

Residential Aged Care Communiqué

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Editorial

This third edition of the Residential Aged Care Communiqué for 2025 includes two cases about medications and medication management. A closer look at the details of each case reveals a common underlying factor which is also an interesting cognitive bias. The bias is how we can all get caught out by favouring or trusting a familiar idea or situation.

In the first case, the ‘familiar’ is caring for a younger resident who has been receiving prescribed antipsychotic medication for a mental health condition most of her life. How we get caught out is our expectation that the medicine is now well tolerated and the likelihood of adverse effects is remote. In actual fact, the likelihood of adverse effects is greater due to accelerated biological ageing experienced by people living with mental illness. The familiarity bias (also known as the status quo bias) refers to our desire or preference to stick with what is known—it makes us feel safer. It also means we do not challenge the status quo.

In the second case, the aged care facility transitioned from paper-based medication charts to a new electronic charting system which led to a medication administration adverse event. The growing reliance on information technology systems in contemporary society and familiarity from our day-to-day use of smart phones, tablets and computers, tends to create a sense that these systems are infallible or maybe just more reliable than people. We struggle to understand the technical aspects and rely on the technical expertise of those who set-up these systems. We often defer to their authority and accept what is presented to us rather than ask questions.

The expert commentary is by an experienced clinical pharmacist Julie Taylor, who raises a range of issues and highlights the need to ask if a medicine is still indicated at the time of administration. Our accomplished case précis author Dr Bronwyn O’Gorman returns with a detailed analysis and we introduce our first time author Dr Issada Trakarnwijitr. Both are active in clinical practice and have provided their perspective of each case, while our nursing faculty have added their reflections on the cases.

Perhaps the best lesson from these two cases and this edition is to remember to question how things are usually done, rather than simply accepting that they are that way because they have always been that way.

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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

Not outside the bounds

Case Number:
2017/0297344 NSW

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i. Clinical Summary

Ms. Y was a 65-year-old woman who lived with severe mental illness from her early adulthood. At the age of 25, Ms. Y entered a mental health institution as a resident and was initially treated for severe depression with electroconvulsive therapy (ECT) before being diagnosed with a schizoaffective disorder. Ms. Y experienced psychosis, which manifested as delusions and auditory hallucinations, and mood fluctuation. The antipsychotic medications prescribed to stabilise her mental health had significant short-term and long-term adverse effects including skin pigmentation, kidney disease, severe constipation, dysphagia, tardive dyskinesia (i.e., an involuntary movement disorder) affecting her tongue, and cognitive impairment. Ms. Y was often confused, easily distracted and acted impulsively.



In late 2016, Ms. Y was admitted to a tertiary acute care hospital with a urinary tract infection (UTI) complicated by severe delirium.

An assessment by the old age psychiatry service determined that polypharmacy was contributing to her protracted delirium. Several of Ms. Y’s antipsychotic medications dosages were subsequently reduced. During Ms. Y’s 3-month long hospital admission a guardianship order was granted to her sister to allow her to make substitute decisions regarding accommodation, lifestyle and healthcare.

In March 2017, Ms Y was discharged from hospital and returned to her accommodation at the mental health facility.

Ms. Y’s guardian determined that a change of accommodation was desirable and sought a transfer to a residential aged care facility (RACF) that had been established specifically for older people with mental health conditions. The RACF had an old age psychiatrist available to consult as part of their treating team.

In July 2017 at the age of 65, Ms. Y moved into the RACF and appeared to enjoy her new home, engaging in group activities and receiving regular visits from family. Unfortunately, three weeks after entering the RACF, Ms. Y became unwell. The new psychiatrist recommended an increased dose of antipsychotic medication. In the days following, Ms. Y’s guardian raised concerns about oversedation and asked for the extra medication to be reviewed.

Ms. Y remained unwell and

in September 2017 she was admitted to the district hospital with a diagnosis of delirium and a relapse of schizoaffective disorder. The hospital medical ward staff received handover from the RACF regarding Ms. Y’s recent illness, medications and her high risk of choking, including a recommendation that all meals be closely supervised. Ms. Y received one-to-one nursing care on the medical ward due to fluctuating delirium with periods of oversedation alternating with episodes of agitation and aggression.



Over a week later, Ms. Y still suffered from a fluctuating delirium and was transferred to a specialist psychiatry ward for older persons with a plan for 15-minutely observations. Consistent with the principles of fostering a restorative environment, a bowl of fruit was freely accessible to all patients on the psychiatry ward.

At 14:30 hours on Ms. Y’s second day in the psychiatry ward, the Nurse Unit Manager (NUM) was completing routine visual observations and came upon Ms. Y sitting in a chair, unresponsive. The rapid response team were called who commenced cardiopulmonary resuscitation (CPR), during which several pieces of a tangerine were found in Ms. Y’s airway and removed.

Resuscitation attempts continued for over an hour but were unsuccessful.

ii. Pathology

An autopsy was conducted at the request of Ms. Y's guardian to confirm her cause of death. The procedures were limited to external examination and toxicology.

Two independent psychiatrists provided expert opinions on the pharmacological management of mental illness in the elderly and in Ms. Y's case specifically.

The coroner predominantly focussed the investigation on two matters:

1. The prescribing history of antipsychotic and sedative medication to Ms. Y.

person, but particularly so in older patients who are more susceptible to developing comorbidity including cognitive impairment and have greater sensitivity to drug side effects.

The experts commented that although Ms. Y was 65 years old at the time of her death, she was physiologically older due to her chronic mental illness.

The coroner was satisfied that the RACF psychiatrist's management plan was in line with previous treatment plans to reduce medication to the lowest effective dose. The coroner heard that when Ms. Y's condition deteriorated shortly after moving into the RACF, the psychiatrist diagnosed a hypomanic relapse of schizoaffective disorder, which was an indication for treatment with an increased dose of antipsychotic medication (olanzapine in Ms. Y's case). The RACF psychiatrist thought Ms. Y did not have a delirium at that time.

“The coroner found that Ms. Y's medications had been relatively static until 10 months prior to her death when she was admitted to a tertiary hospital with delirium.”

The forensic pathologist concluded that the cause of death was choking on tangerine. This occurred in the context of Ms. Y's documented risk of choking, due to factors such as missing dentition, previous choking episodes, unsupervised eating and significant delirium.

2. The adequacy of steps taken to assess and manage Ms. Y's choking risk, particularly during the hospital admission which ended in her death.

iv. Coroner's Findings

In the matter of the prescribing of antipsychotic and sedative medications

The coroner found that Ms. Y's medications had been relatively static until 10 months prior to her death when she was admitted to a tertiary hospital with delirium. Several antipsychotic medications were reduced at that time due to concerns that polypharmacy was causing greater harm than benefit. It was noted that Ms. Y's guardian had similar concerns about medication adverse effects.

The two independent expert psychiatrists agreed with the tertiary hospital assessment and recommendations. They emphasised a goal to minimise the number and dose of antipsychotic medication where possible in any



The coroner reviewed the medical records pertaining to the subsequent district hospital admission in which Ms. Y died. Records demonstrated episodes of significant oversedation resulting in several medications being withheld or reduced. The coroner noted a plan was in place for further medication review on the psychiatry ward however Ms. Y died before that assessment could take place.

Overall, the two expert psychiatrists agreed that the antipsychotic and sedating

iii. Investigation

The death of Ms. Y was reportable to the coroner because her death was unexpected and considered to be the result of accident or injury.

The coroner's investigation included affidavits and statements made by Ms. Y's guardian, the old age psychiatrist in the RACF, members of the hospital treating teams (nursing and medical) and the service director of the district mental health service. Medical records were reviewed from all hospitals and institutions that had provided care to Ms. Y as far back as 2004, 13 years prior to her death.

medications should have been reduced with emphasis on the anticholinergic burden of her polypharmacy. However, there was no consensus on the best time to do so in Ms. Y's case, noting her treatment-resistive illness.

The coroner concluded overall that the medications prescribed to Ms. Y were 'not outside the bounds of appropriate treatment' given the complexities of her condition.

In the matter of the adequacy of steps taken to assess and manage Ms. Y's choking risk

The court heard that Ms. Y had several prior episodes of choking on food. A speech pathologist had recommended a soft moist diet, thin fluids and full supervision at all times during meals. It was noted that Ms Y's choking risk was due to several factors, including:

- poor dentition (Ms. Y had only two natural teeth),
- tardive dyskinesia of her tongue (a complication of antipsychotic medication characterised by involuntary movement),
- dysphagia (associated with antipsychotic medication which is separate to the tardive dyskinesia of her tongue), and
- behaviours, including a tendency to eat and talk at the same time.

The coroner found that despite thorough handover from the RACF to the admitting medical ward and an appropriate 'alert' in the hospital's electronic medical record (EMR), Ms. Y's choking risk was not adequately communicated on transfer to the psychiatry

ward during her hospital stay. Specifically, the ward-to-ward handover did not include speech or diet alerts, any history of prior choking incidents, or any plan to provide supervision when eating.

The coroner highlighted the systemic failures around handover between the medical ward and psychiatry ward as contributing to Ms. Y's death.

The coroner also regarded it inappropriate to have an accessible fruit bowl on the psychiatry ward.

Response to coroner's recommendations:

The service director of the local area mental health service reported the changes that took place in response to Ms. Y's death:

1. The admission task list for the psychiatry ward for older persons now includes referrals to speech pathology and dietetics. Staff are reminded to review patient alerts.
2. The fruit bowl was removed from the psychiatry ward common area and staff informed of the need for choking risk assessment prior to providing fruit. A Dysphagia Fact Sheet was prepared to explain signs of dysphagia.

v. Author's Comments

Ms Y's case is a sad reminder of the debilitating nature of serious mental illness and the double-edged sword that are the medications used to treat it.

"Ms Y's case is a sad reminder of the debilitating nature of serious mental illness and the double-edged sword that are the medications used to treat it."

As was alluded to by the independent expert psychiatrists in Ms. Y's case, there is growing evidence that serious mental illness is linked to accelerated biological ageing as a primary pathology. In people with serious mental illness such as schizophrenia, accelerated ageing subsequently contributes to increased comorbidity (particularly age-related illness such as cardiovascular disease, cognitive decline and dementia) and significant premature mortality (an extraordinary 10-to-25-year reduction in life expectancy).

As a geriatrician working in the residential aged care sector, I see daily examples of discrepancy between chronological and physiological age that can be attributed at least in part to significant psychiatric history, whether that mental illness be currently active or not.

While the process of accelerated ageing may not be easily modifiable it should be recognised given the impact on screening for comorbidity, risk stratification and treatment considerations, particularly with respect to medication side effects and drug interactions.

Ageing affects how drugs are handled in the body (pharmacokinetic changes) and alters the body's response to the medication (pharmacodynamic changes). An example of the latter is an increased sensitivity to anticholinergic drug effects, due to lower metabolism and increased permeability of the blood brain barrier.

We are increasingly recognising the anticholinergic burden of polypharmacy causing harm in vulnerable older adults. In Ms. Y's case there was concern that combinations of antipsychotic medication caused or exacerbated an anticholinergic delirium, prolonging her hospital admission, increasing her risk of choking and ultimately contributing to her death.

KEYWORDS

Choking on food, chronic mental illness, old age psychiatry, antipsychotic and sedative medication, polypharmacy, medication adverse effects.

Editor's Note: Anticholinergic syndrome

For the majority of us who struggle with understanding neuropsychopharmacology, I offer another approach to understanding anticholinergic syndrome. It's a circuitous path that may help the idea to stick. Belladonna also known as deadly nightshade is a plant which contains the chemical atropine. Atropine was used for cosmetic purposes in Renaissance Italy to dilate pupils and make a person look more alluring. Atropine dilates the pupil because it blocks the neurotransmitter chemical acetylcholine from transmitting nerve signals to the muscle in the eye. Acetylcholine is an important part of both the central and peripheral nervous system. In the central nervous system, it has an important role in memory, learning and cognition while in the peripheral autonomic nervous system it acts on physiological responses such as heart rate, skin, bowel and bladder function.



Anticholinergic syndrome arises when acetylcholine is blocked from fulfilling its usual function. This leads to symptoms of delirium, visual hallucinations and confusion (central nervous system effects), and hot, dry, flushed skin, tachycardia, constipation and urinary retention (autonomic nervous system effects).

A wide range of medications can block the actions of acetylcholine to differing degrees—the list of medications is long and not easy to remember.

Medications prescribed to manage the older person with the following conditions are especially relevant;— Parkinson's disease, psychiatric disorders, depression, cardiovascular disease and urge incontinence.

This is different to serotonin syndrome—which we will leave for another time.

Case #2

The trouble with holidays

Case Number:
COR 2020 007109

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i. Clinical Summary

Mrs HD was an 87-year-old woman with a past medical history including ischaemic heart disease, hypertension, a previous subarachnoid haemorrhage, cognitive impairment, anxiety and depression, hearing loss, visual impairment from cataracts, gout and chronic pain. Her regular medications included allopurinol (100mg daily), aspirin (100mg daily), esomeprazole (40mg daily), paracetamol (1g daily), amlodipine (5mg daily), and mirtazapine (15mg nightly).

On 17 December, Mrs HD's residential aged care facility transitioned from paper-based medication charts to a new electronic charting system with a different pharmacy provider and dispensing system.

Over the subsequent days (21-24 December), staff noted Mrs HD becoming increasingly lethargic, drowsy, and pale. On 25 December, a nurse identified that her newly dispensed medication pack contained several drugs not previously prescribed to her, notably risidronate (35mg weekly), hydroxychloroquine (400mg daily), an increased dose

of mirtazapine (30mg nightly), pregabalin (25mg twice daily), thyroxine (75mcg daily), Coloxyl and Senna, and Ovestin cream.

Upon identifying the error, the facility staff withheld her medications, checked her vital signs (which were reportedly within normal ranges), and sought medical advice. Attempts made to contact her regular general

regimen, it was present at a non-toxic level. The coroner noted that by the time the blood samples were obtained, any erroneously administered medications would likely have been metabolized.

The cause of death was determined to be complications arising from a medication administration error in a woman with multiple medical comorbidities.

"In doing so, another similarly named resident's medication chart was mistakenly merged into Mrs HD's electronic chart."

practitioner were unsuccessful due to the holiday period. Instead, the Residential In-Reach medical service was contacted for assistance. At this time, Mrs HD's family were also informed of the medication error and her clinical deterioration, and the dispensing pharmacy was contacted to confirm her correct medications. Unfortunately, Mrs HD continued to deteriorate, she was transitioned to palliative measures and she died on 28 December.

ii. Pathology

The death was reported to the coroner by Mrs HD's general practitioner. Post-mortem toxicology detected therapeutic levels of hydroxychloroquine, mirtazapine, and paracetamol, consistent with recent administration. Although hydroxychloroquine was not part of her original prescription

iii. Investigation

The coroner's investigation focused on the circumstances surrounding the erroneous medication administration during the transition to an electronic system. Statements were collected from the staff of the residential aged care facility and the pharmacy, and Mrs HD's general practitioner.

During the transition to the new electronic charting system, the new pharmacy was provided with paper medication charts to establish electronic records for each resident. In doing so, another similarly named resident's medication chart was mistakenly merged into Mrs HD's electronic chart. The general practitioner signed off on the chart without detecting the discrepancies, and the facility staff administered medications according to the newly dispensed packs and electronic

records, without cross-referencing the original paper medication chart. Over the holiday period, there was also difficulty in contacting the usual general practitioner, although the Residential In-Reach team provided timely medical consultation.



The investigation identified a cascade of failures:

- Pharmacy data-entry error—incorrectly merging another resident’s medication list into Mrs HD’s electronic chart.
- Prescriber oversight—approval of the incorrect chart without thoroughly verifying the medications against her prior records.
- Aged care facility reliance on the new medication packs and electronic chart, without cross-checking against the original paper documentation.
- Compounding these errors was the timing of the transition which occurred over a major holiday period. This was a time known for constraints on resources and with limited access to the facility’s routine practices and medical practitioners.

iv. Coroner’s Findings

The coroner concluded that the medication administration error caused Mrs HD’s sedation, clinical deterioration and death, with her underlying frailty and pre-existing medical conditions contributing to this outcome.

The coroner recommended increased vigilance and robust processes during transitions from paper-based to electronic medication management systems, including:

- Where possible, medication transcribing should be done in a clinical setting by more than one person, and not at a remote pharmacy with a single person.
- Mandatory reconciliation of the new electronic medication charts should be done within the first 24 hours of transitioning.
- It is the prescriber’s responsibility to verify and confirm accuracy before signing off on new medication charts.
- Avoiding high risk periods for major transitions in practice, such as holidays, due to reductions in staffing and resources that occur at those times.



v. Author’s Comments

Effective medication management in aged care is dependent upon clear, accurate, and timely transfer of information between three organisations and multiple stakeholders – the general practice clinic and the medical practitioner who prescribes the medications, the pharmacy and the pharmacist who dispense the medications, and the aged care facility and the nurse who administers the medications.

This case demonstrates how mistakes can align to produce a

severe and preventable adverse outcome – the so-called “Swiss cheese” model of error. While electronic systems are generally introduced to improve safety, the initial transition phase poses a heightened risk if robust cross-checks, staff training, clear communication pathways, and an incident management system are not in place.

Key lessons include the need for precise and timely communication among healthcare personnel, particularly when caring for vulnerable and high-risk populations. Careful planning, staff training, and thorough post-implementation audits are essential to ensure a safe system rollout, as well as accountability for medication reconciliation and well-defined contingency measures, particularly during public holidays and periods of reduced staffing.

Dangers of 'set and forget'

Julie Taylor
BPharm(Hons)

Julie has extensive experience as a clinical hospital ward pharmacist including education and leadership roles and is currently one of the senior pharmacists overseeing medication management of older people at Barwon Health.

It is extraordinarily easy to “set and forget” when it comes to prescribing, dispensing and administering regular medications. As a pharmacist, when patients are prescribed a new medication for a newly diagnosed chronic condition, a significant part of my role is educating them about the benefits of said medication and reiterating the importance of taking the medication as prescribed to manage the condition and reduce the risk of future complications.

Take this to lower your blood pressure and reduce the risk of heart attack or stroke.

Take that, it will help to manage your pain. And this will strengthen your bones and reduce your risk of fractures, but only if you take it for several years.

There is a greater focus on prevention of future risk in clinical practice these days which is often not a priority for older people especially those living in residential aged care settings.

For a patient we considered “stable”, there is a risk of complacency, and an attitude of “if it’s not broken, don’t fix it”.

Older patients are vulnerable to this complacency – many have enormous faith in any decision made by their regular general practitioner (GP) thanks to long-term relationships and these patients would never consider questioning their GP.

condition due to very low levels of the white cells, neutrophils), which can occur at any time during treatment. Stringent monitoring procedures are in place, including at a minimum, monthly blood tests prior to prescribing or dispensing further supply.

“Patients in aged care who have cognitive impairment rely on their caregivers to consider the risks and benefits of their medications.”

When discussing deprescribing with patients I’m often told “*Well I must need it because my GP keeps prescribing it!*” or “*I never thought to ask [if I could stop it]*”. Patients can feel they have no agency to question if their medications are still indicated, or if the risk outweighs any therapeutic benefit over time. Patients in aged care who have cognitive impairment rely on their caregivers to consider the risks and benefits of their medications.

Do they still need an antihypertensive medication given their falls risk is already very high, and they feel dizzy?

Do they need multiple hypoglycaemic agents to manage their diabetes when they are eating differently compared to 20 years ago, when first prescribed?

Antipsychotics come with a long list of potential adverse effects, and the risk of developing adverse effects may increase over time. For example, the medicine Clozapine is known to cause agranulocytosis (a potentially life-threatening

Monitoring frequency is increased in the event of acute illness, or any change in neutrophil count.

Olanzapine, clozapine and quetiapine contribute to a variety of metabolic syndromes, including weight gain, dyslipidaemia and hyperglycaemia. For a 25-year-old patient, the initial weight gain may be evident when their clothing no longer fits—and is perceived as a nuisance. However, thirty years later on, if the long-term olanzapine therapy has contributed to drug-induced or disease-induced diabetes, the patient is at risk of all the serious diabetes-related complications.

Extrapyramidal side effects of antipsychotics include dystonias, akathisia, Parkinsonism and tardive dyskinesias. Up to one third of patients taking the older types of antipsychotics (such as haloperidol) for more than 10 years will develop tardive dyskinesias, and the risk appears highest among older patients, women, smokers and patients with diabetes.

Symptoms can improve by reducing the dose of antipsychotic, or switching to an alternate agent, but may persist despite stopping or swapping medications.



Anticholinergic burden must not be forgotten. Any medication with anticholinergic effects carries the risk of sedation, confusion, dry mouth, blurred vision, constipation, and urinary retention. Many medications prescribed for incontinence exploit these side effects. Anticholinergic delirium particularly affects older patients, and those with Parkinson's disease.

All medications can be harmful if used in the wrong patient, or at the wrong time, or in the wrong combination, or for the wrong duration. Medication reviews need to occur at regular intervals instead of waiting for adverse effects to appear. Add an extra "right" to the list – is this the right medication "right now"?

List of Resources

1. A tool to calculate your patient's anticholinergic burden: a score of 3+ is associated with an increased risk of cognitive impairment and mortality. <https://www.acbcalc.com/>.
2. STOPP/START criteria for potentially inappropriate prescribing in older people: version 3 <https://bmjopenquality.bmj.com/content/bmjopenquality/5/1/u207857.w4260/DC1/embed/inline-supplementary-material-1.pdf?download=true>.
3. Deprescribing guidelines and algorithms for commonly used medicines: <https://deprescribing.org/resources>.
4. Aged Care Quality and Safety Commission: Six steps for safe prescribing antipsychotics and benzodiazepines in residential aged care: https://www.agedcarequality.gov.au/sites/default/files/media/acqsc_six_steps_for_safe_prescribing.pdf.
5. Hilmer SN, Gnjdjic D. The anticholinergic burden: from research to practice. Aust Prescr 2022;45:118-20. <https://doi.org/10.18773/austprescr.2022.031>.

Comments from our Senior Nursing Faculty

Nursing Faculty Contributors

(alphabetical order)

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Wayne Lester, Senior Advisor Quality and Risk, Victoria

Shannon Xu, Aged Care Nurse Practitioner, Victoria

“In a workplace environment with high workload demands and resource limitations, it’s easy to feel rushed and pressed for time. Take the time to understand medication management with particular attention to side effects common in older adults. Something familiar to all RACF staff is that the residents with long-term mental illness may age faster physically, making them more sensitive to their usual medications increasing the risks of

oversedation and choking. Another common issue is the anticholinergic burden associated with polypharmacy in vulnerable older adults which contributes to confusion, delirium, increased risk of falls, choking, and even death.”

“Individually, we should look to invest a few extra minutes to thoroughly review and verify medications each resident is administered as this can make a significant difference to patient outcomes. As a team we can raise the issue with the pharmacists and the general practitioners especially if residents show signs of delirium or cognitive changes. At a facility level we should consider avenues to promote ongoing education for nursing staff about medication risks and side effects. Review these two cases with your team and ask, ‘Could this have happened within our facility?’ Why, why not? Then consider, assume the medication error did occur, how would we handle the situation with the resident, the family, the prescriber, the nursing staff?”

When reviewing the facility’s approach to medication management consider what is in place to support the resident and staff when a medication error occurs. How does the facility assist staff to:

- Understand the resident’s diagnosis to ensure that the prescribed medications are appropriate and clinically justified.
- Recognise and report when there is a medication mismatch with the resident’s clinical condition, which could indicate a prescribing error.”

“Optimal medication management requires an integrated system with excellent teamwork from multiple different health professionals. Nurses are the final checkpoint before a medication is administered. Question anything that doesn’t make sense – it protects patients, residents and staff safety.”

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