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Editorial

Every anniversary prompts people to reminisce and reflect on the achievements of the past and express hopes for the future. In our twentieth year of publication of the Residential Aged Care Communiqué we reflect on the original purpose of our existence which remains our guide for the future. The Communiqués are designed to share the learnings from the coroner courts investigations around Australia and internationally that highlight issues that impact the safety and well-being of older persons in residential aged care settings. Our hope is by sharing this information the service providers, health professionals and care workers are better able to reduce harm and improve quality of life for older people.

Our first edition published in October 2006 and this seventy-sixth edition report on learnings from preventable deaths related to restrictive practice. The two editions illustrate how aged care practice has become more sophisticated in the past two decades. In 2006 the concerns were due to deaths from physical restraint—a hazard that is overt and proximal to the death. In 2025, our first case demonstrates the importance of monitoring residents when least restrictive option is enacted to support access to outdoors. While the second case demonstrates how an increase in restrictive practice to protect a resident from road trauma hazards is a contributing factor to death.

Both cases in this edition are examples where the form of restrictive practice was the environment as opposed to physical or chemical mechanisms. In each case there were inadvertent consequences that were remote to when the decision was made to decrease or increase the restrictive practice.

Aged care services continue to improve their capacity to manage quality of life and resident choices with a profound change over the past two decades. Many aged and health care professionals report a sense of being in a Catch-22 or 'damned if you do and damned if you don't' situation when balancing efforts to support resident's choice and ensure their safety. The new Aged Care Act 2024 which came into effect on 1 November 2025 presents us all with a challenge for the future. That is, developing more sophisticated approaches to promoting independence, choice, better care, hazard identification, and risk mitigation.

Our case précis authors include Dr Andrea Bee, Dr Tamsin Santos and Dr Jesse Zanker. All three geriatricians are active in a broad range of clinical practice and provide their perspectives along with reflections from our nursing faculty. The relevant expert commentaries from past editions are included in the resources section. This highlights how many of the fundamental issues in these two cases recur.

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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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Case #1
Safer independence

Case Number:
2023/880 Queensland
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i. Clinical Summary

Mr. X was an 85-year-old male with cognitive impairment who resided in the Memory Support Unit of a regional residential aged care facility. Past medical history included dementia (mixed Alzheimer's Type and vascular aetiology) with secondary parkinsonism, Hypertension, Type 2 diabetes and moderate aortic valve stenosis. He mobilised with a self-propelled wheelchair.

On the morning of a hot summer day, Mr. X self-initiated moving to an outdoor garden area and rested in a position that was not easily visible to those inside the aged care facility. Clinical staff had planned to check on Mr X each hour. The first check was completed and he was sighted by staff at 09:57 hour however the scheduled 11:00 hour sighting was not conducted.

The area Mr X choose was unsheltered and, on that day, the maximum temperature reached was approximately 30°Celsius.

At 1200 hour a Registered Nurse conducting the medication round discovered Mr X was not in his room and a search was initiated. It was approximately 12:18 hours when staff found Mr X on the concrete ground in an outside area of an unsheltered patio in the sun and was noted to be hot to touch. It appears he had been in this area for 2 hours and 18 minutes.

Paramedics were called and when they arrived, Mr X was observed to be unresponsive with Glasgow Coma Scale (GCS) score of 3, respiratory rate 40 breathes per minute, oxygen saturations 80%, heart rate 150 beats per minute, systolic blood pressure 60mmHg, body temperature of 41.7 degrees Celsius and a blood sugar of 13.2 mmol/l. External cooling measures were applied with wet towels, ice packs and the use of fans while a transfer to hospital for further investigation and treatment was being organised.

Upon arrival to a regional acute care hospital, his temperature remained critically high at 40.6 degrees Celsius and although his blood pressure had improved, he remained tachypnoeic and tachycardic. His periphery was noted to be dusky with swelling over the left wrist and hand, an erythematous right foot, there was a red rash over his arms, abdomen and thighs which were considered to be possible burns.

Investigations in hospital revealed an elevated creatinine kinase consistent with rhabdomyolysis, an elevated troponin consistent with cardiac damage and heat related illness and raised urea and creatinine consistent with marked acute kidney injury and an associated hyperkalaemia. Imaging of the chest and brain did not reveal any acute pathology.

Mr X did not show any significant improvement despite ongoing treatment. Following discussions with his next of kin, it was agreed treatment would focus on comfort measures. Mr X died in hospital, seven days after the incident.

ii. Pathology

A post-mortem external examination, imaging, document review and toxicology studies were undertaken by a forensic pathologist. Areas of erythema on the limbs and abdomen and blistering of left wrist and distal lower limbs were considered to be consistent with burns. There were not any significant signs of fall related trauma.

An autopsy was not performed in view of the next of kin's objection to internal examination and the coroner determined it was not necessary.

The cause of death was found to be Heat stroke with the other significant conditions of Alzheimer's and vascular dementia, diabetes mellitus and aortic stenosis.

iii. Investigation

Queensland police attended the facility on the day of Mr X's death to obtain information to assist the coroner's investigation. As the death appeared 'violent or unnatural' it was within the definition of a reportable death in the Coroners Act 2003. Police investigations did not identify any suspicious circumstances surrounding the resident's death.

It was unclear what caused Mr X to collapse to the ground. It may be primarily a heat related event, mechanical fall, or medical event, such as a faint, cardiac event or underlying illness such as infection.

The facility notified the Aged Care Quality and Safety Commission (ACQSC) of the incident and a Serious Incident Response Scheme (SIRS) investigation was commenced. ACQSC issued a Notice to the Facility who provided a comprehensive response within one week.

The facility explained Mr X was a very determined man who could become both physically and verbally aggressive, refusing hygiene and assistance with meals. In previous discussion with his wife (enduring power of attorney) the decision was made to support his preferred independent movement in his wheelchair and his choice of daily activities, supporting his dignity of risk.

The Facility noted on the day of the incident that weather was hot with the temperature reaching 30 degrees Celsius. As Mr X was able to independently propel his wheelchair he was placed on hourly physically sighting observations.

> **"It was concluded that had the initial hourly sightings been carried out, the well-being of the Mr X would have been maintained."**

On the day, only a single observation had been missed and when the second observation occurred, and Mr X was not located in his room, a search was undertaken.

It was concluded that had the initial hourly sightings been carried out, the well-being of the Mr X would have been maintained. As a result of this incident a range of actions were put in place by the Facility some of which include

- Update to procedures and education about hourly sighting charts to achieve a completion rate of 100%, including agency staff and onboarding of all new staff,
- Expanding the nature of the hourly sighting to be conducted. These were changed to a two-person task with broadened search areas for wandering residents and to include checking the outside garden areas.
- The effectiveness of the new procedures is evaluated via face-to-face assessment quizzes and a compliance audit which is discuss at monthly clinical meetings and at a regional level.
- An alarm to the outside door has been installed and an assessment of the physical outdoor environment for measures to improve resident safety was completed.

Two open disclosure meetings were held involving the facility managers, Mr X's wife, additional family member and a legal representative.

The staff member who failed to undertake the critical sight observations had their employment terminated and has been the subject of a mandatory report to the Office of the Health Ombudsman.

iv. Coroner's Findings

The coroner found that the resident accessed an unsheltered outdoor garden area by a self-propelled wheelchair and during an extended period of unmonitored time, suffered significant environmental exposure and injury, resulting in his death.

That the incident has been the subject of a comprehensive investigation by the regulator (ACQSC), with acknowledgment of the failures and the significant actions taken by the facility.

The Coroner concluded that it was a preventable death which occurred in the context of staff failure to undertake periodic visual safety and wellbeing checks.

outdoor areas of aged care facilities need to be useable, accessible, welcoming, safe and ideally easily visualised from inside also. Closed Circuit Television (CCTV) in

> **"Weather variability needs to be factored into the daily care routine for aged care staff and adjusted where there are severe weather days."**

The Coroner was satisfied that the significant actions taken by the Facility following the incident will prevent a similar incident from occurring again in the future.

v. Author's Comments

Coauthor's comments Dr Andrea Bee

Most residents have a daily routine which may include accessing outdoor areas or even beyond the perimeter of the Facility unaccompanied. This case highlights multiple issues of which three are addressed. Firstly, the importance of visual safety checks on residents, equally for the immobile and the mobile residents, with or without dementia. Secondly the need to adjust daily routines to accommodate extreme weather days. Thirdly the challenge of maintaining adequate hydration in frail older people especially when there is a run of hot days.

Most residential aged care facilities have a process for daytime and nighttime visual safety checks. It takes time and diligence to ensure all areas of a facility, both indoors and outdoors, are checked to account for all the residents. In this particular case, it is unclear how one of the hourly checks was missed resulting in the resident unsighted for over two hours. The communal and entry/exit areas can be very beneficial to support monitoring and retrospective follow-up of incidents.

Ideally, CCTV placement should also include the outdoor areas especially those which are less visible from inside.

Weather variability needs to be factored into the daily care routine for aged care staff and adjusted where there are severe weather days. Rain affected surfaces can be a slipping hazard outdoors. Heat can be a risk for dehydration and heat-stroke. More frequent rounding and prioritisation of the outdoor areas may be beneficial. Perhaps some areas ought to be restricted during the heat of the day, sunscreen and hats being offered when outdoors, provision of extra drinks when outdoors also.

Where there are periods of extreme heat, some aged care facilities provide extra 'drinks rounds' where staff go around offering residents a drink and may also place 'drinks stations' in communal areas for residents and visitors to help themselves, where safe and appropriate to do so.

Furthermore, the weekly menu could be adjusted to increase the amount of higher fluid content options e.g. icy poles, ice cream, jelly, watermelon etc. There are also various factors which can make maintaining hydration in the older person challenging. The older person may have a reduced thirst drive as they age, may be on diuretic medications, be on fluid restrictions, limited to thickened fluids or may not have the mobility, dexterity or thought process to self-initiate drinks.

Ultimately, providing safety and quality of care in a residential aged care setting is a balance between enabling mobility and freedom of movement and minimising the associated risk which comes with such activity.

Coauthor's comments Dr Tamsin Santos

While the key message is that the coroner found the death of this resident was preventable it is worth taking the time to delve deeper into the case. Specifically, to better understanding the care provision for resident's living with dementia.

The facility worked well with Mr X's wife (who was his appointed enduring power of attorney) to understand him, his wishes and preferences. This included discussing options for care and any risks associated prior to this incident occurring.

The facility partnered with the resident and his representative to put their wishes at the foundation of the care plan. The facility is to be commended for being supportive of the resident's rights to dignity of risk, autonomy and independence.

The facility response to the death of Mr Z was comprehensive undertaking a detailed review leading to actions. In order to better protect this vulnerable population, the facility revised their hourly check strategy and implemented door alarms, automated reminders, 2-person system as a backup, education and review of compliance.

Further questions come to mind.

- How have these changes increased the workload of staff?
- How many residents are in their unit that require an hourly check?
- How many staff are available during the day and overnight?
- How long does this observation sighting task take to complete and document?
- Are there other unseen workload demands in the dementia care unit? Such as, do any residents in the unit have 1:1 staffing care needs?
- What happens in the event of another emergency which requires more than 2 staff to handle it?

This is a complex area of care, balancing care demands and safety with resident choice and respect of dignity and autonomy. While some of the questions about managing the safety of this vulnerable population have been answered there remain a range of issues around feasibility and sustainability of the implemented strategies.

vi. Keywords

visual safety checks, dehydration, sunburn

Residential Aged Care Facility, Management of Semi-Mobile Residents with Dementia, Environmental Hazards, Compliance with Observation Requirements, Heat Stroke.

Case #2
Distressed fall

Case Number:
2023 Tasmania
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i. Clinical Summary

Mrs DW was a 93-year-old widowed former nurse living with dementia in a residential aged care facility. Her past medical history included a stroke complicated by onset of depression, Type 2 diabetes mellitus, reflux oesophagitis, arthritis, falls and dementia. Mrs DW was described by her sons as being 'full of beans' until the death of her husband which occurred when Mrs DW was 70 years old.

When Mrs DW reach the age of 90 years she began to have more frequent falls, on one occasion sustaining a head strike requiring admission to hospital. Rather than returning home, Mrs DW entered an aged care facility as a permanent resident.

Mrs DW used a four-wheeled walker for mobilising and required assistance for dressing and personal care. Mrs DW had frequent witnessed and unwitnessed falls while a resident in care. Mrs DW's medication list was not provided in the case notes.

Approximately two months before her death Mrs DW was relocated to a secure section of the facility due to repeated departures from the facility to, in her words, 'play chicken' with cars. The facility staff obtained consent from her son for this change in accommodation.

An Enrolled Nurse (EN) who cared for Mrs DW prior to her relocation to the secure section of the facility, detailed Mrs DW's 'rapid deterioration' over two months following the move. Mrs DW was described as often becoming distressed, which typically involved 'walk[ing] really fast, yell[ing] at people and stat[ing] she wanted to get out of here.' In the days preceding her fall, Mrs DW declined to consume meals and medication and expressed paranoid thoughts about staff poisoning her tea.

Days prior to her final fall, consent was obtained from Mrs DW's son by the general practitioner (GP) to prescribe pain relief via topical route (buprenorphine patch), suspecting pain may be contributing to her symptoms. The patch, however, was not administered.

On Christmas Eve, Mrs DW had a fall in the communal area witnessed by two staff members. In the hour preceding the fall, Mrs DW was distressed, attempting to depart the secure facility by 'rattling' the windows and using her walker to 'ram' the exit door.

Moments prior to her fall, two staff reported moving away from Mrs DW in the hope this would be calming, however Mrs DW 'jerked' her walker, fell backwards and hit her head on the exit door or floor.

Paramedics transported Mrs DW to a tertiary hospital where she was found to have a large bleed around her brain (subdural haemorrhage) and deemed unsuitable for surgical intervention. Mrs DW was provided with palliative care and died in hospital three days later.

ii. Pathology

The coroner determined that Mrs DW died from injuries sustained in a witnessed fall with head strike causing a catastrophic subdural haemorrhage.

iii. Investigation

A public inquest into Mrs DW's death sought to resolve questions raised in the coronial investigation concerning Mrs DW's care and supervision preceding her fall and subsequent death. The coroner determined that Mrs DW care and management while a resident was of good standard. It was Mrs DW's agitation that caused her fall, according to the coroner. The scope of the inquest was to clarify [1] inconsistent accounts of care staff, [2] uncertainty about circumstances of the fall, and

[3] the appropriateness of the response to Mrs DW's agitation.

[1] Accounts of staff and missing records

Three care staff gave evidence in the enquiry. Minutes prior to Mrs DW's fatal fall, the enrolled nurse (EN) departed the secure wing at the request of the Registered Nurse (RN) to co-administer a Schedule 8 medication (Targin) to another resident. A Schedule 8 medication, such as an opioid, is a drug subject to restrictions due to its potential for addiction or dependence. A Schedule 8 drug register is required by Poisons Regulations 2018 to be kept for at least two years after the creation of the record. No drug register was available to be presented in evidence from the night of Mrs DW's fall. Knowledge that the register was missing arose approximately four years after its record date.

"No drug register was available to be presented in evidence from the night of Mrs DW's fall. Knowledge that the register was missing arose approximately four years after its record date."

The RN co-administering the Targin to another resident was deemed by the coroner to have 'poor' memory of that evening and was unable to corroborate the EN's account. Further examination of the drug chart for the resident receiving Targin confirmed that the medication was administered at the time reported. The coroner thus determined that the account of the EN, who reported returning to the secure wing minutes prior to Mrs DW's fall, was accurate.

[2] Circumstances of fall

The coroner determined that the evidence given by two care staff who witnessed Mrs DW's fall was consistent and credible. As the EN's temporary absence and return to the secure wing prior to the Mrs DW's fall could be corroborated by a drug chart (but not a drug register), the coroner determined that supervision of Mrs DW was adequate at the time of her fall.

[3] Response to symptoms

The response to Mrs DW's symptoms of dementia was described in non-pharmacological and pharmacological approaches.

Mrs DW had a care and assessment plan which the coroner determined was followed by care staff. Strategies contained in the plan included, (i) engaging Mrs DW in useful activity, (ii) calming the environment, (iii) listening actively acknowledging her feelings, (iv) providing one-on-one emotional support from staff and family, and (v) making a telephone call to her son and daughter-in-law.

The described pharmacological approaches for Mrs DW's symptoms were pain relief (regular paracetamol) and the antipsychotic medication, olanzapine.

The coroner's finding did not include details about who prescribed the olanzapine nor the duration, however a referral for a geriatrician had been made but assessment was pending.

Mrs DW's tea was in fact being used as a vessel to administer dissolved olanzapine.

Although the administration of the buprenorphine was not determined by the coroner to be a matter of urgency, the delay in its administration was found to be due to pharmacy not receiving a prescription from the GP. The coroner was not able to conclude that Mrs DW would be less agitated at the time of the fall if the buprenorphine patch was in use.

iv. Coroner's Findings

The coroner did not make any recommendations pursuant to the Coroners Act following this inquest.

v. Author's Comments

A typical outcome of moving a resident to a secure section of a facility, against their will, is increased agitation and deterioration in their well-being. Mrs DW's perception of this move may have been that it was unjustified, leading her to take matters into her own hands by repeated attempts to depart and refusing medications and food. Although a geriatrician referral was made, this occurred one month after Mrs DW moved to the secure wing. Referral and review, prior to the move, may have optimised Mrs DW's symptoms and possibly prevented the move altogether.

Curiously, Mrs DW's belief that her tea was being poisoned was described as paranoia; however, it was confirmed that olanzapine was being provided surreptitiously in her tea. Dissolved olanzapine is bitter, which may explain Mrs DW's fear of being poisoned. It is established that bitter flavours often taste worse for people with dementia than for those with intact cognition. Further, antipsychotics such as olanzapine are a last resort for behavioural and psychological symptoms of dementia and are an established falls risk factor.

Aside from the environmental restrictions placed on Mrs DW by her residence in the secure wing, neither the facility manager nor coroner commented on the use of olanzapine as a chemical restraint. This contrasts the definition of the Aged Care Quality and Safety Commission, who define chemical restraint as 'the use of a medication or a chemical substance to influence a care recipient's behaviour.'

Finally, this case highlights the importance of sound and secure systems of documentation.

The public enquiry in this case took place due to the initial accounts (witness statements) from facility staff about what had occurred lacking the details required by the coroner to address the question of whether the fall was preventable. One example is the absence of the drug register which would have served as the source of corroborating evidence to account for staff whereabouts and perhaps negated the need for a public inquest which did not result in any practice-changing recommendations.

vi. Keywords

Falls, Schedule 8 medications, dementia

Comments from our Senior Nursing Faculty

Case #1. Safer independence—Balancing Enablement, Safety, and Dignity of Risk

"This case illustrates the necessary balance that must exist between promoting independence and maintaining safety in residential aged care settings. Encouraging mobility and autonomy reflects the principles of enablement and re-ablement now central to the new Aged Care Act enacted 01-Nov-2025 (especially Standard 3.2) . However, these principles also increase the need for professional and organisation accountability. Nurses must ensure that a resident's dignity of risk—the right to make choices that involve some risk—is supported by sound risk assessment, consistent observation, and clear communication.

In this case a single missed hourly check had tragic consequences. Junior nurses should recognise that observation charts are also vital clinical interventions. Every entry verifies a resident's safety. Safe care is about anticipating deterioration, adjusting routines for environmental hazards such as heat, and recognising when independent mobility may become unsafe.

This case is an example of how every task, no matter how small, impacts resident safety. By applying active thinking to a task, we avoid the trap of it becoming a tick-box exercise. For example, approach hourly visual checks as an occasion to assess wellbeing: breathing, colour, alertness, positioning, and environment and look for agitation, confusion, or wandering. Also consider, how the environment and weather create risks that are not usually recognised by older people with cognitive impairment. Active thinking takes us from observing a fact—it's hot, cold, and raining outside—to how do these conditions help or harm a resident?—to what is a reasonable approach to support dignity of risk and minimise harm?

Remember - enablement does not mean abandonment."

Case #2. Distressed fall—Ethical Medication Practice and Person-Centred Care

"This case highlights the highly complex intersection between dementia care, medication administration, ethics, and communication. The administration of olanzapine in a cup of tea, removes the resident's right to participate in decisions about her care. Even if consented to and monitored under strict clinical guidelines this may be considered chemical restraint, and at the very least ethically questionable.

All behaviour has meaning, try to understand why the behaviour may be occurring: pain, fear, prior trauma, miscommunication, or environmental triggers often underlie agitation. Identifying and addressing these first is important. Recognise and validate behavioural changes as signs of unmet needs (fear, discomfort, confusion) and avoid labelling them as "challenging behaviour" without considering underlying causes.

For junior nurses, remember to prioritise non-drug approaches: calm support, validation, sensory therapy, activities, and family involvement. The use of medications may be appropriate only if other strategies fail, with clear clinical reasons.

Review medications regularly for the clinical indication and side effects, noting that antipsychotics can increase fall risk in older adults. Nurses have an important role to coordinate, encourage, monitor escalate regular medication reviews by pharmacists, general practitioners and geriatrician.

A key lesson is that every medication carries ethical as well as pharmacological implications. It is important to document care promptly and accurately, particularly with the "off label" use of antipsychotics like Olanzapine for the management of behaviours rather than for treatment of diagnosed psychotic illness."

Nursing Faculty Contributors

(alphabetical order)

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Shannon Xu, Aged Care Nurse Practitioner, Victoria

List of Resources

1. Residential Aged Care Communiqué Oct-2006 Vol 1 (1) Restraint
2. Residential Aged Care Communiqué Dec-2009 Vol 4 (3) Extreme Heat
3. Residential Aged Care Communiqué Sep-2011 Vol 6 (3) Smoking Dignity and Risk
4. Residential Aged Care Communiqué Jun-2014 Vol 9 (2) BPSD
5. Residential Aged Care Communiqué Feb-2022 Vol 17 (1) Falls and falls management
6. Residential Aged Care Communiqué Nov-2023 Vol 18 (4) Timeliness and checks
7. Commonwealth of Australia, Department of Health and Aged Care 2022: Guiding Principles for Medication Management in Residential Aged Care Facilities ISBN: 978-1-76007-470-8

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