THE COMMUNIQUÉS

VOLUME 21. ISSUE 03.

August 2026 Edition

# Residential Aged Care Communiqué

ISSN 1834-318X

**NEXT EDITION**
NOVEMBER/2026

# Editorial

Welcome to the third issue of the Residential Aged Care Communiqué for 2026. This edition examines two cases that appear quite disparate but share a common theme: what can happen when the usual systems of care that we take for granted and depend upon contribute to harm.

These cases will prompt readers to reflect on how well we understand the nuances of some common practices. The first case revolves around health and aged care staff understandably accepting clinical observations and laboratory test results that influenced their decision-making and ultimately contributed to suboptimal care. The principle at the core of this case is that the standard reference ranges applied when assessing health status or organ function may not be appropriate for older people. Good practice requires understanding whether the reference ranges being used, whether clinical (e.g. vital signs) or laboratory-based (e.g. renal function), are derived from the general adult population or have been specifically validated for older people. An equally important step is to compare an older person's current measurements or observations with their previous and usual pattern.

The second case highlights the important lesson of understanding why a specific intervention is being implemented. In this case, the facility had instituted 15-minutely observations of residents in response to a failure in the call bell system. This was considered a reasonable approach for that situation. However, some may misinterpret this level of observation as being sufficient to monitor a person living with dementia who has significant behavioural and psychological symptoms.

We welcome back our case précis authors, Dr Lisa Mitchell and Dr Chelsea Baird, along with a detailed commentary from Nurse Practitioner Shannon Xu. All three are actively engaged in clinical practice in aged care and bring valuable insights and different perspectives to the cases.

Finally, we are holding another one-day short course on Friday 13 November 2026 in partnership with the Australian Centre for Evidence Based Aged Care. The course will focus on the subject of Resident-to-Resident Aggression in Aged Care.

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The Residential Aged Care Communiqué is distributed by the not for profit group 'The Communiques Australia Inc'. (COI--A0106775D)

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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:
**racc@thecommuniques.com**

# Short course:
## Resident-to-Resident Aggression in Aged Care

Resident-to-resident aggression is one of the most common causes of harm in residential aged care, yet it remains one of the least understood. Clinicians are often required to balance safety, autonomy, dignity and quality of life while managing complex situations that rarely have simple solutions.

This one-day medico-legal short course brings together an exceptional multidisciplinary faculty to explore resident-to-resident aggression from clinical, ethical, legal and organisational perspectives. Learn from Professor Simon Bell (medication safety), Associate Professor Stephen Macfarlane (aged psychiatry and Dementia Support Australia), Professor Michael Daffern (forensic behavioural science and violence prevention), Kirsty Bennett (dementia-supportive design), Dr Briony Jain (research and policy), Mr Chris Lee (Victoria Police) and Jo Hall (health law and governance).

Participants will gain practical insights into prevention, risk assessment, behavioural support, the role and limitations of pharmacological interventions, specialist services, police involvement, governance responsibilities and medico-legal consequences. The workshop also examines emerging policy and regulatory challenges shaping aged care practice.

Facilitated by Professor Joseph Ibrahim, Amelia Grossi, Mr Bill O'Shea AM and Mr Phil Grano OAM, this is a rare opportunity to learn from leading experts across medicine, law, policing and public policy.

This course is not to be missed.

Places are limited to maximise discussion and learning.

**Date:** Friday 13 November 2026

**Format:** La Trobe University City Campus, Melbourne, or online

**Registration:** https://pay.latrobe.edu.au/EvProvost/booking?e=PRO_EV384

# Case #1
# A different equation

**Case Number:**
03/2024 South Australia

**Case Précis Author:**
Dr Lisa Mitchell BSc MBBS FRACP MPH MBioeth

*Geriatric medicine specialist, general physician, and Healthcare Bioethics Researcher*

## i. Clinical Summary

Mrs MG was an 89-year-old female who had been a permanent resident of an aged care facility for four years. Past medical history of heart failure due to ischaemic cardiomyopathy, hypertension and chronic kidney disease and her prescribed medications included diuretic agents and an angiotensin II receptor blocker.

It was the middle of spring when Mrs MG became unwell with a respiratory tract infection which appeared to respond to treatment with oral antibiotics (cephalexin). A urine specimen was collected and was sent to the microbiology laboratory for culture and sensitivities around the same time.

The laboratory report results described the presence of the bacteria Klebsiella aerogenes in her urine which was sensitive to two antibiotics only, gentamicin and norfloxacin. Mrs MG appeared to have remained lethargic after initial treatment with cephalexin. The general practitioner prescribed a 9-day course of gentamicin 80mg intramuscular injections on the basis the presence of the bacteria was the cause of lethargy.

Mrs MG did not improve as might be anticipated following commencement of the antibiotic therapy. Over the course of two weeks her condition deteriorated, with increased lethargy, declining to take medications, reduction in oral intake, refusing food and developed a pressure injury. The facility staff organised a transfer to an acute care hospital for a clinical assessment. The general practitioner was informed the following day about the transfer.

Mrs MG was admitted to hospital for management of acute on chronic renal failure and dehydration. Despite this treatment, Mrs MG continued to decline and died in hospital one week later.

## ii. Pathology

The pathologist's cause of death was 'acute-on-chronic renal failure in a woman with ischaemic heart disease, hypertension, congestive cardiac failure and gentamicin therapy'.

## iii. Investigation

The hospital medical staff reported the death to the coroner documenting in the medical deposition a 'potential iatrogenic cause of severe acute kidney injury' as the gentamicin may have contributed to her death.

The coroner sought the opinions of forensic pathologists, and a senior experienced geriatrician who completed an independent clinical review before holding an inquest to further investigate the circumstances leading to death. The coroner was also provided with statements and oral evidence from the general practitioner, the aged care provider operating the facility and Mrs MG's family.

Three matters were considered in detail. First, whether the laboratory report of an estimated Glomerular Filtration Rate (eGFR) reliably reflected renal function, second whether gentamicin was contraindicated or an inappropriate choice, and whether the nature of clinical and laboratory monitoring of Mrs MG was appropriate.

First, the question of whether the estimated Glomerular Filtration Rate (eGFR) reliably reflected renal function was raised by the independent expert in geriatric medicine. He opined the method used to calculate the estimated glomerular filtration included in pathology laboratory reports of renal function may underestimate the severity of impairment. He preferred a more accurate method of calculation and that if this had been used it may have dissuaded the general practitioner from choosing to prescribe gentamicin.

The two different methods for calculating eGFR included the 'Modification of Diet in Renal Disease Equation' which was used by the laboratory and the Cockcroft-Gault Equation. The latter is better for medication dosing especially in older people as it includes the person's actual bodyweight rather than a set standard of an average-sized person. The difference is MDRD approach may systematically overestimate renal function. The general practitioner's considered Mrs MG had moderate renal impairment based on the MDRD calculation rather than severe renal failure as revealed by using the Cockcroft-Gault Equation.

Second, much evidence centred on whether gentamicin was an appropriate antibiotic for the treatment of the Klebsiella aerogenes in the urine. The geriatrician opined that norfloxacin would have been a much better choice as it was safer to prescribe in patients with kidney disease, did not require laboratory monitoring and could be given orally. The expert also considered gentamicin was not safe to administer outside of the acute hospital setting which was a setting where antibiotic levels and kidney function could be closely monitored.

Third, was the matter of whether the care by provided by the general practitioner and the aged care home staff was sufficient to monitored Mrs MG and if clinical concerns were escalated. Mrs MG's general practitioner was well known to her and her regular doctor.

When the general practitioner commenced a 9-day course of intramuscular gentamicin it was following a consultation observed Mrs MG was drowsy, lethargic, confused and not finishing her meals.

The coroner noted that the general practitioner did not give any specific instructions to the staff about the nature and frequency for monitoring her clinical state. This contrasted with the level of monitoring that occurred in the week earlier when Mrs MG was being treated for a respiratory tract infection. The general practitioner did not order any blood tests to monitor renal function or the gentamicin levels as is recommended and usual practice. The general practitioner agreed that this should have been done.

Mrs MG did not improve as might be anticipated from antibiotic therapy however the general practitioner wasn't contacted during this time period. Twelve days elapsed from the date gentamicin was prescribed and when the general practitioner next attempted to see Mrs MG. Unfortunately, when the general practitioner attended the facility Mrs MG was at another appointment.

## iv. Coroner's Findings

The coroner found the death was preventable and that the use of gentamicin contributed to Mrs MG's death.

That norfloxacin should have been prescribed instead of gentamicin and that if gentamicin was to be prescribed, it should have been monitored closely with blood tests.

The coroner made several recommendations which were directed to the Royal Australasian College of General Practitioners and the Australian College of Rural and Remote Medicine.

First, to alert medical practitioners to the risks of prescribing gentamicin in a non-tertiary hospital setting and the importance of monitoring. Second, about the dangers of falsely reassuring renal function results presented as the eGFR when prescribing nephrotoxic antibiotics. Third, the need for accurate fluid balance charts when treating residents who are at risk of dehydration and renal failure.

> **"The coroner found the death was preventable and that the use of gentamicin contributed to Mrs MG's death."**

The coroner did not make any findings relating to the care provided by the staff of the facility, instead noting that the aged care provider of the facility had changed their electronic medical record to a program that would allow more accurate charting and recording of fluid observation charts.

## v. Author's Comments

Although the recommendation of the need for accurate fluid balance charts was directed at the general practitioners it is an important message for everyone working in aged care.

It reinforces the important role of fluid intake, management and the potential harms that arise from dehydration for residents. The Aged Care Quality and Safety Commission have resources on managing potential dehydration in residents. This may have been relevant to this case with Mrs MG reported to having lost 7kg of weight in one month, thought possibly related to fluid loss from increased diuretics therapy.

Whilst the coroner focussed on the specifics of gentamicin and nephrotoxic medications, the case raises broader questions about antibiotic management in residential aged care settings. Antimicrobial use in aged care facilities is common with an estimated ¾ of residents being prescribed at least one antibiotic per year, and 10% of residents on antibiotics at any time (Australian Commission on Quality and Safety in Health Care, 2023).

There are concerns that residents may receive antibiotics that are not necessary or not the optimal antibiotic medication for either the infection or the resident. These issues increase the risk of antimicrobial resistance as well as the consequences for individual residents from side effects of the medication.

There are several references available to guide aged care and health care providers on the Antimicrobial Stewardship, the appropriate management of infections and antibiotics in residential aged care settings. These include resources developed by the Australian Commission on Quality and Safety in Health Care and the Aged Care Quality and Safety Commission. The Therapeutic Guidelines are the recommended resource for determining which antibiotic to use, and the Australian Medicines Handbook is the recommended resource for information on doses, monitoring and side effects.

One aspect that wasn't covered in the Coroner's Finding was whether the Mrs MG actually had a urinary tract infection as the cause of her ongoing lethargy following her respiratory tract infection. The request for microscopy and culture of a midstream specimen of urine was requested as an additional test when Mrs MG had initially become unwell with cough, wheeze and malaise, symptoms highly suggestive of a respiratory tract infection. Recall treatment commenced with cephalexin and reportedly improved over a period of several days. It is not evident from the information provided within the coroner's report whether the resident had any symptoms of a urinary tract infection. The specimen was collected and results returned three days later by which time; the respiratory tract infection symptoms seemed to have resolved. However, because the Mrs MG remained lethargic, she was commenced on antibiotics based on the sensitivities of the Klebsiella aerogenes grown from the urine. Other blood tests to look for other possible causes of lethargy (such as worsening renal function or other abnormality) were not ordered and the information available in the coroner's finding doesn't mention if other causes of lethargy such as delirium from the recent respiratory tract infection were considered.

**"Having bacteria in the urine does not mean that a person has a urinary tract infection."**

It is important to highlight that it is very common for older people in aged care facilities to have bacteria in the urine, but having bacteria in the urine does not mean that a person has a urinary tract infection. Many guidelines including the Therapeutic Guidelines indicate that change in mental state (such as lethargy) even with bacteria detected in urine, is not on its own an indication of a urinary tract infection. The Therapeutic Guidelines propose that residents must have at least two criteria to be considered as having a urinary tract infection to warrant antibiotic use.

Another aspect of this case is the difficulties in recognising deterioration in a resident who is already unwell. The Coroner noted that the independent geriatrician's opinion that 'one of the challenges about care at this end of life is that detecting deterioration is not straightforward'. While there are guidance documents for residential aged care staff about recognising deterioration in aged care residents based on the Australian Commission for Quality and Safety in Health Care 'Recognising and Responding to Deterioration Standard', they tend to focus on acute deterioration and change in vital signs. In this case,

the clinical observations of vital signs remained in the normal range, but there were other indications of decline such as drowsiness, reduced oral intake and pressure injuries.

An important consideration the coroner made worth highlighting is the death of Mrs MG coming unexpectedly for her family. A consequence was that the family had little opportunity to prepare for the end of life, creating an additional sense of loss as Mrs MG did not have the opportunity to pass down important aspects of her culture, affecting both her current and future family. Indicators of health decline were evident in the year prior to final illness, these included frequent respiratory tract infections, declining mobility and cognition. There are some practical tools available to help staff recognise the gradual move towards end of life, such as those from End-of-Life Directions in Aged Care. Early conversations with residents and families about these changes can help them work out how best to use the remaining time.

## vi. Keywords

Antimicrobial stewardship, Renal failure, Recognising Deterioration, Antibiotics in Aged Care, urinary tract infection.

# Case #2
# Looking for lollies

**Case Number:**
COR 2023 003306 VIC

**Case Précis Author:**
Dr Chelsea Baird BMed(Sci), MBBS(Hons), FRACP

*Geriatric medicine specialist*

## i. Clinical Summary

Mrs JM was a 96-year-old female resident at a small, aged care facility in a rural town having entered seven months earlier following a fall complicated by a hip fracture.

One morning at the start of winter the director of nursing became aware the call bell system was not working. While awaiting repairs to the faulty system, staff performed 15-minute visual checks of all residents and documented this in a rounding sheet.

Just before 3:00pm a member of staff heard a resident calling out for help and entered Mrs JM's room. On entering the room Mrs JM was observed to be lying on the floor with an obvious leg deformity, suggestive of a fracture.

Mrs JM reported to staff that a fellow resident (Mrs CH) had entered her room twice and was looking for sweets (chocolates and lollies). On the first occasion Mrs JM was able to redirect Mrs CH to leave her room.

However, Mrs CH returned shortly afterwards. This time Mrs JM pressed the call bell to alert staff of the need for assistance. Mrs JM was pushed and punched onto the floor.

Mrs JM was transferred to an acute care hospital where she underwent an open reduction and internal fixation of her right distal femur fracture. Post-operative complications, including aspiration pneumonia ensued. After discussion with her next of kin, Mrs JM was transferred to the palliative care ward and she died one week after her fall.

## ii. Pathology

The forensic pathologist completed an external examination and considered the medical cause of death was 1(a) complications following a fractured distal right femur.

## iii. Investigation

The death was reported to the Coroner as it fell within the definition of a reportable death and an inquest is mandatory when a person causes the death of another.

The police assigned an officer to be the Coroner's Investigator who conducted inquiries taking statements from witnesses including family, the forensic pathologist, treating clinicians and investigating officers.

The Coroner's Investigator initially commenced a criminal investigation into Mrs JM's death including possible manslaughter charges. This revealed that Mrs JM's account of the incident was consistent with what was recorded on the CCTV footage of the hallway at the time. It further revealed that Mrs CH had been living with severe dementia having lost the ability to communicate, required near constant supervision and a history of becoming physically aggressive. An extensive behavioural management plan had been formulated with Dementia Support Australia and a specialist geriatrician input. The medical practitioners and staff at the aged care home opined that Mrs CH's severe dementia meant that she was unable to understand or have any memory of the incident and lacked the required cognitive ability to take any sort of deliberate action against another person.

The coroner's investigator deemed it was not appropriate to pursue the potential criminal aspects of the matter. Mrs CH died approximately four months after the incident occurred.

The call bell system at the facility was reviewed. There had been a number of faults since its upgrade (around seven months prior to Mrs JM's death).

Further upgrades were made in the days following her death, with no further faults reported.

> **"Resident-to-resident aggression will continue to pose a challenge for residential aged care providers."**

### iv. Coroner's Findings

The coroner found that Mrs CH contributed to the death of Mrs JM by causing the fall.

The coroner was unable to find that Mrs JM's death would have been preventable had the call bell system been operational at the time and that the fifteen-minute rounding (in lieu of working call bells) was a reasonable alternative in the circumstances.

The coroner noted that resident-to-resident aggression will continue to pose a challenge for residential aged care providers due to a combination of factors, including an increasing ageing population, an increase in the number of vulnerable people entering care and the difficulties of administering care to a large group of residents with varying levels of needs and cognitive impairment.

# Commentary

**Shannon Xu, RN, MN, NP**

*Nurse Practitioner (Aged Care)*

The two cases provide us with an opportunity to consider some common situations in residential aged care settings where good outcomes depend not only on clinical knowledge, but also on clear communication, sound clinical judgement and person-centred decision-making.

**Informed Consent and High-Risk Antimicrobial Management**

Under the Aged Care Quality Standards, medical and nurse practitioners are required to obtain informed consent before commencing treatment. Care must be transparent, consumer-centred and aligned with evidence-based practice, including antimicrobial stewardship principles. Before starting a high-risk medication, health care practitioners should explain the reason for treatment, potential risks, monitoring requirements and any reasonable alternatives.

In Mrs MG's case, there were gaps in the informed consent process. It is unclear what discussions occurred with the family about the risks associated with gentamicin, particularly its nephrotoxicity and narrow therapeutic window. Given the resident's chronic kidney disease, the risk of acute kidney injury was especially relevant.

The family should have been supported to understand why gentamicin was being considered, its potential risks, and any alternative treatment options.

The identified organism, Klebsiella aerogenes, was sensitive to norfloxacin, providing a potentially lower-risk oral treatment option that could have been administered onsite. Discussing alternatives is an important part of shared decision-making and allows residents and families to participate in treatment decisions.

The monitoring requirements for gentamicin also required careful consideration. Gentamicin needs close monitoring of renal function and therapeutic drug levels to reduce the risk of toxicity. In residential aged care, access to timely pathology services and the ability to respond quickly to abnormal results may be limited. Focusing primarily on the microbiology result, without considering the resident's comorbidities, frailty and the limitations of the care environment, meant the overall treatment risk was not fully assessed or communicated.

**Clinical Deterioration in Frail Older Adults: Looking Beyond "Lethargy"**

Recognising clinical deterioration in frail older people with multiple comorbidities can be challenging. Significant illness may occur without obvious changes in temperature, blood pressure or heart rate. As a result, reliance on routine observations alone may delay recognition of deterioration.

A common term used in aged care is "lethargic". While staff often recognise when a resident is not themselves, the word can mean different things to different people. More useful clinical information includes whether the resident is sleeping more, less responsive, eating and drinking less, requiring greater assistance with mobility, or showing changes in cognition or behaviour.

> **"Recognising deterioration does not automatically mean initiating hospital transfer or aggressive treatment."**

For nursing staff, the key skill is recognising and communicating a change from baseline. Using ISBAR and providing specific examples of what has changed helps clinicians understand the significance of the deterioration and make more informed decisions.

Importantly, recognising deterioration does not automatically mean initiating hospital transfer or aggressive treatment.

Any response should also consider the resident's goals of care, prognosis and wishes. Discussions with families about further investigations, monitoring, transfer to hospital or alternative treatments should weigh the potential benefits against the burden to the resident.

Recognising the presence of "lethargy" is only the first step. The reason for the change must be understood, communicated clearly and acted upon in a manner consistent with the resident's will and preferences.

**The Fifteen-Minute Visual Checks**

The case involving Mrs JM must be interpreted with caution, especially the use fifteen-minute visual checks. These checks are often introduced following a fall or other serious incident. While this may satisfy monitoring requirements, their value as a falls-prevention strategy is often overestimated. It would be wrong to over interpret the coroner's finding of the use of fifteen-minute visual checks—these were deemed appropriate as a precaution to address the failure of the call bell system.

We know that falls and changes in behaviour can occur within seconds. A resident who is confused, impulsive or unsteady may attempt to mobilise immediately after a staff member has checked on them. Regular observations may result in earlier discovery after a fall, but they do not necessarily prevent the fall from occurring.

This highlights the difference between documenting that checks have been completed and actively reducing risk. Effective falls prevention requires understanding why the resident is mobilising, identifying environmental hazards, reviewing medications, addressing pain or toileting needs, and considering appropriate supervision or equipment.

Although observation schedules can support monitoring of high-risk residents, they should not replace clinical assessment and individualised care planning. Excessive focus on completing observations can also increase staff workload and divert time away from direct resident care. Monitoring is most effective when it forms part of a broader, person-centred falls-prevention plan rather than becoming a compliance exercise.

**A Better Way Forward: Preventing Physical Aggression**

Reducing physical aggression in residents experiencing behavioural and psychological symptoms of dementia (BPSD) requires a focus on the causes of distress rather than the behaviour alone. For many residents, aggression is a form of communication that reflects an unmet need, fear, discomfort or confusion.

A more effective approach is to identify triggers early. Pain should always be considered, particularly when a resident cannot communicate symptoms clearly. Tools such as the Abbey Pain Scale can help staff recognise non-verbal signs of discomfort. Other common contributors include constipation, infection, hunger, fatigue and medication effects.

Environmental factors are also important.

Noise, rushed care, unfamiliar staff and changes to routine can increase anxiety and agitation. Consistent routines, familiar carers and a calm environment may help residents feel safer and more secure.

Staff should be supported to recognise early signs of escalation, such as pacing, restlessness, changes in tone of voice or resistance to care. Early reassurance, validation, distraction and allowing time and space can often prevent behaviours from escalating into physical aggression.

Person-centred assessment, early recognition of distress and addressing underlying causes are more meaningful strategies for improving safety, reducing staff burden and maintaining the dignity of residents living with dementia.

# List of Resources


1. **On the subject of antimicrobial stewardship consider**
   Australian Commission on Safety and Quality in Health Care. Guidance for implementation of the Antimicrobial Stewardship (AMS) Clinical Care Standard in aged care. Published 2024. Accessed August 28, 2026. Available at: https://www.safetyandquality.gov.au/sites/default/files/resources/attachments/guidance_for_implementation_of_the_ams_clinical_care_standard_in_aged_care.pdf.

2. **On the subject of urinary tract infections consider**
   Lim LL, Bennett N. Improving management of urinary tract infections in residential aged care facilities. Aust J Gen Pract. 2022;51(10):748-756. Accessed August 28, 2026. Available at: https://www1.racgp.org.au/getattachment/d140bdeb-d0ae-475b-a2ff-27c7f9584064/UTIs-in-residential-aged-care-facilities.aspx.

   Aged Care Quality and Safety Commission. New report finds older Australians given more antimicrobials than wider community. Accessed August 28, 2026. Available at: https://www.agedcarequality.gov.au/news-publications/clinical-alerts-and-advice/new-report-finds-older-australians-given-more-antimicrobials-wider-community.

3. **On the subject of vital signs and recognising end-of-life in older people consider**
   End of Life Directions for Aged Care (ELDAC). Recognise end of life. Accessed August 28, 2026. Available at: https://www.eldac.com.au/Our-Toolkits/Residential-Aged-Care/Clinical-Care/Recognise-End-of-Life.

4. **On the subject of Behaviours and Psychological Symptoms Associated With Dementia consider**
   Burns K, Casey AN, Brodaty H, et al. A Clinician's BPSD Guide 2023: Understanding and Helping People Experiencing Changed Behaviours and Psychological Symptoms Associated With Dementia. Centre for Healthy Brain Ageing (CHeBA), UNSW Sydney; 2023. Accessed August 29, 2026. https://www.unsw.edu.au/cheba/clinical-care/clinicians-bpsd-guide-2023.





**Acknowledgements**

This initiative has been made possible by the voluntary contributions of the authors and editors in collaboration with 'The Communiques Australia Inc'.