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Preventing Elopements from Long-term Care Facilities

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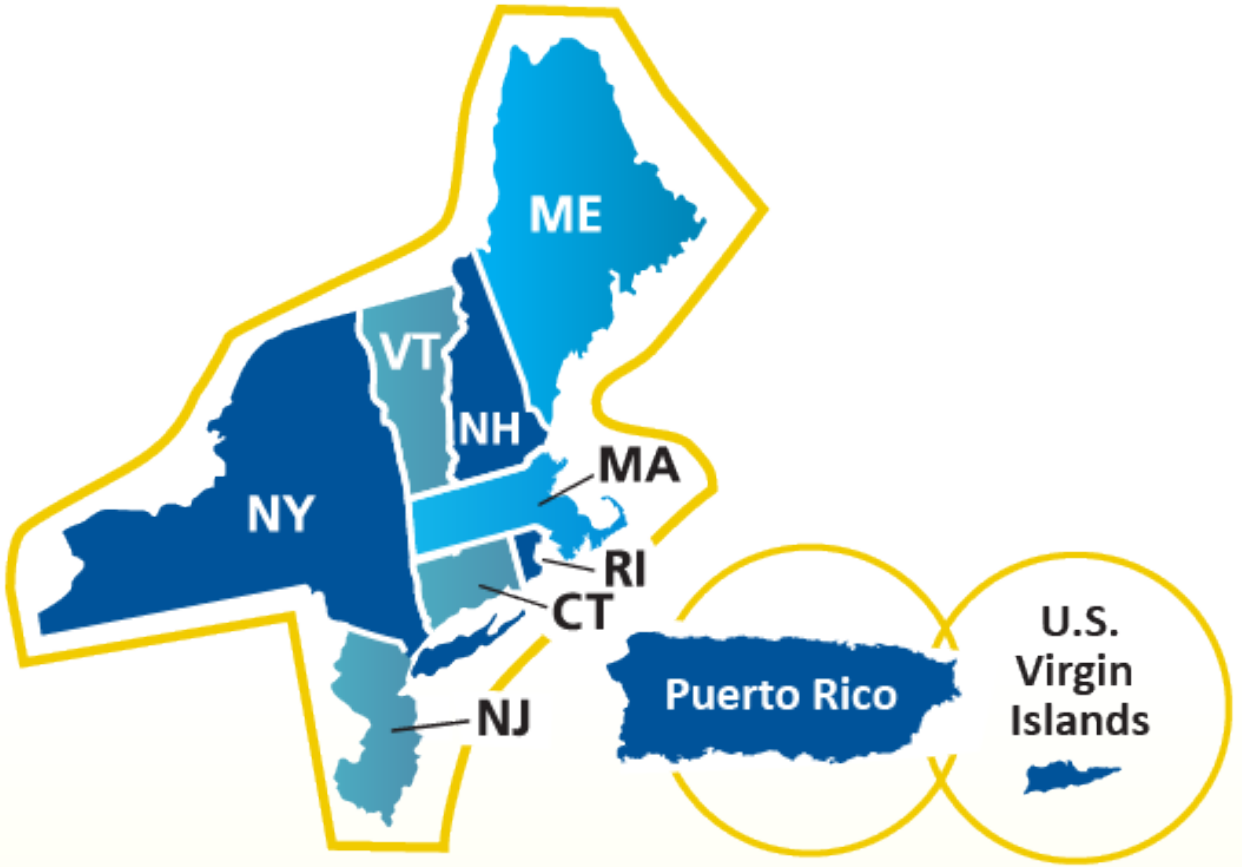

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Elopement

Elopement is a high-risk, preventable event that can result in serious injury, death and Immediate Jeopardy citations

Objectives

- Interpret State Operations Manual (SOM) guidance related to elopement
- Analyze example case failures and their root causes
- Identify high-risk points and prevention strategies
- Apply quality assurance performance improvement (QAPI) framework to reduce elopement risk

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State Operations Manual

SOM - Appendix PP

Wandering and Elopement

- A situation in which a resident leaves the premises or a safe area without the facility's knowledge or supervision.
- Facility policies that clearly define the mechanisms and procedures for assessing or identifying, monitoring, and managing residents at risk for elopement can mitigate risks.
- The resident at risk should have interventions in their comprehensive plan of care to address the potential for elopement.
- A facility's disaster and emergency preparedness plan should include a plan to locate a missing resident.

SOM (cont.)

- Facilities are responsible for identifying and assessing a resident's risk for leaving the facility without notification to staff and developing interventions to address this risk.
- A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident’s departure and/or whereabouts.
- A resident who leaves the facility prior to his or her planned discharge, but with facility knowledge of the departure and despite facility efforts to explain the risks of leaving, would be leaving against medical advice (AMA).
- Documentation in the medical record should show that facility staff attempted to provide other options to the resident and informed the resident of potential risks of leaving AMA.
- Documentation should also identify the time the facility became aware of the resident leaving the facility.

SOM (cont.)

- The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary.

Example of Deficiency:

- The facility failed to implement care plan interventions to monitor a resident with a known history of elopement attempts, which resulted in the resident leaving the building unsupervised, putting the resident at risk for serious injury or death.

Mental Disorder and/or Substance Use Disorder

- Residents with mental disorder and/or SUD may be at increased risk for leaving the facility without facility knowledge (which could be considered an elopement) at various times throughout their treatment, or if going through active withdrawal.
- The facility should explain the resident's right to a leave of absence and explain the health and safety risks of leaving without facility knowledge or leaving against medical advice (AMA).
- The facility cannot restrict a resident's right to leave the facility, but a contract can distinguish between a leave of absence, elopement, and leaving AMA.

Identifying Quality Deficiencies

- The responsibility of the facility's QAA committee to identify quality deficiencies requires that the facility have a system for routinely monitoring departmental performance data to identify deviations in performance and adverse events.
- Adverse events, such as the elopement of a cognitively impaired resident, should be considered a high-risk problem for which corrective action is required.

QAPI Background

- Quality Assurance (QA) is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards.
  - QA is ongoing, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.
- Performance Improvement (PI, sometimes called Quality Improvement or QI) is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.
  - PI aims to improve processes involved in health care delivery and resident quality of life. PI can make good quality even better.

QAPI Resources

- qapifiveelements.pdf
- processtoolframework.pdf
- Nursing Home QAPI -- What's in it for You?
- qapiataglance.pdf

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Case Studies

Case Study A: Wander Alert System Failure

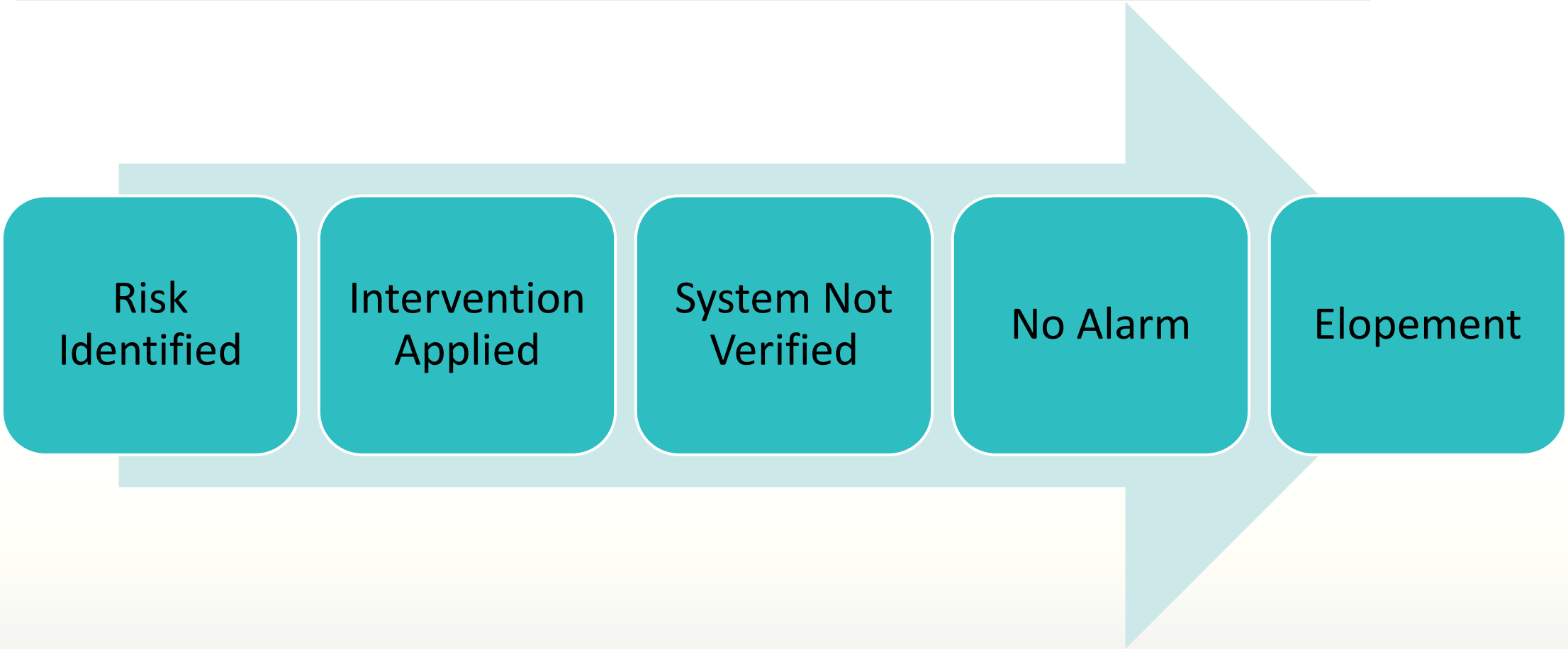
- An ambulatory, cognitively impaired resident was admitted to the facility at 10:00am and eloped undetected from the building at approximately 1:00pm on the same day.
- During admission, the resident verbalized their desire to leave.
- The facility determined the resident was an elopement risk and placed a wander alert bracelet on the resident about an hour after arrival.
- According to interviews with facility staff, the wander alert bracelet was activated, and its indicator was blinking red when placed on the resident.
- The facility did not have a policy regarding the wander alert system.

Root Cause Analysis

- **Failed Safety System:** Wander alert device/system did not function as intended
- **No Standardized Policy:** No procedure for system use, testing, or maintenance
- **Inadequate Supervision:** High-risk resident not closely monitored during admission period
- **Training Gaps:** Staff relied on a visual indicator vs. functional system verification
- **Leadership Oversight Failure:** No awareness or monitoring of system reliability

System Breakdown

Failure occurred at the system verification step—no redundancy or validation.



Key Lessons

- Technology does not supplant supervision
- Visual confirmation ≠ Functional verification
- Highest elopement risk = First 24–72 hours post-admission
- Use layered protection: Technology + staff monitoring
- Policies and audits are critical for life-safety systems

Performance Improvement Plan

Problem Statement

- A cognitively impaired resident identified as an elopement risk exited the facility undetected due to **failure of the wander alert system, lack of policy, and inadequate supervision during admission**, resulting in prolonged absence and risk of harm.

SMART Goal

- **Goal:** Achieve **100% reliable use and verification of elopement prevention systems** and ensure **100% of high-risk residents receive appropriate supervision interventions**
- **Timeline:** Within **(XX) days**, with sustained compliance thereafter

Immediate Resident Safety

- Audit all residents identified as **elopement risk**
- Confirm functionality of:
  - Wander alert devices functioning
  - Exit alarm systems operational
- Initiate **enhanced supervision protocol** for all high-risk residents (e.g., frequent checks, line-of-sight as indicated)

System & Equipment Reliability

- Implement **standardized device verification process:**
  - Test the wander alert bracelet at the time of placement AND confirm door alarm activation
- Conduct **facility-wide alarm system testing**
- Establish a **preventive maintenance schedule** for all elopement systems

****Rationale:* Alarm systems must be reliable and **do not replace supervision**

Policy Development

- Develop and implement a **Wander Alert/Elopement Prevention Policy** including:
  - Criteria for identifying at-risk residents
  - Immediate interventions upon admission
  - Device application and testing procedures
  - Required documentation
  - Staff response expectations for alarms
  - Emergency missing resident procedures
  - Frequency of device testing (shift/daily/weekly).

Staff Education & Competency

- Conduct **mandatory staff training** on:
  - Elopement risk identification
  - Proper use and testing of wander alert system
  - Supervision expectations
- Return demonstration
- Complete **competency validation** for all staff
- Include education during orientation and annually

***Facilities are expected to **train staff and implement policies to minimize elopement risk**

Admission Process Redesign

- Implement **high-risk admission protocol:** Immediate identification of elopement risk
- **No delay** in interventions (device + supervision)
- Team communication at admission handoff
- Require **Add to Baseline Care Plan**

Leadership Oversight & QAPI

- Add elopement prevention to **QAPI agenda monthly**
- Assign oversight:
  - Administrator
  - Director of Nursing
  - Director of Social Services
  - Maintenance/Environmental services (system checks)
- Conduct **quarterly mock elopement drills**
  - **When is your next drill scheduled?**

Monitoring Plan

- **Process Measures (what staff should do)**
- % of wander alert devices **tested at placement**
- % of **alarm systems tested weekly**
- % of **staff completing competency validation**
- % of high-risk residents with **documented supervision interventions**
- **Outcome Measures (what happens)**
- Number of:
  - Elopements
  - Attempted elopements
  - Alarm failures

Audit Plan

- Weekly audits x 12 weeks
- Monthly audits thereafter
- Results reported to **QAPI Committee**
- What actions are recommended as a result of the data?

***Monitoring must be **measurable, sustained, and reviewed by leadership**

Responsibility

- Who will be responsible? - Team approach
- **Administrator:** Policy approval, oversight
- **DON:** Clinical implementation, staff competency
- **DSW:** Resident/family follow-up
- **Maintenance:** Alarm system testing and maintenance
- **Unit Managers:** Daily compliance monitoring
- **QAPI Committee:** Data review and sustainability

Sustainability Plan

- Incorporate into:
  - Orientation training
  - Annual competencies
- Ongoing:
  - Preventive maintenance program
  - Quarterly drills
  - Continuous data tracking and trend analysis

***Sustainable improvement requires **ongoing monitoring and integration into QAPI systems**

Case Study B: Door issues

- A resident with severe cognitive impairment, wandering behaviors, and a wander alert device was found in a non-resident construction area.
- The area had a locked access door requiring a code; however, the door was not secured, allowing the resident entry.
- The wander alert sounded upon the door opening, and the staff deactivated the alarm without checking the area.

Case Study C: Alarm Bypass

- During a survey, an audible door alarm sounded for several minutes. In the activities room, where residents were located, a surveyor found the door ajar, held in place by a large rock, triggering the alarm. The surveyor called the door to the attention of the facility staff in the activities room, who closed the door.
- The staff reportedly use the door as a shortcut to the parking lot behind the building.
- Staff did not check outside to determine whether anyone had walked outside.
- Staff did not count the residents in the activities room to verify whether anyone had left.

Key Takeaways:

- Elopement = preventable high-risk event
- Admission period is the highest risk
- Technology must be verified, not assumed
- Supervision cannot be replaced
- QAPI is required to sustain improvement

Resources

- A Toolkit: Patients At Risk for Wandering - VHA National Center for Patient Safety
- Caring-for-Residents-Who-Wander_V2.pdf
- Investigation-Checklist_V3.pdf

Contact Me

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Learn more about the Northeast QIN-QIO: https://qi.ipro.org/

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