MPSC Call for Solutions

How We Prevent Elopements (Absconding) on Mount Pleasant One

Sinai Hospital of Baltimore

Mount Pleasant One

November 7, 2016
Maryland Patient Safety Center Call for Solutions
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Organization: Sinai Hospital of Baltimore

Solution Title: How We Prevent Elopements (Absconding) on Mount Pleasant One

Program/Project Description, including Goals:
Elopement, also commonly referred to as absconding, is the unauthorized absence of a patient from a mental health facility without permission.”(Brumbles & Meister, 2013). The risk of elopement causes stress and anxiety to the patient, staff, and other personnel. It can lead to detrimental outcomes for the patient, staff, hospital, and community.

Mount Pleasant One (MP1), Inpatient Psychiatric Unit is a 24-bed psychiatric unit at Sinai Hospital. The unit cares for many patients with increased risk of elopement. Risk factors for elopement include elopement during a previous admission, refusal of medication within the past 48 hours, male, greater than 35 years of age, and a diagnosis of schizophrenia.

After discussing elopement in a staff meeting, the staff agreed that there was room for improvement. One nurse championed an improvement project to involve the entire unit.

Tools in place to help prevent elopements prior to the initiation of this project consisted of the MP1 policy on elopement, magnetic door locks, visual cues such as brown lines on the floor to define boundaries, and green magnets on the patient board to indicate risk. Patients also received an elopement risk assessment on arrival, documented on a special form in the electronic medical record.

MP1, Inpatient Psychiatric Unit had seven successful elopements from 2013-2015, prior to the project initiation. The goal of this project was to decrease or eliminate the incidence of patient elopements from the MP1, Inpatient Psychiatric Unit.

Process:
The issue of elopement was first discussed in a staff meeting leading to the initiation of a unit project that centered on a new process for rapid development of workable solutions. Nurses were encouraged to review the literature and query other facilities to generate ideas. An atmosphere of open query was fostered to encourage research, innovative thinking, and promotion of new concepts. When a solution was proposed, a review meeting was held within that same shift, to discuss the evidence base, pros, cons, and feasibility. This gave a sense of importance and credibility to every idea generated. Viable solutions were then piloted and adopted if successful.

Solution:
This project resulted in many interventions implemented individually throughout 2015 and 2016. These interventions included:

• Increase staff awareness (January 2015)
  A staff-driven educational effort improved awareness and led to increased staff vigilance.
• Increase the number of security cameras (January 2015).
Additional security cameras were installed to provide better visualization of entrances/exits.
• Hold clothing for 24 hours after arrival to the unit (February 2015).
The staff observed that patients were more likely to attempt to leave within the first 24 hours of arrival. Holding their clothing has discouraged this.
• Reduced badging access via badge reader (August 2015).
Limiting the number of outside staff with access to the unit has increased the unit’s awareness of people coming and going.
• Escort ancillary hospital staff pushing carts (food & linen) to the unit exit door (August 2015).
By requiring an escort of food and linen carts, patients have less opportunity to leave by hiding behind these carts.
• Use green elopement gowns and green socks (August 2015).
Patients at risk for absconding are now highly visible to the staff.
• Use blackout tape over the badge scanners to block out the five-second flashing green light (November 2015).
Because badge readers blink a green light when the door latch unlocks, creative patients would watch for that light for an opportunity to break through. After covering the light, this no longer occurred.
• Install safety signs (February 2016).
The safety signs have helped the staff on the unit to keep the front of the nursing station (high risk elopement area) visually clear by redirecting patients to the day area.
• Create a “panic button” through the Vocera communication devices (May, 2016).
The Vocera system, used for years for normal communications, was adapted to allow for any staff member to broadcast an immediate and simultaneous alert to all unit employees.

Measurable Outcomes:
A marked reduction in elopements was seen in 2016, after the project began.

Post Implementation Results 2013-2016 DATA: 100% Reduction in Elopement
Sustainability:
A key factor in sustainability is long-term adoption of changes by the staff. Because the solutions were generated and developed by the staff, adoption has been excellent and likely to continue.

Role of Collaboration and Leadership:
This project required a high level of collaboration and participation from many levels of leadership. Leadership embraced the concept of rapid assessment and deployment of staff-driven solutions and worked with staff to determine the feasibility of each idea generated. Solutions that were chosen to implement received leadership support through recognition and resources as well as setting expectations on the unit. The staff also collaborated with leadership from many outside departments including, Security, Facilities, Laundry, Dietary, Telecom, and Risk Management, to ensure that solutions that depended on the cooperation of other departments were workable.

Primary Participants:
Patrick Mayo, BSN, RN
Jonathan Englard, MSN, RN
Troy Modisette, BSN, RN, Nurse Manager of MP1
Courtney Walker BSN, RN
Rebecca West, BSN, RN

Innovation:
Many projects begin with a single idea, often initiated by someone in authority, and months are spent in development and implementation, sometimes losing interest along the way. In this project, the collaboration of staff and leadership to rapidly acknowledge and evaluate all ideas encouraged staff participation and innovation. The resulting solutions were more consistently adopted and embraced by staff, leading to sustainable change. The Vocera panic buttons were an example of adapting a technology developed for one purpose to an entirely different problem and creating a new solution.

Culture of Safety:
The heightened awareness of the issue of elopement and the involvement of the entire staff in finding solutions, led to open discussions about safety. Because their ideas were quickly acknowledged and evaluated for this targeted issue, thinking critically about safety became a habit for these nurses and technicians, and their ideas were not confined to this one issue.

Patient and Family Integration:
The heightened awareness of this issue also led to open discussions with patients and family members regarding the importance of safety in the unit.
References


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