County of Los Angeles **Department of Health Services**

OLIVE VIEW-UCLA MEDICAL CENTER/HEALTH CENTERS
MENTAL HEALTH NURSING
POLICY & PROCEDURE

NUMBER: 5817
VERSION: 3

SUBJECT/TITLE: **ELOPEMENT PRECAUTION GUIDELINES**

MD ORDER: **YES [ ] NO [ ]**

POLICY: Patients being treated for emotional or behavioral disorders and who are placed on a mental health hold in the psychiatric units are assessed for risk of elopement on admission and on an ongoing basis.

Steps will be taken to reduce the risk for elopement by ensuring that immediate and appropriate interventions are implemented.

PURPOSE: Provide guidelines in the use of the 'Elopement Assessment Tool' for the assessment and management of patients at risk for elopement from a psychiatric unit.

DEPARTMENTS: **MENTAL HEALTH NURSING**

DEFINITIONS: Emotional or behavioral disorder: Refers to any DSM (Diagnostic and Statistical Manual of Mental Disorders) diagnosis or condition, including those related to substance abuse.

Elopement: running away; the act of leaving, without permission from the place one is expected to be.

PROCEDURE: On admission and each shift thereafter, the RN will utilize the Elopement Assessment Tool to assess a Psychiatric patient for the presence of risk factors for elopement.

I. ASSESSMENT AND INTERVENTIONS

- The RN will use the tool by checking the appropriate box (es) for the presence of Risk Factors for elopement. Patient must exhibit at least one risk factor from the list to be considered at Risk.

A. Risk Factors for Elopement:

1. Standing by the unit door
2. Watching the unit door

3. Involuntary patient
4. Smoker
5. Poor Impulse Control
6. History of Substance Abuse
7. Length of stay > 14 – 30 days
8. Young: < 35 years old
9. Male

- If at least one risk factor is present and the patient is identified as a Risk for elopement, the RN will implement Risk Reduction Interventions listed below.

B. Risk Reduction Interventions

1. Q 15 minute close observation.
2. Consider assigning to room farthest from unit door.
3. Escort patient for off-unit activities.
4. Set behavioral expectations with patient.
5. Encourage purposeful activities.
6. Provide information of treatment / discharge plans.
7. Offer PRN medications as appropriate to decrease anxiety and/or agitation.
8. Encourage verbalization of feelings.
9. Consider a verbal/written behavioral contract.
10. Notify and communicate the elopement risk, precautions initiated, and the status of the patient to the MD, nursing staff, and other members of the multidisciplinary team.
11. Note Elopement Precaution on the multidisciplinary treatment plan, patient board, headcheck board, and assignment sheet.

- The RN will use the tool by checking the appropriate box (es) for the presence of High Risk Factors for elopement.

C. High Risk Factors for Elopement:

1. Actively trying to leave the unit.
2. Has recently attempted to leave the unit secretly or without permission.
3. Verbalizing intent to leave the unit without permission.
4. Prior history of elopement.

- If any of the High Risk factors is present, the RN will implement Risk Reduction Interventions listed below.

D. Risk Reduction Interventions for High Risk Factors:

1. 1:1 constant observation.
2. Seclusion per MD order.
3. Restrict to unit.
5. Set behavioral expectations with patient.
6. Encourage purposeful activities.
7. Provide information of treatment / discharge plans.
8. Offer PRN medications as appropriate to decrease anxiety and/or agitation.
9. Encourage verbalization of feelings.
10. Consider a verbal/written behavioral contract.
11. Notify and communicate the elopement risk, precautions initiated, and the status of the patient to the MD, nursing staff, and other members of the multidisciplinary team.
12. Note Elopement Precaution on the multidisciplinary treatment plan, patient board, headcheck board, and assignment sheet.

II. COMMUNICATION

1. The RN will notify the MD, nursing staff, and other care team members of the assessment findings and interventions implemented.
2. The RN will evaluate the effectiveness of interventions and any change in behavior and communicate with the MD, nursing staff, and other care team members.

III. DOCUMENTATION

1. The RN will document assessment findings including risk factors identified, elopement risk reduction interventions implemented, MD notification, level of precaution, level of observation, and effectiveness of interventions on the Progress Notes.
2. If no risk factors for elopement are identified on assessment, the RN will document this finding on the Progress Notes as well.

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