Reporting Missing Residents

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HCA Healthcare Australia

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Reporting Missing Residents

Staff responsibility

HCA employees working at residential aged care facilities, have an obligation to ensure residents at risk of wandering and going missing are appropriately identified and managed to minimise their risk of harm.

Reflect on how a client could wander and go missing from the aged care facilities at which you have worked.

Legislation

The Aged Care Act 1997

Purpose of Part (Acts 63-1 and 63-1B)

The purpose of this part is to specify: for paragraph 63-1 (1) (m) of the Act, the responsibility of an approved provider to give notification of an unexplained absence of a care recipient in certain circumstances.

Notification of unexplained absences of care recipients to be given to the Minister or Secretary

(1) This section applies to Approved Providers of residential care services.

(2) An Approved Provider must tell the Secretary if:

(a) a care recipient is absent from a residential care service; and

(b) the absence is unexplained; and

(c) the absence has been reported to the police.

(3) The Secretary must be told about the absence as soon as reasonably practicable, and in any case, within **24 hours** after the provider reports the absence to the police.

Who is at risk of going missing?

Residents at risk of wandering are:

- Individuals using respite accommodation
- New residents at the facility
- Residents who have a history of wandering prior to admission.
- Residents who have wandered from or attempted to wander from the facility.
- Residents who for any other reason are deemed to be clients are at risk of wandering.

Reducing the risk

- Doors with Keypads
- Secure and adequate fencing
- **30 minute checks on residents**
- Adequate and secure gates
- Provision of the facility's business cards to be kept in a resident's handbag and/or wallet
- Appropriate Therapy/Lifestyle programs to occupy residents' time
- Ensuring residents have access to shopping or have access to items they might require
- Discussion with families
- Walking groups
- Door alarms
- Sensor alarm mats
- Identity Bracelets,
- Movement alarms

Documentation used by a provider

On admission, if a resident has been identified at risk, the provider will maintain records to demonstrate appropriate care for that resident:

- 'Resident at Risk of Going Missing' Identification Form
- Client Safety Evaluation Chart, including Management Plan.
- Record of client clothing each day using a Daily Safety Observational Check Chart
- The provider must evaluate identified problems and implement necessary management strategies.
- Following the identified problems and development of strategies, this information is then conveyed in the care plan/social leisure plan.
- All clients at risk of wandering and going missing should receive observational checks every 30 minutes.

When a resident is missing

By law, staff at the facility including HCA staff must take specific action when a resident has been reported missing. Residential Aged Care facilities will have a Pathway or Procedure in place that will include all steps to be taken.
Clinical Pathways or Procedures for missing residents will often have very similar features to the one below.

Resident Noticed Missing

Conduct quick search of facility and grounds, including, but not limited to:

- All rooms/adjoining rooms
- Cupboards
- Toilets
- Under beds
- Gardens
- Storage areas
- Laundry area
- Activity area
- Recreational area
- Review visitors log

Has Resident been located within 30 minutes?

NO

- Notify Next of Kin.
- Notify Manager.
- Coordinate detailed search of facility, surrounding streets.
- Review patient files for clinical and behavioural information to assist in location.
- Report matter to Police
- Notify Department of Social Services on 1800 550 552.

Essential steps to be followed in the instance of a Resident noticed missing

- Notify the person in charge of the area, and the manager of the facility
- Conduct a thorough search of the facility
- Notify relatives
- If the resident is not located within **20 to 30 minutes** the Police must be notified and a description of the client using a 'Resident at Risk of Going Missing' Identification Form must be provided to them.
- If Police are notified the Manager must also notify The Department of Social Services as soon as practicable and within 24 hours of the Police being notified.

When a resident returns to the facility

Staff must:

- Notify Person in Charge and Manager
- Notify the Next of Kin
- Notify the police as applicable to the situation
- Examine client for general condition and injuries
- Notify Medical Practitioner or ring an ambulance
- Ensure Incident Report has been completed.
- The Manager must also notify the Department of Social Services as soon as practicable (DSS funded services)

Following the Incident

Staff are obliged to:

- Review the client Management Plan
- Complete Safety Evaluation with appropriate strategies
- Review Safety Evaluation daily for 7 days or until effective management plan is identified, or make changes as required.
- Arrange a Resident/Family conference.
- Return to ongoing management

Reflection

Do you have eyes in the back of your head?

Case Précis Author: Prof JE Ibrahim, Monash University

Clinical Summary

Mr C, a 71 year old male, was transferred from an acute hospital to a metropolitan Residential Aged Care Service (RACS) for secure high level care. Past medical history included Alzheimer's dementia with a tendency to wander, non-insulin dependent diabetes mellitus, depression and schizophrenia. Within a few days of admission, Mr C had absconded out of the RACS on two separate occasions and had been found climbing a fence. To manage the risk of wandering staff were asked to check on Mr C at intervals of 15 minutes. About a week later, just before the security alarm system was routinely activated, night shift staff saw Mr C standing outside his room. Some hours later Mr C was found with his neck wedged into the wooden slats of a picket gate adjacent to an external wall of the RACS. An ambulance was called but Mr C was dead.

Pathology

The cause of death was positional asphyxia.

Investigation

The coroner directed that further investigation was required and held an Inquest to find out how Mr C came to be in that situation. Statements were received from the relevant staff in ACAS, acute hospital, the RACS and the general practitioner. The information available and the assessment completed by the RACS had identified Mr C's tendency to wander; the risk of going missing and the need for supervision in a secured environment. This was also evident from ACAS who had assessed Mr C as requiring high-level care, and noted his potential to wander and the need for secure accommodation. Also there was information from the acute hospital that admitted Mr C from his own home because of escalating agitation and had kept Mr C under constant observation by a 'special' (i.e., a one-to one carer). The RACS staff felt confident that their facility was secure and Mr C would not be able to escape.

However, the investigation revealed that two of the doors, one leading to the laundry and the other to the garden, could be opened from inside the facility by using an internal latch. Mr C's room was adjacent to the garden door. The investigation also discovered that all the external doors were not connected to the security alarm system, in particular the laundry door (this had been disconnected). Finally the system was usually armed late at night, typically after 11pm.

Coroner's Comments and Findings

The coroner commented that the RACS staff had abundant evidence that Mr C was at risk of wandering and going missing and the securing of the premises was inadequate. Also, that staff operated under the incorrect assumption that the premises were secure, and so checking was not crucial. Additionally, the request to staff that Mr C be observed every 15 minutes was not practical and there were no clear policies in relation to the checking of residents. The coroner concluded that Mr C's death was avoidable and it was *"inappropriate for an aged care facility to rely on the security of the premises alone and there should be a regular check made of the residents to ensure their wellbeing and safety".* These are some of the changes the RACS made following Mr C's death: improved building security (e.g., installation of coded keypads and sliding door locks); earlier activation of the alarm system and installation of a swimming pool type gate with rounded surfaces. Staff roles for security were delineated and documentation improved to better record the sighting of residents.

Coroner's Recommendation

The Coroner made one recommendation that:
"The Commonwealth Department of Health and Ageing and the Aged Care Standards and Accreditation Agency conduct a thorough review of the facilities, practices and policies".

Conclusion

Employees working within residential aged care have a responsibility to identify the risk of a potentially missing resident, and follow the organisational documentation path as outlined.

As a healthcare worker it is essential to monitor the care and activities of residents.

Congratulations

You have completed the reading for this part of the course.

You should now complete the multi-choice assessment quiz to successfully complete the **Reporting Missing Residents** course online

Advisory Panel (June 2015)

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Content correct as at June 2015.

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Images

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