

Resident Elopement: Case Study and Lessons Learned

This true-life summary of a nursing home lawsuit will help facilities avoid a similar misfortune

BY LINDA WILLIAMS, RN

Ten percent of all lawsuits involving nursing homes deal with elopements. The following is a summary of a lawsuit against a nursing home concerning a resident who wandered and was found in tall grass with bruises, sunburn and numerous ant bites. The circumstances surrounding this case might be instructive as you consider making changes in elopement protocols appropriate for your facility.

The Situation

An 80-year-old female resident with a history of Alzheimer's disease exited a 60-bed nursing home from a hallway door sometime around 11 a.m. The home had alarmed exit doors, which sounded when she left. A worker went to the door but did not see anyone outside. The worker did not continue to search the premises, assuming someone had accidentally bumped the alarm button without leaving the building.

Two hours later, the administrator found the missing resident lying on the ground outside. She was conscious and had ant bites covering her body. In addition, both of her knees were sunburned. An ambulance took her immediately to the local emergency room, where she was treated and released.

Staffing at the facility exceeded state requirements. There were five full-time and two part-time RNs, eight full-time and four part-time LPNs and 25 full-time and part-time CNAs on site. The staffing pattern called for six on the day shift (1 staff member for every 10 residents) and four during the evening and at night (1 staff member for every 15 residents).

The Lawsuit

After the incident, the resident's fam-

ily sued the facility, demanding \$1 million for the resident's pain and suffering. They charged the facility with negligence in not properly supervising and ensuring the resident's safety.

When a smaller settlement was offered to the family, it was rejected. The family members made it clear they were not interested in accepting less money than their original demand.

The Trial

The plaintiff's counsel hired two expert witnesses to testify against the facility. One was an RN and faculty member at the state university, as well as a nursing home consultant. Her opinion was that the facility violated the standard of care by not having the resident in a locked room. The other expert was a physician, an internal medicine specialist with a subspecialty in gerontology, who agreed with the RN.

The defense counsel hired a physician, who testified that he had no issues with the treatment and care of the resident. Additionally, a psychiatrist testified that the resident had suffered no psychological damage because of the incident. Neither of the defendant's experts was able to appear at the trial, so their depositions were videotaped and played in the courtroom.

The trial lasted nine days and resulted in a mistrial, with the jury being deadlocked. The plaintiff's attorneys noted that they had invested \$75,000 in expenses toward this case, while the family held firm to their \$1 million demand. A new trial was set for six months later.

When the case was tried for the second time, the result again was a hung jury. Some of the jurors wanted to award the plaintiff \$50,000, one thought \$65,000 was appropriate, another said \$200,000, and the foreman recommended \$100,000. The plaintiff made no effort to settle the case and continued to demand \$1 million. A third and final trial date was set.

The Outcome

At the third trial, the jury deliberated for less than an hour and returned a verdict in favor of the nursing home. The resident's legal representative dismissed his legal counsel and filed a motion for a new trial, alleging that his attorney had failed to present 25 witnesses on the resident's behalf. One year later, the state court of appeals upheld the judgment for the defense.

In this case the nursing home prevailed, but its legal costs had mounted, and the facility's staff had endured more than a year of prolonged stress and uncertainty. In short, protecting your residents and facility by implementing and ensuring a sound elopement prevention plan is always the best defense.

The Best Defense

While no one argues that the worker should have stepped outside to check further when the alarm sounded, there

are other measures that staff members can take to prevent or respond appropriately in the event of a similar situation.

Creating a plan. Begin by developing a plan that includes policies and procedures to adequately address the prevention of and response to a resident elopement. Preventive measures should include the following:

1. Develop a method to identify residents who are at risk for elopement, such as known wanderers.

2. Implement appropriate interventions for residents who have been identified as being high risk. These could include:

- keeping behavior logs;
- maintaining supervision and periodic checks, as possible;
- conducting ongoing activity programs to minimize aimless wandering tendencies;
- using identification bracelets and/or alarms worn by residents, as indicated;
- securing exit doors with alarms or electronic locks with keypads that are tested daily, with results documented;
- installing fenced yard controls, along with either an electronic alarm or staff supervision;
- training staff on appropriate response to an alarm and to account for residents immediately if an alarm is sounded and no one is observed near or outside the door; and
- installing window limiters, as approved by state codes.

3. Once a resident has been identified as being at risk for elopement and preventive interventions have been implemented, communicate this to everyone involved in the resident's care, beginning with:

- The resident's care plan, which should list all interventions that are used to prevent an elopement.

- Assignment sheets indicating to all direct-care staff which residents are at risk for elopement and what interventions are needed to prevent this.
- Discreetly posted photos of known wanderers at the nurse's station to alert staff.
- Check-in/check-out logs for use anytime a resident leaves the facility alone, with family or for facility-planned outings.
- Review and discussion by the quality assurance committee of all elopement concerns whenever indicated. Records should be kept of all attempts and incidents so that trends and risks can be identified and reduced.

Handling an elopement. If an elopement occurs, response measures should include:

1. Staff members should try to redirect the resident from the door. If this attempt is unsuccessful, they should notify other staff members and follow the resident, redirecting him/her back into the building. Never leave the resident for any reason if the resident's safety is in immediate jeopardy.

2. Upon notification that a resident is missing, the supervisor should conduct an organized and thorough search of the facility and premises.

3. Should the search prove unsuccessful, the supervisor should immediately notify the police department, facility administrator, the party responsible for the resident, an attending physician and any regulatory agency, as required by law.

4. Cooperate fully with the authorities, who will assume command of the search. Be able to provide them with a full description/photo of the resident.

5. Upon return of the resident:

- perform a complete assessment to determine injuries and treat accordingly;

- notify all previously contacted persons; and
- revise the resident's care plan accordingly, since a new MDS assessment might be needed.

6. An incident report should be completed in a timely manner, per the facility's protocol.

7. Perform a complete and thorough investigation of the elopement as soon as possible, to prevent other occurrences. Follow up the incident by developing a plan of correction.

8. All of the information obtained from the elopement investigation should be summarized and discussed at the next quality assurance meeting.

9. Finally, randomly test all alarms and stage quarterly mock drills to assess staff compliance with the plan.

Training staff. Once these plans are in place, staff training is critical. In-service training should be provided to all staff members during orientation and annually thereafter. A written copy of these plans should be kept near the nurses' station for easy access, as the nurse supervisor will most likely be in charge of the initial search.

By taking these necessary precautions, you have the ability to protect your residents, staff members and the entire facility, now and into the future. No facility is elopement-proof, and that is why planning is essential. **NH**

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