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EVIDENCE-BASED IMPLEMENTATION PROJECT

WORLDVIEWS ON EVIDENCE-BASED NURSING

Elopement: Evidence-based mitigation and management

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Abstract

Background: Elopement jeopardizes patient safety, affects the hospital's reputation, and results in financial ramifications. In an academic community hospital, executive leadership approached a team of nurse leaders for expertise following the elopement of a vulnerable patient.

Aim of the Initiative: The team's goal was to identify evidence-based strategies to mitigate future elopement events. Following an extensive literature review and gap analysis, the organization recognized opportunities pertaining to elopement management, including patient assessment, prevention strategies, and facility-wide response when events occur. The nurse leader team thoroughly searched current literature to answer the Population, Intervention, Comparison, and Outcome (i.e., PICO) questions of interest. Following a critical appraisal of 55 articles, 26 were utilized to make practice change recommendations. The body of evidence included a variety of age groups and diagnoses.

Implementation Plan: After the synthesis of the literature, the team provided recommendations to the organization. These recommendations included the assessment of patient-specific risks and the implementation of elopement prevention measures as fundamental elements for incidence reduction. The team partnered with multidisciplinary stakeholders for the revision of policies, processes, and electronic medical record documentation.

Outcomes: The organization monitored elopement events and the duration of each event throughout the phases of implementation. Pre-implementation data, collected from January to June 2021, demonstrated 34 individual elopement cases lasting an average of 118 min each. In comparison, post-implementation data collected during the same time frame in 2022 found only 12 events lasting an average of 24 min each.

Implications for Practice: The organization implemented evidence-based recommendations to standardize the facility's approach to elopement. With structured assessment, precautions, and response, the organization demonstrated a notable decline in the number and duration of elopement events. Hardwiring processes, analyzing data, and adjusting expectations within an evidence-based framework should assist the organization's drive to further enhance patient safety surrounding elopement events.

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KEYWORDS
absconding, elopement, mitigation, patient safety, vulnerable patient, wandering

CLINICAL INQUIRY

Elopement is defined as an event in which an individual leaves a supervised area without permission (Traub & Vollmer, 2019). When a patient departs from a hospital, rehabilitation centre, or long-term care facility without staff knowledge, it is considered an elopement (Bloomfield & McNee, 2015). When a patient elopes from a safe, supervised space, the patient and organization are at significant risk (Boyle et al., 2017). Specific environmental safety risks associated with patient elopement include traffic accidents, drowning incidents, and weather-related injuries (Phillips et al., 2018). Additionally, elopement from healthcare facilities may result in delayed medical care (Boyle et al., 2017). Ineffective management of elopement not only increases the risk of patient harm but can also erode the public's trust in healthcare organizations (Voss et al., 2019). Furthermore, financial ramifications from litigation, injury compensation, and additional resource utilization may occur due to patient elopement (Voss et al., 2019). Elopement resulting in death or significant injury is considered a reportable sentinel event by The Joint Commission (2021) and is on The National Quality Forum's list of 29 serious adverse events (The National Quality Forum, 2022). Inconsistencies in elopement perceptions lead to challenges in escalating, reporting, and managing elopement events (Stefanacci & Haimowitz, 2013). In addressing elopement risks, patients' mental capacity to make decisions regarding personal safety must be considered (Smith, 2012).

During the 2021 Regular Session of the General Assembly, Maryland approved the Annotated Code of Maryland (General Article §5-606) (Annotated Code of Maryland, 2021). This recently revised law allows two medical providers the authority to deem a patient unable to make informed decisions. Previously, this process required two physicians to assess and deem a patient unable to make informed decisions. The change allows nurse practitioners to be the second provider in this process, supporting the physician teams within the hospital. Without two independent providers certifying and documenting that a patient is unable to make informed decisions, neither the multidisciplinary team nor the hospital has the right to physically stop a patient from leaving a facility. The law change allows the medical provider team to address patient capacity and keep the patient safe during hospitalization.

Following the elopement of a vulnerable adult from an academic community hospital in Baltimore City, a team of master's prepared nurse clinicians evaluated current organizational processes surrounding the management of patient elopements. The team met with multidisciplinary stakeholders to discuss the concerning elopement event and to identify opportunities for improvement. The existing organizational workflow for elopements included overhead paging of a *Code Gray* alert when a patient was identified as missing. In the first 6 months of 2021, there were 34 Code Gray alerts activated. Clinical and non-clinical staff admitted feeling desensitized to alerts, also known as alert fatigue. The Code Gray process relied on the bedside nurse to identify and call the code for a missing patient and search for the patient in collaboration with security. Unclear responsibilities and alert fatigue resulted in response delays, increasing patients' risk for harm during elopement events. The team recognized significant variability in perceptions related to patient elopement risk characteristics, such as the patient's medical and social history, capacity levels, current condition, and high-risk behaviors.

The organization's vision to consistently provide outstanding quality, service, affordability, and outcomes relies on the integration of evidence-based strategies. Using the Advancing Research and Clinical practice through close Collaboration (ARCC©) Model as an organizational framework, the institution spent several years building a force of EBP mentors, including those involved in the elopement initiative. The facility also created a mass of resources that support finding and implementing evidence-based initiatives to meet constantly changing demands (Melnyk et al., 2017).

FORMULATING A SEARCHABLE QUESTION

The team identified the need to review current evidence about best practices in the management of patient elopement. To guide a thorough review of the literature for best practices on elopement mitigation and management, two PICO (Patient, Intervention, Comparison, Outcome) questions were developed:

1. In patients, how does the implementation of precautions compared to no precautions affect elopement?
2. In patients, how does a risk assessment compared to current practice affect elopement?

SEARCH FOR THE BEST EVIDENCE

PubMed and CINAHL were searched using the following key terms: (elopement OR absconding), (precaution* OR intervention*), and (risk assessment OR assessment OR evaluat*). Articles published in the English language between 2011 and 2021 were included in the preliminary body of evidence. Fifty-five articles were critically appraised for quality and relevance using tools provided by the Helene Fuld Health Trust National Institute for Evidence-based Practice in Nursing and Healthcare (Melnyk & Fineout-Overholt, 2015).

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CRITICAL APPRAISAL

The critical appraisal process, utilizing Melnyk (2016) seven steps of evidence-based practice, narrowed the final body of evidence to 26 relevant articles (Figure 1). These articles evaluated various populations and diagnoses associated with elopement, wandering, or absconding. Many of the appraised articles were quality improvement initiatives, evidence-based practice projects, or expert opinions, while a small portion were cohort or case–control studies. Those articles that were low quality or did not answer the PICOT questions of interest were not included in the final body of evidence.

SYNTHESIS

The synthesis of the literature provided the team insight into elopement mitigation and response. Congruent with current practice, definitions for elopement were inconsistent throughout the literature (Chung & Lai, 2011). Most articles included adults (Arbee et al., 2019; Barnard-Brak et al., 2018; Bloomfield & McNee, 2015; Brumbles & Meister, 2013; Chung et al., 2011; Cipriani et al., 2014; Cooke, 2017; Cullen et al., 2015; Gerace et al., 2015; Gu, 2015; James & Maude, 2015; Kang et al., 2020; Marco et al., 2021; Olagunja et al., 2020; Powers et al., 2018; Quigley et al., 2019; Sheth et al., 2014; Simpson et al., 2015; Stefanacci & Haimowitz, 2013; Struck, 2013; Wilkie et al., 2014; Verma et al., 2020; Voss et al., 2019); one article evaluated both adult and pediatric populations (Olagunju et al., 2020). Clinical locations within the appraised articles included outpatient (Barnard-Brak et al., 2018; Boyle et al., 2017; Chung & Lai, 2011; Cipriani et al., 2014; Powers et al., 2018; Wilkie et al., 2014), inpatient (Arbee et al., 2019; Brumbles & Meister, 2013; Cooke, 2017; Cullen et al., 2015; Gerace et al., 2015; Gu, 2015; Kang et al., 2020; Marco et al., 2021; Quigley et al., 2019; Sheth et al., 2014; Stefanacci & Haimowitz, 2013; Wilkie et al., 2014; Verma et al., 2020; Voss et al., 2019), and long-term care facilities (Bloomfield & McNee, 2015; Cipriani et al., 2014; Gu, 2015; Struck, 2013; Sheth et al., 2014) focused on patients with psychiatric diagnoses (Brumbles & Meister, 2013; Cullen et al., 2015; Gerace et al., 2015; Gu, 2015; James & Maude, 2015; Kang et al., 2020; Olagunju et al., 2020; Simpson et al, 2015; Voss et al., 2019), impaired judgment (Barnard-Brak et al., 2018; Bloomfield & McNee, 2015; Cipriani et al., 2014; Gu, 2015; Kang et al., 2020; Olagunju et al., 2020; Sheth et al., 2014; Simpson et al., 2015; Stefanacci & Haimowitz, 2013; Struck, 2013; Verma et al., 2020), or substance abuse disorders (Arbee et al., 2019; Brumbles & Meister, 2013; Cullen et al., 2015; Gerace et al., 2015; Hunt et al., 2016;

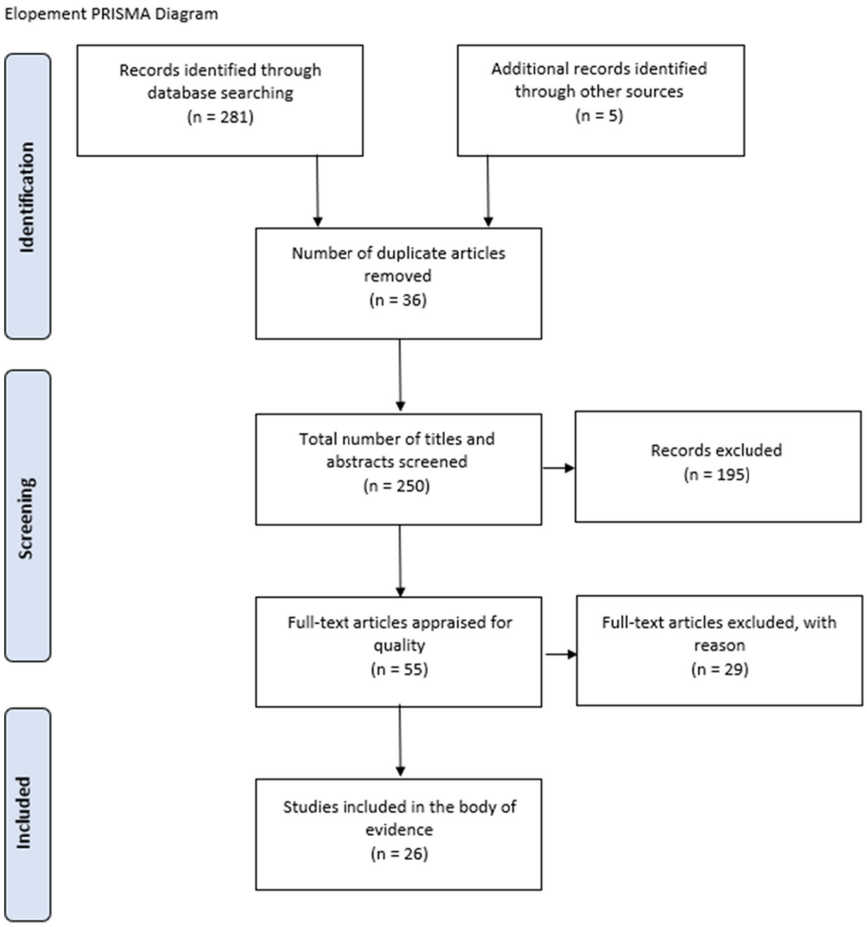


FIGURE 1 Elopement prisma diagram.

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James & Maude, 2015; Kang et al., 2020; Olangunju et al., 2020; Powers et al., 2018; Simpson et al., 2015; Verma et al., 2020; Wilkie et al., 2014). A notable theme from the reviewed articles was the absence of a validated non-psychiatric elopement risk screening tool. Approximately half of the articles noted the (Cooke, 2017) importance of identifying patients at risk for elopement. However, those at risk were primarily identified by previous elopement or elopement attempts (Bloomfied & McNee, 2015; Chung & Lai, 2011; Cullen et al., 2015; Gerace et al., 2015; Gu, 2015; James & Maude, 2015; Simpson et al., 2015; Stefanacci & Haimowitz, 2013; Struck, 2013; Verma et al., 2020). Other contributing risk factors in the evidence included patients with mental disorders, substance abuse, impaired judgment, extreme stress, between 18 and 35 years of age (Arbee et al., 2019; Brumbles & Meister, 2013; Hunt et al., 2016; Gerace et al., 2015; James & Maude, 2015; Marco et al., 2021; Olangunju et al., 2020; Powers et al., 2018; Simpson et al., 2015; Verma et al., 2020), and patients with unmet needs or competing priorities outside the hospital (Bloomfield & McNee, 2015; Brumbles & Meister, 2013; Cipriani et al., 2014; Gerace et al., 2015; James & Maude, 2015; Kang et al., 2020; Quigley et al., 2019; Struck, 2013; Voss et al., 2019). Consistently reiterated throughout the reviewed literature were recommendations for additional research to assist in a standardized, proactive approach to identifying patients' risk for elopement.

Within the appraised literature, quality and statistical analysis were assessed utilizing a variety of tools. For example, Verma et al. (2020) and Arbee et al. (2019) assessed data using the Chi-squared test and Fisher's exact test and reported statically significant findings related to characteristics of patients at risk for eloping. Validated tools to assess risk for violent behaviors were utilized as well. These included the Historical Clinical Risk Management 20 (HCR-20) assessment tool (Olagunju et al., 2020; Simpson et al., 2015) and the Level of Service Inventory-Revised (LSI-R) assessment, a quantitative survey of offender attributes and offender situations relevant for making decisions about levels of supervision and treatment (Powers et al., 2018).

INTEGRATION OF EVIDENCE

The team completed a gap analysis to determine an implementation plan following the literature review and synthesis of the evidence. Implementation recommendations were presented to key multidisciplinary stakeholders to gain the necessary buy-in and support. The implementation plans included modifications to the electronic medical record (EMR), assessment of patient risk, application of prevention measures, creation of an elopement response algorithm, and development of coordinated education. The literature was clear that risk factors for elopement should be evaluated. However, the use of standardized risk scales was underreported. The team collaborated with Clinical Informatics to investigate current EMR capabilities related to elopement risk identification. An existing elopement risk screening tool was identified within a long-term care setting of the healthcare system. The team modified this elopement risk evaluation tool to meet the needs of the acute care, inpatient setting. The tool, available within the EMR system, involved risk factors such as previous elopement attempts or wandering behavior, cognitive impairment, psychiatric disorders, and mobility capabilities. The additions made to the form further capture vulnerable patients at risk for harm should an elopement event occur based on the criteria found repeated throughout the literature evaluation.

Screening for all patients is now initiated within the EMR upon admission to the adult inpatient setting. Screening questions include:

- Is the patient a danger to self or others?
- Has the provider deemed that the patient lacks the capacity to make medical decisions?
- Has a court-appointed legal guardian been established or pending for this patient?
- Is a psychiatric admission and/or evaluation pending?
- Does the patient have an emergency petition?

Patients are automatically identified as high risk for elopement when *yes* is answered to any of the five screening questions. However, patients who are not categorized as an automatic high risk for elopement must have their risk further evaluated utilizing additional screening questions (Figure 2). The additional screening questions produce a final numerical score with a threshold for low-risk versus high-risk determination. The frequency of screening reevaluation was determined by the team with consideration for dynamic patient populations whose risk levels may change over time. However, the team was conscious of potential documentation fatigue and the low likelihood of patients' risk levels changing from shift to shift. Therefore, the complete screening process is prompted for standard completion every 3 days for high-risk patients, every 7 days for low-risk patients, and as needed for any changes in patient condition.

High-risk screenings prompt clinicians to activate a newly developed elopement order set containing nursing orders with the following components: risk reassessment intervals, elopement precautions initiation and documentation, nursing plan of care updates, and reminders to complete an interdisciplinary huddle following an elopement event, should one occur. Additionally, EMR alerts ensure communication of patients' risk for elopement to all interdisciplinary team members. Elopement precautions involve the implementation of visual cues to identify high-risk patients, communication amongst the multidisciplinary team about patients' risk, increased rounding frequency, and movement of patients to rooms that are easily visualized from nursing stations and away from exit points. Visual cues include signage outside of high-risk patients' rooms and green-colored hospital gowns. These visual identifiers aid in increased awareness of at-risk patients within the unit and allow for quick identification of patients attempting to elope (Chung & Lai, 2011; Cipriani et al., 2014; Cooke, 2017; Gu, 2015; Sheth et al., 2014; Stefanacci & Haimowitz, 2013). Elopement precautions are reviewed and documented twice daily by nursing staff to ensure ongoing patient safety.

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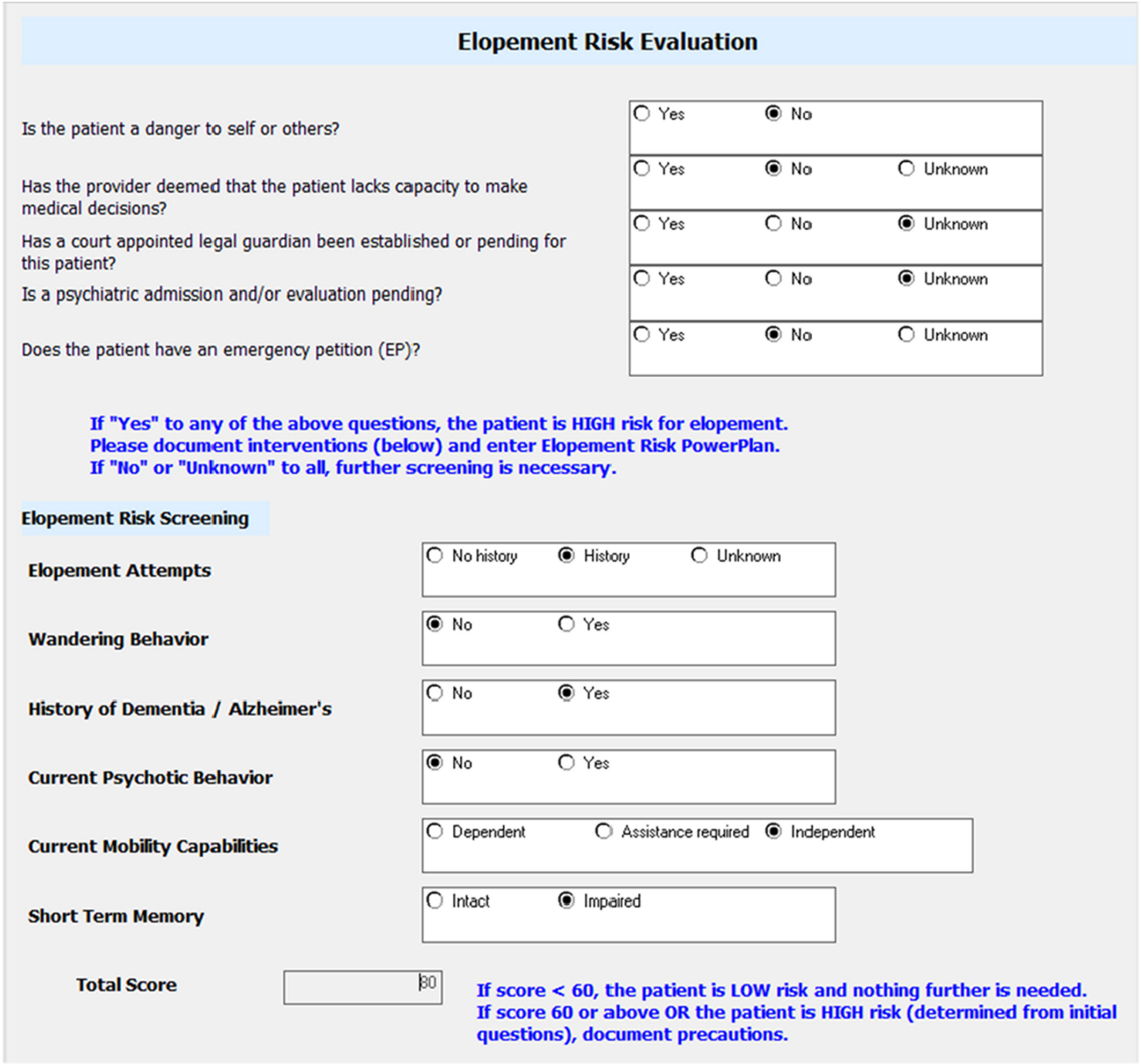


FIGURE 2 Elopement risk assessment tool.

Despite the identification of patient elopement risks and implementation of standardized precautions, the organization must be prepared to respond in the event of an elopement. A multidisciplinary algorithm was developed utilizing the evidence-based recommendations found within the literature (Chung & Lai, 2011; Quigley et al., 2019; Smith, 2012; Struck, 2013; Stefanacci & Haimowitz, 2013). Prior to the algorithm development, the organizational response involved the initiation of a "Code Gray" alert for all missing patients. The algorithm guides the staff through both the low- and high-risk patient response, establishing clear team roles and responsibilities and providing a process map for all involved team members. In addition, the organization utilized the algorithm to allocate resources and recommended response timeframes for both the low- and high-risk patient response (Figure 3). The standardized elopement response begins with the identification of the patient missing from the hospital room. A multidisciplinary huddle is held immediately following the identification of the missing patient. The huddle engages key stakeholders, including nurses, nurse leaders, security, and medical providers, to quickly review the patient elopement risk level and discuss pertinent concerns. If a low-risk patient is missing, the *missing person* pathway of the algorithm is followed. For a patient identified as high risk during this huddle, a Code Gray response is initiated. Event reporting and post-event unit debriefing occur following all Code Gray responses to assist in data collection and evaluation for process improvement.

Numerous changes to current elopement practices resulted in the need for multiple levels of education for all pertinent teams. Education about the background of the initiative and key changes was provided first to leaders using a formal presentation.

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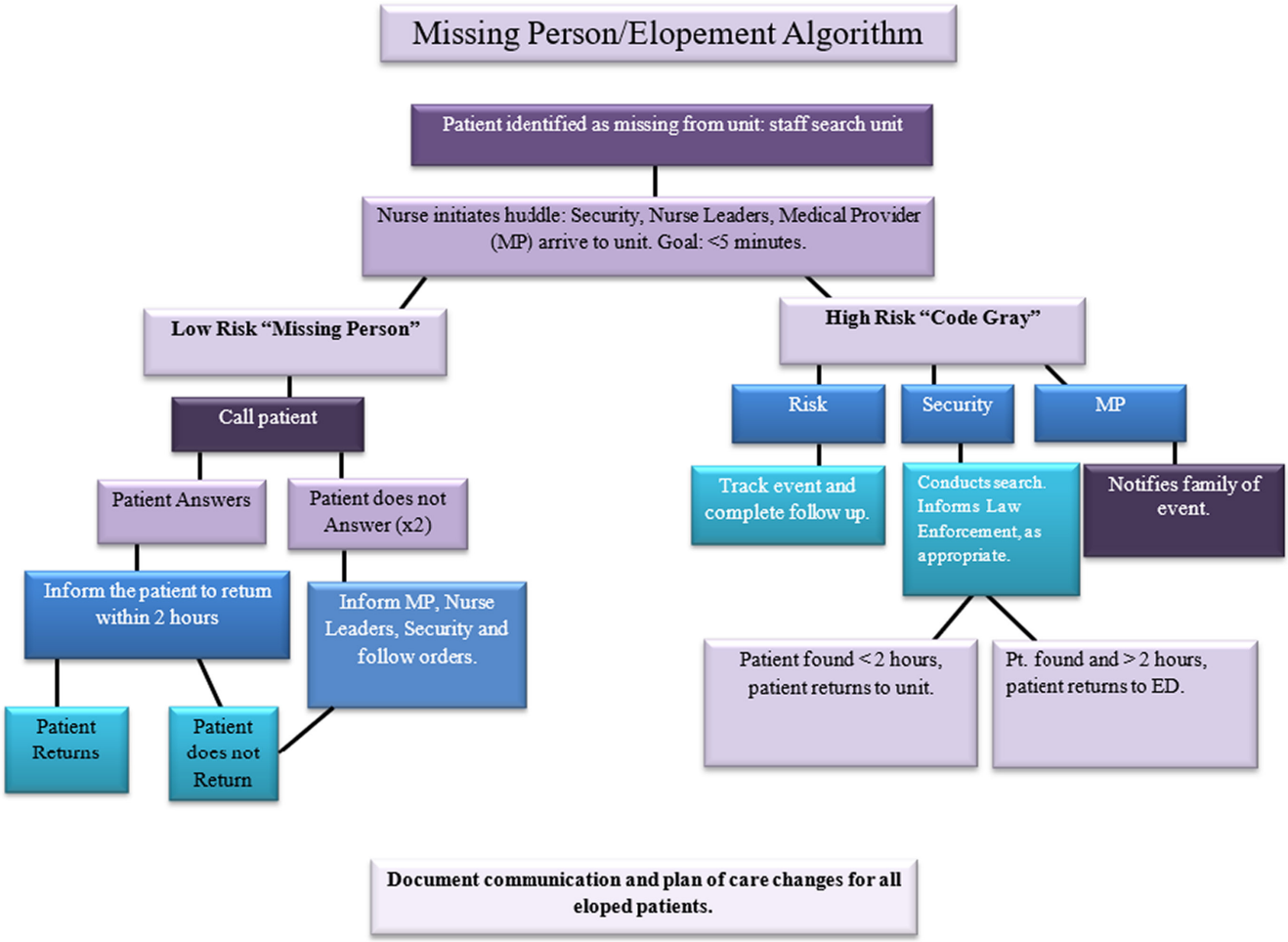


FIGURE 3 Elopement response algorithm.

Direct-care staff were provided with group education at shift change huddles and staff meetings. Additionally, direct-care staff participated in individual, face-to-face education, as available. Specific EMR changes were communicated to the organization through a designated email platform. To promote global comprehension, all members of the organization were provided diverse educational opportunities including a web-based learning management portal, face-to-face departmental staff meetings, interdisciplinary clinician and non-clinician huddles, and just-in-time when an elopement patient was identified.

There were several limitations to elopement prevention and mitigation during the implementation process. First, the lack of current literature pertaining to the inpatient setting presented an initial challenge. The team had to consider literature from multiple populations and settings to determine best practices surrounding elopement mitigation and management for adult inpatients. Second, challenges in standardized reporting structures, once an elopement event occurred, contributed to challenges with data collection. Lastly, the provider's ability to promptly join a multidisciplinary huddle after a patient was identified as missing was inconsistent, requiring additional steps to communicate with the provider prior to further implementing the suggested algorithm steps.

EVALUATION AND OUTCOMES

To measure the effectiveness of the evidence-based program, elopement events and duration of elopement events were monitored prior to and throughout the implementation. The pre-implementation data, collected from January 2021 to June 2021, demonstrated 34 individual elopement cases. On average, each event lasted 118 min. This amount of time was elevated by one outlier which lasted approximately 36 h. From July 2021 to December 2021, when the elopement response algorithm and visual identifiers were implemented, the organization saw a 21% reduction in events from 34 to 26 cases. There was also a notable decline in the average duration of events from 118 to 47 min. Between January 2022 and June 2022, the organization implemented the elopement risk screening in the inpatient adult care setting. With this came a further reduction in the number of elopement cases. From January 2022 to June 2022, there were only 12 events lasting an average of 24 min (Figure 4). These findings suggest that early identification of risk factors, coordinated interventions, and a structured response process are effective strategies to limit the occurrence of elopement, the duration of time away from the care of hospital personnel, and the chance for adverse events.

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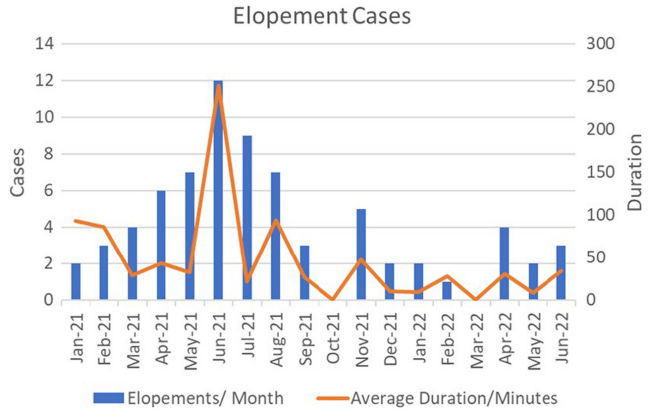


FIGURE 4 Elopement outcomes.

The team acknowledges that there are additional opportunities for future evidence-based improvements related to elopement prevention and mitigation. One opportunity is to implement multidisciplinary debriefing sessions, where each elopement event is reviewed to evaluate adherence to elopement protocols and determine areas for further improvement (Brumbles & Meister, 2013; James & Maude, 2015). A second opportunity is to improve the timely documentation of patient capacity by medical providers. As mentioned previously, a new law in Maryland allows either two physicians or one physician and one nurse practitioner the authority to determine if a patient is unable to make informed decisions during hospitalization. In the current state, there are still incidences where patient capacity is questioned during an elopement event, specifically when provider notes do not discuss a patient's capability of making reasonable or informed decisions. Without this clear documentation, time may be lost reviewing the EMR to make a judgment about the patient's risk level (Brumbles & Meister, 2013; James & Maude, 2015). Increased documentation of capacity by medical providers will help to eliminate confusion. Furthermore, opportunities remain for the development of a standardized organizational reporting tool for elopement events (Smith, 2012; Struck, 2013).

Moving forward, the team hopes to establish additional prevention measures for high-risk patients. First would include the implementation of more structured, multidisciplinary rounds on identified high-risk patients (Cooke, 2017). A second measure would be collaboration with operations to allow for the relocation of high-risk patients to areas within the unit away from exit points (Bloomfield & McNee, 2015; Cooke, 2017; Smith, 2012; Sheth et al., 2014; Stefanacci & Haimowitz, 2013). Additionally, plans to begin elopement drills to reinforce competencies related to elopement identification, prevention, and mitigation are underway.

CONCLUSION

Elopement mitigation strategies can decrease the number of elopements and duration of events (Traub & Vollmer, 2019). Hospitals should assess existing organizational culture and infrastructure prior to delving into elopement management (Smith, 2012). The team used evidence-based recommendations to standardize the facility's approach to elopement. With structured assessment, precautions, and response, the organization demonstrated a notable decline in the number and duration of elopement events. Throughout the implementation of future process improvement cycles, the team will continue to analyze and measure the success of this evidence-based practice initiative.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

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