**ELOPEMENT ... PREVENTION & MANAGEMENT**

This Planning Guide is intended for use related primarily to elopement by individuals with cognitive impairments that leave the premises or a safe area without appropriate supervision.

The plan should include, based on RCF rule requirements: **OAC 3701-16-13 (J)(3):**

(3) Procedures for locating missing residents, including notification of local law enforcement;

**BEFORE/ PREPERATION**

- **Elopement risk assessment**
  - On Admission
  - Annual or change in condition
  - Post-elopement (try to determine resident’s purpose for attempting to leave)

- **For residents at risk:**
  - Resident Identification (photos, name/address/phone/ bracelet or necklace, etc...)
  - Service Plan with activity and social programs

- **Sign in/out procedure** for all residents
  - Communicate sign-in procedure to family members and visitors. Explain reasoning. Information should be shared at Move in with Resident and Family members.

- **Search Plan**
  - Notify manager
  - Identify surrounding high safety risk areas for immediate search;
  - Staff search assignments by regions
  - Search all rooms, closets, storage areas, mechanical rooms, stair wells, etc.
  - Search kit equipment (flashlights, ...)
  - Notify law enforcement **after** internal and grounds search: **OAC 3701-16-13 (J)(3)**
  - Notify family, physician (as appropriate)
Stress Training/Elopement Drills
- Education based on policy and procedure
- Basic training for all staff
- Door alarm system testing, preventative maintenance and documentation, per manufacturer’s specifications
  - Communicate with family/visitor concerning purpose/use of alarmed exit doors, and risk for residents leaving
  - Post notice(s) alerting visitors to check with staff prior to assisting persons to exit
  - Back-up system to ensure security of exit doors in the event of alarm failure: staff notification of failure; assigned door monitors; documentation of door monitoring during system/alarm failure; emergency repair/replacement
- Window Security - windows in resident accessible areas can be secured with window stops to a six-inch opening

DURING ELOPEMENT/EMERGENCY
- Notify Administrator, or manager
- Resident head count
- Implement search plan
- Notify law enforcement if not located in initial building and grounds search
- Notify family member/legal representative
- Implement Media Plan

AFTER ELOPEMENT/EMERGENCY

Post-Elopement Management:
- Immediate physical assessment and medical care if appropriate
- Elopement risk re-assessment (Communities should, on admission and regularly for residents experiencing cognitive decline, assess for wander and elopement risk. Assessing for elopement risk ensures that appropriate precautions and interventions can be put in place)
- Immediate safe intervention for involved resident(s)
- Notification:
  - Law enforcement (follow-up if previously notified)
  - Administrator, nurse manager
  - Physician (as appropriate)
  - Family member/legal representative
  - Legal advisor (if appropriate)
Documentation and Investigation:

- Notification through SRI
- Incident documentation
- Written/verbal witness statements
- Environmental assessment
- Keep-safe interventions

Corrective actions related to system issues

- Failure of the alarmed security system, etc.
- Policy changes, if needed

What is an Elopement?

Elopement is not defined in the RCF rules, although it is alluded to in OAC 3701-16-13 (J)(3). An absence from the Community/Facility that is unknown and put the resident at RISK would be considered Elopement. An RCF resident that is sitting in the courtyard looking at a book or sitting in a chair at the side entrance watching the scenery is not typically an elopement if the resident is cognitively intact. This same situation could be considered elopement if the resident lived in a secured memory unit and had a different level of cognition.

Do we have to report a resident elopement to ODH?

No, unless it was caused by staff neglect. However, you may elect to report it based on company policy. Additionally, if there was serious harm you may want to report it, so that ODH first learns of it from you. ODH has said that in almost any circumstance of elopement, a case for neglect can be built since the RCF failed to “keep the resident safe”. One example could be, the inability to account for a resident(s) on a secured unit.

The new incident management rule, OAC 5160-44-05 (E (1)(d), in place for HCBS waiver recipients would require certain elopements to be reported as Critical Incidents to the AAA case manager or MCO case manager, as outlined in OAC 5160-44-05-(E)(6)(d). Ohio RCF providers are required to report abuse, neglect and misappropriation of property by staff following investigation (not just allegation). Ohio RCF reporting requirements are based on Ohio law and are different than NH reporting requirements. However, whether you report or not, appropriate action must always be taken in response to any incident (for example, notifying the police if applicable) The online self-reporting ODH form was developed for nursing homes and does not allow an alert to ODH without fault identified. For a complete description of ODH self-reporting requirements, go to our Member website: OALA Abuse & Neglect Reporting Guide.
What information is needed on the incident log?

OAC 3701-16-12(B)(2) requires a listing of ...the time, place, and date of the occurrence; a general description of the incident; and the care provided, or action taken. This rule also requires for you to maintain a notation about the incident in the resident’s record and to ...take immediate and proper steps to see that the resident or residents involved receive necessary intervention including, if needed, medical attention or transfer to an appropriate medical facility. There is a sample incident log form on the OALA Member website.