DEVELOPING AN EFFECTIVE ELOPEMENT PREVENTION PROGRAM

PRESENTED BY:

SARAH ROSE, MSN, RN, LNHA

ROSE CONSULTING, LLC

SROSECONSULT.COM

THE BASICS

The basics are what keep people safe but are usually what was missed when a resident elopes.

Environment

Assessment

Intervention

Monitoring

THE BASICS

Interdisciplinary Approach

Baseline and Ongoing Assessments

Care Planning

Staff Education

Resident / Family Education

Visitor / Vendor Education

F689

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§483.25(d) Accidents.

The facility must ensure that –

§483.25(d)(1) The resident **environment** remains as free of accident hazards as is possible; and

§483.25(d)(2) Each resident receives **adequate supervision and assistance devices** to prevent accidents.

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INTENT: 483.25(d)

The intent of this requirement is to ensure the facility provides an **environment** that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:

- **Identifying** hazard(s) and risk(s);
- **Evaluating** and analyzing hazard(s) and risk(s);
- **Implementing interventions** to reduce hazard(s) and risk(s); and
- **Monitoring** for effectiveness and modifying interventions when necessary.

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GUIDANCE OVERVIEW

An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address resident risk and environmental hazards to minimize the likelihood of accidents. A facility with a commitment to safety:

- Acknowledges the high-risk nature of its population and setting;
- Develops effective communication, including a reporting system that does not place blame on the staff member for reporting resident risks and environmental hazards;
- Engages all staff, residents and families in training on safety, and promotes ongoing discussions about safety with input from staff at all levels of the organization, as well as residents and families;
- Encourages the use of data to identify potential hazards, risks, and solutions related to specific safety issues that arise;
- Directs resources to address safety concerns; and
- Demonstrates a commitment to safety at all levels of the organization.

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A SYSTEMS APPROACH

Processes in a facility's interdisciplinary systematic approach may include:

- **Identification** of hazards, including inadequate supervision, and a resident's risks of potentially avoidable accidents in the resident environment;
- **Evaluation** and analysis of hazards and risks;
- **Implementation** of individualized, resident-centered interventions, including adequate supervision and assistive devices, to reduce individual risks related to hazards in the environment; and
- **Monitoring** for effectiveness and modification of interventions when necessary.

ENVIRONMENT

What environmental hazards come to mind?

ENVIRONMENT

- Doors
- Alarm Systems
- Elevators
- Stairs
- Windows (stops, security screens)
- Courtyards
- Gates/Fences
- Outdoor Perimeter
- Other Environmental Factors

ENVIRONMENT

Perimeter Safety – Secure fencing, locked gates, and adequate outdoor lighting.

Safe Outdoor Areas – Designated, enclosed courtyards for residents who wander.

Environmental Cues – Use calming colors, familiar décor, and clear signage to reduce confusion.

Noise & Lighting Control – Minimize overstimulation and ensure consistent lighting, especially at dusk.

Obstruction-Free Pathways – Keep halls and exits free from clutter or movable furniture.

ENVIRONMENT

DOORS

- Hardware functions properly
- No damage or loose parts
- Comply with life safety code
- Visibility (consider using mirrors, cameras when poor)
- Hazardous areas are locked (supply, kitchen, etc)
- Egress doors are equipped with functioning alarms or delayed-egress systems.
- Lock storage and other hazardous areas if non-egress

ENVIRONMENT

WHEN DOORS ARE DAMAGED

Supervision (1:1) of door

Taking door out of service?

Immediate repair

Documentation of supervision of the door

Documentation of communication regarding repairs

Quotes, invoices, service reports

ENVIRONMENT

ALARM SYSTEMS

- System is tested and logged daily / per policy.
- Resident devices are checked for placement, tested, and logged daily / per policy.
- Codes/keys are secured and limited to authorized staff.
- Routinely inspected.
- Any malfunction is reported immediately and repaired.

ENVIRONMENT

ALARM SYSTEM CONCERNS

Staff Response

Residents learn the codes

They disarm with the fire alarm, have a plan!

Too loud or too soft

ENVIRONMENT

ALARM SYSTEM CONCERNS

"One facility had a fancy GPS system, but nobody knew how to use it . After a second elopement, I made the company come and educate us. Residents were wearing bracelets registered to other residents. Some were not even registered. It was a mess. When we looked at the history on the day a resident eloped, they said he was at the door over 50 times that day. The system had a pager and an audio that went to the computer, but nobody knew and it was not activated. Pagers were broken and not replaced. Staff turned over and no current staff knew the system." (Anonymous)

ENVIRONMENT

BUILDING ASSESSMENT TOOLS

Resident Rooms

Common Areas

Non-Resident Areas

Stairs

Non-Resident Areas (loading docks, etc.)

Exterior

ENVIRONMENT

Insights?

ASSESSMENT

Each facility may have their own process for assessing residents at risk for wandering or elopement.

A variety of tools may ne used to identify residents at risk.

ASSESSMENT

Utilize assessment tools such as elopement risk scales or decision trees that consider:

- Diagnosis
- History of wandering or exit-seeking behavior
- Risk Factors
- Triggers / Patterns

ASSESSMENT

ASSESSMENT SHOULD ADDRESS:

- Is the resident independently mobile?
- Is the resident cognitively intact?
- Does the resident have competent decision-making capability?
- Does the resident wander?
- Does the resident have exit seeking behavior?

ASSESSMENT

- Is there a past history of wandering or exiting a home or facility without the needed supervision?
- Does the resident accept their current residency in the facility?
- Does the resident verbalize a desire to leave?
- Has the resident asked questions about the facility's rules about leaving The facility?
- Is there a special event/anniversary coming due that the resident normally would go to?
- Is the resident exhibiting restlessness and/or agitation?

ASSESSMENT

WHEN TO ASSESS

Pre-Admission

Admission (Some consider again at72 hours, Monthly)

Quarterly

Change in Condition

New exit-seeking behaviors

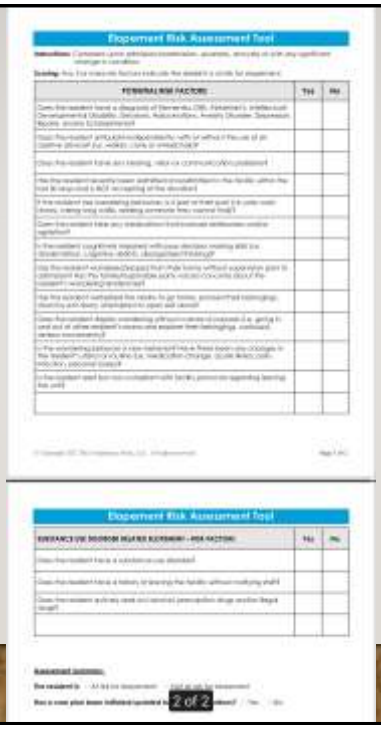
ASSESSMENT

PRE-ADMISSION

Ensure referrals are reviewed thoroughly.

Ensure enough communication/questions are asked to make sure the resident is appropriate for admission per facility assessment.

Perform an "on-site" hospital visit prior to admission, if needed.


Elopement Risk Assessment Tool

Elopement Risk Assessment Tool

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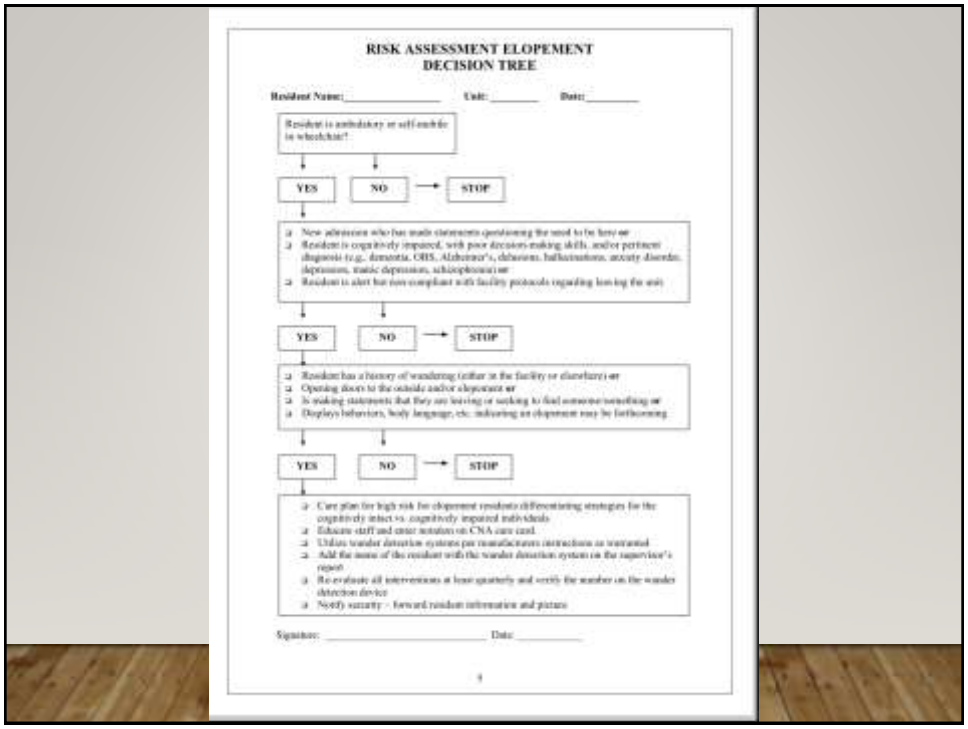

RISK ASSESSMENT ELOPEMENT DECISION TREE

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: _____

ASSESSMENT

F689 INTERPRETIVE GUIDANCE

"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."**

ASSESSMENT

ACCURACY OF ASSESSMENT

If resident left today, would it be an elopement, unauthorized LOA, or AMA?

Resident right vs safety concern

Involve resident representative

Mismatched assessments and care plans

Case by Case Basis

ASSESSMENT

POST-ASSESSMENT

HIGH

MEDIUM

LOW

Next, consider LOA orders

ASSESSMENT

IS THIS AN ELOPEMENT?

- Cognitively intact resident exits main facility and wheels their chair across an outdoor covered pathway to an external chapel on facility premises to see if services are happening (without signing out or notifying staff).
- Cognitively intact residents sit on the front patio of facility to enjoy each other's company (without signing out or notifying staff).
- Cognitively intact rehab resident decides to leave and go home before they are discharged.
- Cognitively intact resident with schizophrenia and a history of homelessness, who is their own responsible party, leaves the facility and doesn't return for three days.
- Cognitively impaired resident walks into the kitchen, another resident room, or an unsafe area.
- Cognitively impaired resident is seen leaving the facility and is easily redirected back into the facility.

ASSESSMENT

LOA Policy

- Need physician's order for LOA (how this can support you)
- Sign out and back in with the nurse.
- Nurse to document expected time of return and how to reach the resident while on LOA.
- Noncompliance with LOA policy.

ASSESSMENT

F689 INTERPRETIVE GUIDANCE (AMA)

"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."

- Obtain signature
- Provide referrals for medical or psychiatric services

ASSESSMENT

If your facility cannot accommodate wandering or exit-seeking behaviors, do not delay transferring the resident to an inappropriate facility.

The challenge with this is understood!

Strategies in your area?

ASSESSMENT

Get resident / representative buy-in

Communicate with the hospital (Case Manager, Social Service, ER Supervisor, etc.)

Have your resources and contacts on hand, in advance (understand insurances, 14 day benefit rules, etc.)

Use your own company resources, sister facilities with more appropriate unites, or transfer agreement facilities.

Consider increased supervision or 1:1

ASSESSMENT

COMMON WANDERING TRIGGERS

- Disorientation
- Anxiety
- Restlessness
- Unmet Needs (Incontinence, Hunger, or Thirst)
- Isolation / Boredom
- Lack of engagement or meaningful activities
- SUD or Mental Illnesses

ASSESSMENT

CHANGE IN CONDITION

- Acute infections (especially UTIs)
- Underlying medical conditions
- Medication changes

INTERVENE

Individualized interventions that address *resident-specific* risk factors.

Strive to maintain the least restrictive environment.

Include resident's family, friends and other representatives.

Include front-line staff.

INTERVENE

Two things can go wrong:

Development of an inadequate plan

Not implementing adequate plan

INTERVENE

INTERVENTIONS TO CONSIDER

Supervision tailored to resident's patterns of agitation.

Room placement

Reality orientation vs. validation techniques.

Color-coded bracelets

Wanderguard

Minimize excess noise and stimuli.

Promote rest

INTERVENE

INTERVENTIONS TO CONSIDER

Coffee, pastry and a newspaper in the morning

Walking club after meals

Avoid crowded events

Medication Reviews

Enough space on the unit to ambulate

Room comfortable, familiar, personalized, and homelike

INTERVENE

INTERVENTIONS TO CONSIDER

Access to look outside (to assess time of day, season, etc)

Camouflaging doors*** per code

Noise reduction initiatives (overhead, personal alarms, etc)

Reduce staff noise (shift change, night shift, etc)

INTERVENE

SECURED UNITS

- Assessment
- Physician Order
- Consent
- Care Plan

INTERVENE

ACTIVITIES

Meaningful

Structured (bingo, participation)

Active (walking club, exercise, dance, outings in nature)

Passive (promote rest & relaxation)

INTERVENE

IMPLEMENTATION OF INTERVENTIONS

Order

Care Plan

Kardex/Assignment Sheet

Staff Training!

Communication is key!

INTERVENE

ELOPEMENT BOOK

Basic descriptive information including height, weight, hair color, eye color, race, If they wear glasses or hearing aids, distinguishing marks, Description of their clothing, allergies, pertinent information, urgent medications. A copy of the resident's photograph. Update the photograph from time to time.

INTERVENE

STAFF TRAINING (Including Agency & Turnover)

Identifying and responding to exit-seeking behavior.

Regular elopement drills.

Clear protocols for immediate search and resident recovery.

Collaboration with local law enforcement if needed. Hospitals, Public Transportation, etc.

Document and report to Administrator/DON when residents demonstrate exit seeking behaviors.

INTERVENE

STAFF TRAINING

If an employee observes a resident leaving the premises, stay with the resident. Attempt to prevent the departure in a courteous manner. Get help from other staff members and the immediate vicinity if necessary. Instruct another staff member to inform the charge nurse and Don that the resident has left the premises. Do not leave the resident alone.

Example with a staff member in the street.

INTERVENE

ROUNDING PRACTICES

Shift to Shift Report – Appts, LOAs, Transfers

Mealtimes

Medication Pass

Midnight Census

MONITOR

Audits of elopement prevention practices (wandergaurd, door checks, behavior monitoring, etc.)

Regular elopement drills

Incident reviews with root cause analysis.

Track/trend elopement related events

Continuous improvement through QAPI

MONITOR

Change in condition

Behavior monitoring processes

Behaviors are attempts to communicate needs

RESPOND

MISSING RESIDENT PROCEDURES

"Furthermore, a facility's disaster and emergency preparedness plan should include a plan to locate a missing resident.

RESPOND

SHOULD INCLUDE

Role Clarity

"Code" Calling

Notifications – Administration/DON

Search Assignment

Police Notification

Department of Health Notification

Family Notification

RESPOND

Documentation of exit seeking behaviors and elopement events is critical and should be as complete and accurate as possible.

Interdisciplinary input should be considered.

Include when resident was last seen.

CONCLUSION

The basics are what keep people safe but are usually what was missed when a resident elopes.

Environment
Assessment
Intervention
Monitoring