What is a standard operating procedure (SOP)?

A standard operating procedure is a set of written instructions that describes the step-by-step process that must be taken to properly perform a routine activity. SOPs should be followed the exact same way every time to guarantee that the organization remains consistent and in compliance with industry regulations and business standards.

Standard operating procedures provide the policies, processes and standards needed for the organization to succeed. They can benefit a business by reducing errors, increasing efficiencies and profitability, creating a safe work environment and producing guidelines for how to resolve issues and overcome obstacles.

How to write a standard operating procedure

An effective standard operating procedure clearly explains the steps taken to complete a task and informs the employee of any risks associated with the process. The manual should be brief and easy to understand, with a focus on how things should be done rather than what needs to be done. Once written, the SOP should be analyzed and updated every six to 12 months to guarantee it remains relevant to the standards and requirements of the organization; any changes made should be recorded.

Before writing the SOP, the author(s) should perform a risk assessment of all the steps in the procedure to determine any obstacles that may arise during the process and any risks associated with those obstacles.

Key questions that should be answered in the standard operating procedure include:

- Who performs what role?
- What does each role do?
- What is the goal or outcome of each person's role?
- Has what needs to happen been explained clearly?

To decide which procedures would benefit from an SOP, organizations should make a list of all their business processes. Managers should discuss employees' day-to-day responsibilities and tasks to ensure all procedures are accounted for. Any tasks that are repeated by multiple employees should be considered for SOP creation.

Step 1: Define the task's goal and why it needs an SOP

The first step to writing a standard operating procedure is to define the task's goal and understand why that goal needs an SOP.

Step 2: Determine format for SOP

Next, the author must decide what type of format they would like to use for the SOP. Sometimes, an organization will have a premade template provided; other times, authors will have to design their own. Some examples of formats include:

- **Flowchart or workflow diagram**: Used to display procedures with unpredictable or various outcomes.
- **Simple steps**: Often written as a bulleted or numbered list, including documents such as safety guidelines. This brief, simple list is best used with procedures that are short and easy to follow.
- **Hierarchical steps**: Also written as a bulleted or numbered list but intended for procedures with many steps and decisions. This list includes a numbered list of primary steps followed by a collection of more specific.

Once a format has been chosen, the author must then decide if the SOP will be available as a written hard copy or if it will be available online.

Step 3: Identify task dependencies

The third step is to determine any dependencies. It is possible that the task being recorded relies on other procedures within the organization. The author should identify these dependencies and decide how to incorporate them into the new SOP, or if it would be better to add the new standard operating procedure into an existing one.

Next, the author should identify their audience to determine how the SOP should be written. For example, an SOP written for employees with previous knowledge will be very different from one written for brand new employees.

Once all these decisions have been made, the author can begin to write the SOP. While writing, a present verb tense and active voice should be used. The author should not use the word "you," but it should be implied. If a style guide is provided by the organization, then the author should adhere to it.

Components of an SOP

The standard operation procedure should include:

- **Title page**. Lists the title of the procedure, for whom it is intended -- the specific role, department, team or agency -- its SOP identification number and the names and signatures of the people who prepared and approved the manual.
- **Table of contents**. Provides easy access to the various sections in large SOPs.
- **A step-by-step list of the procedures**. Includes explanations of the task's goal, roles and responsibilities, regulatory requirements, terminology, descriptions of what needs to be done to complete each step and a discussion of decisions that must be made. This section will make up most of the SOP.

Once the draft has been written, it must be reviewed, edited and tested multiple times. This process should repeat until an SOP has been written that is approved by all stakeholders. At this point, it can be distributed to every person who needs it to do their job.

It is important to allow anyone who will be using the SOP to review the manual throughout the writing process to ensure all necessary steps are included.

SOP best practices

Some best practice suggestions for writing and using standard operating procedures include:

- Establish a common style and format for all SOPs within the organization. Using simple, clear language will help employees understand the manual. A defined collection of fonts, spacing, layout and graphics should also be chosen.
- Employees should be able to easily find content within the SOP. This can be done with the addition of a table of contents.
- Keep all SOPs in one place -- this is best done by keeping SOPs online. This makes any necessary changes or updates easier to make and ensures employees know where to find the information they need.
- Developing an ongoing review and maintenance plan for the SOPs ensures they stay relevant and error-free. SOPs should grow and change with the organization. Out-of-date SOPs are useless.
- Create a plan for distributing the SOP to employees and training them in the procedure. Regular training -- in addition to the initial orientation training -- are

beneficial and ensure all employees know and understand the most up-to-date procedures.

Uses of a standard operating procedure

Standard operating procedures enable organizations to gain a better understanding of their business process and identify areas that need improvement. Reasons to use a SOP include:

- Helping one stick to a defined schedule
- Assisting in training employees
- Guaranteeing compliance standards are met
- Certifying that the procedure will not negatively impact the environment
- Ensuring the safety of all employees
- Avoiding potential manufacturing failures

SOPs are still needed even when other published methods are available. The SOP should describe the procedure in more detail than the published content, as well as explain any differences between the SOP and the published method.

The SOP will fail if employees do not follow it. Management, specifically the direct supervisor, should monitor use of the standard operating procedure to ensure it is being properly employed and maintained.

Benefits of using a standard operating procedure

Two major benefits of using a standard operating procedure include consistency and a decrease in the amount of errors made. An SOP can also help an organization evaluate employee performance, save time and money and create a safer work environment.

In addition, SOPs can improve communication throughout an organization. If a task changes, the SOP is updated and redistributed to anyone who uses it, helping the organization efficiently communicate the change to anyone affected. SOPs also reduce the chance of miscommunication since the detailed steps leave little room for debate or questioning.

Standard operating procedure examples

One example of how an SOP might be used can be found in a manufacturing environment. SOPs are used to record in detail the production line procedures used to train employees and make products.

An SOP might also be used in finance or administrative environments to record the processes needed to properly bill customers and collect payments.

A third example of how a standard operating procedure might be used is seen in customer service, sales and marketing. SOPs can be used to explain the service delivery process and response times, instruct the management of customer complaints and comments or prepare sales quotes.

Banks may also use SOPs to determine the identity of a customer who has walked in and the Food and Drug Administration (FDA) can use SOPs to certify that a company's operations meet agency standards.

Standard operating procedures can also be used to train employees to collect, track and store key performance indicator (KPI) reports or to create a consistent new client onboarding experience.

Finally, SOPs are frequently used when hiring and training employees. In this situation, an SOP can ensure the orientation and training of every individual remains consistent with their peers' experience. An SOP can also guide managers through routine processes, from discipline and corrective actions to performance reviews.

SOP

Example

1

SUBJECT: **Medication Administration** NO: **C-131**
REVISION DATE: December 22, 2017
EFFECTIVE DATE: June 30, 2017
INTENDED USER(S): Arizona Training Program at Coolidge

Purpose:

1.0 To provide ATPC staff consistent policy, safeguarding the administration of all medications and controlled substances, documentation of physicians orders, and communication of information with the physician.

Policy:

2.0 Prior to dispensing any medications or controlled substances, all ATPC employees shall receive instruction in the proper procedures to be used in the preparation, administration, storing, and recording of medications. They will also receive instructions in the common usage of specific medications, the desired results, the common side effects, and the proper procedure to be followed in the event of a medication error.

Procedure:

3.0 Preparation of Medications

3.1 Select member medication. The medication label must be checked against Medication Administration Record (MAR) for accuracy.

3.2 Check the unit dose for expiration date.

3.3 Select drug and compare to medication record.

3.4 Make sure the container is properly labeled. Never use medications from an unlabeled or non-legible bottle**.**

3.5 From stock medications or over the counter (OTC) medications initials may identify the individual or individuals who take that medication.

3.6 Read the label three (3) times.
3.6.1 as selected
3.6.2 during set-up
3.6.3 When returning it to storage

3.7 Medication prepared for administration but not used should be discarded with proper documentation.

3.8 Medications should be prepared precisely according to the physician's orders. If necessary, the physician should be contacted for full and final clarification.

3.9 Medications prescribed for one member may not be given to another member.

4.0 Administration of Medications

4.1 Medications should be prepared and given as near the specified time as possible. Medications can be given one (1) hour before or one (1) hour after the scheduled time.

4.2 The member for whom the medication is intended must be positively identified.

4.3 All medication must be given by the person that prepared the dose.

4.4 No member will be left alone while taking medication. Personnel will ensure that the medication is taken and in the quantities prescribed.

4.5 No medications will be left in the member's room, any exceptions will be documented on the member's planning document.

4.6 Nurse and other personnel shall carefully observe members after administration in order to be on the alert for any adverse reactions.

4.7 Do not administer crushed medications with a tongue depressor. Use a spoon.

4.8 Non-prescription items, i.e.: items that can be purchased without a prescription may be administered by staff based on the physician's order. Such items may include, but are not limited to, ointments for diaper rash, heat rash, and dry skin.

5.0 Procedure for Administering Medications

5.1 Avoid distractions while pouring medications. Remember the five (5) steps for accuracy

- 5.1.1 Right Member
  - 5.1.1.1 Right Medication
  - 5.1.1.2 Right Dose
  - 5.1.1.3 Right Time
  - 5.1.1.4 Right Route
- 5.1.2 Wash hands prior to starting. Avoid handling medications with bare hands.
- 5.1.3 Obtain medication from packet, then read and check label three times.
  - 5.1.3.1 as Selected
  - 5.1.3.2 during Set Up
  - 5.1.3.3 When Returning To Storage
- 5.1.4 If in any doubt about medication, dosage, or time given, check doctor's order before giving; do not rely on medication book. Only valid dosages are those on a signed doctor's order sheet.
- 5.1.5 Initial the medication after it is poured or taken out of the bubble pack, whichever the case may be. Circle in red pen if not given, and chart on the reverse side of the medication sheet why it was not given. Medication records should include: member's name, date, name of drug, dosage, time given, D/C date if applicable, and allergies. Allergies are circled in red.

5.1.6 Crush medications for those unable to swallow whole pills, if approved by pharmacist for that particular drug.
5.1.7 Check identification of each individual prior to administering medications. If uncertain, ask a responsible person. Each member's picture should be maintained in the medication book.
5.1.8 Remain with member until medication has been swallowed.
5.1.9 When all medications have been given, clean area and medication cart.
5.1.10 Clean bottles after pouring medications.
5.1.11 Another staff member may administer medications you set up as long as you are present until medications are administered.
5.1.12 If an individual refuses medications from a tech/nurse, a second tech/nurse can offer the medication after properly identifying each medication by comparing with the bubble pack.
5.1.12.1 The second person would then place their initials directly above or below the first person's initials or circle the first person's initials in red pen and provide explanation on back.
5.1.13 If an individual is going on an outing and has to take medications while gone, the staff person assigned to be the tech that day may set up the medications ahead of time.
5.1.13.1 The tech will circle his/her initials in red on the front of the MAR and then explain on the back of the MAR that the medications set up for "x" time (ex: all 12 pm and 1 pm meds) were pre-poured for the outing.
5.1.13.2 The tech who will be administering the medications on the outing will, prior to leaving, go through the MAR and the pre-poured medications to properly identify each medication and ensure that they are the correct medications.
5.1.13.3 Upon return, the tech who administered the medications on the outing will document on the back of the MAR that they did, indeed, administer the medications.

6.0 Rules

6.1 Give medications only upon written or verbal orders from a physician or legally authorized person.

6.2 Do not give any medication you have not personally set up.

6.3 Never leave unlocked medications unattended.

6.4 Report and record all medication errors and drug reactions in the individual's record and initiate a Client Incident Report.

6.5 Document the effectiveness of PRN medications on the back of the MAR.

7.0 Types of Orders

7.1 Written physician's orders on medical referrals, scripts, or physician order forms.

7.2 Telephone orders. The order is written on the telephone order forms. The original order is then sent or faxed to the physician within 24 hours for his signature. Telephone orders may only be taken by RNs or LPNs. The signed physician's order will go into the chart.

7.3 All orders must be noted in the member's chart.

7.4 The RN will modify the member's MARs in the member's residence to ensure medication updates are communicated and medication is provided correctly;

7.5 All physicians' orders are valid for ninety days in the ICFs and one year in the SOGHs, unless otherwise specified.

7.6 A copy of the current physician's orders must be maintained in the member's home available for immediate reference by any staff member responsible for administration of medications.

8.0 Medication Records

8.1 The Medication Administration Records (MAR) shall be checked against the physician's orders monthly by two qualified Hab Techs or nurses.

8.2 Medication records shall carry the following essential information:
- 8.2.1 Member's name
- 8.2.2 Name and strength of drug
- 8.2.3 Route of administration
- 8.2.4 Time and frequency of administration
- 8.2.5 Specific direction or precaution
- 8.2.6 Initials of person administering medication
- 8.2.7 Stop date of order if applicable
- 8.2.8 Physician's name

8.3 Missing doses from the packets should be immediately reported to pharmacy. All medication that has been delivered by pharmacy should be checked for accuracy at time of delivery or as soon as possible. (i.e.: right member, right drug, right route, and correct amount) Notify pharmacy within 24 hours for any errors found.

9.0 Personnel

9.1 It shall be the responsibility of the Habilitation Supervisors/Nurses to ensure that all medical technician personnel are trained and certified in proper handling, storage, and administration of medications.

9.2 All employees who have been hired as habilitation technicians shall attend and pass the medication administration class as a part of their initial training, and before they are allowed to pass medications.

9.3 After passing the medication administration class, and before passing medications independently, each employee will work with an experienced and

certified medication administration Hab Tech in order to become familiar with the individuals and their special needs.

9.4 Each employee is observed three (3) times performing a complete medication administration prior to performing a complete medication administration on their own.

9.5 Each Hab Tech will be given a written test annually to ensure they are knowledgeable about any changes in policies and/or procedures regarding the administration of medications.

9.5.1 Each certified medication administration employee is required to attend an annual refresher course which includes a medication pass demonstration observed by a registered nurse staff member.

10.0 Discontinued Drugs

10.1 All medications, regardless of source of compensation, shall be considered property of the member and handled as follows:

10.1.1 Discontinued or expired, non-controlled medications can be disposed of by the nurse or a med tech with a witness.

10.1.1.1 Controlled drugs in SOGHs and ICFs shall be destroyed as follows:

10.1.1.1.1 Controlled drugs may only be destroyed by a pharmacist or by a nurse with a witness. Therefore, you must lock the controlled drugs in the narcotic box and notify nursing that you have a drug to be destroyed. You must continue to count the controlled drug until it has been destroyed.

10.2 Record of destruction of controlled drugs shall include:

10.2.1 Name of member
10.2.2 RX#
10.2.3 Drug name/strength
10.2.4 Quantity
10.2.5 Reason for destruction
10.2.6 Person's name that is destroying drug and witness name.

11.0 Proper Storage of Medications

11.1 The following procedure is to be followed by all personnel and provides specific information on policy decisions related to drug storage.

11.2 Areas for medication storage should be functional and should provide:

11.2.1 Adequate space so that medications can be placed and arranged without crowding.
11.2.2 Adequate lighting so that labels can be plainly read.
11.2.3 Separate double locked areas within medicine cabinet/cart for schedule II controlled drugs.
11.2.4 Refrigeration for drugs requiring it.
11.2.5 Separate storage for "external use" drugs.

11.2.6 Locations where personnel will not be interrupted while preparing and administering medications.

11.3 Medications for members are kept and stored in their original container and transferring between containers is forbidden.

11.4 Drug cabinets/carts should be examined weekly or more often by a Habilitation Supervisor. Drugs that appear to have deteriorated or exceeded their expiration date should be disposed of according to policy.
11.4.1 Cabinets and carts are audited by nursing staff on a monthly basis. Nursing staff complete a cabinet/cart audit tool.

11.5 Medications stored in a refrigerator containing things other than drugs must be kept in a separate locked compartment so proper security is maintained.

11.6 Improperly packaged drugs are to be returned to the pharmacy for correction.

11.7 Labels should be clean and legible. Do not alter labels in any way.

11.8 Check all medication labels to determine if refrigeration is necessary.

12.0 Labeling and Packaging

12.1 All packages shall conform to current federal and state packaging, labeling and safety laws.

12.2 All pharmacy labels shall be firmly affixed to package, shall conform to federal and state regulations and shall contain:
12.2.1 Member's name
12.2.2 Physician's name
12.2.3 Quantity, name, and strength of the drug
12.2.4 Directions for use
12.2.5 Any accessory labels or caution statements

12.3 Route of administrations must be indicated on label of all medications.

12.4 Drugs in forms intended for dilution or reconstitution should carry directions for doing so. Whenever possible, dilutions should be done by the pharmacy.

12.5 Containers presenting difficulty in labeling should be labeled with no less than the name of the medication, strength of drug, and name of member and should be placed in larger container or plastic bag bearing a label with the necessary information.

12.6 Medication for which changes in frequency or times of administration have been ordered should be returned to pharmacy for relabeling. If pharmacy will

not re-label, place a sticker on med package that indicates the order has changed and refer to MAR and/or physician's order for clarification.

13.0 Reordering Medications

13.1 The Director of Nursing shall designate persons in charge of reordering medications.

13.2 The nurses designated to reorder medication shall reorder medications when meds are at a seven day supply level to ensure medications are not depleted before a new supply can be delivered.

13.2.1 Staff in each residence assist with reordering medication following the seven (7) day rule. They remove the reorder label and fax it to the pharmacy and notify nursing staff who monitor the order once faxed.

13.3 Any Nurse that finds a medication at a three (3) day supply level shall reorder the medication from pharmacy.

14.0 Filling New Prescriptions

14.1 New prescriptions may be filled in the following ways:

14.1.1 Physician may call it into the pharmacy and fax a copy of the order to the facility.

14.1.2 Telephone orders received by a nurse may be called or faxed into the pharmacy (procedure shall then be followed for noting and getting physician's signature on the telephone order).

14.1.3 Original prescriptions may be taken or faxed to the pharmacy to be filled (a copy of the prescription shall be placed in the member's file).

14.1.4 Med techs working in SOGHs or ICFs may not take telephone orders. They should request that the doctor phone the order into the pharmacy and fax a copy of the order to the facility.

15.0 Medication Errors, Adverse Drug Reactions, and Missed Medications

15.1 Medication errors and adverse drug reactions shall be reported to the prescriber and nurse. The prescriber or nurse will advise what further action is to be taken dependent on if med error is a significant or non-significant med error. A significant med error is one which causes the member significant discomfort or jeopardizes their health and safety and is to be reported to the prescriber/PCP per their direction. Documentation of the date and time of physician notification for significant med errors is to be included in the CIR. A Client Incident Report (CIR) must be completed for both significant and non-significant med errors.

15.1.1 The significance of medication errors is a matter of professional judgment by the prescriber or registered nurse. The three general guidelines in determining significance are:

15.1.1.1 Member's condition when dose was missed or wrongly administered;

15.1.1.2 Drug category if a single medication error could alter the therapeutic blood level of the medication leading to toxicity or reoccurrence of symptoms (list of significant drug categories are in Med Process binder); and

15.1.1.3 Frequency of error if an error is occurring regularly and depending upon the member's condition and the drug category.

15.1.2 All Hab Techs and Nurses are responsible for preventing medication errors. To promote safety in the administration of medications, Hab Techs and Nurses must follow the Medication Administration policy and procedures, the orders of the prescribing practitioner and accepted standards of practice.

15.1.3 For acute adverse drug reactions call 911; for all other drug reactions, contact the nurse or physician for directions. Specify the acute drug reaction on both the CIR and the Medication History. Follow up with the prescriber/PCP to see if it needs to be added to allergies.

15.2 Medications that are missed for any reason shall be reported to the nurse if more than an hour has passed from the time the medication was due. A CIR is required if outside the one-hour timeframe.

15.2.1 If a nurse or med tech fails to initial the MAR when passing meds, an investigation must occur to determine if it is a med error or a documentation error.

15.2.2 The person who finds the blank square on the MAR shall circle it in red and check the bubble pack if applicable. If unable to determine if med was given, attempt to reach the person who left the blank, then write an explanation on the back of the MAR explaining if you were able to reach the person and if the medication was actually given or not.

15.2.3 If the medication was given, it is a documentation error and is reported to the supervisor and nursing staff for follow-up. If the medication was not given, then a CIR is initiated to document the medication error. If you are unable to reach the person to determine if the medication was given, initiate a CIR. Explain that a blank space was left on the MAR where a medication should have been given and that you were unable to reach the previous nurse/med tech.

15.2.4 Under no circumstances is anyone to come in later (after their shift) and initial the MAR.

15.2.4.1 Initialing the MAR at any time after the medication administration has been completed is not allowed.

15.2.4.2 Under no circumstances is anyone to document another person's initials or signature.

15.3 The CIR shall contain the following information

15.3.1 Member's name
15.3.2 How incident occurred
15.3.3 Date and time of incident
15.3.4 Type of error
15.3.5 Member's reaction
15.3.6 Summary of action taken
15.3.7 Notification to the prescriber for all medication errors.

15.4 If a member refuses the medication, wait 15 minutes and try to administer again. If the member continues to refuse, follow the policy for missed medications.

15.4.1 If a member vomits their medication, call the nurse for instructions.

15.4.2 If a member spits their medication out, call the nurse for instructions.

16.0 Communication regarding member care and Incidents

16.1 The facility shall ensure timely and accurate communication from the nurses to the physician including but not limited to falls, medications, member concerns and incidents.

16.2 The Nurse is notified of concerns of care by program and home staff;

16.3 The Nurse is responsible for the notification of falls, matters related to medication, concerns, incidents, and other medically related circumstances regarding the member to the physician.

16.4 The Nurse is responsible for documenting notifications to, and any orders received by, the physician in the member's record.

16.5 The Nurse is responsible to notify the home staff of changes in the member's treatment as ordered by the physician.

16.6 The Nurse is responsible for updating the MAR to reflect the physician's orders.

17.0 Medication Administration Monitoring

17.1 Staff will be monitored when administering medications to ensure
17.1.1 Medications are being administered properly,
17.1.2 Documentation done correctly,
17.1.3 Proper sanitation procedures followed and
17.1.4 Self-administration of medication expectations met.

17.2 In each ICF residence both the RN and Home Supervisor/designee will
17.2.1 Complete at least four (4) Medication Observation Audits monthly and
17.2.2 Submit a copy to the Unit Manager, Director of Nursing and RN Instructor for review.

17.3 In each State Operated Group both the RN and Home Supervisor or designee will
17.3.1 Complete at least one (1) Medication Observation Audit monthly and
17.3.2 Submit a copy to the Unit Manager, Director of Nursing and RN Instructor for review.

SOP

Example 2

Assisted Living Policy and Procedure

Subject/Title:	**Elopement, Risk Reduction Strategies, and Management of Missing Residents**
References:	Alzheimer's Association https://www.alz.org/national/documents/brochure_dcprphases1n2.pdf Pendulum, 4600 B Montgomery Blvd. NE, Suite 204, Albuquerque, NM 87109, (888) 815-8250, www.PendulumRisk.com

I. POLICY GUIDELINES

The facility strives to promote resident safety and protect the rights and dignity of the residents.

The facility maintains a process to assess all residents for risk for elopement, implement risk reduction strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission, and conduct a coordinated resident search in the event of a missing resident.

II. DEFINITIONS

Elopement is the ability of a cognitively impaired resident, who is not capable of protecting himself or herself from harm, to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way.

Wandering refers to a cognitively impaired resident's ability to move about inside the facility aimlessly, but often with purpose and without an appreciation of personal safety needs and who may enter into a dangerous situation.

Elopers are differentiated from **wanderers** by their overt, and often repeated attempts to leave the facility and premises.

III. PROCEDURAL COMPONENTS

A. Assessment

1. The preadmission evaluation process includes a wandering and elopement history and whether the resident can be safely cared for at the facility
2. An elopement risk evaluation is completed on all residents on admission, and with a change in condition or mental status. The initial resident evaluation is conducted on admission and if not possible, then no later than eight hours from admission
3. A facility-approved risk evaluation tool (or scoring system) is utilized
    a. The evaluation is based on various risk factors that may precipitate an elopement event
    b. The risk score includes a defined parameter which, when reached, indicates an increased risk and prompts strategies, as described below
4. The risk evaluation and new resident observation addresses the resident's mobility and psychological, behavioral, physical, and cognitive functions. Specific risk factors include:
    a. An involuntary admission
    b. A history of wandering prior to admission or finding the resident "lost" in the facility after admission. Details of the wandering history may include when the wandering occurs, if more common during daytime or nighttime hours, the usual traffic pattern, if purposeful (e.g. need for food, toileting, exercise), if exit-seeking and other triggers such as pain, noise, and odors
    c. Problems noted in the resident's adjustment to the facility (such as stating a desire to go home, looking for children, attempting to attend functions that are based on a past schedule)
    d. Any cognitive impairment which results in an inability of the resident to appreciate safety risks and an inability to protect himself or herself
    e. A change in the resident's mental status

f. Interference with risk reduction strategies, including an expressed displeasure with a wander bracelet or an attempt to remove it
g. Behavior problems, including those where the resident is not easily redirected or managed when he or she is agitated or aggressive
h. Actual wandering behaviors, including:
    i. Shadowing (following staff or another resident)
    ii. Self-stimulatory (wandering due to boredom or lack of activity)
    iii. Akathisia (motor restlessness characterized by pacing, standing and sitting, or rocking back and forth, which may be caused by psychotropic and antidepressant medications)
    iv. Exit-seeking (the resident is intent on leaving the unit or facility, looking for exits, and hovering at exits waiting for the opportunity to leave with someone, or pushing on a door)

B. Risk Reduction Measures

1. Interventions that may be used for residents identified as high risk for elopement include:
    a. Frequent monitoring of the resident's whereabouts to assure he or she remains in the facility (e.g., every one-half hour check)
    b. Room placement close to common areas such as the nurse's station and away from exits
    c. Promoting activities that are in full view of staff members
    d. Alternative activities to maintain the interest level of the wanderer
    e. Implementation of wander bracelet or other electronic alert systems
    f. Transfer to a more suitable or more secured unit/facility, if necessary
    g. Notification of physician for changes in behavior, such as increasing insistence or attempts to leave
    h. Environmental controls such as:
        i. The physical plant is secured to minimize the risk of elopement through:
            (a.) Functional alarm system for egresses and stairwells
            (b.) Interior courtyards
            (c.) Safety locks or keypad entry that restrict access to dangerous areas
            (d.) Restricted window openings to six inches to allow for ventilation but prevent resident exit
            (e.) Elevator controls
            (f.) Fenced perimeters
            (g.) Camouflaged doors and doorknobs
        ii. Adaptation of the environment with way-finding cues and landmarks
            (a.) Brightly lit, uncluttered paths with many rest areas (indoors/outdoors)
            (b.) Decorations that provide positive distractions and also act as deterrents
2. Additional resident and family involvement and education
3. Verification of control systems
    a. If an electronic surveillance system is in place, door alarms are tested weekly (at a minimum) for proper functioning and the testing is documented
    b. Door alarm codes are changed routinely
    c. Resident electronic monitoring sensors (e.g., bracelets/pendants) are checked every shift for placement and daily for proper functioning and documented in the Resident Record, Treatment Administration Record, Medication Administration Record, or a specifically designed log
    d. A sign-in/-out system is implemented, which requires responsible parties to sign the resident out when leaving and noting an expected return time
    e. Creation of a lost person profile for each resident at risk
        i. Three close-up photographs are taken of each resident on the day of admission
            (a.) The photographs are for identification purposes only

(b.) One photograph is maintained in the Resident Record and the other in his or her Medication Administration Record. A third photograph, with a description of the resident (e.g., height, weight, hair, and eye color), is maintained at the reception desk
(c.) Written consent for photographs is obtained
(d.) Photographs are updated as required to reflect changes in a resident's appearance and at least annually

4. A verification process is conducted to determine the location of each resident after a fire/elopement drill, resident activity, field trip, etc.

C. Interventions

1. Responding to an actual elopement
   a. It is the responsibility of all staff, regardless of the department they work in, to respond to activated door alarms and to return residents to their units
   b. Any resident who leaves his/her assigned unit unaccompanied is approached according to accepted guidelines as follows:
      i. Approach in a calm and reassuring manner
      ii. Have one individual approach the resident. Discourage large numbers of staff around the resident
      iii. Avoid arguing with the resident. DO NOT say "You can't" or "You have to"
      iv. Avoid touching the resident if possible
   c. The family and physician are notified of the incident, and notification is documented in the resident's record
   d. If the resident is placed on increased supervision, safety checks are documented in the resident's record each shift for the duration of the increased supervision
2. When a resident is determined to be missing:
   a. The time that the resident is/was determined missing is noted
   b. The staff members assigned to the unit where the resident resides verify that the resident has not been signed out
   c. The staff notify the Administrator that a resident is missing
   d. Staff members, in accordance with the facility's search team plan, conduct a thorough search to locate the resident. If the resident is not located, proceed with the following:
      i. Staff members search the entire facility and grounds. Prior to beginning the search, the resident's photograph is viewed by all staff involved in the search
         (a.) All areas of the building, grounds, and neighboring streets are systematically searched when a resident is missing or has eloped (may use a facility map that is marked off when an area is checked)
         (b.) The Administrator assigns each staff member a sector when searching for a resident to minimize overlapping or overlooking of an area
         (c.) When conducting a search, look under beds and furniture, in closets, showers, under desks, locked rooms/offices, walk-in refrigerators and freezers, and behind doors. When conducting a search in storage rooms look behind boxes, in boxes, and on shelves. The search area also includes stairwells, elevators, and the roof, if there is roof access. A resident who has eloped may be frightened and may be hiding. Being thorough in the search is of extreme importance
         (d.) When finished searching a sector, findings are reported to the Administrator for further instructions
      ii. If the resident has not been found after a period of ten minutes, the Administrator or designee calls the police and reports the resident missing
      iii. When the police arrive, the Administrator provides the officer with a picture and other pertinent information such as:
         (a.) What the resident was wearing

(b.) How the resident was ambulating, with a cane or walker
(c.) The resident's cognitive status, confused, agitated, etc.
(d.) Information as to where resident may be going, if known
(e.) A resident profile, which includes the resident's previous address and family's address, is available in the resident's chart for this purpose

iv. The Administrator notifies the family and attending physician if the resident is not found in the facility or on the grounds

3. When a resident has been found:
   a. The Administrator notifies all staff that the resident has been found
   b. The resident is examined for injuries
   c. The attending physician is notified of the resident's status
   d. The resident's responsible person is contacted and informed of his/her status
   e. The resident's service plan is updated, including:
      i. Additional measures such as a wander bracelet if not in current use
      ii. 15-minute safety checks or continuous observation if transfer to a more secure facility is determined
   f. If the resident is placed on increased supervision, safety checks are documented in the resident record each shift for the duration of the increased supervision
   g. A Missing Resident form is completed, and all staff involved sign the form. The form is forwarded to the Administrator or Resident Services Coordinator
   h. The incident is reported to the state authorities as required

D. Documentation

1. All elopement attempts and events are documented in the resident record, including objective and factual statements regarding:
   a. Circumstances and precipitating factors
   b. Interventions utilized to return the resident to the unit
   c. The resident's response to the interventions
   d. Results of reevaluation upon the resident's return and the condition of the resident
   e. Care rendered
   f. Notification of police, physician, and family
   g. Physician orders following notification
   h. Additional risk reduction strategies implemented
2. Resident-specific safety concerns are noted on the resident care plan and interventions that address his or her needs. Interventions to reduce risk are reviewed by the interdisciplinary team on a quarterly basis, at least, or with a change in condition for effectiveness of risk reduction strategies. These measures include realistic and measurable goals and avoiding statements such as "will have no events or no injuries related to elopement"
3. An Incident Report is completed and forwarded to the Administrator or the Resident Services Coordinator
4. Completion of the Incident Report is **not** noted in the resident's medical record
5. Resident/family education about additional risk reduction strategies is documented

E. Elopement Drills

1. Elopement drills are conducted on a regular basis, at a minimum semiannually
2. Results of the drills are used for staff education
3. Documentation of elopement drills (and actual elopements) are noted on the forms attached to this procedure (see Attachments 1, 2, and 3)

F. Education

1. If possible, family education is conducted on admission or at any time the resident is identified as a high risk for elopement
2. Staff training at orientation and during annual in-services is provided, including the risk factors for elopement and the specific risk reduction measures in place at the facility

3. Elopement risk reduction strategies are reviewed with all staff, including the method and frequency of assessing effectiveness

G. Quality/Risk Management Review

1. Based on compiled incident report data, a periodic trend summary is provided and discussed at the Quality Management/Risk Management Committee meetings
2. Data should include:
   a. The number of residents identified as at risk for elopement
   b. The number of elopement attempts
   c. The number of events
   d. Outcome severity

Elopement
Attachment 1
Elopement Drill or Post-Elopement Follow-up Report

Elopement Drill: _____ Actual Elopement: _____ Date: _____

Missing Resident Name: _____

Staff Person on Duty: _____

Time Started: _____ Time all Clear: _____ Total Time: _____

Supervisor or RSC Notified: _____ Time: _____

Administrator Notified: _____Time: _____

Police Notified: _____ Time: _____

Family Notified: _____ Time: _____

Resident found: _____ If yes, time: _____

Number of Staff in Participation: _____

Staff Performance Results: Excellent _____ Good _____ Fair _____ Poor _____

Staff did _____/ did not _____ respond in accordance with established procedures.

Comments:

_____

_____

_____

_____

_____

_____

_____

Conductor(s): _____

Elopement
Attachment 2
Resident Elopement Search Drill
Staff Sign-In Log

Signature	Print Name	Department

Elopement
Attachment 3
Elopement Drill or Post-Elopement Checklist

Date: _____ Time: _____

Resident Name: _____ Room #: _____

Resident Missing Time: _____ a.m. p.m.

Resident Found Time: _____ a.m. p.m.

Circle the following Yes or No

1. Did staff verify resident was not signed out?	Y	N
2. Did staff check unit?	Y	N
3. Did staff notify supervisor?	Y	N
4. Was the Administrator notified?	Y	N
5. Was a full search of the facility and grounds implemented?	Y	N
6. Were the police notified?	Y	N
7. Was search called off when resident was located?	Y	N
8. Was resident examined when located?	Y	N
9. Was resident's physician notified when resident was discovered missing?	Y	N
Found?	Y	N
10. Was family and/or responsible party notified when resident was discovered missing?	Y	N
Found?	Y	N
11. Was incident/event report completed?	Y	N
12. Was notation included in the Resident Record?	Y	N
13. Did the alarm system function (if an egress system was in place)?	Y	N

Name of person completing report: _____

SOP

Example 3

TO BE TYPED

STANDARD OPERATING PROCEDURES

STAFF RESPONSIBILITIES DURING AN EMERGENCY

In addition to regular day to day job duties during non-emergency situations as described in the Employee Handbook, the following job requirements must be observed and carried out during an emergency. The purpose of these responsibilities is to ensure that everyone is safe and secure during an emergency with no loss of life or injury. The following responsibilities take effect as soon as an emergency is declared. Emergencies include tornadoes, fire, hazardous material incidents, and power outages during severe hot or cold weather and hurricanes.

A. **The Administrator** will inform the facility staff of an emergency as soon as she/he is made aware of the emergency. However, if the Staff finds out first, then the staff should immediately contact the administrator to make her/him aware of the emergency.

B. **The Administrator** is responsible for implementing the procedures for an emergency, including evacuation procedures if they are necessary, and notification to the receiving facility.

C. If necessary, depending on the type of emergency, **the Staff** must return to work within one hour of being notified.

D. **The Staff** will assist in the gathering and evacuation of residents, staff and essential food, water and supplies, if evacuation is necessary.

E. **The Administrator** will supervise and assist in the gathering and evacuation of the residents, staff and essential food, water and supplies (if evacuation is necessary).

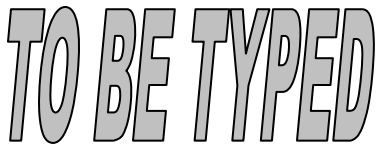
F. **The Administrator** will ensure that the residents' families remain informed of the residents' well being and the new location, if evacuation is necessary.

G. **The Staff** will not leave the facility until relieved.

H. In the event of an emergency, **the Staff** will go room to room and inform residents (waking them up if necessary). In the event of a fire, please refer to the Fire Safety Plan for emergency procedures during a fire.

STANDARD OPERATING PROCEDURES

STAFF RESPONSIBILITIES DURING AN EMERGENCY
(Continued)



I. As soon as the facility is made aware of the emergency, the family members of the residents will be contacted immediately. Family members will be contacted via telephone at the phones provided to the facility. (home, work, pager, cellular)

J. If an evacuation is necessary, there will be a room-to-room search to ensure that all residents are out of the facility, and the resident log of outgoing residents will be checked to ensure that all residents are accounted for.

K. **The Staff**, if responsible for the re-entry, will receive the same information from television and radio announcement. If structural soundness of the building is in question, re-entry will be allowed only upon approval by the structural engineer.

L. This facility will have monthly fire drills, and external drills every May before the hurricane season. For external drills, all procedures will be rehearsed except the physical removal of residents. Meetings will be held after all drills in which **the Administrator**, staff and residents will be identify deficiencies. The deficiencies will be discussed and corrected in the written procedures and emergency plan.

M. During an emergency, third party providers, such as the drinking water company, will be contacted by **the Administrator** at least 24 hours in advance to notify of additional needed for drinking water.