This residency requirement does allow for interruption due to hospitalization.
2. The resident has not been granted leave for more than 18 days during the current calendar year.
3. The leave is for therapeutic purposes.

Rehabilitation:

Rehabilitation patients may be granted leave in preparation for discharge as follows:

1. The leave is for therapeutic reasons and imminently leading to discharge and must be both documented in the medical record and in the physician’s treatment plan.
2. The leave is up to two days at a time.

Medicine:

1. It is not in the best interest of hospital patients to leave the campus, but they are encouraged to enjoy the hospital grounds in between times of the provision of medical care.

***B. Process*:**

Nursing Facility:

1. A resident requesting a leave of absence from the nursing facility shall complete a Resident Leave Request (see attached*). Requests for leave of absence by the resident will be submitted a minimum of forty-eight (48) hours in advance.
2. This form shall be submitted to medicine and nursing.
3. The physician or registered physician assistant (RPA) will complete and sign the Leave and Pass Authorization based on clinical evaluation and discussion with the resident. The nursing unit shall issue to the patient a pass (see attached*). Nursing shall ensure that the resident has his/her identification bracelet attached prior to issuance.
4. The nursing unit shall enter on the pass and in the medical record the date and time the resident leaves the facility.
5. The nursing unit shall also complete the portion of the pass indicating the total number of leave days used during the 12-month period. Residents in the nursing facility are eligible for an authorized leave of absence for up to eighteen (18) days per twelve (12) month period. Any request for leave in excess of the 18-day policy limit or any request for leave exceeding 14 consecutive days must be referred to administration for approval. The resident is eligible for an authorized leave of absence after thirty (30) consecutive days following the current admission.
6. Upon the resident's return, hospital police will:
   (a) Record the actual date and time of patient's return to the facility in the security log.
   (b) Mark through the pass card with an ink pen to ensure that the card cannot be altered and used again.
7. The nursing unit shall reflect the time of return to the unit in the medical record.
8. Should a resident in the nursing facility request an extension beyond the 18-day limitation, the patient shall be referred to his social worker who will request an extension. This request for an extension must be submitted to the finance office at least one week prior to the proposed leave date.
9. Should a resident not return on the requested date of pass, the nursing unit should notify the finance office.

Rehabilitation Service Patients:

A Rehabilitation patient may request authorization for overnight leave under the following conditions:

1. A patient requesting a leave of absence shall be preparing for imminent discharge and shall complete the Patient/Resident Leave Request.
2. This form will be submitted to medicine and nursing.
3. The physician will assess whether the patient is medically stable and whether the leave has a therapeutic purpose. If so, authorization for the leave in excess of regular census hours, along with the therapeutic reason for the leave, shall be noted in the "physician's order" section of the medical record. (The reason for non-issuance of a pass shall be documented in the progress notes.) The head/charge nurse shall issue the patient a pass. Nursing shall ensure that the patient has his/her identification bracelet attached prior to issuing a pass**.**

******* *Documents are not attached, but denote need for respective forms.*

4. The nursing unit shall enter on the pass and in the medical record the date and time the patient leaves the hospital.
5. The nursing unit shall also complete the portion of the pass indicating the total number of leave days used during the calendar year.
6. The nursing unit shall reflect the return time in the medical record.

Patients deemed safe for a leave, escorted by a family member, next of kin, or responsible party, will be identified by a yellow wristband. Accompanying family/person will sign the pass and assume responsibility for the patient's safety.

Patients not adhering to this policy will be provided with a copy of a notification letter, receipt of which will be noted in the medical record. Further passes will be determined with the participation of the interdisciplinary team.

2. DAY PASSES

A. Nursing facility residents may obtain day passes.

1. For residents, day passes may be issued for one or more days (from 10:30 a.m. to 9:00 p.m., to be adjusted seasonally or for special circumstances) at the discretion of the physician/RPA who will assess whether the patient is medically stable and whether the request has a therapeutic purpose. If so, authorization shall be noted in the "physician's order" section of the medical record. In the event of a request for the authorization of a day pass for multiple days, in addition to the physician/RPA approval, the interdisciplinary team shall review the request to determine its appropriateness consistent with the care plan. Requests for authorization for multiple-day passes shall be reviewed once a month by the team to evaluate any change in condition**.** If approved, a separate pass will be issued each day, weather permitting, by nursing to enable the nursing staff to assess the resident and observe any change in the resident's condition. Nursing shall ensure that the resident has his/her identification bracelet attached prior to issuance**.**
2. Eligible residents will request a day pass at least 24 hours in advance. Exception may be made by the ADON in conjunction with the unit physician, giving consideration to as to whether the resident's medical condition, medication needs and related equipment needs can be safely met on shorter notice. The resident remains responsible for returning to the facility by 9:00 p.m. on the day of the pass.
3. Approved day passes must be documented in the resident's medical record.
4. The appropriate Day Pass Form must be completed and a copy maintained by nursing until the resident's return.
5. Residents who overstay their day pass and/or leave hospital premises without following facility procedures, will be provided with a copy of a notification letter receipt of which will be noted in the medical record. Further passes will be determined with the participation of the interdisciplinary team.
6. Patients deemed safe for a leave, escorted by a family member, next of kin, or responsible party, will be identified by a yellow wristband. Accompanying family/person will sign the pass and assume responsibility for the patient's safety.
7. The head/charge nurse will process the day pass and document in the medical record. The nurse will inform the assigned interdisciplinary team if the resident does not adhere to the pass policy, and document this in the medical record.

3. CAMPUS PASSES

A. Eligibility:

1. For those patients who are assessed by the physician/RPA as medically stable, and who wear their hospital identification bracelets, campus passes may be issued for one or more days, weather permitting, for use between the hours of 10:30 a.m. to 9:00 p.m. (which will be seasonally adjusted) upon assessment by and at the discretion of the physician/RPA. This pass permits the patient to enjoy the area outside the buildings on hospital grounds, for periods when medical care is not scheduled,

   Patients who overstay their day pass and/or leave hospital premises without following facility procedures, will be provided with a copy of a notification letter, receipt of which will be noted in the medical record. Further passes will be determined with the participation of the interdisciplinary team.

   The patient remains responsible for returning to his/her unit by 9:00 p.m. on the day of the pass.

   Patients deemed safe for a leave, escorted by a family member, next of kin, or responsible party, will be identified by a yellow wristband. Accompanying family/person will sign the pass and assume responsibility for the patient's safety.

B. Procedure:

1. Patients will request the campus pass from nursing staff.
2. The first Campus Pass Form request by the patient shall be referred to the unit physician/RPA by the nursing staff who will assess and document in the progress notes whether the patient's medical condition, medication needs, and equipment needs can safely permit issuance of the pass. Should the physician/RPA determine that a pass should be issued for one or more days, this order shall be noted in the "physician's order" section of the medical record.
3. Once this initial assessment is completed for the respective patient, additional assessments and changes in the physician's order will be required only when there has been a change in circumstance in the patient's condition as noted by unit staff. In the event that the physician/RPA determines that the patient is permitted daily renewal of the pass privilege, a separate pass still must be issued each day by nursing to enable the nursing staff to observe any change in the patient's condition.
4. The head/charge nurse will process the campus pass and document the patient's departure in the medical record accordingly. Verification that the patient is wearing a hospital identification bracelet is required before the pass is issued. The nurse will inform the interdisciplinary team if the patient does not adhere to the pass policy, and will document this in the medical record.
5. The hours and days permitted for campus passes are subject to modification due to weather or at the discretion of hospital administration in the best interests of the patients.

4. GENERAL RESPONSIBILITIES FOR ALL PASSES

1. It shall be the responsibility of the patient/resident requesting the pass to apply sufficiently in advance to allow for all necessary medications to be provided or other preparations to be made. It is also the responsibility of the patient/resident receiving the pass to adhere to this policy, to sign the pass acknowledging the conditions under which it is issued, and to present the pass to the hospital police officer upon exiting, which shall be done only through the main lobby.
2. It shall be the responsibility of the physician/RPA to approve passes for one or more days and to document same in the medical record.
3. It shall be the responsibility of the head/charge nurse to process authorization for a pass; to ensure documentation in the nurse's notes section of the medical record for day and overnight passes; to confirm that patients/residents wear their ID bracelet before issuing the pass; and to call an interdisciplinary team meeting when a patient/resident does not adhere to the policy. Each time the patient/resident makes a leave request, the nurse must also check the daily patient log/report to ensure that only one pass per day is given. For multi-day passes, the nursing staff must assess the patient's medical stability each day a pass is requested.
4. It shall be the responsibility of the hospital police to:
   a) check the pass and the identification of patients/residents when leaving the hospital building and to make the appropriate entries in the hospital police log book.
   b) retrieve passes when the patient/resident returns to the hospital building and note time of return. (The patient/resident can obtain an unexpired pass from hospital police if she/he desires to leave the hospital again.)
   c) bring to the attention of the Administrator on Duty or the Assistant Director of Nursing when the pass policy is not adhered to, so that appropriate action can be taken.
   d) to notify the Department of Nursing if a patient/resident attempts to or leaves the hospital without a pass.

A. Patient/Resident Return:

1. The head/charge nurse shall:
   a) record the date and time of return in the daily report (except for campus passes)
   b) document in the medical record the return of the resident or rehabilitation patient from overnight pass or if the patient/resident fails to return from or does not adhere to the day/campus pass.

5. FAILURE TO RETURN

If a patient/resident does not return from pass and/or fails to notify the Department of Nursing of an impending delay, the following shall occur:

1. Any hospital patient who fails to return to the facility by 12:01 a.m. of the day after leaving the facility without authorization will receive a notice upon his/her return documenting the event.

Reviewed By: _____ Date:_____

Reviewed By: _____Date:_____

STAFF TRAINING
SAMPLE INTERVENTIONS FOR
RESIDENTS EXHIBITING WANDERING BEHAVIOR

In addition to staff training on the facility's specific policy related to missing residents, all staff/all departments need to receive training on general interventions to be used on residents seeking to elope from the facility.

General interventions may include:

1. Validate the resident's concerns.

2. Re-direct the resident. Attempt to engage him/her in an activity such as:
   a. Folding laundry
   b. Wiping tables
   c. Rolling up balls of yarn
   d. Sweeping the floor

3. Never leave resident who is attempting to leave the facility until he/she is in a safe area.

4. Ask the resident where they are going and why are they leaving? The answers the resident gives to these questions will determine the appropriate response. Examples:
   a. "I have to go meet my son's school bus". An appropriate response may be "Mary, you still have 2 hours before the bus arrives why don't you come with me until then"
   b. "My daughter is picking me up soon". An appropriate response would be "Mary, I'm sorry, I forgot to tell you that your daughter called and she is having car trouble and won't be able to come today".

5. Educate staff on the times of day that trigger exit seeking behavior – after meals and at the afternoon change of shift.

6. Educate staff on the various alarm systems utilized for wandering residents.

7. Educate staff on the importance of visual checks of residents identified at risk for wandering.

8. Role play with staff on resident elopement behaviors.

BUILDING ASSESSMENT GUIDELINES
UNSAFE WANDERING & ELOPEMENT

The layout, design, and security features of all portions of the facility are assessed to determine each component's potential impact on unsafe wandering and elopement. Include exterior spaces used or possibly accessible to residents.

Due to the significant differences in staffing and operational practices that may occur in nursing homes over the course of the day and week, the assessment should be completed on both weekdays and weekends and for each shift.

Reassessments should be done as structural and operational changes occur at the nursing home. Investigations of unsafe wandering and elopement must include an evaluation of contributing building features and systems. Necessary revisions to the building assessment tool and continuing revision of security and supervisory and operational procedures are expected to result from changes to the building and from incident investigations.

The behaviors and underlying cause of each resident's wandering may differ. All measures developed to safeguard residents prone wandering or elopement must be individualized.

The sample tool below represents one possible assessment scheme. The tool begins by identifying risks in the resident room, moves to areas on the unit, and continues progressively moving to areas at increasing distances from the resident room. Since most elopement risk factors are common to many areas of the building, specific probes appear the first time a risk factor is identified and are not repeated for each area of the building. Some unusual or high hazard features that may pose additional safety or elopement risk are included at the end as are some general pointers regarding security features and systems.

SAMPLE BUILDING ASSESSMENT TOOL

BUILDING STRUCTURAL FEATURES

1. On Unit Spaces

A. Resident Rooms

- Windows
  - stops or security screens are present to prevent access to grade, adjoining roofs, accidental falls, or suicide attempts
  - stops or security screens are secured in a manner that cannot be easily undone
- Doors
  - is the door to the corridor in a location that is visible to staff from the nursing station and/or areas routinely traveled/occupied by staff during the course of their duties?
  - does the room have a second door to the exterior, a porch or another corridor, if so, is the second door secured or in a location that is visible to staff from the nursing station and/or areas routinely traveled/occupied by staff during the course of their duties?
  - does the room connect to an adjacent room via the toilet room or another door, if so is the door to the corridor from the adjacent room in a location that is visible to staff from the nursing station and/or areas routinely traveled/occupied by staff during the course of their duties?

B. Communal Areas –lounges, dining and activity rooms and areas

- Windows
- Doors
- Stairs
  - is the door to the stair in a location that is visible to staff from the nursing station and/or areas routinely traveled/occupied by staff during the course of their duties?
  - is the door to the stair alarmed?
  - is the door to the stair locked? (if a required exit, only those locks complying with the Life Safety Code and other applicable Fire and Building Codes may be used, see DAL0307 Protected Environments.
- Elevators
  - is the elevator visible to staff from the nursing station and/or areas routinely traveled/occupied by staff during the course of their duties?
  - is use of the elevator restricted through the use of swipe cards, keypads, wander-guards or some other manner?

C. Non-Resident Areas – staff, storage, utility, mechanical spaces, etc

- is access to the area restricted/supervised? If not
- is egress from the areas is restricted/supervised
  - Windows
  - Doors
  - Stairs
  - Elevators

D. Unit – egress from the corridor spaces of the unit

- Windows
- Doors
- Stairs
- Elevators

E. Adjacent Units
- assess in the same manner as the resident's home unit
- do not assume all units are the same

2. Off Unit Areas

A. Resident Use Areas
- Windows
- Doors
- Stairs
- Elevators

B. Non-Resident Use Areas
- Windows
- Doors
- Stairs
- Elevators

C. *Access Paths to Off Unit Areas* – does the building design promote or hinder supervision of ways of travel; access to non-resident and other areas of concern both in and out of the building is restricted and/or supervised?
- Windows
- Doors
- Stairs
- Elevators
- other corridors

3. Exterior

A. Doors to the Exterior
- Supervision – are doors located in an area that permits staff supervision?
- Locks – do fire codes permit locking; is it practical to lock the door?
- Number of Exits – is the door a required exit, if not, can the NH safely eliminate this designation and restrict egress by locking?

B. *Resident Use Areas* – patios, courtyards and other exterior areas are located/equipped to permit supervision; use is limited to those assessed as not at risk for unsafe wandering and/or the area is fenced in.

C. *Non-Resident Use Areas* – resident access is restricted; access points and routes are restricted/supervised.

4. Main Entrances

5. Roofs

6. Loading Docks, Staff, and Service Entrances

7. Tunnels

ALARM & SECURITY DEVICES and SYSTEMS

Right Device:	is it properly installed; does it serve the intended purpose?
Inspections:	is the device inspected on a routine basis and maintained?
Identifiable:	are alarms coded or emit or transmit a distinct signal?
Volume:	can the alarm be heard in all or most areas and over various ambient sound levels?
Staff Training:	is staff aware of its presence, its intended use and shortfalls; do staff know how to properly use the device - turn it on, off, reset it?