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Editorial

Welcome to 2023. We launch our first issue for the year with high hopes and optimism that we will overcome any challenges we may face. Over the past three years most of our time and resources have been consumed by the pandemic — this year we will endeavour to escape from those constraints and expand our efforts more broadly. This issue presents the case of a resident who literally escaped from a residential aged care home and sadly was never found.

The term 'escape' is usually associated with adventure and excitement. Recall the 1963 classic film with Steve McQueen in 'The Great Escape' which now celebrates its 60th year since its release. More contemporary experiences involve attending an 'escape room' where finding clues and solving puzzles within a time limit is considered a fun way to celebrate special occasions. A more sinister interpretation refers to absconding, that is, situations where a person flees from custody or prison.

Neither of these situations accurately describes our case of what happened when a male resident set off to return home to his loved ones. The underlying factors that created the circumstances for such an occurrence to happen are commonplace and often seemingly trivial. An interesting aspect of the case is that the movement of the resident was described as 'wandering' which was inaccurate, misleading, and almost certainly contributed to care staff underestimating the risk of him leaving the facility. A description that acknowledged his behaviour was repeated and purposefully focussed on returning home would have been a more accurate alert.

Our expert commentary is provided by Dr Marta Woolford who completed her PhD on the subject of unexplained absences in residential aged care. Her academic qualifications along with her experiences of working in aged care provide profound insights into the subject. We also have a commentary from our faculty of senior nurses about the case and lessons to be learned for practice. The list of resources provides further detail for who those who want to explore the topic more deeply.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at:
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Communiqué Podcasts & Webinars

A podcast version of this edition will be available later this year. While waiting for that release, remember, our extensive podcast catalogue of previous editions for the Residential Aged Care Communiqué, along with our sister publications, the Clinical Communiqué and Future Leaders Communiqué is available and free to download through our website or via Spotify, Apple, and Stitcher.

Also, take the time to listen to the two podcast episodes developed, written, narrated, and directed by medical students across Australia, drawing on content previously developed by junior doctors. Titled, *Medical Student Communiqué Podcasts*, the two episodes examine specific issues of patient safety - the role of protocols, and communication between junior and senior staff.

The three webinars from our 2022 Spring Series are now available. Each of the episodes covers a different ethical dilemma in aged care with expert opinions and are approximately 60 minutes in duration. Episode #1: 'Go away and leave me alone!' explores what to do when a resident with dementia refuses to eat, Episode #2: 'But the resident didn't want to go to ED' explores who decides when an unwell resident with dementia should go to the emergency department and Episode #3: 'Let me eat what I want!' explores how to approach a resident with dementia who may choke when eating what they want.

Case
Cold, wet, in the dark, and alone

Case Number: 2017/23809 NSW
Case Précis Author
Dr Chelsea Baird
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i. Clinical Summary

Mr S was a 76-year-old socially active and physically strong man with a three-year history of dementia and myelodysplastic syndrome. Further investigation of the myelodysplastic syndrome required Mr S to undergo the procedure of a bone marrow biopsy under local anaesthetic. Directly following this procedure Mr S's wife noticed a change in his mental state, characterised by an increase in paranoia and fearfulness.

Four days after his procedure, Mr S was admitted to an acute care hospital where he remained for two weeks. As an inpatient, Mr S remained unsettled with episodes of 'wandering corridors', 'threatening to walk home' and 'wanting to find the way out of here'. On one occasion after his wife left the hospital following a visit, Mr S became very upset. He told staff that he was going to make his own way home and that they should leave him alone. Mr S walked out of the hospital. He was quickly located by security staff who found him walking in the middle of the road a few hundred metres from the hospital.

The security staff restrained Mr S in order to protect him from an approaching car which had stopped to avoid colliding with him. Mr S resisted the security staff whilst being returned to hospital but settled quickly once he returned to the inpatient ward.

It was determined that Mr S be discharged from hospital for a period of respite to an aged care facility with expertise in dementia care.

Mr S was transferred to a local residential aged care facility and accommodated in the secure wing of the service. On the day of transfer, verbal handover from the hospital staff was provided to the patient transport staff who escorted Mr S to the aged care facility. They arrived in the late afternoon and were met by the care manager who was provided with an envelope containing transfer documents from the hospital. The aged care facility progress notes entered into the computer did not indicate any concerns about Mr S absconding.

As expected with a change in environment, Mr S was generally unsettled in the aged care facility. He was restless overnight, walking around the inside of the building and seeking the exit doors, and telling staff he was waiting for a lift home. On the second night, Mr S was awake most of the night, sitting in the foyer area with a plastic bag waiting to go home — this information was recorded on a sleep chart.

"Later that same day, afternoon staff found Mr S kicking at a rear door and using a piece of dowel to attempt to prise the door open, stating 'I'm trying to get out of this place'."

On the morning of his fourth day at the facility, the recreational staff observed that he was agitated, repeatedly requesting that the police be called. Whilst staff were making Mr S a cup of tea, an occupational therapy student on placement witnessed him enter a secure courtyard and attempt to climb the gate. He was partly over the gate when staff called out and Mr S returned inside to have a cup of tea. The incident was reported to the team leader.

Later that same day, afternoon staff found Mr S kicking at a rear door and using a piece of dowel to attempt to prise the door open, stating "I'm trying to get out of this place". The piece of dowel broke, and Mr S threw it to the ground. The aged care facility staff perceived this as an aggressive gesture and contacted the care manager.

Staff attempted to redirect Mr S by offering a cup of tea and taking him into the same courtyard where he had earlier climbed the gate.

In the courtyard, Mr S remained agitated, pacing back and forth alongside the fence and staff were not able to redirect him to return inside. Once again Mr S scaled the gate, kicking out at the staff member who tried to grab his legs. Mr S jumped to the other side and walked away from the courtyard across the facility property. A nurse quickly caught up with Mr S via a rear door, however, did not make any physical contact due to concerns about his recent aggression.

Mr S continued to move across the property and saw a ladder leaning against the wall of a nearby independent living unit and moved it to the 1.85m perimeter fence. He climbed the ladder, jumped over the fence, and walked away quickly towards a nearby highway. The nurse was unable to follow him and returned inside to alert the care manager.

Staff immediately notified Mr S's wife and began a search. Using a car, the staff drove along the highway then onto Mr S's house. When they were unable to locate him, the facility manager then notified local police.

Police coordinated a search of the area using volunteers from local search and emergency services. The weather at the time was cold with rain, and sunset was imminent.

The search was called off later that evening due to adverse weather conditions. Mr S's wife had also searched for him along the highway by car.

Over the next few days, the police received reports from a number of members of the public, reporting seeing an older man run across the road and then head north along the highway. Coordinated land and aerial searches took place, as well as a media campaign and canvassing of local hospitals, bus companies, friends, and family of Mr S.

Unfortunately, these subsequent searches did not uncover any further information about Mr S or his whereabouts.

ii. Pathology

An autopsy was not possible as Mr S's body was not recovered.

The coronial inquest determined the cause of death as hypothermia secondary to becoming lost in surrounding bushlands after scaling the fence at the RACS in order to be with his wife.

iii. Investigation

An inquest was required as there was not sufficient disclosure that Mr S had died. There was a seven-volume brief of evidence and witnesses included staff from the aged care facility, police and two experts. Court room evidence was taken over four days.

A major focus of the inquest was evaluating the extent of search and rescue efforts. Weather and nightfall hampered efforts to look for Mr S on the evening of his disappearance.

The search and rescue expert explained that night-time foot searches on land are dangerous, and a possible option was to use a vehicle moving slowly up the tracks.

Police initially felt that Mr S had likely entered bushland and succumbed to the elements within a 3km radius of the aged care facility. The following day, the search area was extended to a 20km radius of the aged care facility when it was recognised that despite living with dementia, Mr S was quite physically fit. No signs of Mr S were found and after two days the search was suspended.

The survivalist expert considered that Mr S most probably died within 48 hours due to exposure. This was due to combination of factors including (i) Mr S's underlying conditions of dementia and deafness, (ii) fatigue due to the walking, (iii) dehydration due to lack of fluids, (iv) being dressed in light non-waterproof clothing which would have been wet and cold, and (v) it was the middle of winter.

The aged care facility conducted their own review. This identified numerous deficiencies relating to their admission and handover processes, documentation and communication with families, and staff training to identify those at risk of absconding. The coroner found that because of these pre-existing deficiencies, the risk of Mr S absconding was not recognised. Nor were there processes in place to escalate concerns about Mr S leaving the facility.

Key information was not documented or relayed in a handover. This included details of the episode whereby Mr S had left the hospital, which was provided by the patient transport staff in a verbal handover to the aged care facility. The patient transport staff also informed the care manager about Mr S's risk of absconding and his behaviour of repeatedly asking them to take him home and, pointing in the direction of his house. The coroner was critical of the aged care facility's admission processes, noting that the care manager had verbally identified behaviours of concern during their meetings with Mr S's wife but had not included any mention of these in his care plan.

Another gap was that the care manager did not read the contents of the written handover contained in the envelope as it was the duty of the registered nurse (RN) on shift to read the transfer documents in order to complete the admission process. As a consequence, this information was not contained in Mr S's care plan.

The facility did not have a behaviour management plan in place for Mr S despite the widespread knowledge of his behaviours. In particular, there was no risk assessment undertaken that identified the very high risk of Mr S absconding. Handover processes were also found to be grossly deficient, with staff working on that afternoon shift unaware of Mr S's attempt to climb over the gate earlier that day.

Finally, the lack of appreciation by staff of the risks more generally, and the fallacy that the fence and gate surrounding the courtyard of the secure wing could not be breached, was based on an assumption that residents were too frail to do so.

iv. Coroner's Finding

The coroner made four recommendations including that the use of rescue and cadaver dogs be extended and greater liaison between interstate policing resources be considered. The coroner also recommended that all land search operations should be maintained for three days after the calculated maximum survival period for missing persons.

The aged care facility gave evidence of multiple changes to improve and address the recognised gaps in care. These included: a policy that the facility's RN meet the resident in hospital or receive a phone handover from hospital nursing staff prior to admission; improved handover procedures and pre-admission risk assessments; increased staffing at busier times; and a process for multidisciplinary, resident and carer meetings within 21 days of admission to review the resident's needs.

v. Author's Comments

Care transitions across settings are everyday occurrences in our aged care and health care system. We rarely give these processes a second thought as these are a routine part of our workdays.

> **"Pre-existing cognitive impairment increases the person's vulnerability to becoming more confused or disorientated."**

Contrast this perspective with that of our residents, patients, and families, for whom these care transitions are significant events and often represent a new life stage. Whether it be from home - to the acute care hospital - to the nursing home setting, patient transfers set into motion a series of processes which we take for granted. Along with the physical movement of the person from one location to another, there is a need for transfer and integration of complex information from multiple sources that impact on management decisions and plans for ongoing care.

At a clinician level, the arrival of a person signifies that there is a new resident whose needs must be met and where a number of rigorous internal procedures must follow, in addition to performing our daily tasks.

Transitions are periods of high risk. Transitions involving older people or residents with cognitive impairment are particularly high risk. Pre-existing cognitive impairment increases the person's vulnerability to becoming more confused or disorientated. The person may not be able to provide any corroborating information. The transition is universally recognised as challenging and unsettling for people with dementia.

It is also a difficult time for families and carers, for whom the decision to move a loved one into permanent care may evoke many emotions.

Research has primarily focussed on the risks of medication errors in transition to long term care. More research is needed about the emotional and psychological disruptions for residents with cognitive impairment, and how best to prepare them for the change in living arrangements. A large Australian cohort study of older people entering residential aged care found that 18% had an unplanned hospitalisation within 90 days, and 22% had an emergency department presentation (Inacio et al., 2021).

Male gender, complex health care conditions, a history of delirium, lower functional status and higher behavioural needs were risk factors for hospital admission, with 22% of admissions for injuries, poisoning and other external causes.

This case exemplifies the importance of diligent planning prior to transfer between health and aged care settings. Risk assessment must be prospective, and based on accurate, current information. Valuable sources of information include families and carers, nursing and medical staff, psychologists, neuropsychologists, and other allied health professionals.

Everybody has a role in preventing adverse events and identifying practical solutions. Care providers must communicate with each other.

Community supports must be timely and responsive. Health care organisations, such as hospitals, must balance their desire for rapid patient flow or throughput with the need for staff to have the time and resources to complete a timely, comprehensive transition.

More widely, there is a need for integrated systems, to facilitate the flow of accurate information, avoid duplication of workload and prevent errors. Families and carers are valuable resources, and their advocacy should be welcomed. Preparing for and anticipating risk will help reduce the dangers associated with care transitions.

vi. References

Inacio MC, Jorissen RN, Wesselingh S, Sluggett JK, Whitehead C, Maddison J, Forward J, Bourke A, Harvey G, Crotty M. Predictors of hospitalisations and emergency department presentations shortly after entering a residential aged care facility in Australia: a retrospective cohort study. BMJ Open 2021;11:e057247. doi:10.1136/bmjopen-2021-057247

vii. Keywords

Unexplained absences, care transitions, abscond, dementia, handover

Preventing unexplained absences: recommendations for managing unexplained absences among residential aged care residents

Dr Marta Woolford PhD
Research Fellow, Monash Health

'Unexplained absence' describes an event in which a residential aged care resident leaves the facility without informing caregivers and their whereabouts are unknown. Often referred to as 'absconding', 'wandering', and 'elopement', unexplained absences are reported to occur in approximately 11% to 31% of residential aged care residents.

For the care provider, unexplained absences are a complex and challenging event to manage. The event is most commonly seen in persons with cognitive impairment, in particular dementia. Once outside the facility, residents may become lost and disorientated and enter unsafe areas and be harmed. Hence, strategies that focus on limiting opportunities for residents to leave the facility may seem appropriate. However, focusing on limiting the level of activity and movement of residents with the use of physical and pharmaceutical restraints worsens physical function and impacts the well-being and quality of life of residents. The management of unexplained absences must consider and support residents' rights to their freedom of movement and autonomy.

For this reason, the recommendations for managing unexplained absences presented in this commentary extend beyond focusing solely on the event and rather focus on broader organisational practice and processes.

Standardised transition

The first recommendation for practice is for every residential aged care facility to have in place a well-managed and standardised transition process that is built into organisation-wide processes; commencing before admission day.

The transition of an older person from the community setting into residential aged care is a complex event that comprises multiple interactions, processes, information, and internal and external stakeholders (e.g., the older person, their family, aged care staff, hospitals, and governments). Every stakeholder has varying and numerous needs, responsibilities, and obligations. On the day of admission, residents and families often arrive worried and anxious, and staff are expected to continue to provide care to existing residents with multiple health and care needs. Overall, the setting is dynamic, and unpredictable with multiple permanent and agency staff changes throughout the day.

How well the transition process is managed can impact residents' safety, clinical care, well-being, and the extent to which they adjust to living in an aged care home. A standardised approach would ideally prompt actions, delegate responsibilities, define stakeholders, and outline key documentation and information to collect, complete and share at each point of the transition. This includes processes and responsibilities of direct and non-direct care staff at the (1) pre-admission; (2) admission day; and (3) post-admission stages.

A standardised approach must explicitly guide staff on the collection of critical information, such as behaviours of concern, unmet needs, and health concerns, as well as opportunities to address these, at each stage of the transition. A standardised approach that is built into operational and governance processes avoids transitions that are idiosyncratic, varied, and dependent on the capacity and understanding of the staff member(s) on duty.

Communication of new resident's admission

The second recommendation for practice includes the communication of a new resident's admission to all direct and non-direct staff working or volunteering in the facility. If possible, this should occur at the pre-admission stage.

Often, staff learn of a new resident's transition well after admission day. When staff have knowledge about a new resident's planned arrival, together with critical information about the resident, opportunities for all staff to observe for any unmet needs, and support the resident in their transition, are provided. For example, staff who have knowledge that a new resident's transition was involuntary and reluctant may take extra time to engage with the resident and support them to participate in meaningful activity. These actions of staff may help residents to adjust and accept the transition sooner compared to admissions where the resident feels invisible in what is now their new home.

Maintain familiarity

A further recommendation for practice is to, as much as possible, maintain familiarity for new residents. It is well recognised that persons with and without dementia thrive on the familiarity of place and people. Maintaining familiarity may include: personalising a new resident's room before admission to cultivate a sense of home on admission day; encouraging family and friends to visit the resident often; understanding residents' needs about what they enjoy and involving them in similar activities soon after admission; and creating an environment of familiar routines, activities, and objects which supports residents to feel comforted and calm, and adjust to living in an aged care home.

Environmental interventions

Finally, efforts for the prevention of unexplained absences can include inexpensive environmental interventions.

For example, ensuring doors to courtyards/gardens; and sections inside the facility, remain unlocked and accessible. This way, residents can engage daily with different environments throughout the home; and self-perceived freedom of movement within the facility and outdoor spaces is maintained. An additional environmental strategy includes the availability of activity stations for residents to participate in meaningful activities throughout the day – not limited to scheduled lifestyle programs. Perhaps controversially, supporting residents to participate in the facility through meaningful roles such as household tasks (e.g., folding clothes) can be of benefit. This intervention may seem unrelated to an unexplained absence. Yet, participation in activities and roles that people have done throughout life is reported to foster a sense of purpose and familiarity is maintained.

This in turn may reduce a resident's need to leave the facility and to return to their home in the community setting.

"It is well recognised that persons with and without dementia thrive on the familiarity of place and people."

A more comprehensive list of recommendations is available from the list of resources.

References:

1. Woolford MH, Willoughby M, Bugeja L, Weller C, Ibrahim JE. Chapter 9 Unexplained Absence. In Ibrahim JE: Recommendations for prevention of injury-related deaths in residential aged care services. 11/2017; Monash University., ISBN: 978-0-9941811-3-8. Available at: https://static.wixstatic.com/ugd/cef77c_7b24ebdc9ea64d3d9de4e5eaf6adf75a.pdf.

What do senior nurses think...

by our RAC Communiqué nurse faculty

We had an overwhelming response from our faculty of senior nurses, some of the content from the five experienced nurses who collectively have over 100 years of experience is summarized below.

It could happen to anyone

It occurs more often than most of us realise because we have been fortunate to avoid a catastrophic outcome. We can have detailed plans in place for the care team, but often in care environments there can be many things happening at the same time requiring staff attention, aside from common deficits in workforce.

Safe to discharge?

Initially I wondered was Mr S considered safe to be discharged given the circumstances describing him being so unsettled while within the hospital? If he was absconding from the hospital, why was it felt that another significant environmental change was warranted? The additional resources available in the hospital setting, such as the security guards, was a major reason tragedy did not befall Mr S earlier.

What was the diagnosis?

What was the specific diagnosis of dementia, were the mental state changes of paranoia and fearfulness post anaesthesia indicative of an induced delirium? Given this possibility, is a discharge appropriate?

Strategic partnerships

Care of older persons needs to be seen as a partnership of shared responsibilities between the various health and human services. Hospitals and aged care homes should have strong strategic bonds. The hospital and the aged care home staff should know each other and should be important to each other. Professional relationships are crucial because we are all part of the same health eco-system. It's time aged care took its rightful place as not only a key priority in the health service delivery answer but as a keystone in ensuring quality of care for the most vulnerable.

Communication between aged care homes and hospitals should be transparent and truthful.

It is often challenging to transfer patients to their next destination when the receiver is concerned about managing a complex or unusual situation. Acute hospitals are under significant pressure to promote patient flow which may lead to incomplete disclosure of information. Giving accurate information, including the challenges as well as supporting the receiving destination to manage the situation with copies of management charts and strategies, is essential.

Often the receiver needs more time and support as they will be a smaller, less resourced facility than the acute care hospital.

Handover

Handover should not be the responsibility of patient transfer staff.

Clinical handover should ideally be driven by the receiver of the resident to ensure that their facility is suitable and capable of managing the care needs. This is not only related to behaviours, but also other factors such as bariatric status and special care needs. Ideally the receiving facility will have an ISBAR prompt checklist that goes over all required information including risk status to ensure communication of crucial information.

Asking about any identified behavioural or absconding risks as part of this pre-transfer handover will help to ensure the receiver is fully prepared. This may include additional staffing for the first 24 hours to support the care transition. It also allows pre-planning of how staff will manage a resident who is a potential absconder.

For example, organizing to be able to frequently observe location, and documenting clothing, so the last known clothing can be notified to searching staff/police/family if required to assist the search.

Getting pages of photocopied black and white notes that don't highlight the important ISBAR points is really challenging for the receiver. Better to call in advance and allow a verbal handover with opportunity to clarify points of care/risks/care needs and ask questions where required verbally. The photocopies and transfer documents are often helpful as a source of information later in the resident's stay.

Admission is an important time

I would welcome the day when the discharge from the hospital flowed into admission into the aged care home and vice versa by staff sharing the continuum of care. I wonder if senior staff had more time to think about the suitability of Mr S coming into their aged care home would the admission have been declined. The admission process in this case seemed person-specific (care manager) and not system focused.

Not every moment is the right time to admit a challenging resident. Understanding the impact of resident mix is crucial in ensuring the strategic approach to care delivery. Management should carefully consider the environmental liveability and capacity of resourcing to meet challenging residents' care needs.

The arrival time of a resident into aged care doesn't seem like a big deal — but I can guarantee it has a substantive effect on the delivery of care and assessment and often has a flow on effect well beyond the first day. Arrival in the late afternoon is not ideal because access to administrative service, medical services, pharmacy, allied health, and comprehensive assessment screening is often not possible. It's likely some crucial tasks were rushed and/or missed if admission into the aged care home was late in the day.

Prioritisation

New residents showing signs of disorientation and confusion upon admission is not uncommon. Understanding when to escalate these issues is one of the complexities that every registered nurse working in aged care is presented with. The challenge is when faced with complex situations, there is often not enough time dedicated to considering the critical implications — being time pressured results in the practice of dealing with things moment to moment. Often this leads to the failure of not seeing the 'bigger picture'. Prioritisation is a skill which requires critical thinking. To do this you need to have the time, space, personal experience, and other like-minded problem-solving professionals.

Involve whole workforce

This is an at-risk situation where all staff in the area need to be aware. This includes clerical, cleaners and food delivery staff, allied health, medical and security staff in facilities where they are employed. There are many times where ensuring the whole team's awareness of the risk has resulted in the resident being prevented from leaving, or if absent, found quickly.

All staff need to know of the potential risks and what the managers' expectation is of them, in their role, should they see the resident trying to leave. This should be done in advance wherever a risk is identified and reinforced every shift. Families should also be part of this awareness, as a resident's desire to leave often escalates after a family visit is completed.

Shift to shift handover is important to highlight the risk and preventative actions to the whole team. It's also an opportunity for the manager to reinforce any special circumstances for situations and the manager's expectations of the staff caring for the resident.

Proactive approach

Transition to an unfamiliar environment and new care staff is recognised as a higher risk period for new residents especially if they are already distressed, anxious or confused. A proactive approach would be to allocate additional care time on admission to support the transition, reduce any unmet care needs and monitor for delirium.

A pro-active approach to hazards, such as the location and access to a ladder requires a regular environmental review and audit.

Staff should be trained and know how to escalate matters to access additional help quickly.

Need for escalation

By day four the emergency management plan should have been activated as the situation was beyond the expertise and abilities of the aged care home to safely contain the risks.

Mr S was apparently physically fit and resourceful, suggesting that earlier notification of police was needed as he may have covered a greater distance more quickly than most other residents. Failure to decisively make an early call for assistance and additional resources created further vulnerability.

Importance of family

I am astounded that the staff did not contact the family and ask them to assist. It seems like common sense, and it would be my first course of action, after the initial episode. Residents will often be reassured by the presence of family/carer/friends, and this can reduce the risk of absconding and/or need for restrictive practice. I think seeking family to assist, if possible, either face-to-face or even virtually, may help calm a situation. This needs to be included in the care plan and actions.

Flexibility in allowing family to attend outside visiting hours is essential to support the resident, staff, and family when unmet needs behaviours are present. Keep the family up to date and informed of all you are doing.

The family may be very helpful in planning as they often know the triggers and actions they have taken to successfully de-escalate and/or distract.

Avoiding difficult conversations with family when something has gone wrong helps nobody. Make the call, tell them what's happened, apologise, and tell them what you are doing to address it. Reassure them that the organisation will report this incident officially and review what changes need to occur to prevent future incidents.

Being open and transparent is best. Tell them to contact you as the manager with any questions to ensure they get communication directly and not via the care team which could be inaccurate. Tell the care team that any calls from the family should be put through to the manager (that is you) to deal with. This supports timely, accurate communication in an adverse incident scenario and helps to build trust and avoid mixed messages.

The search

If this was a child, would the search strategy and resources have been the same or different? Not being found must have caused unimaginable distress for him, his wife and family.

List of Resources

1. Woolford MH, Willoughby M, Bugeja L, Weller C, Ibrahim JE. Chapter 9 Unexplained Absence. In Ibrahim JE: Recommendations for prevention of injury-related deaths in residential aged care services. 11/2017; Monash University., ISBN: 978-0-9941811-3-8. Available at https://static.wixstatic.com/ugd/cef77c_7b24ebdc9ea64d3d9de4e5eaf6adf75a.pdf

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3. Woolford MH, Bugeja L, Weller C, Boag J, Willoughby M, Ibrahim JE. Recommendations for the prevention of deaths among nursing home residents with unexplained absences. International Journal of Older People Nursing 2019. Sep; 14(3). e12237. https://doi.org/10.1111/opn.12237

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