Pulse Newsletter Health Care Practice

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When I practiced as an ICU nurse, I was never as panicked as when I could not find my patient!! Usually, this was just a patient attempting to "go out for a smoke" or "find the cafeteria" but it could also have had more devastating consequences. Later, as a claim professional, I handled many cases where wandering or elopement resulted in injury to a patient. Wandering and elopement is a real problem, even in the acute setting. Usually related to dementia, but not always, this behavior can put the patient and the organization at significant risk.

Here are a few claims I have been involved in that illustrate the problem.

A 74-year old male patient disconnected himself from his IV five hours after open heart surgery to walk out to the porch to have a cigarette. He was discovered 15 minutes later with significant blood loss, which led to his death. No one noticed an IV pump alarm.

An 86-year old woman, with a history of dementia, found her way out of her room, up a stairwell and on to the roof of the hospital. The weather was very hot and she died of hyperthermia. The door to the stairwell was not on the alarm system.

An 87-year old dementia patient was admitted to the hospital for a gastro-intestinal bleed. She wandered from her room and crawled in bed with another patient. The other patient notified the nurses but, before they could get there, the patient left and fell in the hallway breaking her hip. The other patient sued as well as the wandering patient's family.

A 92-year old patient with no history of dementia or wandering, pushed her wheelchair outside, and then sat down in the wheel chair on a steep hill. She rolled down the hill and tipped over causing significant brain damage.

A 77-year old man with dementia walked out of the hospital during the night and found his way to a railroad track where he was injured by a passing train.

So how does this happen? Aren't the nurses watching?

Wandering and elopement in acute hospitals is not an infrequent event. Although long-term care facilities are used to dealing with this issue, acute care hospitals appear to be less prepared.

The acute setting is much different than a long-term care setting, where the patient's propensity for wandering is known and there is long-term observation of the patient. Long-term care organizations also tend to have wandering technology, such as "Wander Guard" and other protection for the patients at risk for this behavior. In the acute setting, we tend to rely on our alarm systems for cardiac monitoring and IV monitoring to alert us when the patient is disconnected and may me up and about. This may not be enough. Added to this is the patient's disorientation in a new environment, which promotes confusion and may result in wandering.

Wandering and elopement should be considered a true emergency. Rapid response is essential. According to a recent *Journal of American Nursing* article, only 46% of those who went missing were

found within five hours; 36% were found between five and 12 hours later, and 9% required searches of 12 to 24 hours. The remaining 9% took longer than 24 hours to find. Those not found within 24 hours are more likely to be found dead than alive. http://journals.lww.com/ajnonline/Fulltext/2008/10000/Wandering_in_Hospitalized_Older_Adults_.28.aspx

Here are some risk management techniques:

Have a plan

- Anticipate that there will be patients who wander and prepare policies and training to respond to a wandering or elopement event.
- Designate an elopement center of command.
- Elopement tool kit with flashlights, diagram of building, list of key phone numbers etc. should be readily available at the command center.
- Include drills and feedback from wandering events.
- Involve local police in the plan.
- Train and educate staff on the plan and coordinate training with local authorities.
- Anticipate media coverage and how to respond.
- Plan for disclosure issues with the family.

Assessment

- Perform a thorough assessment of the patient for wandering potential at the time of admission.
- Communicate with family members regarding the patient's propensity to wander.
- Complete a thorough review of the patient's history.
- Assess the patient frequently for status changes that might promote wandering, including medication changes.
- Develop an assessment tool for wandering that meets best practices. http://www.wanderingnetwork.co.uk/Dewing%20Wandering%20Risk%20Assessment%20Tool%20version%202%20Sept%2008.pdf

Protection

- Thoroughly orient the patient to the surroundings, call lights and bathroom.
- Consider the physical layout of the facility and anticipate problems for patients with dementia, such as nurses' line of sight to patient rooms.
- Do not position patient close to outside doors.
- Provide for appropriate functioning of alarm technology and conduct safety checks.
- Provide intense supervision of the patient by frequent checks and appropriate alarms.
- Layout of units should be assessed to identify strategies to improve the safety of people with dementia.

Response

- Institute emergency elopement-wandering plan.
- Search should include unpredictable places, such as closets, stairways, rooftops and ventilation ducting.
- Extend radius of search as instructed by law enforcement or according to internal plan.
- Involve others as appropriate, such as other areas of the community as instructed by the elopement response plan or law enforcement.
- Prepare for response to hypothermia or hyperthermic and other emergency treatment, such as dehydration.
- Communicate with family according to plan.
- Centralize all media inquiries to designated person according to plan.
- Follow up on response and evaluate the process; make changes and drill on areas for improvement.

Conclusion

Wandering and elopement is a real emergency. Most common causes of death are exposure to adverse elements, being hit by a vehicle, drowning and injury from falls. Rapid response is essential. Planning and prevention can save lives and the risk of liability.

References

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