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VIEWPOINT®

LONG TERM CARE

Risk Management Strategies for Healthcare Professionals

Wandering and Elopement

Introduction

Elopement liability claims have increased over the past few years, and as of 1999, elopement claims were the highest average costing claim against long-term care facilities, averaging $215,000 per claim.[1] Each year, cognitively impaired residents or residents suffering from dementia find their way out of health care facilities, go astray, and are often found injured, deceased, or in some situations, not found at all. These instances are widely publicized and can damage the reputation of the facility, without considering the actual injury or harm caused to the resident and their family. This makes routine assessments of all residents and the timely identification of those at increased risk for eloping, along with the implementation of security interventions, vital to the success of health care facilities in the prevention of resident elopements.

"Wandering" or "Elopement"

The term "wandering" has been used to describe several types of behaviors, and in one model proposed by J. P. Butler and C. A. Barnett in 1991,[2] these behaviors can be categorized as one of four types: purposeful, aimless, escapist, and critical. This model defines the "purposeful" wanderer as a resident who walks around with apparent intent. The staff, as well as the wanderer, is aware of where he or she is. The most appropriate response to this type of wandering is to accept the behavior as normal, as there is minimal risk for an elopement attempt.

The "aimless" wanderer is described as being confused about where he or she is, but the caregivers are aware of the resident's location. This resident moves about without purpose, looking for some unknown location, or thinks he or she is in a previous home. This type of wanderer often enters other residents' rooms and explores others' belongings, or perhaps enters hazardous areas of the facility. Safety hazards arise from the potential for these residents to be harmed in unsafe conditions, but they are generally not exit-seeking.

The "escapist" wanderer is characterized by multiple attempts to leave the facility and often expresses a desire to return home. Unlike the aimless wanderer, the escapist represents a deliberate attempt to get somewhere, and the resident can slip away from the facility undetected. These residents are clearly elopement risks and require increased supervision or environmental precautions.

The last category, the "critical" wanderer, poses the greatest risk to a facility. This individual cannot differentiate safe from unsafe situations. This type of resident strays from the facility, but does not understand the implications of doing so. The wandering becomes critical the minute the resident leaves the premises, and has been linked to out-of-facility deaths.[3]

Identification and Assessment of those at Risk

The initial step in elopement prevention is to identify those residents with the potential to wander or elope. This preliminary assessment should be conducted during the pre-admission or admission process to determine the resident's history of wandering, as well as any alterations in mental status or medications that could contribute to a risk for wandering or elopement. Often, the inception of wandering begins before admission to a nursing home or assisted living facility, as families may find it difficult to provide the constant direction needed for an elderly person who wanders. Not all residents who will wander will have a history of this behavior, and claims data show that nearly half of elopement cases and associated accidents occur within the first 48 hours of nursing home admission.[4] Therefore, consistent monitoring is needed for all new residents to ensure a new behavior is not developing. Regular re-assessments should also be conducted to ensure a change in status has not occurred.

After a resident has been identified as a risk for elopement, it is imperative to determine the specific risks and interventions needed for that resident. This should be conducted over a period of a few days and shifts by various nursing personnel in order to identify any trends in a resident's wandering behavior. A resident-specific care plan should be generated and followed to maximize the benefits of the interventions and minimize the risks for the facility.

Strategies for Prevention

The first line of defense against resident elopement is a well-informed, competent staff. All facility staff need to know which residents are likely to attempt to leave the facility or to get lost within the facility. Exits should be highly monitored after meals, at shift changes, and during urgent situations, as these are the times most recognized for residents to depart unnoticed while the staff is preoccupied with other events.

Environmental precautions and interventions include visual barriers, modifications to the environment that may enliven or arouse the senses, wandering paths, and special care units. Common environmental modifications to minimize elopement-seeking behaviors include continuous pathways, camouflaged doors and doorknobs, decorative fencing, enclosed outdoor spaces, improved facility signage, and elimination of dead-end passageways.

Door alarms are the most commonly used physical intervention by facilities, however, boundary alarms are only as good as their usage and maintenance. Electronic bracelet monitoring or patient tracking is also becoming increasingly used to monitor residents who are at risk for elopement. Due to the possible negative perceptions with

this type of resident monitoring, a discussion with family members is highly recommended before implementing this system. When used correctly, electronic devices (e.g., door alarms, video cameras, patient tracking devices) can greatly reduce the incidence and severity of potentially dangerous elopements. However, keep in mind that when an alarm sounds, it must always be responded to without delay. Even a few erroneous alarms may result in a lack in staff attentiveness. Maintenance logs and alarm test records should also be kept and utilized according to policy to document the integrity of the system at all times.

Missing Resident Protocols

If an elopement should occur, facilities must have a plan to locate a missing resident and all staff should be familiar with it. According to the Center for Medicaid & Medicare Services (CMS) nursing facility guidelines,[5] finding a missing resident is considered part of the disaster and emergency preparedness plan, and staff should be primed for swift mobilization should a resident be noted as missing. There are several components that a missing resident plan should include:

- photographic identification of all residents (with appropriate signed consents);
- thorough facility and grounds search, including normally "locked" areas;
- call for additional staff to aid in the search and notification of management;
- notification of local police and request for their assistance in the search;
- notification of state agencies as required by law in some jurisdictions; and
- detailed documentation of all actions taken and efforts made.

Missing resident drills, like fire or bomb drills, should also be executed from time to time to assist the staff in the implementation of an efficient search when necessary. Routine education with documented competency exams should also be conducted to ensure that all staff members are familiar with the procedures to follow should an incident occur.

Liability and Regulatory Standards

As mentioned previously, the average cost of an elopement claim within a long-term care facility is $215,000. This is expected to rise as individual verdicts rise across the nation. In 1998, a Florida jury awarded $6 million to a resident by finding that the facility was aware of the resident's tendency to wander, yet failed to protect the resident.[6] A Louisiana jury awarded a $200,000 verdict to a surviving widow when her spouse was struck and killed by a vehicle after eloping from a LTC facility.[7] A Texas jury awarded $3.3 million to the family of a nursing home resident who wandered from the facility and died of heat exposure.[8] Wandering by residents who are cognitively impaired is seen as a predictable risk, and facilities that neglect to effectively safeguard wandering residents, and subsequently respond swiftly to the reports of missing residents, may be found accountable for injuries suffered by such residents.

In addition to civil liability, facilities are increasingly being fined by their regulatory agencies for failure to prevent elopements. In 2000, an elopement by a resident from an Illinois nursing home cost the facility $10,000.[9] Coincidentally, the Illinois Department of Public Health cited this facility after discovering that this same resident had wandered unnoticed from the facility in the past, and on one occasion, was found walking in the snow without shoes. In 1998 the Kansas Department of Health and Environment also fined a facility $2,800 for breaching the nursing home regulation pertaining to elopement.[10] Ultimately, if a facility is aware that a specific resident is at risk for elopement, then it has a duty to provide the care required to protect the resident from foreseeable danger.

Conclusion

The risk of elopement has been, and continues to be, a daily challenge in providing continuing care to residents with cognitive deficits and dementia. The key to elopement prevention lies in an effective, individualized resident assessment and comprehensive plan of care. Knowing those residents who are most likely to exhibit wandering and elopement behavior, and the times and events in the day that stimulates such behavior, enables the staff to foresee this behavior and plan daily interventions to lessen the likelihood of such events. Many interventions may be useful in decreasing elopement risks over time, but no intervention should replace careful supervision and accountability of all front-line facility staff.

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1 *Addressing Resident Wandering and Elopement Issues,* n.d. Retrieved November 14, 2002, from the World Wide Web: *www.praeventus.com/elopement.html*
2 Hazardous wandering and elopement, *ECRI HRC Risk Analysis, Vol. 3, Long Term Care 2* (May 1999), 1-10.
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4 Ibid., 4.
5 Ibid., 1-10.
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7 Ibid.
8 Harris v. Texas Health Centers, Inc. Case No. 95-CV-0920 [Galveston City (Tex.) Dist. Ct.]
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10 *Addressing Resident Wandering and Elopement Issues,* n.d. Retrieved November 14, 2002, from the World Wide Web: *www.praeventus.com/elopement.html*

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