Elopement and Self Harm and/or Harm to Third Parties

Sector: Mental Health

Elopement may occur when a patient/client leaves a healthcare organization without healthcare provider knowledge of the departure or fails to return from a granted pass or leave. Some patient/clients who elope may be at risk to self-harm and/or harm a third party, while others lack insight into why they are hospitalized or should remain hospitalized. In this case, injury, to self or others may occur, but is not due to particular intent and can be driven purely by a compelling need to return home. If harm comes to a patient/client or a third party, organizations may be held liable.

COMMON CLAIM THEMES

- Elopements resulting in suicides, homicides and assaults.
- Decreased vigilance towards voluntary clients/residents contributing to delayed:
  - Awareness of missing/eloped clients/residents;
  - Code yellows/searches.
- Inconsistent screening/assessments of clients/residents for elopement risk.
- Cumbersome code yellow/search protocols;
- Poor documentation practices (e.g. charting-by-exception).
- Poor privileges and pass assignment practices:
  - Reliance on admission status (voluntary/involuntary versus clinical status) and individual healthcare provider judgment privilege/pass assignment;
  - Levels of supervision not modified despite changes in clinical at-risk status;
  - Informal/poor patient/client sign in/out processes.
- Inappropriate level/type of supervision during facility led community excursions/field trips.
- Delayed notification of:
  - Material clinical status changes to the most responsible practitioner and substitute decision maker/family;
  - Missing patient/client status to the most responsible practitioner, substitute decision maker/family, and/or third parties at imminent risk for harm and the police.

CASE STUDY 1

A voluntary client at a mental health facility, with a history of paranoid schizophrenia and severe substance abuse, was found dead by police after an authorized leave from a unit. Investigation into the client’s death determined the client had committed suicide. Expert review of the case was critical of several aspects of the care provided to the client prior to their death. Experts noted the healthcare providers on duty the night of the client’s elopement appeared unaware of the procedures for informing responsible practitioners and nursing leadership of unauthorized leaves from the unit. Experts concluded that a number of applicable organizational policies and procedures were unclear, resulting in healthcare provider confusion regarding interprofessional expectations, roles and responsibilities. Experts noted there were significant misunderstandings with regard to how to manage elopement incidents involving voluntary clients. In addition, experts suggested the monitoring of the client was inadequate, with the involved healthcare providers failing to note the client’s check-in times when they left or returned from passes.

CASE STUDY 2

A client with a history of elopement and violent behaviours was admitted on a voluntary basis. The client was granted unrestricted unaccompanied grounds privileges. The client’s mental health status deteriorated however his admission status and privileges remained the same. During rounds the client could not be located and a search of the healthcare organization’s premises was initiated. The client’s family was notified but they were not informed of the client’s recent deterioration, including harm threats against the family. The police were eventually contacted by the healthcare organization, but by that time the client had killed a family member. Review of the case suggested the delay in detecting the client’s elopement, conducting the search and notification of the police was due to reliance on the client’s voluntary status.

Canadian Case Examples
REFERENCES

- HIROC claims files.
- Pinfold V, Duggan A, Huxley P, et al. (2010). *The development of an online training resource for mental health professionals to involve carers in information sharing*.
Elopement and Self Harm and/or Harm to Third Parties

MITIGATION STRATEGIES
Note: The Mitigation Strategies are general risk management strategies, not a mandatory checklist.

Reliable Care Processes
- Adopt a validated, objective assessment tool/practice to detect and assess clients/residents at risk for elopement.
- Develop and implement a decision tree/algorithm to guide decision making for the assignment of patient/client passes and privileges that consider the need:
  - For passes and privileges to be authorized by the most responsible practitioner;
  - To ensure passes and privileges are assigned based on patient/client’s current clinical status, regardless of admission status (voluntary or involuntary);
  - To ensure all clients/residents (voluntary and involuntary) on pass formally sign in and out with staff;
  - To consider the assignment of a healthcare provider or security to guard against elopement until medically cleared, admitted or transferred;
  - For access to a safe, secure lockable room(s) for observation/monitoring.
- Develop and implement a decision tree/algorithm/guideline to guide decision making for elopements/code yellows of both voluntary and involuntary clients/residents that includes:
  - Search procedures defining staff roles and responsibilities, including conducting timely searches, regardless of the patient/client’s voluntary or involuntary status;
  - The need to immediately notify the most responsible practitioner (versus notification after the search);
  - Timely notification of the family/substitute decision maker and police;
  - Timely notification of the local police.
- Ensure timely documentation, disclosure and investigation of significant elopement, self harm or harm to third party adverse events including review of video surveillance after elopement incidents.
- Debrief with staff and provide/offer employee assistance support when elopement outcome results in unanticipated death or harm of the patient/client and/or a third party.

Facility Design Issues
- Conduct (and document) regular environmental assessments to evaluate units/buildings for risk of elopement.
- Implement environmental safeguards to enhance patient/client supervision (e.g. keypad coded elevators; monitoring bracelets, video surveillance).

□ Ensure guidelines set by federal, provincial/territorial and city legislation/regulations for physical space are adhered to.
□ Create a policy for video retention and responding to requests from law enforcement.
□ Implement measures to reduce door alarm malfunctioning including:
  - Prohibiting staff from disabling alarms (outside of predefined conditions and controls);
  - Conducting scheduled testing of alarms (e.g. daily or per shift);
  - Immediately reporting malfunctioning alarms.

Patient/Client and Family-Centred Care
□ Notify the substitute decision maker of unsafe wandering or if the patient/client is at risk for self harm and/or harm to third parties; consider developing educational materials to educate substitute decision makers/families about wandering and elopement.

Documentation
□ Maintain up-to-date photos of clients/residents. File photographs and identifying information on all clients/residents available for the purpose of searches by staff and police.
□ Ensure complete, consistent, and timely documentation of:
  - The elopement risk assessment at the time of admission and at predetermined intervals as applicable;
  - Interventions to address the patient/client’s risk of elopement, goals to prevent harm to the client and/or third parties (i.e. within patient/client’s care plan);
  - The steps undertaken in response to suspected elopements by voluntary or involuntary clients/residents including:
    - Who was contacted (security staff, most responsible practitioner, family, police, etc.) and when;
    - When code yellow/missing person was initiated.

Monitoring and Measurement
□ Conduct periodic code yellow drills; document date, time and attendance.
□ Implement formal strategies to ensure initial and ongoing competency of all staff (nursing, support workers, etc.) in the recognition of wandering and elopement behaviours and in the appropriate intervention techniques to minimize patient/client wandering risk.
□ Implement formal strategies to monitor adherence to elopement and pass assignment protocols (including documentation and communication expectations).