The nightmare of the missing patient

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Too often, when patients go missing from healthcare facilities, they end up dying, as endless newspaper articles attest. Security directors responsible for patients at risk of eloping need a plan for prevention and searches and need to test the plan regularly. If a patient does disappear, the authors say, do not overlook locked rooms, washrooms, and stairwells.

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What keeps you up at night? An active shooter event? A fire? A workplace violence event? For those of us with elderly clients who suffer from dementia, it is the missing client.

Although workplace violence is on the rise and certainly can have tragic consequences, usually the effects are minor. Toay's healthcare facilities are equipped with modern fire alarm systems for detecting and extinguishing fires, and the instances of fires in healthcare facilities have dropped in both frequency and intensity. The possibility of having an active shooter event is also very rare; the phrase "greater chance of being struck by lightning" is frequently used to describe the chance of an active shooter event occurring. But clients in healthcare facilities go missing almost every day, often with fatal outcomes.

There are two types of clients that go missing: those that know they are missing and those that

don't. Clients who know that they are missing often include escaped prisoner patients, behavioural or mental health clients, and those who leave against medical advice. In most of these cases, people are making a conscious and informed decision to leave (or escape) from the facility. Clients who don't know that they are missing—our focus in this article—most often include elderly individuals who have symptoms of dementia (either long-term or temporary) or who suffer from diseases such as Alzheimer's. Wandering within the facility and elopement (leaving the facility) are serious problems and are particularly prevalent in long-term care facilities.

Over the past years, there have been numerous instances involving clients who have wandered away from the safety of their room or from the facility. A quick search of the internet will produce dozens of incidents from Canada, the United States, Great Britain, and other countries around the world. Tragically, many of these cases have ended with the client dying from extremes of weather or from medical issues (such as lacking needed medicines while they were lost). In some of these cases, the missing person was found several hours or days later, deceased, inside the facility, in a stairwell or washroom.

News reports frequently state that the clients managed to leave the facilities for a variety of reasons: unlocked doors, faulty alarm systems, alarm systems that were disabled, doors held open by others (delivery persons or other visitors), or other similar security breaches.

According to the Canadian Institute for Health Information, an estimated 21% of long-term care residents wander at least once every seven days. As our population ages at an uneven rate (there are now more people over 65 years than under 16), the incidents of wandering and elopement will only increase.

Let's look below at steps security professionals can take to reduce the likelihood that patients will go missing.

COMMON TECHNOLOGIES

Healthcare facilities frequently use a wide range of technology, from basic to advanced, to try to reduce the risk of client elopement. The basic technologies in-

clude CCTV cameras and access control systems. The more advanced technologies include electronic client-wandering and GPS devices (which are often integrated with CCTV and access control systems).

Many instances in which a client has gone missing have involved the failure of technology. And some of the cases occurred because the technology was bypassed or disabled. Most jurisdictions require fire-safety and alarm systems to be tested on a daily, weekly, monthly, or annual basis to verify their operation. Regardless of the type of technology that is implemented in a healthcare facility to reduce elopements, it should also be tested and verified on a regular basis. At a minimum, to ensure that the wandering-client system functions properly, the facility staff should conduct daily, documented checks of the exit and entry points. Any abnormalities should be addressed immediately.

CPTED IN REVERSE

One of the many tenets of Crime Prevention Through Environmental Design (CPTED) is to provide increased layers of protection the closer a person gets to the "asset" that you are protecting. This layered approach is frequently referred to as the Onion Principle. A healthcare facility's main pharmacy, cashier office, and maternity unit should be more difficult to gain access to and should have increased levels of security.

To prevent wandering or elopement by clients at risk, the CPTED principles need to be reversed. One way this can be done is to guard or protect the unit's main and secondary entrances with technology. For example, the RFID or GPS monitoring devices that activate alarms or maglocks when a resident is in the vicinity of the door can be very effective. These devices and systems can be very expensive to install, however, and do not necessarily always prevent a client from leaving. As noted above, to make the best use security and safety technology, you need be sure it is tested and verified on a regular basis.

Additionally, some design features can be added that make it more difficult for an at-risk client to get to an exit door. A common feature in many facilities is the use of decorative door vinyl or paintings to alter the appearance

of the door, thus distracting the client. (Some decorations, for instance, make the door look like a bookcase). Clients who exhibit exit-seeking behaviour or have "sundowning syndrome" (the tendency become more confused toward evening) are less likely to be drawn to exits when the doors are disguised in this manner.

The facility may also look at locating clients who are at greatest risk of elopement as far away from the exit door as possible. CCTV systems can be placed in the hallways, with supplemental monitoring at the nursing or team station to increase the chances that staff will observe would-be elopers as they get closer to the door.

EMERGENCY RESPONSE PLANS

Every healthcare facility should have an emergency plan that addresses a missing client. The following aspects should be considered during the plan's development:

- Staffing levels (both day and night shifts). Can your plan be managed by staff on duty on the night and weekend shifts?
- Timelines for activating and escalating the plan.
- Procedures for notifying the client's family. At what point does the family get notified that their family member is missing, and who makes that call?
- Procedures for notifying police agencies.
- Search patterns and grids.
- Maps. Are they accurate and do they cover ALL areas, including stairwells and maintenance and facility areas?
- Extra keys to assist with the search of the facility.
- Communication and media-release plan. Who within your organization speaks with media? What information is provided?
- Who is in charge of the search effort? Is the search coordinated by Security? Administrator? Maintenance?
- Incident Management framework.

Before the plan is finalized, have it reviewed by your local police agency, especially if part of your plan includes expectations that the police will respond in a particular manner and perform specific functions. Depending on the size of your police agency, it may not be able to assist you in the way you have suggested. Your plan could also be

linked to other municipal agencies, the transit authority, and your local gas and electric company, cell phone providers, and cable TV providers. In many cases, those entities have more vehicles on the road and in service than your local law enforcement agency does. It may even be possible to link in with local taxi and ride-sharing services to assist in an external search of your facility and the community.

TESTING AND TRAINING

You should also consider how your plan will be tested and reviewed. Once it is finalized, it is time to start a regimen of testing. If you are testing only to meet the minimum requirements set forth by your governing agency, you are likely setting yourself up for failure.

One important consideration to factor in is employee retention. If you are completing only one community supported drill and one tabletop drill each year, how many new employees have you missed during the training process? According to the 2019 National Healthcare Retention & RN Staffing Report, the average U.S. hospital turnover rate in 2018 was 19.1% (the highest recorded rate in a decade), and since 2014, the average hospital turned over 87.8% of its workforce.

Does the testing include a tabletop exercise, a live drill, or a combination of the two? By running drills on a quarterly basis, you will have greater success in exposing new employees to your plan. Many organizations utilize the "water cooler" approach to discuss emergency plans in 5- to 10-minute intervals during shift change. The key to success is to put the plan out there for people to train on as often as possible.

DUTY TO REPORT

Multiple regulatory government agencies govern the operations of healthcare facilities and their adherence to legislated requirements. It is incumbent on the facility to ensure that its management and leadership are aware of the different agency requirements and timelines for reporting a sentinel event.

Prior to 2008, you may have reported only incidents that resulted in injury to the resident. Many reporting authorities today, however, require you to report any elopement by a cognitively impaired resident, regardless of

whether an injury has occurred.

Agencies often define an elopement as a time where a resident leaves the facility's "safe zone" without the knowledge or authorization of staff. It is important to remember, however, that an elopement can also include situations when a resident does not leave the property but merely slips beyond a controlled door. You should always err on the side of caution and report an incident or, if you are in doubt, reach out to your governing body. Failure to report an incident not only results in hefty fines but also greatly diminishes your facility's credibility in the eyes of the community. Failure to report may also result in the healthcare facility losing its license to operate and being forced to shut down.

CMS FINAL RULE

On September 16, 2016, the Centers for Medicare and Medicaid Services (CMS) published the final rule on Emergency Preparedness Requirements for Medicare and Medicaid. The rule became effective on November 15, 2016 and was implemented on November 15, 2017. It establishes national emergency preparedness requirements for Medicare and Medicaid participating providers, intended to ensure that the providers are able to train and plan for natural as well as man-made disasters. The intent of this rule is no doubt a more coordinated response to disasters and the ability to network within our communities.

There are four core elements of the emergency preparedness plan:

1. Risk assessment using an "all hazards approach."
2. Communications plan that complies with federal and state laws.
3. Policies and procedures.
4. Training and testing.

RESOURCE MATERIALS

The International Association for Healthcare Security and Safety (IAHSS) has developed a series of industry guidelines and design guidelines that are intended to assist healthcare administrators in providing a safe and secure environment while meeting international, state/provincial, county and local requirements; the guidelines are also intended to be in harmony with all regulatory, accreditation, and other healthcare professional association require-

ments. New guidelines are added several times each year, and they are constantly being updated and revised to ensure that they reflect recent changes in best practices, changes in legislation, or new technology. The various IAHSS guidelines address many topics, including security program administration and operations, investigations, security-sensitive areas, and emergency management. These guidelines provide a wealth of information to the new security manager as well as to the seasoned industry veteran.

There are also several independent publications that provide information to assist with developing your security program or your organization's response to the missing client. These include *Hospital and Healthcare Security, 6th edition,* by Tony York and Don MacAlister (Butterworth-Heinemann) and *Security Management for Healthcare, 1st edition,* by Bernard Scaglione (Routledge).

SUMMARY

Patient elopement is serious and can have catastrophic outcomes if the individual is not found promptly. It is imperative that your facility has a solid plan to identify patients at risk for wandering and put safeguards in place to prevent these events. The response to an elopement must be rapid, well planned, and thorough in order to find the patient before it's too late.

Practice your emergency response plan to prepare staff for real-life events. Whatever approach your facility uses for elopement prevention, remember that a coordinated effort and communication are essential to the plan's success. Don't let the missing patient become your worst nightmare.