Patient Safety Tip of the Week

July 7, 2020

Another Patient Found Dead in a Stairwell

Missing person found dead in stairwell. That's a headline we've certainly heard many times in the past. The most recent one was slightly different in that this was not a patient in an acute care facility. But it does raise important points about what to do when a patient goes missing.

The 62-year-old man was a veteran living in a residential facility run by an independent not-for-profit company in a space it leases in a section of a building on a VA hospital campus (Romine 2020, Estes 2020, Cohan 2020, CBS Boston 2020). He was last seen at the facility on May 8 and had been reported missing on May 13. He was found dead in a stairwell on the campus of the adjacent VA hospital on June 12. The stairwell was only 60 feet from the room in which he resided, and he was found wearing the same clothing he had on the day he went missing. The cause of death has not yet been published, but early reports say foul play was not considered to have been a factor.

The residential facility did a search of its grounds once it was recognized the resident was missing. It also notified both the local town police department and the VA police responsible for the rest of the VA campus. Reports state that the agreement with the VA had some sort of wording that prevented the residential facility from searching any of the other VA property, including the stairwell where the resident was eventually found, though this restriction was disputed by the VA. The stairwell was an emergency-exit stairwell from a VA campus building. The VA campus has been described as a "sprawling 177-acre VA site, which resembles a college campus" and the local police and the VA police force apparently share jurisdiction for emergencies on the campus (Estes 2020).

It's not clear from the reports whether the resident ended up in the stairwell by exiting the door that led to the stairwell, though the co-resident who found his body did apparently exit via that door into the stairwell.

Despite the finger-pointing about who was responsible for what, there are valuable lessons here. Many acute care hospitals have on their campus other facilities, like skilled nursing facilities or assisted living facilities. In addition, some acute care hospitals have on their campus privately managed areas that rent space (eg. a private MRI program or a

physician-owned outpatient practice or a privately-run parking garage). In all such arrangements, there must be good communication, shared responsibility, and coordination of effort any time a patient or resident or even a visitor goes missing.

This topic was in the headlines several years ago after a patient was found dead 17 days after going missing at a San Francisco hospital (see our October 15, 2013 Patient Safety Tip of the Week "Missing Patients" and our December 2013 What's New in the Patient Safety World column "Lessons from the SFGH Missing Patient Incident"). But we had first addressed the issue in our July 28, 2009 Patient Safety Tip of the Week "Wandering, Elopements, and Missing Patients" and most recently in our April 7, 2015 Patient Safety Tip of the Week "Missing Patients and Death".

In the latter column we discussed multiple incidents and cases of missing patients and noted several **themes** recur:
- Someone often sees them but does not recognize they are wandering
- No system to help other staff identify patients who have been labeled at risk
- Automatic locking doors may prevent re-access to the unit
- No coordinated response
- Overreliance on "Security" to find them
- Taking too long to issue a "missing patient code"
- No assessments for wandering risk

And all types of facilities need to develop policies and procedures for:
1) doing an **assessment for risk of wandering** or elopement
2) implementing **risk reduction strategies** for those patients at risk
3) performing a **prompt and thorough search** when a patient is missing

It was noted above that residents of this facility were free to come and go. But we would expect that such a facility would have **sign out/sign in logs** (with planned destinations) to help them keep track of the residents. Having such a log should have led to earlier recognition that the resident had gone missing. When we said above "taking too long to issue a missing person code", we were usually talking about minutes or hours, not days or a month. But even in this case, had the facility noted the resident had not returned overnight, initiating a search conceivably might have found him while still alive.

But the next most critical elements are what you do upon recognizing a patient has gone missing. When a patient is discovered to be missing a **brief** search of the local unit should be done. If the patient is not found immediately, the "**code**" for a missing patient should be issued. That is called to the hospital operator and announced over PA system. While most hospitals still use arcane codes for various emergencies, many are moving to "plain language" codes for these alerts. In the case of a missing patient a "plain language" code with the description of the missing patient has the additional advantage that visitors and other patients in the hospital might identify the missing patient. Some facilities use an alternative system to alert staff to missing patients. They may use text messages sent out in a "blast" fashion to computer terminals and staff smartphones, the equivalent of the well-known "Amber alert" when a child in the community goes missing. This sort of

system can have the advantage of including a description of the patient and perhaps a photograph (that's one of the many benefits of having digital patient photographs in your electronic health rccord). But the disadvantages of the "blast" system are that it may take longer to implement, and you lose the chance that a visitor or other patient might identify the missing patient.

Once the "code" is announced or the alert otherwise issued, there must be a **coordinated** effort to **search** for him/her. The facility should have a "**grid search**" where every area of the hospital and surrounding grounds has a designated person to search it. A **central command post** is set up, with a map having a predefined grid, and staff call in to that post once they have searched their sector. In addition, most facilities and campuses like this have closed-circuit TV (**CCTV**) monitoring of exits and other portions of the grounds. Someone must be assigned to look at those surveillance tapes, attempting to go back as far as the time the patient/resident was last seen. That might include CCTV feeds from areas such as parking ramps. Yes, these searches are resource intensive, both in terms of personnel needed and time needed. That highlights the point above about **overreliance on "Security"**. There is a tendency for everyone to think that ii is the job of the security force or police force to look for missing persons. When you are concerned about the health and safety of a patient or resident, it's actually everyone's concern. A well-coordinated "grid" search, where each square is assigned to one individual, can usually be performed expediently and with minimal distraction from their other responsibilities.

We also recommend early outdoor search since a patient can easily stray far from the building (or into automobile traffic) in a very short period of time. We also recommend that the local police department be notified immediately by the operator when the "code yellow" (or whatever code name you use for missing patients) is called (and don't forget to include the police in your planning process).

And, of course, we invoke our old mantra "**Never ass-u-me**" because it will make an ass out of you and me. In this case, it sounds like several parties each "assumed" the other party had searched the implicated stairwell.

Doors. Several aspects of doors may be relevant. Most **emergency-exit doors** are **self-locking**. So, when someone exits through them, they cannot re-enter via that door. That was likely a factor in the death discussed in our December 2013 What's New in the Patient Safety World column "[Lessons from the SFGH Missing Patient Incident](#)". We even once got a cellphone call from a physician who responded to a cardiac arrest and got locked in a stairwell and could not get back into any unit! Also consider that there are times when your locked doors will be automatically unlocked (eg. fire alarms) creating an opportunity for a wandering patient to leave the unit.

Door alarms are only as good as the system you have in place to respond to a door alarm being triggered. It is unclear whether the door alarm in this facility was operational or not. The co-resident who found the deceased resident did exit via the emergency-exit door to that stairwell. Did an alarm trigger when he opened that door? Did anyone

respond to that alarm if it did occur? And how often do you check to see if the door alarms are in working order?

In our June 16, 2020 Patient Safety Tip of the Week "Tracking Technologies" we also discussed motion-sensitive surveillance cameras. Some motion-sensitive surveillance cameras can distinguish humans from other causes of motion and send an alert to a smart phone or other notification device. They can be placed, for example, in a stairwell that a patient might utilize to abscond from a secure unit. In addition to providing the real-time alert, they also typically store video of an event for a specified time period. That may be important in the search for a patient found missing.

And, speaking of alarms, there are other alarm issues pertinent to missing patients. Review of the death of a patient who wandered out of a San Diego hospital several years ago (Luke 2014) illustrates several **problems related to reliance on alarms**. First, the patient's bed alarm never sounded. Then, once staff realized the patient was missing, they tried unsuccessfully to page Security and then tried to contact Security by pushing a panic button twice, also with no response. When state inspectors investigated, they found that the panic button had been broken for 8 days. In fact, they found the hospital failed to routinely test the buttons and failed to repair them when broken and that one out of every four panic buttons at the hospital didn't work.

In our February 4, 2014 Patient Safety Tip of the Week "But What If the Battery Runs Low?" we described the following scenario: You implemented a "panic button" system to protect your behavioral health workers from assaults by patients on your locked behavioral health unit. The worker is in a situation where she fears potential harm from a patient and presses the panic button. However, the battery in the panic button is dead. Fortunately, other staff were within audible range of her shouts for help and responded before she was assaulted. The lesson is that any alarm or alert system, regardless of whether it is battery-operated or otherwise, needs frequent testing to ensure it is in working order.

Stairwells. In the current case, the man was found in the stairwell of part of the building that apparently had been closed off to stop the spread of the coronavirus (CBS Boston 2020). It's not just wandering patients or patients seeking to elope that use stairwells. In our December 2012 What's New in the Patient Safety World column "Just Went to Have a Smoke" we mentioned a Denzel Washington movie "Flight". In one scene there are 3 hospital inpatients who happen to come to the same **hospital stairwell to smoke**. One is a trauma patient, another an oncology patient, and the other a substance abuse patient recovering from an overdose. We wondered how often that scene might actually take place. To our amazement the same week a study came out in the Archives of Internal Medicine (Regan 2012) that answered our question! The answer: 18.4% of patients who smoke will smoke at some time during their inpatient hospitalization! That study was several years ago but we still continue to see smokers who get hospitalized and sneak off to smoke. Stairwells are often the most accessible locations to try to smoke.

In our April 7, 2015 Patient Safety Tip of the Week "Missing Patients and Death" we also mentioned that **construction sites** are particularly vulnerable for a few reasons. First, you often have outside workers there who are not thinking about patient safety. So, they may leave doors unlocked. Second, construction sites have lots of opportunities for someone to injure themselves. So, make sure you pay close attention to any sites at your facility with ongoing construction.

And don't forget the risk of losing a patient to wandering or elopement during patient **transports**. One of the items we recommend including in your "**Ticket to Ride**" checklist/communication tool for transports (eg to Radiology) is information about wandering risk.

One of the recurrent themes we noted earlier is that **someone often sees the patient but does not recognize they are wandering**. Another case illustrates yet another common problem – staff may unwittingly facilitate the patient leaving the facility. Wandering patients or patients desiring to elope from behavioral health units **often follow staff out of doors that are usually locked**. A 65 y.o. man with a neurological condition and confusion was on an understaffed ward (Brooke 2017). He wandered off the ward and out of the hospital, only to be found many days later dead in a wooded area several miles from the hospital. Cause of death was presumed hypothermia. He had gotten out of the hospital by following a staff worker through a secure door and was let through further locked doors by a nurse who assumed he had previously been allowed through.

Many hospitals use **color-coded wristbands (or color-coded hospital gowns)** to identify patients at risk of wandering. That is generally a good idea. For example, in the case above, it might have alerted the staff member not to allow the patient to exit the door. The problem is that there is still no widely accepted standard for such color-coding. An orange wristband might signify wandering risk at one facility, but might signify something totally different at another facility. That can be problematic when staff work at more than one facility.

Our June 16, 2020 Patient Safety Tip of the Week "Tracking Technologies" discussed a whole host of potential **technologies** that can be used **to track patient movements and location**. These include devices that are based on **RFID, GPS, Bluetooth, WiFi, infrared and other technologies**. We're not sure how applicable these are to the type of residential facility involved in the current case. But if you are a facility dealing with patients with delirium, dementia or other cognitive impairment who might be at risk for wandering, use of such tracking devices makes a lot of sense.

We've previously emphasized that technology will always be only part of the response to missing patients. It **should never be the sole modality relied upon**. A VA analysis suggests GPS beats RFID in most scenarios (VA 2013). But the specific technology chosen will likely differ from facility to facility and may depend upon the need to integrate with other technology needs. For example, though GPS probably would be best for locating patients who have left the facility or hospital grounds, some hospitals may prefer RFID because they are using an RFID system for inventory tracking. Bluetooth

would have limited applicability because of limited range. Many of you probably already use low-power Bluetooth for tracking items like your keys (or maybe your TV remote!). But in the context of missing patients Bluetooth applications would most likely only be of use in alerting staff when a patient leaves the Bluetooth receiving area (about the size of a typical inpatient floor). Similarly, the bracelets used in newborns to prevent abduction can alert staff when a patient leaves the unit but are of little help in locating a patient once they have already left the unit.

Ironically, the VA had one of the earliest Real Time Location Systems (RTLS) but implementation of that system was cost-prohibitive and replete with errors and mismanagement, having been deployed without adequate oversite and without required security controls testing (VA OIG 2017).

Communication. In many of our prior columns on missing patients, we have stressed the importance of communication, both internally and externally. We recommend that the family or next of kin or significant other of the missing patient be notified as soon as possible and be kept up to date on the status of the search. Such communication is important, not only in the name of transparency, but also because the missing patient may contact those family members. Those family members may also have suggestions about where the patient might go. Multiple other communications issues were discussed in our December 2013 What's New in the Patient Safety World column "Lessons from the SFGH Missing Patient Incident".

We refer you back to our Patient Safety Tips of the Week for April 7, 2015 "Missing Patients and Death" and July 28, 2009 "Wandering, Elopements, and Missing Patients" for good discussion of assessment of patients for wandering risk, ways to reduce the risk of wandering, and staff education and drills. In those columns we also noted that it's always a good time for facilities to say "**could that happen here?**" and do a thorough review of your policies and procedures for missing patient incidents, including making sure you do appropriate drills for such incidents. You probably will be unable to prevent every potential wandering patient or elopement. When one does occur, do a **debriefing** session as soon as possible to identify potential missed clues and other useful lessons. Then do a formal RCA (**root cause analysis**) within a short timeframe. There are always valuable lessons learned that hopefully can prevent other similar incidents in the future. But even if you've not already had a patient go missing it's good to do a **FMEA** (failure mode and effects analysis) to determine your potential vulnerabilities. And make sure you do **drills**, with thorough critiques and debriefings following the drills. When you do your FMEA, consider also what happens to locking doors when a fire alarm goes off. You might even consider doing your missing patient drill immediately following a fire drill.

See our previous columns on wandering, eloping, and missing patients:

- July 28, 2009 "Wandering, Elopements, and Missing Patients"

- December 2012 "Just Went to Have a Smoke"
- April 2, 2013 "Absconding from Behavioral Health Services"
- October 15, 2013 "Missing Patients"
- December 2013 "Lessons from the SFGH Missing Patient Incident"
- April 7, 2015 "Missing Patients and Death"
- October 6, 2015 "Suicide and Other Violent Inpatient Deaths"
- April 12, 2016 "Falls from Hospital Windows"
- September 18, 2018 "More on Hospital Suicides"
- January 22, 2019 "Wandering Patients"
- June 16, 2020 "Tracking Technologies"

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