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MEDICINE | December 2007 | **SPOTLIGHT CASE**

Elopement

Commentary by Debra Gerardi, RN, MPH, JD

Case Objectives

- Define elopement and differentiate it from wandering and leaving against medical advice.
- Identify leading contributors to elopement events.
- Describe strategies for preventing elopement and steps for responding after a patient elopement has been identified.
- Identify legal risks associated with elopement.

Case & Commentary: Part 1

A 61-year-old male with a history of chronic pancreatitis and cardiomyopathy attributed to alcohol was admitted for chest pain, acute on chronic renal failure, and altered mental status. After being treated for his worsening cardiomyopathy and renal failure, his mental status began to clear. On the morning of anticipated discharge, he was not in his room at the time of the physician's visit. Such behavior was typical for this patient, who was known for being one of the hospital's "frequent flyers." However, when he did not return 3 hours later, security was called to locate him.

Finding that a patient has "gone missing" is a scary situation for providers and patients' families. According to the VA National Center for Patient Safety (NCPS), *elopement* is defined as: "A patient that is aware that he/she is not permitted to leave, but does so with intent."(1) In many cases of elopement, the patient may have a decreased mental capacity related to dementia or temporary delirium, or intermittent mental status changes related to medication, disease, or traumatic injury.(2) Despite the level of capacity or intent, both of which may be difficult to determine, eloping patients are often at risk for serious harm, and there are many cases where patient elopement has resulted in death.(3) On the other hand, *wandering* refers to a patient who "strays beyond the view or control of staff without the intent of leaving (cognitive impairment)."(1) Wandering can also lead to significant safety risks when the patient has decreased capacity.(2) (For more information on elopement terminology, see Table.)

Leaving against medical advice (AMA) 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.(4) Fully competent patients are legally able to discharge themselves without completing treatment. In such cases, the physician should inform the patient of the risks associated with leaving. In most organizations, this conversation is recorded in the medical record and the patient is asked to sign a form indicating that they are aware of the risks and that they are leaving against medical advice. Patients who are able to make determinations about their own care should be given guidelines upon admission that outline their rights and responsibilities while hospitalized, including the need to communicate with staff prior to leaving a treatment area.

The Joint Commission's sentinel events policy defines "any elopement, that is unauthorized departure, of a patient from an around-the-clock care setting, resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function" as a reportable sentinel event.(5) This reporting requirement reflects the level of harm to the patient regardless of the patient's intent to leave or mental capacity. The National Quality Forum has defined 27 serious adverse events and includes death or serious harm associated with elopement (disappearance) for more than 4 hours among its list of patient protection events.(6) According to Joint Commission sentinel event statistics, the primary contributors to elopement are breakdowns in patient assessment and team communication.(7) Protection of patients from elopement risks requires attention to preventive measures through assessment and elopement precautions as well as appropriate intervention after elopement occurs.

Adequately assessing patients for elopement risk factors and use of elopement precautions can prevent elopement and improve safety.(8) Such an assessment and possible precautions have been outlined in an elopement tool kit created by the VA Center for Patient Safety.(9) A "yes" to any of the following assessment questions indicates that the patient is at risk for 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?

In this case, the patient had a known history of altered mental status at the time he was deemed to be missing from his room, and his disappearance was not an uncommon event. Using the VA criteria, he clearly was at risk for elopement. For patients who have intermittent mental status changes, it is foreseeable that they could be at risk for serious harm if their capacity changes at a time when they are not adequately supervised. For this reason, the physician and staff in this case should have initiated elopement precautions despite his pending discharge and intermittent orientation.

Patient care involves many gray areas in which professional judgment is required. Keeping the patient safe is the primary goal and should guide all decision making. For patients who are competent and who have left the area without informing staff, response to their absence is based on what is reasonable for the particular situation. For some organizations, an absence of 45 minutes triggers the elopement protocol and patient search.(10) Other organizations deem elopement response necessary when "it becomes reasonably certain the patient is missing without authorization."(11) To prevent unnecessary searches, units should have procedures in place for patients to sign out or otherwise communicate with the nursing staff before leaving the area.

Frequently referred to as "Code Green," the response to elopement requires both actions by staff in the area from which the patient is missing as well as an organization-wide response. A typical protocol includes the following steps:

- Notification of the operator by unit staff indicating a Code Green/Elopement.
- Notification of security with a description of the missing patient and pertinent clinical information.
- Notification of the patient's physician.
- Immediate search of the unit and surrounding area by unit staff.

- Immediate search of hospital and grounds by security personnel.
- Notification of the patient's family by the physician.
- Notification of police by security as appropriate.
- Notification of appropriate administrative personnel.(12)

Procedures differ among organizations. However, the key is to do what is reasonably necessary to return the patient to a safe environment. Patients who have been missing for a significant period of time, most typically 4 hours, are typically readmitted rather than just returned to their unit. Other organizations use midnight as the indicator.(10,12) Providers should consult with organization policies for specific guidelines.

Case & Commentary: Part 2

Ultimately, the patient was found outside of the emergency department (ED), with ED Discharge Instructions in his hand. The patient apparently told the ED staff that he had recently been discharged and was waiting for a ride. He was brought into the ED. Because he was a "frequent flyer" there and complained of pain, he received his "usual" 1 mg of intravenous Dilaudid and 2 liters of intravenous hydration and was promptly released with oral pain medications, despite being noted as mildly confused by the ED staff. In the course of his ED visit, no one questioned the presence of a hospital ID bracelet and hospital gown; additionally, the hospital computer system failed to recognize that the same patient had been admitted simultaneously to both the inpatient floor and the ED.

An immediate organizational response should be initiated when any patient with decreased mental capacity has left the unit or treatment area without authorization. Health care organizations should have policies and procedures in place indicating the steps that personnel are to follow in any elopement situation, and adequate training should be provided for all staff. These protocols should include assessment and prevention procedures to reduce the risk of harm for patients with diminished capacity. Such preventive measures may include placing the patient on an observation protocol (special precautions for patients requiring frequent or constant monitoring). Such a protocol may include locating the patient close to the desk, placing an electronic monitoring device on the patient when available, partnering the patient with a roommate, or requesting a family member or nursing assistant to sit with the patient. Additional precautions common in mental health and rehabilitation facilities include automatic door locks, alarms, and diversion activities.(13)

In the case above, we cannot determine if there was not a policy for staff to follow or if they merely failed to follow the existing policy. If inpatient staff had initiated a Code Green type of response, it would be likely that the ED staff would have been aware of the missing patient and may have noticed that he was in their area before discharging him (provided that the procedure notified all areas of the facility). Adequate communication of such an event across the entire organization is essential so that a concerted effort can be made to locate the patient and safely return him to an appropriate level of care.

Given the recurring shortage of staff and the increasing complexity of patient care, use of technological solutions to prevent elopement is becoming more common.(14) Use of radiofrequency (RF) devices can make the difference, particularly when they are paired with routine risk assessment and solid team communication. Wrist bracelets (15) that are linked to signal detection devices within the unit can trigger an alarm when a patient wanders too far from their room. This helps staff who are busy with other patients and who may not notice when the patient leaves. In some facilities, the alarm can be linked to systems that automatically lock doors. In one ED, the use of the RF devices and a new triage protocol reduced the

need for one-to-one monitoring of at-risk patients by half.(16)

Care of patients in health care facilities is predicated on the patient's consent to treatment. Patient consent is obtained on admission to a facility and often throughout the course of a hospitalization for particular procedures. When a patient is mentally able to consent to treatment and is able to fully partner with health care professionals, the decisions of the patient regarding receipt of care must be honored. Competent patients who choose to leave without completing treatment cannot be held against their wishes. Doing so damages trust and impacts the reputation of the facility. In addition, providers would be at risk for claims of assault, battery, or false imprisonment.(17)

In all situations, including this case, there is a legal duty to exercise reasonable care and attention for the patient's safety, as their mental and physical conditions may render them unable to look after their own safety. Health care professionals have a duty to adequately supervise and observe patients and to maintain safe conditions on the premises.(18) Additional liability can ensue when there is negligent administration or failure to administer medications, when there is failure to notify the physician of changes in the patient's condition, and in situations where there was a failure to properly search for the patient following elopement.(19) Patients with diminished capacity, such as in this case, pose a threat to themselves and perhaps to others. Failing to initiate an immediate system-wide search put the patient at further risk and created a liability risk for the providers and the organization.

Linking adequate assessment, precautions, good team communication, updated technology, and immediate system response with an overarching goal of safe patient care can improve outcomes for patients at risk for elopement, reduce costs, and limit liability for care providers and the organization.

Take-Home Points

- Elopement is a serious event that requires a system-wide, organized response.
- Breakdowns in team communication and patient assessment are the top contributors to elopement events.
- Patients should be assessed for elopement risk on admission and throughout their hospitalization.
- Patients at risk for elopement should be put on special preventive precautions.
- Response to elopement by patients with diminished capacity should be immediate and include unit staff, security, and, when appropriate, local authorities.

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Faculty Disclosure: *Ms. Gerardi has declared that neither she, nor any immediate member of her family, has a financial arrangement or other relationship with the manufacturers of any commercial products discussed in this continuing medical education activity. In addition, the commentary does not include information regarding investigational or off-label use of pharmaceutical products or medical devices.*

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Table

Table. Terminology

(Go to table citation in commentary)

VA NCPS definitions (1)
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."
Legal definitions (2)*
Elopement—legally defined as a patient who is incapable of adequately protecting himself, and who departs the health care facility unsupervised and undetected.
Wandering—defined as occurring when patients aimlessly move about within the building or grounds without appreciation of their personal safety.

*__Note:__ These are general legal definitions; variations will occur from state to state.