

**51st ASHE**  
Annual Conference & Technical Exhibition  
**2014**

**Hospital Security and Patient Elopement:  
Protecting Patients and Your Healthcare Facility**

ashe.org/annual  
Tom Smith, CHPA, CPP  
Healthcare Security Consultants, Inc.

**SURVIVAL**  
For the **FITTEST**

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**“Good judgment comes from experience and a lot of that comes from bad judgment”**

**Will Rogers**

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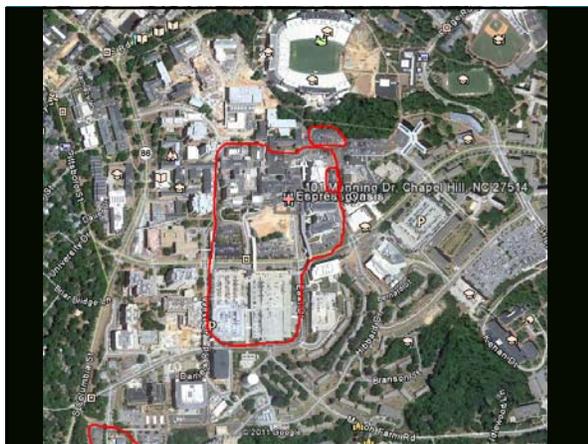
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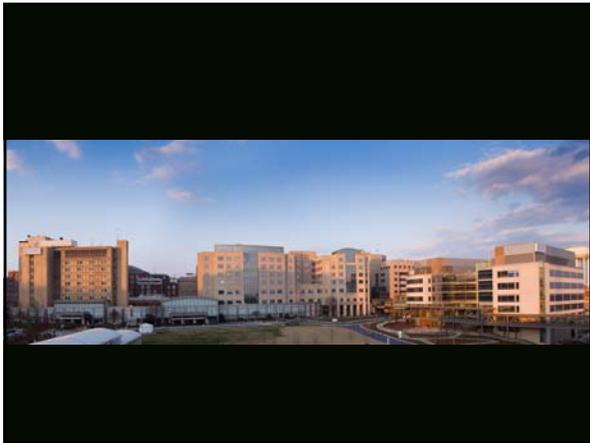
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### UNC Hospitals Background

- Beds 803
- Employees (paid FTE) 7,215
- Attending physicians 1,091
- Housestaff (residents) 763
- Clinic visits 918,524
- ER visits 67,122
- Surgical Cases 28,000 Transplant Cases 288 Births (deliveries)
- Volunteers 1,937
- Operating budget \$969.5M
- Physical plant: 2.1 million square feet of leased and owned floor space.

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### Session Objectives

- Describe the elements of an elopement prevention and response plan.
- Develop an action plan for assessing patient elopement risk and implementing preventive actions.
- Identify health care-related standards and guidelines aimed at reducing patient elopement.
- Discuss the significance of patient elopement and wandering incidents in health care facilities generally and in your facility specifically.

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### Security & Safety is Often Incident Driven



After a mental patient escaped from \_\_\_\_\_ Regional Medical Center's emergency room and shot himself in the head, hospital officials quickly altered visitation policies and tightened security.

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### Elopement Background

- 1998 - TJC Sentinel Event Alert Issue 4 Approves 8 Voluntarily Reportable Events including elopement.
- 2007 Agency for Healthcare Research and Quality (AHRQ) Web Site Materials Dedicated to Reducing Patient Elopement
- 2008 International Association for Healthcare Security & Safety Releases Operational Guideline on Patient Elopement
- 2009 VA National Center for Patient Safety Web site established covering Escape and Elopement Management.
- 2014 Agency for Healthcare Research and Quality (AHRQ) Web Site Materials Dedicated to Reducing Patient Wandering
- Recent Events in the News relating to patient wandering and patient elopement.

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### Cost of Elopement

- Can have major effect on bottom line.
- Fines – By CMS / Immediate Jeopardy
- Legal Implications / Civil Action
- Public loss of confidence

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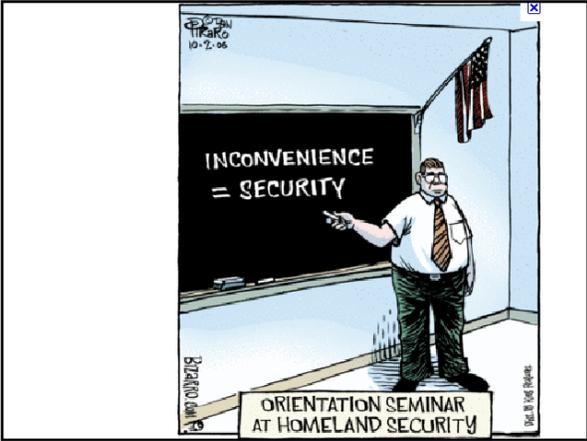
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### Typical Incidents

- Elopement: BMH patient's family awarded \$12,000,000 for wrongful death
  - Ten BMH patients taken outside by one MHT
  - Patient scales 12' Fence and jumps to death
  - No emergency response plan

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**Typical Incidents**

- **Elderly woman wandered away from her hospital room and died on rooftop in freezing temperatures**
  - Door to the roof had a broken lock
  - New procedure designed to quickly locate missing patients.
  - Search procedures not in place.
  - Signs added to all mechanical room doors indicating they must remain locked.
  - enhanced maintenance program has been established for mechanical door testing
  - Family says, ... "if this procedure was in effect a month ago, would their mom still be here today?"

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**Typical Incidents**

- **Investigation Finds Hospital, Sheriff Dept. Made Errors in Missing Patient Case**
  - Orders to not leave patient unattended were not implemented.
  - No Emergency Plan / search procedures in place.
  - Miscommunications occurred between Sherriff's Deputies and Staff.
  - Sherriff's Deputies were not trained in stairwell alarm procedures.
  - Attorney for family spoke on Good Morning America, calling the hospital's actions "completely inexcusable."
  - CMS found "systemic" failures.

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**The Centers for Medicare and Medicaid Services (CMS)**

- Elopement is a serious concern for HCFs and regulators alike
- Breeches to patient safety determined to be elopement can result in CMS finding of immediate jeopardy, along with significant civil monetary penalties or other CMS-imposed remedies."

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**CMS Expectations**

- 100% Compliance 100% of the time. This is not The Joint Commission (TJC)!
- Focus is on how, rather than what care is provided.
- Burden is on HCFs to show compliance with CoPs 100% of the time, where the action is at point of care.

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**Background**

- Health Care Facilities / Organizations (HCFs) accepting payment for Medicare and Medicaid patients are required to meet certain Federal standards called "Conditions of Participation" (CoPs).
- These requirements are promulgated by the CMS to improve quality and protect Health and safety
- COPs are regulatory standards hospitals agree to follow as a condition to receive federal \$
- State Healthcare licensure agencies conduct surveys of hospitals and enforce compliance with COPs.

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**Background**

- HCFs are subject to random onsite reviews and surveys.
- Unannounced surveys can result from patient or public complaints or inquiries.
- Incidents reported in the media also attract CMS attention.
- To meet demand for compliance surveys and address concerns about Healthcare quality CMS is enlarged compliance survey staff in 2010.
- Your likelihood of experiencing a survey is greater than ever before.

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### CMS / TJC Implications of Elopement Incidents

- Publicized major incidents draw attention.
- Some never events must be reported. Review what is reportable with your compliance staff.
- Same process used for investigating complaints.
  - Review of incident reports (hospital, and police reports)
  - Interviews with patients, staff, police and any witnesses
  - Policy review
  - Training record review
- Policies – Staff must be able to articulate and demonstrate policy requirements.
- Training records must be produced.

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### TJC Sentinel Event

- A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. **Such events are called "sentinel" because they signal the need for immediate investigation and response.**

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### Root Cause Information for Elopement-Related Events Reviewed by TJC 2004 – 2013 (N=88) (Resulting in death or permanent loss of function)

2004 through 2013 (N=88)	
<i>The majority of events have multiple root causes</i>	
Communication	62
Assessment	60
Physical Environment	58
Leadership	57
Human Factors	45
Care Planning	18
Continuum of Care	14
Information Management	7
Special Interventions	7
Medication Use	5

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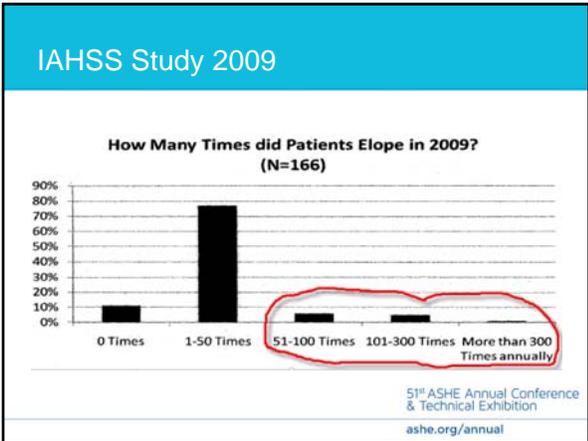
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- ### Regulatory Implications for Security Programs
- Patient Restraint and Use of force
  - Criminal Incidents
    - Criminal Incidents Involving Patients
    - Infant and Pediatric Abduction
    - Other major incidents posing risk to patients
  - Patient Elopement
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- ### Policy Considerations
- **Remember, there is no such thing as an elopement proof facility.**
  - Policies should avoid wording such as “ensure, assure, shall, must”.
  - Policy should be worded “to reduce the potential for” or “to attempt to prevent elopement”, or to take reasonable measures to prevent ...”
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**IAHSS Patient Elopement Guideline / Policy Considerations**

**STATEMENT:** Healthcare Facilities (HCFs) providing inpatient services will develop a multidisciplinary procedure for preventing and responding to patient elopements. The procedure should distinguish between elopements; wandering; and leaving “against medical advice” (AMA).

- Definitions for Elopement, Wandering, and AMA.
- Prevention Procedures
- Response Plans

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**IAHSS Patient Elopement Guideline / Policy Considerations - Prevention**

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

- Assessing each patient’s elopement risk.
- Steps to consider for patients at a high risk of elopement:
  - Room location
  - Wearing distinctive color gown
  - High tech options (RFID or other tag)
- A means of identifying patients who are authorized to leave the unit.

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VHA NOPS Escape and Elopement Management

**Risk Assessment**

If any of the following questions are answered "yes" then consider the patient to be a risk for escape or elopement.

- Does this patient have a court appointed legal guardian?
- Is this patient considered to be a danger to self or others?
- Has this patient been legally committed?
- Does this patient lack the cognitive ability to make relevant decisions?
- Does this patient have a history of escape or elopement?
- Does this patient have physical or mental impairments that increase their risk of harm to self or others?

*If any of the following questions are answered "yes" then consider the patient to be a risk for escape or elopement.*

- Does this patient have a court appointed legal guardian?
- Is this patient considered to be a danger to self or others?
- Has this patient been legally committed?
- Does this patient lack the cognitive ability to make relevant decisions?
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### IAHSS Patient Elopement Guideline / Policy Considerations – Response Plans

- Search of floor by clinical staff and notification of security if patient not found.
- Search facility buildings and grounds.
- Consider mass notification alert similar to “Code Pink”. Some HCFs use “Code Walker”.
- Clear distinction for Security Officer role in returning patient. Do they chase and use force? How far?
- Notification of Law Enforcement within reasonable time.
- Notification of patient’s family
- Documentation is critical.

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### Patient Elopement Case Study

- Mental Health Patient Assisted in Eloping by visitor
- Security Implications:
  - Visiting Policy
  - Design of doorway in locked unit
  - Procedures for access by visitors
  - Patient at risk for elopement access to exit door

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Corrective Action Plan				
Contributing Factor	Plan for Corrective Action	Responsible Person	Completion Date	Plan for Monitoring
Visitor forcefully blocked door open when exiting INSN allowing patients to escape from unit	Complete installation of all interim phase elopement buffers on 4ND and 5NDM doors		4NDM 10/18/10 5NDM 10/19/10	Expectation of zero elopements from psychiatric units. Any elopement that occurs will undergo a RCA
Lack of clarity in visitation policy that addresses after hour visitation in Psychiatry	<ul style="list-style-type: none"> <li>Revise visitation policy</li> <li>Educate all nursing staff in Psychiatry</li> <li>Implement protocol for identifying adult visitors to Psychiatry with picture ID</li> <li>Require visitor sign in log</li> </ul>		10/20/10 10/20/10 10/20/10 10/20/10	<ul style="list-style-type: none"> <li>Nurse Managers to monitor visitor log for 3 months to assess compliance with visitor ID verification. Complete January 15, 2011</li> <li>Expectation that all adult visitors will provide picture ID plus staff to document on visitor log.</li> </ul>
Patient at risk for elopement allowed to enter near baby rail door	<ul style="list-style-type: none"> <li>Designate safety zone around locked doors in which patients are not allowed to loiter</li> <li>Educate staff about 18Mts zone</li> <li>Modify, define area by taping off zone</li> <li>Area to be tied in different color to delineate zone</li> </ul>		10/18/10 10/19/10 10/19/10 10/24/10	Expectation of zero elopements from psychiatric units. Any elopement that occurs will undergo an RCA
Psychiatry staff triggered panic button immediately but did not provide specific patient identifiers for “Code Walker”	<ul style="list-style-type: none"> <li>Reeducate staff on Code Walker Policy</li> <li>Reeducate police</li> <li>Discuss that all psychiatric elopements are Code Walker</li> </ul>		10/20/10 10/21/10	Conduct mock Code Walker on 5NDM, 4NDM and 5NDM. Completed by 10/21/10

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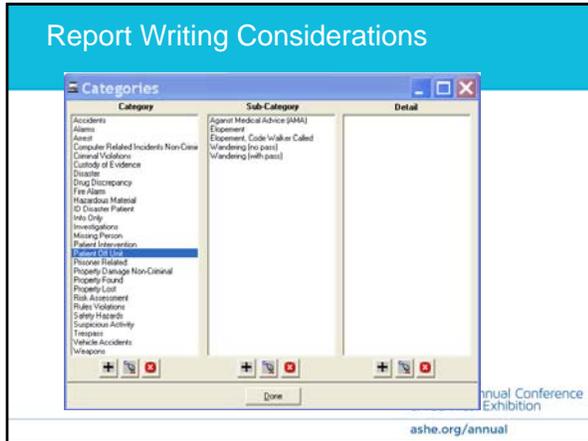
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## Report Writing Considerations



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## Design Considerations



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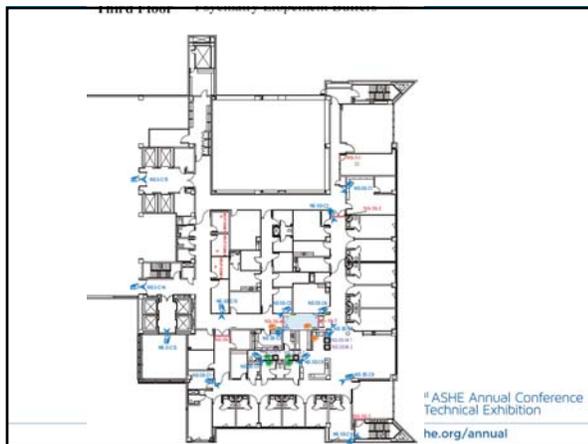
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**Policy, Procedures and Training**

- The biggest mistake we make is assuming that, after a policy is written and the staff are informed, compliance with the policy is consistent and complete. Without constant attention, employees will forget to follow all the steps. Processes will drift if the managers lose their focus.
- The old three legged stool concept: if one of these is missing the stool falls.
- “Don’t expect what you don’t inspect”

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

CMS Online State Operations Manual (Rev. 47, 06-05-09).  
[http://cms.gov/manuals/Downloads/som107ap\\_a\\_hospitals.pdf](http://cms.gov/manuals/Downloads/som107ap_a_hospitals.pdf)

Healthcare Security Basic Industry Guidelines. IAHSS Web sources

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

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

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Use these\*  

 **Not these  
On Patients**

\*If approved for restraint at your HCF. 5th ASHE Annual Conference & Technical Exhibition  
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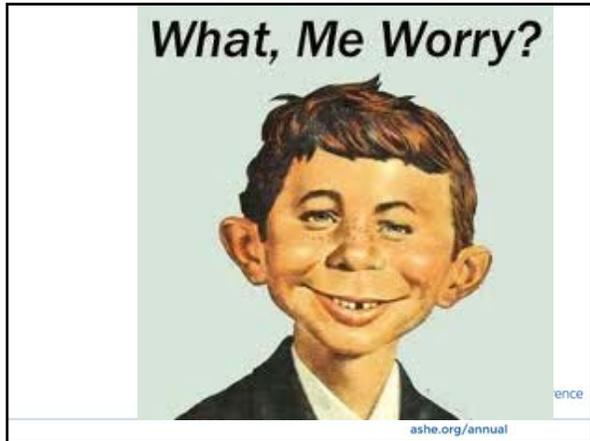
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