Australian Government
Aged Care Quality and Safety Commission

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Serious Incident Response Scheme (SIRS)
Insights Series: Report 2 – 2023
Residential Aged Care Services

Unexplained absence from care

Contents

Introduction

This is the second in a series of Insights reports that the Aged Care Quality and Safety Commission (Commission) is producing on the Serious Incident Response Scheme (SIRS).

The series will explore the 8 reportable incident types under the SIRS in residential aged care.

The SIRS was introduced in residential care in April 2021 to help providers reduce and prevent serious incidents and the harm they cause. It also allows for better oversight of the aged care system.

The Insights report series aims to help providers:

- improve how they respond to serious incidents with a focus on the experience of people receiving aged care
- identify and apply learnings to put preventative measures in place at an operational and governance level
- enhance quality of care and build on a positive care culture in residential aged care settings.

Many serious incidents that happen in aged care are preventable. Improvements in providers' responses to serious incidents are crucial to reducing harm to people in their care and stopping incidents from happening again.

An important education resource

The Insights reports are intended to be a valuable learning resource for providers. Providers can use the guided questions in each case study to run workshops and discussions with staff and management teams, and to identify learnings that they can apply to their service.

We also include questions for boards and senior leadership. These can help guide their consideration and actions when an incident happens. Effective incident management needs leadership at all levels of an organisation. This starts with the board and entire leadership team.

Message from the Commissioner

Janet Anderson PSM

All Australians have the right to feel safe and live dignified, self-determined lives that are free from exploitation, violence and abuse. This includes older Australians receiving government-subsidised aged care services, who have specific rights and protections.

The Serious Incident Response Scheme (SIRS) was introduced into residential aged care in April 2021 to protect those receiving government funded aged care services from harm and abuse.

To support this objective, I am pleased to present this report as part of our series of Insights reports on SIRS. It is based on the intelligence we gather as the national aged care regulator. The Insights series is designed to help improve providers' management of serious incidents through education and reflection.

Each report will use case studies of real situations and incidents with the names and identifying particulars removed. The case studies are offered as learning opportunities to support providers to improve their practices.

This second report in the series looks at unexplained absence from care. This incident type is a Priority 1 notification which means that all unexplained absences must be reported to the Commission within 24 hours.

Reassuringly, it is one of the lowest reported incident types, accounting for just over 1,700 SIRS notifications to the Commission in the 12 months to March 2023 (see Appendix A, Table 1).

This incident type goes to the heart of provider responsibilities to keep every person living in aged care safe, while at the same time supporting their right to live their best life and have choice and freedom of movement.

The insights in this report's case studies will guide providers to take actions and update processes across all levels of their services to reduce the occurrence and impact of such incidents.

As with our first report on unreasonable use of force, we are concerned about providers' assessment of impact in the notifications we receive of unexplained absences from care. Providers assessed:

- 91% of unexplained absences incidents as having no to minimal physical impact
- 95% as having no to minimal psychological impact.

Our review of notifications shows that this is a significant underassessment. Recognising impact is vital to managing incidents appropriately, and ensuring that anyone affected by an incident receives the care and support they need. It is also essential to promoting people's confidence in the staff and their commitment to keeping residents safe and supporting their wellbeing.

Our report also highlights missed opportunities for prevention. We have found that residents involved in an unexplained absence incident have often tried to leave the service multiple times before. Some have also been involved in other SIRS reported incidents (see Appendix A, Table 5).

Recognising the warning signs and making good use of behaviour support plans is vital in preventing risk to all aged care residents. How a provider responds to an incident when it does happen is central to making sure other residents are not involved in similar incidents.

I encourage you to consider how you can apply the insights offered in this report to your service and to share your learnings with us.

Janet Anderson PSM
Commissioner

Observations from the Chief Clinical Advisor and the Executive Director, SIRS

Dr Melanie Wroth MBBS, FRACP and
Ann Wunsch, Executive Director SIRS

Like the first Insights report on unreasonable use of force, this report takes a person-centred case study approach. It provides insights from the 1,713 incidents of this type reported to the Commission between 1 April 2022 and 31 March 2023.

Our aim is to help providers and their governing bodies to improve their response to serious incidents in their services and prevent incidents from occurring and reoccurring.

A provider's self-initiated investigation is a vital step in addressing and mitigating risk of harm to consumers. When done well, this can avoid the need for Commission involvement and escalation.

Unexplained absence from care is a Priority 1 (P1) reportable incident. This means that providers must report this incident to us within 24 hours of becoming aware of it.

Some providers continue to incorrectly report these incidents as Priority 2 (P2), 116 in the reporting period. P2 incidents are incidents that providers need to report to us within 30 days.

This report focuses only on residential care incidents. Reporting of SIRS incidents in home services commenced more recently (1 December 2022) and those notifications will be the subject of future reports. Nonetheless, we encourage home services providers to consider and reflect on the insights and learnings within this report in relation to their practices and service delivery.

Unexplained absence from care accounts for a small proportion of reported incidents in residential care compared with other incident types. It is less than 10% of P1 notifications and only 3.6% of P1 and P2 notifications combined. However, it is of concern because it carries with it high risk to the resident, including risk of death.[1,2]

1 Woolford, M. H., Bugeja, L., Weller, C., Boag, J., Willoughby, M. & Ibrahim, J. E. 2019, Recommendations for the prevention of deaths among nursing home residents with unexplained absences, International Journal of Older People Nursing, vol. 14.

2 Woolford, M. H., Bugeja, L., Weller, C., Johnson, M., Chong, D. & Ibrahim, J. E. 2018, 'Unexplained absence resulting in deaths of nursing home residents in Australia—A 13-year retrospective study,' International Journal of Geriatric Psychiatry, vol. 33, pp. 1082-1089.

Message from the Chief Clinical Advisor and the Executive Director, SIRS

Consumers who live in residential care are entitled to enjoy the same freedoms as the general community, including not having restrictions on their rights or freedom of movement. The Charter of Aged Care Rights (the Charter) under the *Aged Care Act 1997* sets out the legislated rights of a consumer receiving Government subsidised aged care services.

If a resident is not allowed free access to the community, this is considered environmental restraint and can only be used if there is a risk of harm. This means that the risk of harm to a resident in the community must have been assessed and found severe enough to justify preventing them from leaving the service when they want. These residents when missing are therefore at high risk of harm.

SIRS data between 1 April 2022 and 31 March 2023 found that only 22.7% of absent residents were found at the service, at a private home or at a hospital. A worrying 77.3% of missing residents were found in a location listed as 'other'. This suggests that these missing residents were in a location where they were not safely supervised during their absence (see Appendix A, table 7).

Our analysis of unexplained absence from care case studies and the SIRS data shows the following key issues:

- Providers underassess the impact that unexplained absences have on people, particularly the psychological impact.
- Providers can strengthen how they oversee their legislative compliance, manage and use restrictive practices and develop personalised behaviour support plans.
- The need for individual care plans that consider both a person's risk of harm and right to freedom of movement.
- The need for better risk assessment for individual residents and the local physical environment of the service.
- Governance that promotes and fosters improved oversight and continuity of person-centred care, particularly in services that have high staff turnover and/or reliance on agency staff.
- The need for providers to be open and transparent (using timely open disclosure processes) with residents and their families and representatives.

The themes include impact to residents, risk assessment, incident prevention and appropriate use of restrictive practices. We have based these themes on common elements in the notifications and reports we receive as well as information from our regulatory actions. We have created the case studies from actual notifications in a way that protects confidentiality.

We hope this report helps providers gain insights into how they can improve their operations in order to deliver high quality care to their consumers.

Dr Melanie Wroth MBBS, FRACP
Chief Clinical Advisor

Ann Wunsch
Executive Director SIRS

Issues highlighted by the case studies

Underassessed physical and psychological impacts

No matter the level of impact the provider records in their notification, the Commission will review the report. Our assessment of the situation will inform our follow up and whether there is any extra information we need.

A resident being found and returned safely to the service does not mean that they have not found the incident distressing. It may have had immediate and ongoing psychological and physical impacts. These impacts may not be obvious or the resident may not be able to communicate the impact. Being taken back to a service can be very distressing to a resident who is trying to leave or who does not want to be there.

Several of the case studies show a gap between the assessment of impact in the notification and our assessment of impact after review. In 3 of the 5 case studies, we found that the initial assessment of impact was missing detail of the complexities that may come with this incident type. In case study 1, Robert's psychological distress before and after the incident was not fully understood and therefore under assessed and not addressed. In case study 5, the provider had not noted the considerable distress that Guan experienced when he entered the service on a Public Guardian's decision, nor the significant differing opinions within the family.

Case study 3 highlights a provider underestimating physical and psychological impact. Sarah's case study shows the physical environment, safety and clinical risks that a provider must manage.

In Sarah's case, the Commission was not satisfied with the provider's response, the case was escalated and we issued an Incident Management Compliance Notice.

Restrictive practices

Unexplained absence from care has a large crossover with restrictive practices. Some restrictive practices are not used and managed properly, as shown in case study 1.

Restrictive practices are any practice or action that restricts a person's rights or freedom of movement including to the community.

We receive a small number of notifications for 'inappropriate use of restrictive practices' (107, or 1%, of P1s and 582, or 2%, of P2s in the last 12 months - see Appendix A, Table 1.) However, inappropriate use of restrictive practices is often found in other notifications. When a provider submits a notification, they can provide extra information within 5 days of the original report. They do not have to submit a new incident notification. We will still take action to address any issues relating to restrictive practices even if the provider has categorised this as a different incident type.

Robert, case study 1, lives in a secure unit in an aged care residence, as did 24% of residents who were notified missing in the last 12 months (see Appendix A, Table 6). The Commission's review of the notification, and the investigation undertaken by the provider at our request, found evidence that staff were using restrictive practices inappropriately when they locked Robert inside his room. This restrictive practice directly contributed to his unexplained absence from care. As in the cases of Sarah and Aldona, a resident who is determined to leave will try to find a way. In Robert's case, this was by tearing the flyscreen off a window in a locked room. Reasons why a resident wants to leave vary and are often linked to distress. They need to be understood and addressed.

The provider's review of the case found that instead of being given time in the garden and fresh air to calm his agitation, as included in his behaviour support plan, Robert was locked in his room. The review also found that the act of locking Robert in his room alone did not comply with the legislation and had not been recognised as seclusion.

The issue of inappropriate use of restrictive practices will be a focus of a future SIRS Insights report. You can find our SIRS decision support tool and information about provider responsibilities in relation to restrictive practices on our website. We designed the perimeter restraint tool to help providers to identify what is and is not an environmental restraint.

Individual care plans and oversight

The connection between restrictive practices and unexplained absence from care shows the need for proper assessment, and individual care and behaviour support plans. This is particularly true when providers are considering environmental restraint to protect residents from a risk of harm. An environmental restraint is a restrictive practice that restricts a person's access to all parts of their environment (including items and activities), such as locking a door to a garden, or preventing people from participating in activities like watching TV or making a meal.

Residents who can safely go into the community should be allowed the same freedom to move around as those living in their own private home. Providers need to manage this freedom through:

- effective assessment
- supporting and supervising residents where needed
- strong communication processes
- a risk assessment of the physical environment specific to the person and their circumstances
- developing safety strategies, such as ensuring residents have a mobile phone with them or identification with the address and contact details of the service.

We see this in case study 2. Josephine lives in a wing that is not secured. Her absence had posed no risk to her. What concerned the Commission was that she had not been seen since the day before and it was about 20 hours before the provider noticed that Josephine was missing. In this case, the safety of all residents was at risk, not because of the absence of physical restraints or appropriate behaviour support plans but because of care and oversight problems relating to knowing the whereabouts of their residents.

Adding to the Commission's concern about how the provider managed this incident, it was discovered that Josephine was blamed for the oversight failure and staff processes.

It was noted that Josephine stayed in her room for several days afterwards. However, the provider had reported that the incident had no impact on her when it was apparent that there had been significant psychological impact.

As we can see in other case studies such as Aldona in case study 4, a similar lack of oversight carries risks of serious harm or death.

A time escalation policy is helpful to clarify the timely sequence of actions for staff when a resident is missing. This includes exactly who to contact in specified timeframes including management, police, family and CEO.

Risk assessment of residents

Residents are most likely to try to leave a service unnoticed in the first month or so after going into an aged care home. This is particularly true when they are in respite care and not expected to stay long-term.

Providers should be aware of risks when residents are new to the service, including on respite, and may have entered residential care unwillingly or unhappily. New residents can be particularly unsettled and unfamiliar with their surroundings, and it is a time when staff are still getting to know them.

We see this in case study 4. Aldona was reported missing on her third attempt to leave the service.

Investigating this case, we found little evidence that the provider tried to understand why she wanted to leave. There was no risk management plan or care plan for Aldona, even though she had made several attempts to leave the service and had been showing signs of depression.

This case study is an example of how gaps in a service's culture, communication, person centred and clinical care, and governance can lead to the worst outcome for a resident.

In some cases providers may consider use of technology such as monitoring and location devices to enable some residents to access the community more safely and maintain independence. This can allow residents to be quickly located and assisted if required.

Legal guardianship and communication

Residents who come into a service under a Public Guardian or equivalent can be vulnerable in residential care. In many cases, they have no family or friends to advocate for them. Sometimes family members may not agree about the person's care and whether they should even be in residential aged care. Providers must communicate with the Public Guardian when they make decisions about the care of the new resident, including when restrictive practices are considered or implemented.

Guan, in case study 5, was admitted to a service after a decision of the Public Guardian. His daughter removed him from the aged care service without consent in the middle of the night. The Public Guardian was not listed as a contact even though they were the decision maker for Guan. The provider also did not understand the family situation. Better lines of communication internally and with the Public Guardian would likely have led to better management of risks.

Adding to Guan's vulnerability, the service relied on agency staff who had not been briefed about Guan's situation or about the behaviour of his daughter Fiona.

While instances of residents being removed from care by family members or other carers are rare in the SIRS incident notifications, this case study raises important issues for care of vulnerable residents. It also focuses on the need for clear individual care plans that are accessible and used by staff.

Case study 1:
Inappropriate use of restrictive practice contributed to unexplained absence

Incident description

During medication rounds, care staff noticed that a resident, Robert, was absent from his room in the secure unit. The room had been locked from the outside and when staff entered, they saw the window open and a torn fly screen on the ground outside. CCTV footage showed Robert leaving the service by following a delivery driver through a back gate. The notification we received stated that Robert had 'absconded' from the service and that staff had contacted police. The provider assessed the incident as having low psychological impact as Robert was found quickly and without immediate signs of injury.

Commission action

Robert had been named in several prior notifications of unexplained absence received from the provider. The Commission asked for more information* to assess the provider's ability to manage the risks to residents in their care and prevent incidents from happening again.

On assessing the information provided, the Commission found that the provider may have been using restrictive practices inappropriately and that the provider had not considered the ongoing distress to Robert and other residents. We directed the provider to conduct a formal investigation and provide us with a copy of the investigation report.

Background

Robert had been agitated in the days before the incident and had made several attempts to leave the service. Robert was reported as having a severe cognitive impairment, which can include loss of memory or thinking processes. He had an updated behaviour support plan after he had gone missing two previous times. He was moved from an open area of the service to the secure unit where he was living at the time of this incident.

On the day of the incident, the door to his room had been locked from the outside, because Robert was becoming increasingly agitated. However, Robert's behaviour support plan noted that he likes to walk in the garden when he is agitated and that staying in his room increases his agitation.

* Issued under section 95c of the Aged Care Quality and Safety Commission Rules 2018.

Moving Robert to the secure unit was not identified as environmental restraint and locking him in his room alone was not identified as seclusion. Both of these measures are restrictive practices.

The provider's review of part 4A of the Quality of Care Principles showed them that staff had not complied with the legislation regarding the use of restrictive practices.

After the incident, Robert's behaviour support plan was updated and he was given an exit alert bracelet. This tells staff the location of the person.

The provider also carried out risk assessments and restrictive practices reviews for all its residents in secure units. They particularly focused on those who had tried to leave the service or often expressed that they wanted to leave as these residents were clearly not happy with the environmental restraint. The review identified the need for personalised plans and more person-centred care.

Guided questions
Case study 1

1. Why might a resident want or try to leave a service? How can you address each of these reasons?
2. What things could you assess to help understand the risk of harm to a resident if they are free to go into the community? How does your service balance this risk with resident rights?
3. Given that Robert had a history of trying to leave, what do you need to do to understand why he wants to leave? What actions can you take to respond to this?
4. What do you think a person-centred care approach would look like both before and after Robert's unexplained absence?
5. Does your service use terms like 'absconded' or 'escaped'? What impact does this wording have on how staff think about a resident?
6. How has the information about inappropriate restrictive practices mentioned above changed the way you think about this incident?

Case study 2:
Gap in oversight leads to communication breakdown about overnight home visit

Incident description

Josephine is an 80-year-old aged care resident. She was not in the dining area at breakfast time, which was different from her usual routine.

After a search of the service, staff found that no one had seen Josephine since lunch time the day before and the sign-out book had not been used.

Staff called the police and then Josephine's husband. He told them that Josephine was at the family home on a planned overnight visit and he would drive her back by 7pm.

Commission action

We asked for more information because it took such a long time for staff to notice that Josephine was missing. Our review of the additional information provided found that it was still missing important details, so we did our own investigation.

Background

The Commission's investigation found that the reception desk was unattended when Josephine left with her husband. Josephine had told staff on the day of the incident that she was looking forward to spending time with her husband at home.

The staff assumed that the visit had been documented appropriately and did not confirm that the duty manager knew Josephine was leaving or remind her to use the sign-out book.

Our investigation also reviewed a similar incident that had occurred more recently involving a different resident, and found that the provider had not taken sufficient steps following the incident involving Josephine to prevent its reoccurrence.

The investigators were particularly focused on why it had taken around 20 hours before staff realised Josephine was not at the service. The service had been unusually busy when Josephine left, with one staff member on leave and several other staff attending to a resident who had fallen. When Josephine returned, a staff member shouted at her and her husband. It was noted that in the days after she was yelled at, Josephine stayed in her room more and missed several breakfasts in the cafeteria.

The provider put strategies in place to minimise the risk of someone leaving the service unnoticed again. This included education for all staff about the sign-out policy and an update to make sure that all residents with mobile phones have their phones with them when they leave.

A fact sheet was given to residents, families and representatives that included plain language instructions for letting the service know about any planned and unplanned outings.

The service also updated procedures for staff to make sure that residents are sighted at regular intervals. Handover and home leave procedures were strengthened to ensure that staff noticed any unexplained absences early.

The service found that Josephine had actually followed procedures except for signing out when the office was unattended, and they understood that it was unacceptable for staff to blame her or yell at her. An apology was given for this behaviour. Further, being accused of having done something wrong clearly distressed Josephine and had a significant impact on her. This should have been recognised by staff straight away and support and reassurance provided to her.

Guided questions
Case study 2

1. What procedures does your service have to make sure residents are sighted at regular intervals? Does this vary according to their cognitive ability? How sure are you of the maximum time each resident is not seen and checked by a staff member?
2. The service was busy and the desk unattended. What systems could you put in place to ensure that the person can still leave and staff are notified about this?
3. One staff member shouted at Josephine and her husband and appeared to blame them. Is this a code of conduct matter? How confident are you that the workplace culture in your service/s would prevent this from occurring?
4. How could you communicate with and support a resident who has been shouted at, accused or abused?
5. What are the factors that your service takes into account when deciding whether to call the police about an incident?

Case study 3:
‘Tailgating’ poses danger to resident

Incident description

At the evening medication rounds, staff found that Sarah, who lives with Parkinson’s Disease, was missing. The service is near a motorway. The provider called the police about the incident. A short time later, staff found Sarah in the local park in her pyjamas. The police arrived and helped her into their car and drove her back.

The provider assessed the incident as having no impact.

Commission action

After reviewing the notification, we found that we needed more information. A review of the service’s previous SIRS notifications showed that Sarah and other residents had been named in multiple notifications of unexplained absence. We also found that the provider’s assessment of the incident as having no impact was incorrect. This and the provider’s lack of preventative measures led the Commission to issue an Incident Management Compliance Notice.

Background

The provider assessed the incident as having no impact. Even though there were no physical injuries, the Commission’s review found that Sarah was at risk of serious harm given the location of the service and that she was found cold and very distressed. She had also left her walking frame behind, which she had started using after a recent series of falls, increasing her risk significantly. After the incident, Sarah had increased symptoms of Parkinson’s because she missed her dose of medication while she was away from the care home. There was clearly both physical and psychological impact.

The main exit of the residential facility has a keypad lock, but the service knew the door would stay open if it was not closed firmly. There were no signs to tell visitors about this. The faulty door led to residents opening it and leaving the service after visitors left by the main exit. When closely following another person out this is often called ‘tailgating’.

In the provider’s notification, they outlined the actions they were now taking for Sarah including updating her care plan and repairing the door lock. There was no timely, frank, open and empathetic discussion with Sarah, her family and the staff involved (a process known as open disclosure). Sarah did not have a behaviour support plan.

Case study 3

The service is in a high-risk location and had had multiple past incidents of unexplained absence. There was no evidence that they had a prevention strategy to minimise the risk for all residents or to fix the door before the latest incident. Sarah did not want to be at the service and the service had not tried to understand why and how they could make her life there better, or to help her to look at options to live somewhere else.

After the Commission escalated the incident, the provider started a service-wide education strategy about tailgating. They also introduced new processes to assess risks and the behaviour support plan each time a resident tried to or successfully left without the service knowing. Environmental restraint processes were fully reviewed.

Guided questions

Case study 3

1. Does a resident have the right to leave your service if they do not want to stay? How can they be assisted? What is the process in your service when you are planning to overrule a resident's right to access the community?
2. How does your service assess the impact of an incident on a resident and others who may be affected? How do you record this?
3. What could Sarah's service have done to stop this incident from happening?
4. How does your service communicate with staff, visitors and delivery drivers to make sure tailgating does not happen?
5. The family was not contacted for some time. Why might this happen? In your service, at what point would you contact the family to let them know about the incident? Who is responsible for contacting the family?
6. The provider responded with strategies to prevent Sarah from leaving. What else could they have done to address the fact that she wants to leave and the distress she feels when prevented and restricted? Who would assess the risks of leaving? How would this be part of her behaviour support plan?

Case study 4:
Failure to comply with the Quality Standards linked to death of resident

Incident description

Aldona, a 92-year-old respite resident living with dementia, could not be found at the service, which is near a river. Management, the police and Aldona's family were all contacted. Not long after, police found a deceased person, who was later identified as Aldona, in the nearby river.

Commission action

The provider's initial report described the incident as a 'misadventure' and stated that they had started a review of the perimeter fencing. We found that this was the only action taken to manage or minimise the risk of a similar incident happening again. We asked for more information.

Given the seriousness of the outcome and the provider's initial report, the Commission initiated an investigation.

On completion of this, we found that the provider did not comply with several Quality Standards. The provider was required to take the following actions to comply:

- Do individual risk assessments for each resident for possible absences. The assessments were to identify potential risk and strategies to minimise that risk. The provider was then expected to implement those strategies.
- Address service environmental issues identified in the provider's environmental audit.
- Review how the service investigates incidents to make sure that the factors that cause or allow an incident to occur are understood and considered as part of continuous improvement planning.
- Make sure they provide Incident Management System training to each staff member at the service.
- Report on how they have implemented these actions 4 weeks after receiving the notice.

Background and insights

Aldona had been at the secure service for one month on respite. She spoke Polish and had very little English, which increased her social isolation at the service and decreased the ability of staff (none of whom spoke Polish) to understand her wishes and needs. The service started an interim care plan for Aldona and specifically noted that she was not at risk of trying to leave the service. This was despite information documented in her National Screening and Assessment Form and advised by her family.

During the respite period at the service, Aldona had:

- been showing signs of depression
- been banging her head and kicking the door and walls

- been refusing to eat
- made 2 attempts to leave the service before this incident.

The provider had recommended a sight chart and was arranging for Aldona to be moved to a more secure service but these actions had both been delayed. The Commission found that despite the warning signs, the service had not done anything either to stop Aldona from trying to leave or to understand what might be motivating this behaviour so they could better support her.

The Commission was also concerned that the provider had not used an interpreter and had not referred Aldona for depression and risk of nutritional decline when she stopped having regular meals.

By not allowing Aldona free access to the community, the provider was practising environmental restraint. This may have been warranted, but processes to check the need for and legality of this arrangement were not used.

Aldona left through a door that was unlocked to allow for deliveries. The service changed all deliveries to be made during business hours after the incident and started new processes to prevent tailgating.

Guided questions
Case study 4

1. What person-centred approaches can you suggest that may have helped Aldona's mental health and social isolation?
2. How does your service coordinate the transition period for a new or respite resident? Why is this a time of psychological upheaval for many people? What do you do to support people during this time?
3. Given the information above, why do you think Aldona wanted to leave the service? What can you do to recognise warning signs in residents and support them?
4. What could have made Aldona feel more relaxed and comfortable at the service?
5. Do you have residents in your service kept against their will? Why can't they leave? Are all of the processes in place to assess and support them? Are you confident your service is acting legally in restricting anyone from having free access to their environment?

Case study 5:
Resident under Public Guardianship removed by daughter from aged care home

Incident description

78-year-old Guan recently entered the residential aged care service on a decision of the Public Guardian. He lives with severe dementia and is unable to care for himself. Staff found his room empty and his bed made. Staff attempted to contact Guan's daughter, Fiona, several times but she did not answer.

CCTV footage showed Fiona taking Guan from the service the night before. The police were contacted and found Guan at Fiona's home. There was a confrontation as Fiona insisted that Guan stay with her. Guan was eventually brought back to the service but it was noted that he was confused and distressed. The provider reported the incident as low impact with 'minor physical injury or discomfort' which resolved without needing medical attention.

Commission action

We asked for more information to assess the risks to Guan and other residents and the provider's ability to manage those risks. We found that the provider's assessment of the incident as having low impact was incorrect.

The provider's SIRS notification history showed several notifications for other residents where the service did not use available information to inform care needs or manage known risks.

Given the seriousness of the incident and the provider's history, the Commission initiated an investigation.

Background and insights

Guan entered the service on the decision of the Public Guardian, due to neglect at home where he was living with his daughter Fiona. She had objected to the decision. Guan also resisted the move, resulting in a traumatic transition to the service. Guan's admission forms stated that his other children were supportive of his move to the service but were in ongoing conflict with Fiona about this.

Guan's interim care plan did not list the Public Guardian, his legally appointed decision maker, as a contact. It also did not highlight that the Public Guardian had asked for staff to supervise Fiona's visits with Guan.

Case study 5

Fiona's visit on the night of the incident was unsupervised and the agency staff on duty did not know the history as they had different levels of access to residents' records. Staff saw Guan and Fiona leave the service, did not question this, and no handover was done at the end of their shift. Staff did not discover Guan's absence until an hour into the morning shift.

When Guan was returned to the service, he was agitated for several days and had to be encouraged to eat.

The provider's previous incidents demonstrated consistent delays in assessment and implementing or updating behaviour support plans. The provider also relied significantly on CCTV to know where residents were and their movements around the service instead of personal checking of their wellbeing.

Guided questions
Case study 5

1. What policies are in place at your service for residents who are under the Public Guardian or who have other substitute decision making needs? What staff training is available? Who documents which people need to be contacted about a resident? What is that person's knowledge of the legal and social complexities that might come up?
2. What procedures does your service have to make sure that residents are safe when visitors attend the service? Do you have procedures that can help identify visitors who may need to be supervised?
3. How do you induct or hand over to agency or new staff, who are unfamiliar with residents, the need to attend to risks associated with a resident wanting to leave?
4. How do you support continuity of person-centred care where you have a high number of temporary staff?
5. After Guan was separated again from his old home and his daughter and brought back to the service, how would you assess his level of distress and what could you do to make sure he is psychologically safe?
6. At your service, would a person being agitated in this way be considered for chemical sedation and restraint? How does your service make these decisions? Which staff members have the knowledge and skills to develop person-centred behaviour support plans and identify, assess, monitor and minimise the use of restrictive practices?

Unexplained absences: key take-aways

- Around 91% of residents who are absent without explanation have some form of cognitive impairment, ranging from mild to severe (Table 4). However, the rates of severe cognitive impairment (26%) are lower than seen in other incident types, and rates of mild cognitive impairment are higher (20%). A one-size-fits-all strategy to keep residents safe is unlikely to be effective.
- People with no or mild cognitive impairment may not be at risk of harm if they leave a service to go into the community. Some people are very familiar with the local community and environment or have retained road and danger awareness skills. As always, great care should be taken to comply with and document required processes before interfering with a person's rights. A supported decision making approach should be taken where there are concerns about risk of serious harm to the person.
- Many residents who go missing from services have made several prior attempts to leave. Failure to manage that risk can lead to a successful attempt and the possibility of serious harm.
- Around 40% of notifications of unexplained absence involve a resident who has been reported in a previous SIRS notification. Even if the previous notification is for a different type of incident, it is a sign that the person may need more support or that the provider needs external help. Repeat incidents show that the response to the first incident may not have been sufficient or effective. Providers should consider repeat incidents involving the same resident as part of their regular review approach.
- Many residents who go missing have been showing signs of distress before they leave. Responding to this distress in an appropriate and empathetic way as well as understanding why a resident wants to leave are important ways to minimise risk.
- A serious incident is one that caused, or could reasonably have caused, a person physical or psychological injury. In some cases of unexplained absence, a resident does not experience harm as they are found with family or carers. However, where the provider did not know that the resident was absent, the Commission would consider that the resident and other residents could have been at risk of harm.
- Managing risk means the provider needs to manage and be aware of environmental risks such as services close to busy roads, bushland or waterways.
- The risk of a resident leaving without explanation is highest in the first month they are at the service. This is a time of upheaval and unfamiliarity for people, and an individual care plan may not yet be in place. Providers must think about supporting new residents, implementing care plans and managing risks earlier.

Unexplained absences: key take-aways

- Residents in care against their will e.g., under the authority of the Public Guardian (or equivalent), or where family members are in conflict about care arrangements, may be particularly vulnerable.
- Services should predict possible incidents by understanding risks and introducing preventive and proactive behaviour support. This should be part of their incident management arrangements with clear governance processes.
- For residents living with dementia, being unable to remember the incident or explain their feelings should not be taken to mean that there was no impact.
- Assessing the impact of an incident should not just be about immediate physical injuries. Physical impact can be delayed or hidden and can include:
  - hyper or hypothermia
  - dehydration and sunburn
  - missed medication
  - injury from activity that a person is not used to, such as if walking long distances or on uneven terrain – joint and muscle soreness, blisters, unattended continence needs.
- Psychological impact always needs to be considered and may not be obvious. It can include:
  - psychological abuse and exploitation in the community
  - fear and anxiety
  - feelings of abandonment and helplessness
  - confusion if in an unfamiliar environment
  - frustration at being found
  - distress at being returned to the service
  - distress and fear associated with police involvement.
- There are connections between unexplained absence and restrictive practices. If addressing a risk of harm to a resident includes use of a restrictive practice such as preventing exit from the service, then services must give early attention to assessment, documentation, behaviour support and meeting legislative requirements.
- Providers must give careful thought to how securing services to protect vulnerable residents may impact on the freedom of other residents. In addition, consideration should be given to how it may affect processes for evacuation in the case of an emergency.
- Providers should take care to identify the correct incident type for reporting. This may not always be clear if more than one category applies. However, the incident type you select does not impact how the Commission investigates the incident.
- If a resident poses serious ongoing risks to themselves or others, urgent intervention (including accessing expert advice) should happen. Distressed residents need help – which may involve their referral to an external expert.

Questions for boards and governing bodies to ask when investigating an incident

Providers have a responsibility under the Quality of Care Principles to manage incidents. This includes assessing:

- all the things that could have contributed to the incident
- how they could have prevented the incident
- what actions could they take to improve how they prevent, manage and resolve similar incidents.

As explained in the Quality Standards, providers must use an open disclosure process when things go wrong. This means that providers must have an open discussion with people receiving aged care and their representatives when something goes wrong. This is particularly the case if the incident has harmed or could have caused harm to a person in aged care. Providers need to use open disclosure as part of how they respond to any incidents impacting people in aged care, whether or not they are SIRS reportable incidents.

More information to support boards and individual board members in responding to and preventing incidents can be found at 'Governing for Reform' on the Commission's website.

What works for you?

If you have some examples of how you have effectively managed similar scenarios, please email us on SIRSinsights@agedcarequality.gov.au

Questions to ask include:

- How do we foster an open culture that ensures staff are encouraged and supported to report incidents and near misses?
- What evidence do we have that all staff feel comfortable reporting incidents and understand their mandatory reporting responsibilities?
- Do we regularly receive data from our incident management system that helps us to identify trends, issues and areas where we need to improve, including strategic improvements?
- Are we confident that our service is meeting incident reporting requirements and using open disclosure and frank discussions with the resident/s affected by each incident? Who is responsible for this?
- Are we practising truly person-centred care which addresses why some residents want to leave the service and how to support them?
- Do our responses to an incident support the rights of people in aged care and the principles of dignity and choice?
- When serious incidents are reported to us, does it show evidence that the incident was investigated thoroughly, including consideration of:
  - causes, trends, and implications for others beyond the affected people
  - prevention strategies, including improving person-centred care.

Useful resources

The following resources can help support providers to meet their requirements under the SIRS to manage and take action to stop serious incidents from happening:

1. SIRS reportable incidents – Unexplained absences
2. Effective serious incident investigations guidance for providers
3. Perimeter restraint self-assessment tool
4. Effective incident management systems
5. Introduction to SIRS
6. SIRS guidelines for aged care providers
7. Creating behaviour support plans
8. Dementia Australia
9. The decision support tool
10. The 'your role in SIRS' online guide
11. Open disclosure in aged care
12. Code of Conduct for Aged Care
13. Minimising the use of restrictive practices.

1 https://www.agedcarequality.gov.au/resources/sirs-reportable-incidents-unexplained-absence-care
2 https://www.agedcarequality.gov.au/resources/effective-serious-incident-investigations-guidance-providers
3 https://www.agedcarequality.gov.au/sites/default/files/media/Perimeter Restraint Scenarios.pdf
4 https://www.agedcarequality.gov.au/resources/effective-incident-management-systems-best-practice-guidance
5 https://www.agedcarequality.gov.au/sirs/introduction-sirs
6 http://www.agedcarequality.gov.au/resources/serious-incident-response-scheme-guidelines-residential-aged-care-providers-0
7 http://www.agedcarequality.gov.au/news-centre/clinical-alerts/behaviour-support-plans
8 http://www.dementia.org.au/
9 https://www.agedcarequality.gov.au/sirs/decision-support-tool
10 https://www.agedcarequality.gov.au/sirs/welcome-your-role-sirs
11 https://www.agedcarequality.gov.au/resources/open-disclosure#%3A~%3Atext%3DOpen%20disclosure%20is%20the%20%20open%2Cperson%20receiving%20aged%20care%20service
12 https://www.agedcarequality.gov.au/providers/code-conduct-aged-care-information-workers
13 https://www.agedcarequality.gov.au/consumers/minimising-restrictive-practices

Appendix A

The following tables show key data and information collected through the SIRS reporting and notifications.

Table 1: SIRS Priority 1, Priority 2 and total notifications in residential aged care by incident type 1 April 2022–31 March 2023

	Priority 1		Priority 2			
Reportable incident type	**Number**	**% of notifications**	**Number**	**% of notifications**	**Total**	**% of all notifications**
Unreasonable use of force	8,673	51%	20,217	68%	28,890	62%
Neglect	2,841	17%	4,758	16%	7,599	16%
Psychological or emotional abuse	655	4%	3,363	11%	4,018	9%
Unlawful sexual contact or inappropriate sexual conduct*	1,813	11%	444	1%	2,257	5%
Unexplained absence from care^	1,597	9%	116	<1%	1,713	4%
Unexpected death^	855	5%	16	<1%	871	2%
Stealing or financial coercion	495	3%	313	1%	808	2%
Inappropriate use of restrictive practices	107	1%	582	2%	689	1%
Total	**17,036**	**100%**	**29,809**	**100%**	**46,845**	**100%**

Note: Not included in this table are 638 notifications that either were not classified as Priority 1 (P1) or Priority 2 (P2) when we extracted the data or that we have assessed as out of scope for SIRS. These include:

- 163 P1 notifications.
- 184 P2 notifications
- 291 notifications that have no P1 or P2 classification.

* On 3 October 2022, the legislation changed to make notifications of this type a P1, similar to notifications of unexplained absence and unexpected death.

^ Under the SIRS legislation, notifications of this type are P1 notifications. Where notifications of this type are reported as P2, the provider selected P2 in the My Aged Care form when they submitted the notification.

Source: Notification data as of 31 March 2023, extracted 3 April 2023. Data may change if reproduced in future.

Priority 1 reportable incidents are incidents:

- that have caused, or could reasonably have caused, a person receiving aged care physical or psychological injury or discomfort that needed medical or psychological treatment
- where it is reasonable to contact the police (this includes all incidents involving alleged, suspected or witnessed sexual assault)
- where there is the unexpected death of a person in aged care or their unexplained absence from the service.

Priority 2 reportable incidents are incidents:

- that do not meet the criteria for a Priority 1 reportable incident. Providers must notify the Commission within 30 days of becoming aware of the incident.

The Commission reviews all incident notifications within 24 hours of receipt and will take appropriate and proportionate action as required.

Appendix A

Table 2: Percentage of total SIRS notifications by reported physical impact 1 April 2022–31 March 2023

Reportable incident type	No impact	Minor impact	Needed onsite treatment	Needed hospitalisation (not permanent)	Permanent impairment	Severe permanent impairment or death	Blank^
Unreasonable use of force	62%	30%	6%	2%	<1%	<1%	<1%
Neglect	45%	20%	18%	17%	1%	1%	<1%
Psychological or emotional abuse	94%	5%	1%	<1%	<1%	<1%	<1%
Unlawful sexual contact or inappropriate sexual conduct	94%	5%	<1%	<1%	0%	0%	<1%
Unexplained absence from care	82%	9%	2%	6%	<1%	<1%	<1%
Inappropriate use of restrictive practices	90%	7%	1%	1%	1%	<1%	<1%

^ Blank shows that no impact information was included in the notification.

Source: Notification data as of 31 March 2023, extracted 3 April 2023. Data may change if reproduced in future.

Table 3: Percentage of total SIRS notifications by reported psychological impact 1 April 2022–31 March 2023

Reportable incident type	No impact	Minor impact	Needed onsite treatment	Needed hospitalisation (not permanent)	Permanent impairment	Severe permanent impairment or death	Blank^
Unreasonable use of force	52%	46%	2%	<1%	<1%	<1%	<1%
Neglect	65%	30%	2%	2%	<1%	<1%	<1%
Psychological or emotional abuse	22%	72%	6%	<1%	<1%	<1%	<1%
Unlawful sexual contact or inappropriate sexual conduct	51%	44%	4%	<1%	<1%	0%	<1%
Unexplained absence from care	73%	22%	2%	3%	<1%	<1%	<1%
Inappropriate use of restrictive practices	79%	19%	2%	<1%	<1%	<1%	<1%

^ Blank shows that no impact information was included in the notification.

Source: Notification data as of 31 March 2023, extracted 3 April 2023. Data may change if reproduced in future.

Appendix A

Table 4: Percentage of total SIRS notifications by reported level of cognitive impairment of the person involved 1 April 2022–March 2023

	Reported Level of cognitive impairment of the person involved					
Incident Type	**Severe**	**Moderate**	**Mild**	**None**	**Unknown**	**Blank^**
Unreasonable use of force	53%	30%	10%	6%	1%	<1%
Neglect	27%	30%	22%	20%	1%	0%
Psychological or emotional abuse	22%	28%	24%	23%	2%	0%
Unlawful sexual contact or inappropriate sexual conduct	45%	31%	13%	9%	1%	<1%
Unexplained absence from care	26%	45%	20%	6%	3%	<1%
Unexpected death	24%	30%	25%	19%	2%	<1%
Inappropriate restrictive practices	55%	29%	10%	5%	<1%	0%
Stealing or financial coercion	12%	25%	33%	28%	2%	<1%
Total	**44%**	**30%**	**14%**	**11%**	**1%**	**<1%**

^ Blank shows that no cognitive impairment information was included in the notification.

Source: Notification data as of 31 March 2023, extracted 3 April 2023. Data may change if reproduced in future.

Table 5: Unexplained absence notifications where the person involved has been named in a past SIRS notification 1 April 2022–March 2023*

Reportable incident type	Total number of incidents of this type	Incidents where person was named in a past incident	Percentage %
Unexplained absence from care	1,713	704	41%

* These figures report providers responses to the question on the My Aged Care notification form, 'Has the affected care recipient been named or described in any incident previously?' The past incident can be a different incident type.

Source: Notification data as of 31 March 2023, extracted 3 April 2023. Data may change if reproduced in future.

Note: This data is a checkbox ticked or left blank by the provider on submission of the notification.

Appendix A

Table 6: Unexplained absences from a secure or not secure wing 1 April 2022–31 March 2023

Reportable incident type	From a secure wing	Not from a secure wing	Blank^	Total
Unexplained absence from care	404	1,270	127	1,801
Proportion	**24%**	**76%**	**–**	**–**

^ Blank shows that no information related to secure wing was included in the notification.

Source: Notification data as of 31 March 2023, extracted 3 April 2023. Data may change if reproduced in future.

Table 7: Reported location where missing resident was found 1 April 2022–31 March 2023

Location found	% of total incidents
At the service	10.6%
Family home	7.7%
Hospital	4.4%
Other	77.3%

Please note: the percentages in the above table are based on 1,677 unexplained absence notifications where the location found field was filled in. We have excluded the 36 notifications with a blank 'location found' field.

Source: Notification data as of 31 March 2023, extracted 3 April 2023. Data may change if reproduced in future.

The Aged Care Quality and Safety Commission acknowledges the Traditional Owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

November 2023

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