Elopement: Hospital Settles For Dementia Patient's Death.

The eighty-eight year-old patient was taken to the hospital by her son after he found her sitting in his own back yard in a confused mental state.

After a week in the hospital she was sent to a nursing home. She remained at the nursing home three months before being sent back to the hospital.

On admission to the hospital this time it was noted she had had a stroke and she was diagnosed with dementia and normal pressure hydrocephalus, all of which would tend to account for her diminished level of mental awareness.

Even before she left the hospital's E.R. it was already documented in her chart that she had become agitated and did not want to stay in bed, had tried to remove her own hep lock and climb out of bed and appeared to be a risk to herself. A vest restraint system was started for her in the E.R. before she was transferred to a med/surg unit.

Two days later an interdisciplinary plan of care was formulated. High on the problem list was the fact the patient was "attempting to discontinue therapeutic interventions," meaning that the patient was trying as best she could to remove her vest and wrist restraints.

Care Plan Called For Restraints
Care Plan Was Not Carried Out

The same day the interdisciplinary plan of care was instituted, however, the patient's nurses discontinued her restraints, which went completely contrary to the care plan.

Early the next morning the patient's physical therapist noted that she was not in her Posey vest which she was not tolerating and that she had been placed in a recliner at the nursing station due to her increasing tendency to wander. An occupational therapy note an hour later placed the patient's location in her room.

The patient's son claimed later that he often found his mother wandering about the hospital unit when he came to visit her and that it seemed to him, although they were fully aware of her tendency to wander, that none of the patient's caregivers were making any attempt to deal effectively with the safety risk that posed.

At approximately 5:00 p.m. the elderly dementia patient turned up missing from the hospital's med/surg unit.

At 7:55 a.m. the next morning, December 3, she was found on the hospital roof dead from hypothermia.

An investigation traced her route away from the med/surg unit through a fire door which had no alarm, up a flight of stairs to the top floor, through a door to a mechanical room that was supposed to be locked and from there through a door to the roof that was also supposed to be locked and have an alarm.

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The family's lawyers were able to dig up maintenance records which showed that a broken lock on the door from the stairwell to the mechanical room was reported but never fixed.

They also discovered that the hospital had been written up by state survey inspectors for twenty-four miscellaneous care-plan violations over a nine-month period.

It also surfaced that the hospital had experienced twenty to thirty episodes of patient elopement during the two years prior to this patient's death, without policies or procedures being updated or emergency drills being conducted to reeducate caregivers on the specific steps to take when a patient elopement was discovered.

The lawsuit filed by the son as probate administrator in the Court of Common Pleas, Allegheny County, Pennsylvania resulted in a $900,000 settlement paid by the hospital prior to trial. **Diggs v. UPMC Med. Ctr., 2010 WL 3233128 (Ct. Com. Pl. Allegheny Co., Pennsylvania, July 23, 2010).**